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THE DEVELOPMENT, IMPLEMENTATION, VALIDATION AND EVALUATION OF A CONTINUING PROFESSIONAL DEVELOPMENT LEARNING PROGRAMME FOR NURSES WORKING IN SAUDI ARABIA

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Dissertation presented for the Degree of Doctor of Philosophy at the University of Stellenbosch

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DECLARATION

I, the undersigned, hereby declare that the work contained in this dissertation is my own, original work and that I have not previously in its entirety or in part submitted it at any university for a degree.

Signature: …… Date: ……..

ABSTRACT

The Saudi Arabian Government has implemented a nation-wide policy to prepare its people for the workforce and has directed that the Saudi Council for Health Specialties (SCHS) be established. Under the SCHS umbrella the Saudi Nursing Board (SNB) has been formed for the purpose of regulating the nursing profession. While Saudi Arabia has for many years been dependent on the international community for nurses, it is now establishing its own nursing workforce. One challenge for the SCHS and the SNB is to ensure that practice standards are developed, since ultimately nursing practice affects the quality of the patient services and patient health outcomes.

The Saudi nursing profession has a responsibility to develop its social mandate and provide a full range of services to the Saudi public. Systems and education programmes are required for all aspects of the regulatory process, including continuing professional development. Effective regulation systems are not based on a "one size fits all" approach. Furthermore, nurses need to insist on high quality education to develop both basic and ongoing competence and should be able to depend on the profession for social status and credibility.

The purpose of this research was to develop, implement, validate and evaluate a continuing professional development learning programme for nurses working in Saudi Arabia. The learning programme was built from a vision of nurses (regardless of country) engaging in lifelong learning for the purpose of ensuring quality patient care and population health. The development of a continuing professional development learning programme is an initial step in fulfilling the need for educational structures to support standards of practice.

The overall outcome of the research was functional by nature in that the knowledge of continuing professional development in nursing was generated and applied to nursing practice in Saudi Arabia. In view of the nature of the question, a mixed methodology was selected. Although the qualitative aspect was dominant, both the qualitative and quantitative aspects were used simultaneously. The design included exploratory and descriptive aspects. Furthermore, the researcher employed qualitative methods to develop, implement and evaluate the provisional

learning programme and quantitative methods to validate the provisional programme, resulting in a partial explanation of the research phenomenon. The primary theoretical drive was inductive, as the purpose was to discover rather than to test the learning programme contents.

Botes' Research Model and King's Theory of Goal Attainment were utilised. They complemented each other, as they both support a comprehensive, dynamic scientific approach to learning (health) outcomes influenced by the quality of nursing practice and practice environment.

The research, which was outcomes–based, was carried out in the context of quality patient care (population health) and nursing practice situated within the Saudi Arabian setting, where the nursing regulatory system is emerging. As the questionnaire mean ($\overline{X}$) results revealed scores of 3.0 to 3.9, data saturation was achieved during the first round of the Delphi technique. Fourteen experts from six different countries were asked to validate the provisional learning programme, which was duly done. The programme was implemented in a tertiary research hospital in Saudi Arabia. Formative and summative evaluations were also conducted. The results of the implementation and evaluation affirmed the effectiveness of the learning programme.

Boyer's Model for Scholarship was used to triangulate the research findings. These results formed the basis for the recommendations and final summary. The five broad recommendations that emerged from the research were that nurses should take on self-regulatory and leadership responsibilities; that they should engage in continuing professional development collaboration; that the nursing profession's self-regulation responsibilities be acknowledged; that a healthy (quality) workplace environment be ensured; and that further research be done in this field.

OPSOMMING

Die regering van Saoedi-Arabië het 'n landwye beleid geïmplementeer om die mense van die land vir die arbeidsmag voor te berei en het opdrag gegee vir die stigting van die *Saudi Council for Health Specialties (SCHS,)* 'n raad wat spesifiek met gesondheidsdienste gemoeid is. Die Saoedi Raad vir Verpleging (*Saudi Nursing Board* oftewel *SNB*) is tot stand gebring met die doel om die verpleegdiens in die land te reguleer. Nadat Saoedi-Arabië vir baie jare van die internasionale gemeenskap vir verpleegkundiges afhanklik was, word 'n eie verpleegkorps nou in die land gevestig. Een van die uitdagings waarmee die SCHS en die SNB te kampe het, is die noodsaaklikheid om te verseker dat standaarde vir die praktyk ontwikkel word, aangesien die verpleegpraktyk inderdaad die gehalte van pasiënte-diens en gesondheidsuitkomste beïnvloed.

Die verpleegberoep in Saoedi-Arabië is daarvoor verantwoordelik om sy maatskaplike mandaat te ontwikkel en 'n volledige reeks dienste aan die mense van die land beskikbaar te stel. Stelsels en opvoedkundige programme is nodig vir alle aspekte van die reguleringsproses. Dit sluit voortgesette professionele ontwikkeling in. Vir 'n reguleringstelsel om werklik doeltreffend te wees moet dit op spesifieke behoeftes gerig wees en kan een stelsel nie aan al die vereistes van diverse instellings voldoen nie. Dit is noodsaaklik dat verpleegkundiges op onderrig van 'n hoë gehalte aandring ten einde basiese en voortgaande bevoegdheid te ontwikkel. Daarbenewens behoort hulle op die beroep te kan steun vir sosiale status en geloofwaardigheid.

Die doel van hierdie navorsing was om 'n voortgesette leerprogram vir die professionele ontwikkeling van verpleegkundiges wat in Saoedi-Arabië werk, te ontwikkel, te implementeer, te valideer en te evalueer. Die leerprogram het onstaan uit 'n visie van verpleegsters (ongeag hulle land van oorsprong) wat hulle met lewenslange leer besig hou met die doel om diens van 'n hoë gehalte aan pasiënte asook bevolkingsgesondheid te verseker. Met die ontwikkeling van 'n leerprogram vir voortgesette professionele ontwikkeling is die eerste stap gedoen om in die behoefte aan opvoedkundige strukture ter ondersteuning van praktykstandaarde te voorsien.

Die algehele uitkoms van die navorsing was funksioneel van aard deurdat die kennis van voortgesette professionele ontwikkeling in verpleging deur die verpleegpraktyk in Saoedi-Arabië gegenereer en ook daarop toegepas is. Vanweë die aard van die navorsingsvraag is besluit om 'n gemengde metodologie, dit is kwalitatiewe en kwantitatiewe aspekte gelyktydig te gebruik, met die kwalitatiewe aspek as die dominante metode. Sowel verkennende as beskrywende aspekte is in die ontwerp ingesluit. Daarbenewens het die navorser kwalitatiewe metodes gebruik om die voorlopige leerprogram te ontwikkel, te implementeer en te evalueer, en kwantitatiewe metodes om die voorlopige program te valideer. Die navorsingsverskynsel is deur middel van 'n gedeeltelike verklarende metode ontleed. Die primêre teoretiese dryfkrag was induktief, aangesien dit die doel van die navorsing was om die leerprogram se inhoud te ontdek eerder as om dit te toets.

Daar is van Botes se Navorsingsmodel en King se Teorie van Doelbereiking (*Theory of Goal Attainment*) gebruik gemaak. Hulle het mekaar aangevul aangesien albei 'n omvangryke, dinamiese wetenskaplike benadering tot leer- (gesondheid-) uitkomste, wat deur die gehalte van verpleegpraktyk en die praktykomgewing beïnvloed word, ondersteun.

Die navorsing, wat uitkomsgebaseerd was, is uitgevoer binne die konteks van pasiëntediens van gehalte (bevolkingsgesondheid) en verpleegpraktyk, gesetel in die Saoedi-Arabiese milieu, waar die reguleringstelsel vir verpleegkunde aan die ontwikkel is. Data saturasie is reeds bevestig tydens die eerste rondte van die Delphi tegniek met gemiddelde tellings van ($\overline{X}$) 3,0 en 3,9. Die navorsingsontwerp is daardeur verder versterk. Veertien deskundiges van ses verskillende lande is gevra om die voorlopige leerprogram te valideer, wat hulle ook gedoen het. Die program is in 'n tersiêre navorsingshospitaal in Saoedi-Arabië geïmplementeer. Formatiewe en summatiewe evaluering is gedoen en die resultate van die implementering en evaluering het die doeltreffendheid van die leerprogram bevestig.

Boyer se Wetenskaplikheidsmodel (*Model for Scholarship*) is gebruik om die navorsingsbevindinge te staaf. Hierdie resultate het die grondslag gelê vir die aanbevelings en die finale opsomming. Die vyf breë aanbevelings wat uit die navorsing voortgekom het was dat verpleegkundiges self-regulerende en leierskapverantwoordelikhede aanvaar; dat hulle aan samewerkingsaksies ten opsigte van voortgesette professionele ontwikkeling deelneem; dat die verpleegberoep se

verantwoordelikhede ten opsigte van selfregulering erken word; dat 'n gesonde (gehalte-) werkomgewing verseker word; en dat verdere navorsing op hierdie gebied gedoen word.

DEDICATION

I dedicated this thesis firstly to my friend, colleague and mentor Dr. Thelma van der Merwe, a true international leader in all four domains of nursing practice. Secondly, I dedicate it to my Saudi nurse colleagues and friends, particularly Rana Mulla and Bushra Al-Hunaidi. Shukran!

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While working in Saudi Arabia, I have been befriended by many Saudi and non-Saudis. I dare not list their names (or countries) as I will most certainly forget someone. I extend to each of you a special thank you for your friendship and for enriching my many experiences.

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CHAPTER ONE: OVERVIEW OF RESEARCH

1.1 INTRODUCTION

The aim of the research was to develop a learning programme for the continuing professional development of a multinational nursing workforce in Saudi Arabia. Knowles (1990) provides a vision for professional development. He believes what we do for a vocation and how we live our lives are not separate, but continuous processes and suggests education should be based on a vision of lifelong learning and continuity of the two. Further, the object of education should not merely fit individuals for specialised vocations. It should also animate these vocations with ideals of excellence in order ultimately to improve the human condition (Boyer, 1990).

Throughout the world the nursing workforce has undergone major changes and the pace of change seems to accelerate daily. Because of the dynamic changes, it is essential for nursing not only to play a pivotal role within a health care system, but also to maintain this role. The changes require that nurses continue to search for new knowledge, skills and health strategies so as to maintain quality nursing, which includes "changes in the way quality is maintained within professional education" (Bryant, 2005:5).

Muller (2003) states that nurses are professionally, ethically and legally responsible and accountable for the quality of the care they render, where quality refers to the degree or standard of excellence in the care delivered. However, nurses of the twenty-first century must also be sensitive to the social and health care changes that influence nursing practice in all domains and the development of nursing knowledge, particularly while working within a foreign country such as Saudi Arabia. Advanced technology development, health policy issues and reimbursement mechanisms play a major role in the planning and delivery of comprehensive, culturally sensitive nursing practice.

Through regulation and credentialing processes, the regulatory body ensures that qualified (registered) competent nurses are identified and thus the public is protected from unsafe nursing. The nursing profession has a responsibility to develop its social mandate and provide a service of

an acceptable quality to the public. Therefore, the nurse practitioner demands high quality education within a professional, ethical and legal framework and thus depends upon the profession for social status and credibility (Canadian Nurses Association [CNA], 2001a; International Council for Nurses [ICN], 1996; Affara & Styles, 1992).

Nursing has a social agreement with the public which is fulfilled in part through responsive and responsible self-regulation. Donabedian (1976, quoted in Affara & Styles, 1992) describes self-regulation as a social contract between the public and the professions. Under its terms, the public grants the professions authority over functions vital to itself and permits them considerable autonomy in the conduct of their own affairs. In return, the professions are expected to act responsibly, always mindful of the public's trust. The aim to assure quality self-regulation is at the heart of this relationship. Self-regulation is the authentic hallmark of a mature profession (American Association of Colleges of Nursing [AACN], 2002; Percival, 2001).

Self-regulation is based on the premise that the nursing profession has acquired the knowledge and skills to set its own standards for the practice and conduct of its members (Muller, 2003). Historically, professional self-regulation referred to the work of the nursing regulatory body. Today it also involves practising nurses. For the latter, self-regulation encompasses fitness to practise and maintenance of competence and for the regulatory body it entails standards (credentials) for professional practice and conduct (ICN, 2003; CNA, 2001c; 2002c).

The regulation of nursing refers to the ability of the profession to act in the interest of the public. Nurses implement regulation through the control of their professional, ethical and legal decisions. Regulation is the key to professional practice brought about by the forms and processes in which the professional nursing body implements order, consistency and control over its members (Styles & Affara, 1997). Credentials are defined as a legal predetermined set of professional ethical standards, such as licensure or certification, establishing that the nurse has achieved professional recognition in a specific field of nursing (Glanze, Anderson & Anderson, 1990).

Continuing professional development is one mechanism through which nurses fulfil their obligation to the public's trust. It is also a strategy by which nurses strengthen their practice base and may

include formal education and informal learning as well as acquiring practical experiences (Bryant, 2005; American Nurses Association [ANA], 2000b). A quality work environment forms the basis for professional development (Lowe, 2002). In turn, professional development is an integral part of a quality work environment and is intentional and ongoing (CNA, 2001b; Registered Nurses Association of British Columbia [RNABC] 2002). (Under the Government of British Columbia legislation the RNABC was changed to the College of Registered Nurses of British Columbia on August 19, 2005. As the docotorate research was completed prior to the official name change, publications were referenced with the RNABC name.) For the overall sustainability of a high quality workplace in a health care organisation, many elements are needed. No single discipline can capture the processes and structures to facilitate quality outcomes. The Canadian Policy Research Networks (CPRN), propose a multi-disciplinary and holistic approach based on the following factors: the broad work environment and human practices that shape it; job design and organisational structures including technology; employment relationships which cover issues from trust to commitment to communication, and industrial relations (CPRN, 2002).

The Canadian Nurses Association identifies professional development as one of the indicators for a quality practice environment (CNA, 2002b). Professional development is described as a process rather than a product through which to manage one's career. It is a lifelong, systematic learning process extending throughout one's professional career. It includes formal and informal learning, such as learning on the job. The purpose of professional development is to build on what is known (constructivistic learning) in order to assure continuing competent practice by maintaining and enhancing professional and technical knowledge and skills (Alsop, 2000). Ultimately, professional development has a positive effect on patients' health outcomes (Lowe, 2000; CNA, 2001b; RNABC, 2002) as it enables quality care (Bryant, 2005). Continuing professional development is also a mandatory requirement for nurses from Western countries such as Canada, the United States of America (USA), the United Kingdom (UK), Ireland and New Zealand. Many Western countries have adopted competency-based practice as a method by which to set standards for practice (Bryant, 2005).

Competencies reflect knowledge, skills, values and attitudes (KSVA) and judgment. The International Council for Nurses (ICN, 2003:44) defines competencies as "…a level of performance

demonstrating the effective application of knowledge, skills, and judgment". Judgment includes attitudes and values, as nursing competence is dependent on the nurse's own belief, ethical values, attitudes, accountability and knowledge. These attributes should match the expected outcomes (Whittaker, Carson & Smolenski, 2000; Nadan & Eriksson, 2004).

According to Bryant (2005:3) "(E)mployers and health service administrators also have a responsibility to ensure that the health professionals they employ are competent to provide care which is at a standard acceptable to the public who are recipients of that care." The challenge for regulatory boards and employers is to ensure that nurses are competent throughout their careers, not just with their initial licensure or employment. Once competence has been determined the regulatory board and the employer have an obligation to assess and hold nurses accountable for their practice. To achieve this outcome all concerned need to take an active role in assessing, maintaining and enhancing a nurse's practice competence (Brunke, 2005; Muller, 2003).

Nursing competency has as its basis a strong foundation of nursing and human sciences, liberal arts, research and ethics. Competencies form the basis of nursing practice, preparing nurses to care for patients of all ages across the whole continuum of care in multiple settings both within and outside of the hospitals. When met and sustained, these competencies ensure that nurses have functional knowledge in health promotion and illness prevention as well as acute and chronic disease management and care of dying patients and their families. Furthermore, competence supports nursing practice in education, management and, research as well as in evolving areas such as informatics, infectious diseases, genetics, environmental health and immunology (RNABC, 2000b).

Career management is a stage of the journey through one's professional life that is guided by a vision or mission. In the case of the nurse, it relates to how he or she chooses and expects to use her or his time in the employment arena. Career management is an integral aspect of continuing professional development. Moves may be planned or may come about as opportunities arise. In any new job it is likely that there will be new learning which will be ongoing. New learning will mean new qualifications, thus meaning validation of the learning process and practical competencies (Alsop, 2000). In order to optimise career opportunities, it is essential to identify

one's own strengths, weaknesses, opportunities and threats. It is also essential for seeking future promotion or employment (Donner & Wheeler, 2004). Each professional sets his or her own pace and direction to follow, thus developing from novice to expert (Benner, 1984). Regulatory boards, as well as performance appraisal and accreditation processes, require that the professional will demonstrate and maintain competencies.

The Joint Commission International (JCI) proposes that the environment in which standards are implemented play a pivotal role (JCI, 2003). The JCI has also identified continuing education as an essential component for quality patient care. Therefore it is logical that professional development within a health care system be based on standards as well. Standards are classified according to outcome, structure, and process (Donabedian, 1980; Van der Merwe, 1994a). According to the literature (Finnie & Usher, 2005; Heliker, 1994; Hill, Dewar & MacGregor, 1996), educators recommend that higher education be outcomes-based as it empowers the learners not only to undertake further academic studies but also to develop personally and professionally toward a greater awareness of changing public needs. Mustard (2002) contends that assessment of competencies on the job is the most reliable method for determining whether nurses are competent. Any form of competence assessment should be integrated and include reflective practice as well as sound relationships between educators, managers and learners (Van der Merwe, 2005). A portfolio chronicling learning outcomes provides evidence of current practice aiding in the maintenance of competence (Bryant, 2005; McMullan, Endacott, Gray, Jasper, Miller, Scholes & Webb, 2003).

Not only is it every nurse's right to have access to quality professional development, but it is the responsibility of all professional nurses to engage in professional development. The World Health Organisation (WHO) emphasises that improved nursing education is crucial if nursing practice is to remain relevant to the health needs and expectations of the society (WHO, 2001). Globally where national health systems are operative, the issue of cost-effectiveness may tend to divert attention from the quality of education. There is also discontent regarding a minimum approach to measuring standards, particularly as it may not provide adequate incentive for improvement (Finnie & Usher, 2005). These authors developed a structural model for measuring educational quality adding, however, that there is no magic solution.

If the health care system is both based in and concerned with quality, accreditation and standards, as outcomes are a critical aspect of practice standards, it is only logical that education and therefore professional development should be based on outcomes (Finnie & Usher, 2005). An obvious choice would thus be outcomes-based education (OBE). OBE means clearly focusing and organising everything in an educational system that is essential for all learners to be successful in learning. This means starting with a clear picture of what is important for learners to demonstrate and integrate into practice and organising the learning programme, instruction and assessment to ensure that learning ultimately takes place and is applied to practice. The key to having an outcomes-based system includes developing a clear set of learning outcomes around which all of the system components can be focused; establishing the conditions and opportunities within the system that enable and encourage all learners to achieve the essential outcomes; and expecting learners to demonstrate clear learning results during and after significant learning experiences (Spady, 1994). A multinational workforce within Saudi Arabia should be supported with OBE. This will mean that OBE will help to sustain and enhance competencies and thus quality nursing as prescribed by the regulatory boards. In the following section, the research problem statement is described.

1.2 PROBLEM STATEMENT

The development of competent, skilled health personnel is a priority in all Eastern Mediterranean countries, including Saudi Arabia (WHO, 2001). The Government of Saudi Arabia has directed that the workforce be gradually nationalised through a policy known as Saudisation of the workforce. A continuing professional development learning programme should also facilitate the Saudisation policy effectiveness with regard to nursing practice. One of the outcomes of this learning programme would therefore be to develop capacity and prepare future Saudi nurses for leadership and practice roles and responsibilities.

Health care service providers in Saudi Arabia are predominantly westerners. In the Western world, health care human resources are under considerable strain as a result of, amongst others,

imbalances between the workforce supply and demand and an aging nursing population. These macro-pressures have increased the strain in Saudi Arabia particularly in relation to nursing recruitment and retention. Evidence suggests that if it is not controlled, the current nursing shortage will escalate into national or even international health crises by the year 2010 (AACN 2003a; Janiszewski, 2003).

The slow growth in the supply of new Western nurses can be contributed to the decline in numbers of schools of nursing (AACN, 1999a, 2001). On the other hand, schools of nursing have faculty shortages that make it even more challenging to increase the number of students (AACN, 1999b). The Western nursing workforce is further affected by a highly competitive and diverse labour market. Similar patterns are seen worldwide (Parker, 2002).

Furthermore, the aging of the Western nursing workforce has become a major worldwide issue. Statistics reveal that the largest cohort of currently practising nurses will be in their fifties and sixties in the next decade and many of these nurses are decreasing their work time or are retiring. In comparison to other American workforce occupations, the average age of nurses has increased at more than twice the rate. Additionally, American nurses under the age of 30 decreased by 41 per cent from 1983 to 1998 (AACN, 2002). Similar patterns are seen in other countries (Parker, 2002). According to the AACN (2002), the demand for nurses with basic degrees encompassing skills in critical thinking, case management and a variety of health promotion skills across a number of in- and outpatient care areas, has intensified. Due to the diversity and rapidly changing population demographics, the demand for more culturally competent nurses with knowledge of health promotion and prevention, midwifery, child health, critical care, mental health, gerontology and long-term care nursing has also increased (ICN, 2003). These facts are analysed and underscored in a Report of the Eastern Mediterranean Regional Office (WHO, 2001).

The ongoing ability of the nurse to integrate and apply knowledge, skills, judgment and interpersonal attributes is based on a continuing competence development and commitment to lifelong learning. Thus nursing education should focus on a pro-active approach, one that promotes good practice and prevents poor practice through continuous quality improvement and

competence-based education. This approach to quality nursing practice is a dual responsibility shared by the employer and the nurse as part of self-regulation. It has the potential to enhance the quality of the organisation and outcomes of patient care (Bryant, 2005; CNA & Canadian Association of Schools of Nursing [CASN], 2004b).

The population in Saudi Arabia is young, with approximately half below the age of 19 years (Central Intelligence Agency [CIA], 2003). With such a young population and a long-term dependency on outside countries for its health workforce, the realisation of the Saudisation policy requires definite, structured processes and ongoing collaborative commitment by all individuals employed within the health care system. Although the Saudi Nursing Board (SNB) is emerging, the nursing profession in Saudi Arabia still lags behind. The SNB has notified all health agencies that nurses must register and that non-Saudi nurses are to maintain their respective country regulation. The SNB also requires nurses to retain verified evidence of ongoing professional development when they re-register. However, practice standards have yet to be articulated (Abu-Zinadah, 2004). Nevertheless, the maintenance of competence can provide an extra advantage to the Saudi Arabian nurse. By working closely with competent nurse practitioners, newly appointed professional Saudi Arabian nurses have an opportunity for role socialisation as well as for increasing practice knowledge, skills, competence and confidence. Therefore, it is crucial to implement a structured professional development regulatory system so as to implement and maintain registration/licensure and enhance the practice of nurses and thus to protect the public.

Furthermore, as nurses come into Saudi Arabia with differing scopes of practice and experience, most require professional development support to practise competently within their new multinational workplace. This problem needs to be systematically addressed to have a unified legal way of working. Against this background, it is imperative to implement pro-active effective measures to enhance the process of Saudisation by implementing a comprehensive regulatory system for nursing practice in a structured, culturally sensitive and systematic manner.

In light of the above, the problem of both Saudi and non-Saudi nurses maintaining and enhancing competence and functioning within the boundaries of country specific regulatory board

requirements, the following question is asked: *What should the contents be of a learning programme for the continuing professional development of nurses in Saudi Arabia?* In the next section, the purpose of the research is identified.

1.3 RESEARCH PURPOSE

The purpose of this research was to design, operationalise, validate and evaluate a learning programme for the continuing professional development of nurses working in Saudi Arabia. The outcomes of the research were implemented in two phases. Phase I had one outcome (I) and Phase II had three outcomes (II, III and IV) (see Table 1.1).

Table 1.1: Research phases, research outcomes and description of outcomes

Research phases	Research outcomes	Outcomes description
Phase I	Outcome I	▪ Inductively design a provisional learning programme for the continuing professional development of nurses working in Saudi Arabia (see Chapter 4: Section 2.4.1) ▪ Implement provisional learning programme (see Chapter 4: Section 2.4.2) ▪ Complete literature research (see Chapter 2: Section 2.4) and extrapolated empirical indicators (see Chapter 2: Table 2.14 a, b and c)
Phase II	Outcome II	▪ Validate the provisional learning programme (see Chapter 4: Section 2.4.3)
	Outcome III	▪ Evaluate the final learning programme (see Chapter 4: Section 2.4.4) ▪ Finalise learning programme (see Appendix F)
	Outcome IV	▪ Prepare the research findings for publication in a peer review journal ▪ Submit paper to a peer review journal

The next section identifies the central theoretical assumption of the research.

1.4 CENTRAL THEORETICAL ASSUMPTION

In qualitative research the hypothesis is replaced by the central theoretical assumption. The assumption is a statement about the research domain which forms part of the existing theory of the discipline or related disciplines. Theoretical assumptions (see Chapter 3: Section 3.3.3) give form

to the central theoretical statement of the research (Botes, 2000). Thus the theoretical assumptions for this research (see Chapter3: Section 3.3.3.4) are based on King's Theory of Goal Attainment (King, 1995). The central theoretical assumption for the research is that the implementation of a structured continuing professional development learning programme for nurses working in Saudi Arabia should:

- facilitate quality nursing practice;
- facilitate personal and professional development; and
- support the implementation of nursing legislation.

In the next section, the research design and methodology are described.

1.5 RESEARCH DESIGN AND METHODOLOGY

The research design utilised a mixed methods approach (see Chapter 3: Section 3.3.2). The research decisions made in the design phase deal with the research strategy or overall approach, the methods of data collection, methods of data analysis, the target population, methods of sampling and methods of validity and reliability (Botes, 2000). The research design and methods are briefly described according to the research model, research rationale, research strategy, target population and samples, data collection and analysis, trustworthiness, and strategies of reasoning.

1.5.1 Research model

The research design is based on the Botes' Model (in Rand Afrikaans University, 2000) consisting of three orders (see Figure 1.1).

- *The first order* is the nursing practice which includes four domains – clinical practice, management, education and research (ICN, 2003) (see Chapter 3: Section 3.3.1).

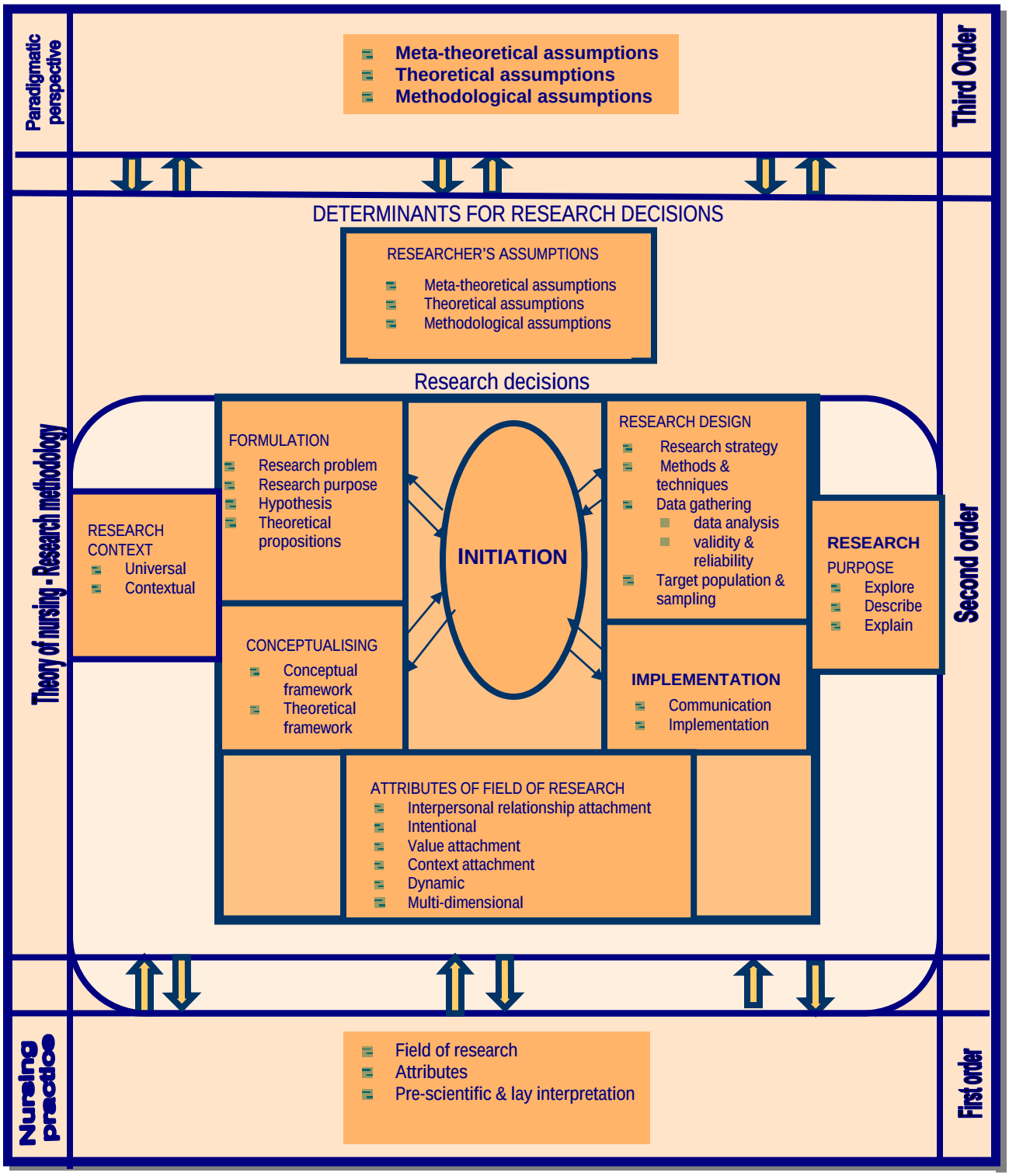

Figure 1.1: Research model (Botes, 1998)

- *The second order* includes the theory of nursing or the research methodology based on the determinants for research decisions (see Chapter 3: Section 3.3.2).
- *The third order* is the paradigmatic perspective which includes metatheoretical, theoretical and methodological assumptions (see Chapter 3: Section 3.3.3).

King's Goal Attainment Theory (1995) was utilised for the conceptual framework and it guided the researcher's professional experience, the review of the literature and inductive development of the provisional learning programme. King identified the focus of nursing as being on the health of the individual, groups and communities of people as individuals interact with each other and within their family, group, community, and social systems (environments). This theory, which has been derived from a system's framework, is concerned with human transactions in different types of environments. The researcher had no preferences for any specific methodology. Figure 1.2 is a graphic representation of King's conceptual framework. This framework is explained further in Chapter 3 (see Section 3.3.3.4).

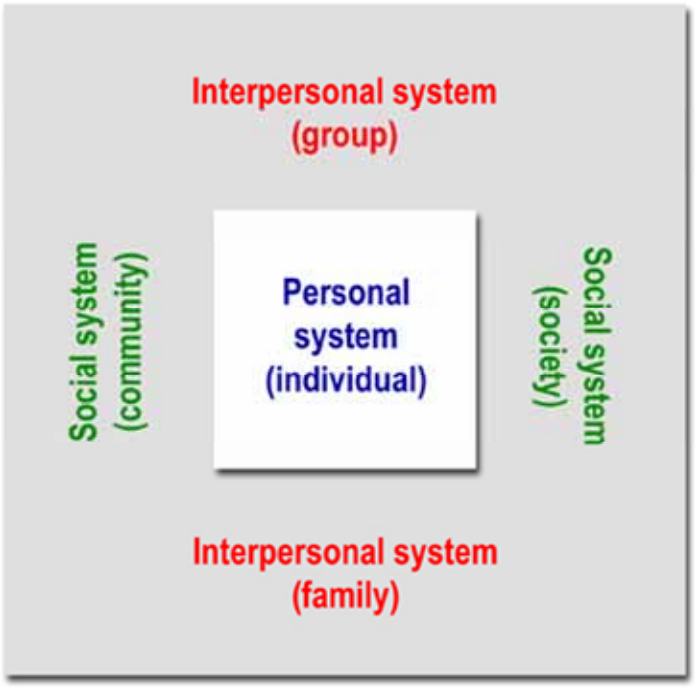

Figure 1.2: King's nursing conceptual framework: dynamic interactive systems
(Source: Sieloff-Evans, 1991)

The Botes' Model (1998) emphasises the following:

- *The researcher must be active in the field of research.* The researcher, as a nursing educator in Saudi Arabia, had been active in professional development research in Canada for 10 years and in Saudi Arabia for four years.

- *The research must focus on the practice.* The researcher designed a learning programme for the continuing professional development of nurses in Saudi Arabia. This learning programme was validated by 14 international experts who judged it against the demands of professional nursing internationally. Therefore it should also support effective continuing professional development with respect to nursing, an emerging nursing regulatory council/board and ultimately quality patient care.

1.5.2 Rationale for utilising the Botes' Model

The rationale for utilising the Botes' Model (1998) (see Figure 1.1) in the research was based on the fact that the model provided a holistic perspective of the research process, and therefore lent itself to all methodologies (Botes, 1989; Rand Afrikaans University, 2000). In addition, using the Botes' Model in Saudi Arabia provided a unique opportunity to test this model within a different socio-economic context and with a multinational workforce of nurses.

1.5.3 Research strategy

The research methodology included an exploratory, descriptive and partially explanatory design and utilised a mixed methods approach dominated by a qualitative orientation (see Chapter 3: Section 3.3.2). The research strategy implemented was the scientific process in nursing which includes assessment, planning, implementation and evaluation combined with the steps in the

research process and research outcomes. Table 1.2 provides an explanation and application of the research methodology and Table 3.5 in Chapter 3 highlights the research strategy.

Table 1.2: Research design and methodology: concepts, explanation and application

Concept	Explanation	Application
Mixed methods (qualitative and quantitative)	▪ Developed theoretical perspective and tested assumptions (Creswell, 2003) ▪ Guided study using Botes' Research Model (1998; 2000) and King's theoretical framework (King, 1995) to guide the research process ▪ Trustworthiness (see Table 1.4: Section 1.5.6; Chapter 3: Section: 3.3.2.2 i f; and Chapter 5: Section 5.4) ▪ Communication, observation and interpretation of data (see Chapter 4: Section 4.4)	▪ Emic perspective – insider/informant's view (see Chapter 3: Section 3.3.3.2 iil; Chapter 4: Section 4.4.2 and 4.4.4; and Chapter 5: Section 5.4) ▪ Etic perspective – outsider, researcher or scientific explanation (see Chapter 3: Section 3.3.3.2 ii; Chapter 4: Section 4.4.3) ▪ Literature research (see Chapter 2:Section 2.4) ▪ Structured questionnaire (see Appendix A) completed by 14 international experts (see Chapter 4: Section 4.4.3)
Exploratory	▪ Research in relatively unknown field ▪ Gained new insight and understanding	▪ Inductively developed learning programme (see Chapter 4: Section 4.4.1) ▪ Literature research (see Chapter 2: Section 2.4) ▪ Extrapolation of empirical indicators (see Chapter 2: Table 2.14 a, b and c) ▪ Expert opinions were sought (see Chapter 4: Section 4.4.3)
Descriptive	▪ Methodical collection of accurate data on the domain of the phenomenon studied (Morse, 2003)	▪ Triangulation of data (see Chapter 3, Table 3.7; and Chapter 4: Section 4.4.5 and Table 4.18)
Partially explanatory	▪ Causality partially emerged due to number of experts and implemented and formative and evaluation processes	▪ Learning programme validated by 14 international experts (see Chapter 4: Section 4.4.3)

1.5.4 Target population and sample

The target population for this research was purposefully selected from the following: nurses who were enrolled in one of two diploma programmes; nurses with minimal to no experience who were enrolled in a new graduate programme (see Chapter 3: Section 3.3.2.2 i c; and Chapter 4: Section

2.4.2); literature review (see Chapter 2: Section 2.4 and Chapter 3: tables 3.6 a, b and c); and international experts from South Africa, Canada, USA, Australia, Egypt and Saudi Arabia (see Chapter 3: Section 3.3.2.2 i c; and Chapter 4: Section 4.4.3).

1.5.5 Data collection and analysis

As it was a design of mixed methods, the data collection and analysis were conducted simultaneously during the two research phases (see Chapter 3: Table 3.5; Chapter 4: Section 4.4; and Chapter 5: Section 5.3). Techniques for obtaining qualitative data were through dialogue, formative and summative evaluation, practice experiences, field records and review of select literature. Data collection also included an inductively developed provisional learning programme which was validated via a structured questionnaire completed by 14 international experts from six different countries (see Chapter 3: Section 3.3.2.2 i d; and Chapter 4: Section 4.4.3).

1.5.6 Trustworthiness

In qualitative research validity and reliability are replaced by trustworthiness. To ensure trustworthiness in this research, the researcher utilised the trustworthiness model described by Lincoln and Guba (1985) and Guba (1981). This model is based on the identification of four aspects of trustworthiness as presented in Table 1.3 (see also, Chapter 3: Section 3.3.2.2 i f).

Table 1.3: Trustworthiness (Source: Lincoln & Guba 1985; Guba 1981)

Aspects of trustworthiness	Definition
Truth value/ Credibility	Based on discovery of human experience as it is perceived and observed by the research participants, thus an emic (insider) approach is used
Applicability/Transferability	Refers to the extent to which the findings can be applied in other contexts, within other groups. It is the ability to generalise results with regard to bigger populations
Consistency/Data dependability	The results remain the same during repetition of the evaluation, using the same research participants
Neutrality/ Reliability confirmable	Implies the freedom of prejudice in the research procedures and results

1.5.7 Strategies of reasoning

The strategies of reasoning implemented in this research are the following: induction, deduction, derivation, analysis, synthesis, and critical reflection. For definitions of each strategy and how they were applied in the research see Chapter 3: Section 3.3.2.2. i e. In the next section, the scope of the research is highlighted.

1.6 RESEARCH SCOPE

The research took place in four countries: Saudi Arabia, South Africa, the USA and Canada. The reason for choosing Saudi Arabia was that the nurse researcher was working there at the time of the research. Saudi Arabia provided a rich field for research as the nursing profession was just beginning to emerge and the workforce, which included nursing, was being nationalised. South Africa was chosen because both supervisors originate from that country and the researcher was enrolled in a doctorate programme at a South African university. The USA is a country where many Saudi nurses have been educated. Canada was the home country of the researcher and where her nursing licence was held. Lastly, in the province where the researcher was registered, continuing professional development was legislated through the Nurses' (Registered) Act. The research took place within the context of nursing regulation, continuing professional nursing development, and nursing practice utilising outcomes-based education and a constructivistic learning approach. In the next section, ethical considerations are identified.

1.7 ETHICAL CONSIDERATIONS

The names of the research participants, as well as the experts and the organisation involved, were not identified. In addition, completion of questionnaires and participation in all research activities

were voluntary. Written permission granting authority for the research was given by a senior hospital administrator where the research was conducted. The research data were verified by an independent statistician/ researcher. In the following section, research concepts are defined.

1.8 CLARIFICATION OF RESEARCH CONCEPTS

The following theories, models and concepts were utilised to structure the research:

- *Accountability*: This word comes from the French word “compter” or “conter” meaning to count or to enumerate (Matek, 1977). An individual is accountable when she/he is responsible and bound to give account, thus it is a state of being answerable for one’s actions and decisions (see Chapter 2: Section 2.4.1.2 ii).

- *Adult learners*: Knowles (1984) describes adult learners as being self-directed, deriving only positive benefits from experiences, as possessing great readiness to learn, voluntarily entering an educational activity which is life- and task-centred, or undergoing problem-centred orientation to learning, and being internally motivated (see Chapter 2: Section 2.4.3.3).

- *Adult learning principles:* These principles were utilised in the implementation of the provisional learning programme. Galbraith (1998) says implicit within principles of effective practice is the teacher/facilitator has an understanding of self, and of adult learners; provides a climate conducive to learning and exploring new ideas, skills and resolutions and a forum for critical reflection. Another vital characteristic is being able to assist adults with the process of learning how to change perspectives, shift paradigms and replace one way of interpreting the world by another (see Chapter 2: Section 2.4.3.3).

- *The Canadian Nurses Association’s Model for Continuing Competence*: According to Affara (2002), countries have adopted a number of models to promote continued competence, but the best overview of the different elements to support maintenance of competence originate with

the Canadian Nurses Association (CNA). The CNA model's elements include: code of ethics, standards of practice for registered nurses, entry level competencies, continuing competence throughout career, and lifelong learning – both continuing education and nursing practice experience. This model was described in the literature review (see Chapter 2: Section 2.4.3.1).

- *Curriculum development* (learning programme): It is defined as a plan or a written document that includes strategies, for achieving desired outcomes. In outcomes based education (OBE) the term curriculum is substituted for the learning programme and thus these terms were utilised synonymously during the research. As OBE literature does not advocate any curriculum emphasis, different theories and models were used to explore curriculum development guidelines when the provisional learning programme was designed. (For further explanation of OBE see Chapter 2: Section 2.4.2.3.)

- *Domains of nursing practice*: These are the clinical, educational, management and research domains.

- *Nurse*: The ICN (2003:13) defines a nurse as "… a person who has completed a basic, generalised nursing education and is authorised by the appropriate regulatory authority to practise in his/her country…" Therefore, the nurse is prepared and authorised to engage in the general scope of nursing practice, including the promotion of health; prevention of illness; and care of physically ill, mentally ill and disabled people of all ages; and in all health care and other community settings; to carry out health care teaching; to participate fully as a member of a health care team; to supervise and train nursing and health care auxiliaries; and to be involved in research.

- *Nursing*: The ICN (2003:13) defines nursing as "…an integral part of the health care system, encompassing the promotion of health, prevention of illness, and care of physically ill, mentally ill and disabled people of all ages and in all health care and other community settings. Within this broad spectrum of health care, the phenomena of particular concern to nurses are the individual, family, and group responses to actual or potential health problems. These human

responses range broadly from health restoring reactions to an individual episode of illness to the development of policy in promoting the long term health of a population."

- *Nurses' Act*: Most countries have a legislated Nurses' Act which contains laws and administration regulations defining nursing practice and establishing legal standards. Such acts regulate the practice of nursing, and safeguard the public by setting standards for education and practice and investigation of standards violations (ICN, 1998).

- *Quality nursing*: According to Muller (2003) the characteristics of nursing excellence (quality) are the following: *applicability* – to make the right decision at the right time; *acceptability* – to be legally and culturally acceptable; *safety* – to maintain a therapeutic environment (physical, mental, and spiritual) with appropriate risk management; *equality* – money, race, sex and social status will not play a role; *accessibility* – to provide health care services, facilities, equipment and expertise of personnel; *effectiveness* – to be assessed in the clinical results and resource utilisation; *professional knowledge and competence* – should be according to the needs and demands that are set; and *satisfaction* – demonstrated by the patient, family, physicians, nurses, management, and other team members.

- *Quality practice environment*: It is an environment in which it is possible to render nursing practice excellence and thus positively affect patient care outcomes (CNA, 2001b; 2002b). For the overall sustainability of a high quality workplace in a health care organisation, many elements are needed. No single discipline can capture the processes and structures to facilitate quality outcome. The Canadian Policy Research Networks (CPRN, 2002) propose a multi-disciplinary and holistic approach (see Section 1.1). Developing and supporting a quality practice environment is a shared responsibility between nurses and other health professionals, employers, governments, regulatory bodies, professional associations, educational institutions and the public (CNA, 2001b) (see Chapter 2: Section 2.4.2.4).

- *Registered nurse*: For the purposes of this research a professional nurse is defined as one who had graduated from an accredited nursing programme, maintained licensure/ registration with a professional regulatory board inside (for non-Saudi nurses also outside) of Saudi Arabia.

- *Scope of practice*: This aspect communicates to others the competencies and professional accountability of the nurse (ICN, 1998). The nursing scope of practice includes the activities nurses are educated and authorised by a nursing act and regulatory board to perform (CNA, 1993). A scope of practice defines the limits of practice of a registered nurse (ICN, 1998). Scopes of nursing practice differ between and within countries (CNA, 1993) (see Chapter 2: Section 2.4.1.2 i).

- *Self-regulation in nursing*: It is based on the premise that the nursing profession has required the knowledge and skills to set its own standards for the practice and conduct of its members (Muller, 2003). Historically, professional self-regulation referred to the work of the nursing regulatory body (ICN, 1998). It also involves practising nurses. For the latter, self-regulation encompasses fitness to practise and maintenance of competence and for the regulatory body it entails credentials (standards) for professional practice and conduct (CNA, 2001c; 2002a; Muller, 2003) (see Chapter 2: Section 2.4.1.2 iii).

- *Standards*: These "are the desirable and achievable level of performance against which actual practice is compared" (ICN, 2003:28). Standards types are structure, process and outcomes (Donabedian, 1986; Van der Merwe, 1997a).

- *Standard development* encompasses a process of commitment, development, standardisation and formalisation. Outcomes-based education encompasses standards and is an imperative in the process of standard development implementation (Van der Merwe, 1994c).

- *Tertiary hospital*: Throughout the industrialised world, a range of sophisticated hospital-based procedures exist that are generally expected to be concentrated in a small number of acute care facilities rather than scattered or disbursed throughout a region or country. Thus a tertiary

hospital is one that provides highly specialised care and requires specialised skills, technology and support services.

- *Trans-cultural nursing*: This type of nursing is defined as cultural competence, a process as opposed to an end point, in which the nurse continuously strives to work effectively within the cultural context of an individual, family or community from a diverse or different cultural background (Leininger, 1988). Denzin and Lincoln (2000) contend that the qualitative researcher is not just an observer but a player in history making. He or she and their respective research subjects' class, race, gender, and ethnicity shape the process of the inquiry. Therefore this means that qualitative research is also a multi-cultural process.

- *Trans-cultural nursing model*: Leininger's Model for Transcultural Nursing (Leininger, 1988, 2001; Leininger & MacFarlene, 2002) was used, as working with a multinational workforce in a Muslim culture required developing cultural awareness, cultural knowledge, cultural skills and cultural encounter. Culture was viewed from values, beliefs and behaviours learned and shared within a group of interacting multinational nurses working in a Muslim context.

- *Triangulation*: This refers to the use of multimethods as an attempt to secure an in-depth understanding of the phenomenon in question (Denzin & Lincoln, 2000). Triangulation is not a validation strategy but an alternative which adds rigour, breadth, complexity, richness and depth to a study.

- *Crystallisation*: Richardson (2000:934) argues against triangulation, advocating instead for crystallisation. "Crystals are prisms that reflect externalities and refract within themselves creating different colours, patterns, and arrays, casting off in different directions." Thus, when used as a strategy, events can be viewed simultaneously as opposed to sequentially or linearly, enabling the researcher to tell the same tale from different points of view (Denzin & Lincoln, 2000), as truth depends on how events are interpreted and by whom (Richardson, 2000).

1.9 CHAPTERS OF THE DISSERTATION

Table 1.4 provides an overview of the five chapters of the dissertation.

Table 1.4: Summary of research chapters

Chapters	Summary of chapters
Chapter 1: *Overview of research*	▪ Described the research aim - to develop, implement, validate and evaluate a learning programme for the continuing professional development of nurses working in Saudi Arabia
Chapter 2: *Literature review*	▪ Synthesised the literature research and identified empirical indicators (Table 2.14 a, b and c)
Chapter 3: *Research design* and methodology	▪ Described the research design and methodology and strategy ▪ Utilised mixed methodologies (primarily qualitative simultaneously mixed with quantitative - QUAL + quan)
Chapter 4: *Presentation, analysis and interpretation of results*	▪ Described the inductive development, operationalisation, validation and evaluation of the provisional continuing professional development learning programme ▪ Included data collection, analysis and results ▪ Conducted data collection, analysis and interpretation simultaneously ▪ Utilised strategies for reasoning: induction, deduction, derivation, analysis, synthesis and critical reflection (see Chapter 3: Section 3.3.2.2 i. e) ▪ Identified contents for the provisional learning programme ▪ Validated by purposefully selected international experts ▪ Reapplied revised content in practice ▪ Continuously evaluated outcomes ▪ Triangulated the research findings and demonstrated research scholarship achieved (see Table 4.18) ▪ Confirmed content and finalised learning programme (see Appendix F)
Chapter 5: *Research synthesis, conclusions and recommendations*	▪ Provided research summary (rationale and design and strategy), limitations, recommendations and conclusions and final summary

1.10 REFERENCING STYLE, AND LAYOUT OF THE THESIS

The Abridged Harvard referencing method was applied in preparing the dissertation. This method included the style, editing, formatting and lay-out.

1.11 SUMMARY

The research was conducted during an era of major global changes in nursing which require that nurses continue to search for new knowledge and skills so as to render professional, ethical and legal nursing. Therefore, for nurses to maintain self-regulation and fulfil their agreement of safe nursing to the public, it is imperative that they continuously develop professionally regardless of the country in which they are practising. The purpose of this research was to develop, implement, validate and evaluate a learning programme for the continuing professional development of nurses working in Saudi Arabia. This chapter provided an overview of professional development, the problem statement and a brief description of the research design and methodology. The literature research synthesis is presented in Chapter 2.

CHAPTER TWO: LITERATURE REVIEW

2.1 INTRODUCTION

Health care systems worldwide are undergoing change. Advances in information technology have connected the world, facilitating both the exchange and the speed at which knowledge can be translated into usable forms instantly (Decter, 2000; Wheatley, 2002). Nurses, who make up the largest professional group in any health system, have to equip themselves with the necessary knowledge, skills, values and attitudes (KSVA) to meet the changing health needs of the public in an appropriate manner. The International Council of Nurses (ICN) identifies continuing competence as one of the characteristics of strong 21st century regulatory models (Affara, 2002).

As noted in Chapter 1: Section 1.3, the purpose of this research was to design, implement, validate and evaluate a learning programme for the continuing professional development of nurses working in Saudi Arabia (see Chapter 4: Section 4.4 and Appendix F). In many countries, governments and health professions alike are aware of the critical importance of continuing education to the quality of practice rendered, and in some countries continuing professional development has been legislated (Affara, 2002). In this chapter the literature was explored in relation to the continuing professional development of nurses to gain further insight into and understanding of the phenomenon, the continuing professional development of nurses. The empirical indicators (see Tables 2.14 a, b and c) derived from the literature research were also a key component in the design and implementation of the provisional learning programme in Phase 1: Outcome I (see Chapter 1: Section 1.3 and Table 1.1 and Chapter 4: Sections 4.4.1 and 4.4.2). In the next section, the purpose of the literature review is identified.

2.2 PURPOSE OF THE LITERATURE REVIEW

Creswell (2003:30) recommends a literature review be used "…in a manner consistent with the assumptions of learning from the participant…not prescribing the questions that need to be answered from the researcher's standpoint". As noted in Chapter 1 (Table 1.2), the research design

is a mixed methods design, which is an integration of a qualitative and a quantitative approach. (For an additional description see Chapter 3: Section 3.3.2.) Creswell (2003) says that the approach to and placement of the literature in the research text varies greatly with different forms of qualitative approaches, as well as between qualitative and quantitative approaches. This suggests that a researcher can use either a qualitative or a quantitative approach to the literature with a mixed methods approach. Placing the literature review at the front of the study served to frame the research problem within a global context rather than one unique to Saudi Arabia. The next section briefly describes the conceptual framework for the literature review.

2.3 CONCEPTUAL FRAMEWORK

The conceptual framework for the literature research, depicted in Figure 2.1, was adapted from the competencies framework for the generalist nurse provided by the International Council of Nurses (ICN, 2003). It was made up of three components: professional, ethical and legal practice; nursing education practice; and continuing professional development. The continuing professional development learning programme was situated at the base of the figure with arrows from and flowing into the various concepts. The framework made it possible to focus the review and thus key empirical indicators (see Tables 2.14 a, b and c) were elucidated from the literature to assist in the formation of the provisional learning programme as Phase 1: Outcome I (see Chapter 1: Section 1.3 and Table 1.1 and Chapter 4: Section 4.4.1) of the research design.

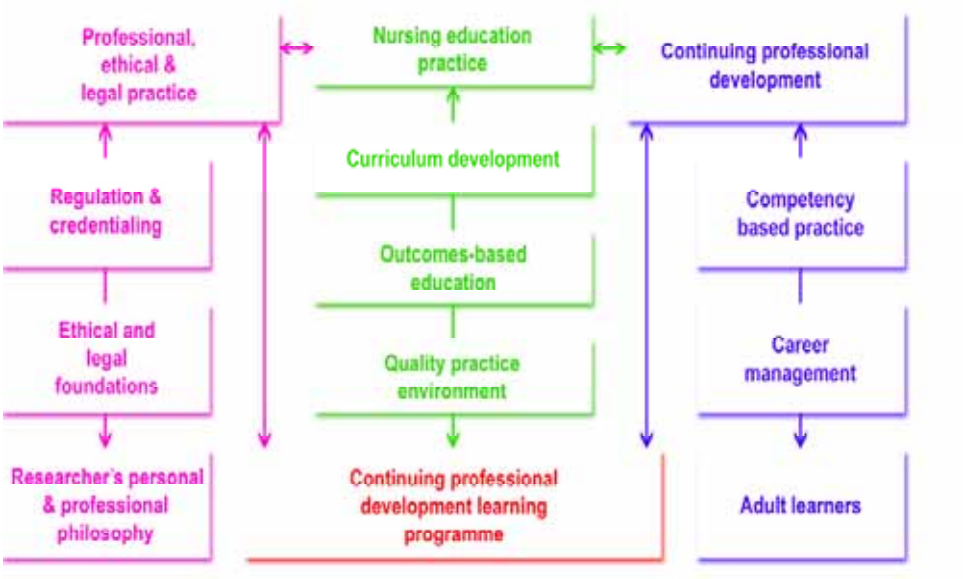

Figure 2.1: Literature review conceptual framework

In the next section the literature review synthesis is presented.

2.4 LITERATURE REVIEW

As nursing practice is dynamic and constantly changing, nurses have a responsibility to maintain and continually enhance their knowledge to facilitate quality nursing practice (ICN, 2003). Personal and professional learning needs, however, vary from nurse to nurse and within the stage of individual experiences as categorised by Benner (1984) from novice to expert. Regardless of their stage of professional development, nurses must maintain a professional, ethical and legal practice (ICN, 2003) through the regulation of the nursing profession as well as through self-regulation by nurses.

2.4.1 Professional, ethical and legal practice

The regulation of health professions is undergoing scrutiny in many countries and is one of the highest priorities of nursing; something towards which it is continually working and actively developing and updating (Percival, 2001). While its priority remains constant, the language and activities required continue to evolve (Brunke, 2005; Styles & Affara, 1997).

The purpose of this section is to provide an overview of regulation and credentialing, to describe the ethical and legal foundations of professional nursing practice and to provide an overview of the researcher's personal and professional philosophy.

2.4.1.1 Regulation and credentialing

The primary purpose of regulation is to protect the public from potential harm that can occur when unqualified workers provide nursing care. An unqualified worker is defined firstly as an individual who is not a member of a regulatory board/council and secondly as a registered nurse without relevant and current knowledge in the field of practice (CNA, 2001a). Implementation of a regulatory framework to strengthen nursing practice also enhances the social agreement of nurses to protect the public (Styles & Affara, 1997; WHO, 2002; CNA, 2001a; Muller, 2003). The ICN (Styles & Affara, 1997:45) defines regulation as "all of those legitimate and appropriate means – governmental, professional and private" whereby the following goals are reached:

- define the profession and its members;
- determine scope of practice;
- set standards for education;
- set standards of ethical and competent practice;
- establish systems of accountability; and
- establish credentialing processes.

Finocchio and colleagues, with the Taskforce on Health Care Worker Regulation (1995 quoted in Brunke, 2003) take a broader perspective on regulation. According to Brunke (2003:144), "They believe that regulation of the health care workforce best serves the public's interest if it promotes effective health outcomes and protects the public from harm; ensures accountability to the public; respects consumers' rights to choose their health care providers from a range of safe options; facilitates effective working relationships among health care providers; and provides for professional and geographic mobility of competent providers."

The professional nursing council or board must act in the interests of the public, controlling and regulating its members' practice, identifying those who are qualified registered nurses and ensuring they are competent to practice. The nursing board must also identify what should be done when there is unsafe nursing (CNA, 2001a; Styles & Affara, 1997).

Regulation encompasses credentialing processes, including registration, licensure, qualification, accreditation, certification, and endorsement. "Credentialed individuals, institutions, programmes, services and products are designated by credentialing agents (governmental and non-governmental) as having met specified standards" (Styles & Affara, 1997:2). Under the leadership of the ICN, nurses throughout the world assemble periodically to examine and provide policy support for regulation and credentialing.

In Saudi Arabia, the Saudi Council for Health Specialties (SCHS, 2003) has been instituted and granted the legal responsibility to protect the public, and the Saudi Nursing Board (SNB) works within its policies and procedures. The SNB has recently notified all nurses who work in Saudi Arabia that they must register by January 2005 (Abu-Zinadah, 2004). Non-Saudi nurses must continue to maintain their country's registration. In Saudi Arabia nurses are required to function ethically under the Gulf Cooperation Council's (GCC) Code of Professional Conduct for Nursing enacted in May 2001 (Khofa, n.d.). The SNB is not yet (December 2005) a member of the ICN.

2.4.1.1 i) International Council of Nurses (ICN)

Founded in 1899, the International Council of Nurses (ICN) is today a federation of national nurses' associations (NNA) representing nurses in more than 120 countries. The ICN, with its headquarters

in Geneva, Switzerland, works to: promote quality nursing care for all people; support sound health policies globally; advance nursing knowledge; advocate for the presence worldwide of a respected nursing profession; and support a competent and satisfied nursing workforce (ICN, 2004). Its current goals are:

- to bring nursing together worldwide;
- to advance nurses and nursing worldwide; and
- to influence health policy.

The ICN advances nursing, nurses and health through its policies, partnerships, advocacy, leadership development, networks, congresses, special projects, and through its work in the arenas of professional practice, regulation and socio-economic welfare. The ICN Code of Ethics for Nurses (ICN, 2000) is the foundation for ethical nursing practice throughout the world, and ICN standards, guidelines and policies for nursing practice, education, management, research and socio-economic welfare are accepted globally as the basis of nursing policy and practice (WHO, 2002; Affara & Styles, 1992; Styles & Affara, 1997).

Nevertheless, in 1997 the ICN conducted a study to identify the nature of its national associations and discovered that only seven percent (7%) have a regulatory mandate (ICN, 2001). By way of an example, although the Canadian Nurses Association (CNA) is the national association representing Canadian nurses at the ICN, it does not have a regulatory function. Rather the CNA is a federation of provincial/territorial associations of which not all have a direct public protection mandate. In Canada, according to the constitution, the responsibility for health, welfare and education fall under the provincial/ territorial governments which in turn have delegated the right to self-regulation to the respective nursing regulatory board. The largest province, Ontario, has granted the primary nursing responsibility for public protection to the College of Nurses of Ontario (CNO) and the professional association is mandated to the Registered Nurses Association of Ontario (RNAO). The RNAO represents 14 366 of 81 679 registered nurses (Canadian Institute of Health Information [CIHI], 2001) and is the official CNA representative for Ontario nurses. In total, the CNA speaks for 113 120 registered nurses, approximately one third of the Canadian registered nursing population (Lemire-Rogers, 2003).

The Order des infirmières et infirmiers du Québec (OIIQ) withdrew from the CNA in 1985 (Lemire-Rogers, 2003). Both the QIIQ and the CNO have ex officio seats at all CNA meetings. Nationally, the Canadian Federation of Nurses Unions represents the provincial nurses' unions that have the mandate to protect the nurse and speak on behalf of the profession in the realm of competencies. Regardless of these various mandates and nursing organisations, governments as well as other professional organisations formally recognise the CNA as the professional voice for Canadian nurses (Lemire-Rogers, 2003).

In South Africa, nurses are represented at the ICN by the Democratic Nursing Organisation of South Africa (DENOSA) and regulated in practice by the South African Nurses Council (SANC). DENOSA has both professional and union responsibilities and since its inception in 1995 has gained significant international recognition and credibility (Muller, 2003). Presently the CNA and DENOSA are collaborating to advance the nurse's role in HIV/AIDS care in South Africa (CNA, 2004c). Ethical and legal foundations for nursing practice are further explored in the next section.

2.4.1.2 Ethical and legal foundations

Ethics is the philosophical study of morality, of what is right or wrong behaviour, enabling us to examine the things that influence moral decisions, obligations, and duties to others, personal character, the nature of good and underpinnings of what makes a good society. "Because ethics is the study of right and wrong, it involves the analysis of what we ought to do, what our duties and obligations are to other people and what kinds of behaviour we should expect from others" (Hardingham, 2003:341). Internationally, the ethical foundation of nursing practice is founded in the ICN Code of Ethics for Nurses first developed in 1953 (Muller, 2003). The ICN Code has been revised several times; is accessible via the worldwide web (ICN, 2000); and is based on the following responsibilities: to promote health, prevent illness, restore health, and alleviate suffering. Reflected within the Code of Ethics are the following principal elements that outline the standards for ethical conduct:

- nurses and people;
- nurses and practice;
- nurses and the profession; and

- nurses and co-workers.

The various ethical responsibilities of the nurse are described within these elements and are reflected in the standards. The standards embody the application of the ICN Code of Ethics (ICN, 2000) in relation to three groups:

- practitioners and managers;
- educators and researchers; and
- national nurses' associations.

Nurses should be familiar with the ICN Code of Ethics and should apply its principles within their nursing practice regardless of where they work. The ICN Code of Ethics should be implemented not only from a professional and scientific basis but also from a caring ethos (Muller, 2003), particularly when ethical issues arise. The identification of ethical issues is not straightforward, for example in relation to informed consent some people such as nurses and other health professionals have greater access to information about health care, professionals, programmes and institutional problems than most patients. Hence health professionals have a moral obligation, as well as a legal one, to ensure that fully informed consent is obtained (Hardingham, 2003). Besides having a moral obligation, nurses and other health professionals can be held accountable for their actions in a court of law as well as within the organisation and by their professional regulatory board.

Nursing is regulated by country specific professional legislation that defines, describes and controls the practice of nurses. Authority to regulate the nursing profession comes from legislation enacted from either the provincial/state or national level. The exact nature of legislation varies within countries and between countries. The first proclaimed nurses' act (1882) was under the direction of medical practitioners in South Africa (Muller, 2003) while the most recent call for nursing regulation was in Saudi Arabia (Abu-Zinadah, 2004). Between the years 1988 and 1993, seventy-five countries enacted legislation that is directly related to regulatory policies and practices or to the policy environment that touches on nursing practice (Styles & Affara, 1997). Generally nursing regulatory bodies have authority for:

- standards of education and qualification of its members;
- standards of practice and professional ethics;

- use of title;
- scope of practice;
- professional discipline;
- approval of education programmes for entry to the profession; and
- continuing competence requirements for its members.

A current debate in the area of legislation is whether certain services should be restricted to one or more designated health professions (Styles & Affara, 1997). In Ontario, Canada, only designated professions can perform certain regulated tasks (CNO, 1995). Nursing operates within a context of legislation, health policy and changing demographics and epidemiological profile of patients/clients. Work trends are constantly changing while health care services need to remain cost-effective and responsive to the needs of the patients/clients (Bryant, 2005). When determining what a nurse may legally do in any situation, the statutory definition of nursing has to be considered (CNA, 1993). What a nurse is authorised to do is defined under her/his scope of practice.

2.4.1.2 i) Scope of practice

A scope of practice defines the range of roles, functions, responsibilities and activities that nurses are educated, competent and authorised to perform, including context of and boundaries around nursing practice (CNA, 1993). A scope of practice can be defined through legislation, public policy, national and local guidelines, education and individual levels of competence. Legislation specific to nursing practice is found within the respective nurses' acts. Other acts or policies within a particular country also define practice parameters or may have specific implications for nursing. Some professional scopes of practice overlap while others may be shared between disciplines. While restrictive scopes of practice can protect the public from unsafe practitioners, they can also exert control over professionals not enabling them to practise to the "extent of their competence, changing consumer needs" or to respond to the "increased demands of the health care system" (Styles & Affara, 1997:11). The Canadian Nurses Association, Canadian Medical Association and Canadian Pharmacists Association have developed joint principles for their respective scopes of practice (CNA, 2003a), thereby decreasing the potential for rigid boundaries between these groups.

Canadian nursing regulatory bodies have also established broad range goals/principles recognising a continuum of educational preparation, from basic to advanced. National regulatory bodies in other countries such as the United Kingdom and the United States have taken a similar approach. As nursing scopes of practice are broader than that of an individual's ability, nurses must practise within the limits of their preparation, education and current competence. Hence the actual scope of practice of individual nurses is "influenced by the settings in which they practice, the requirements of the employer, and the needs of their patients or clients" (CNA, 1993:2). Nurses also need to practise within their scope and accept professionally responsibility and accountability for their practice (Muller, 2003).

2.4.1.2. ii) Professional accountability

Professional accountability is defined as the responsibility of the nurse for acts and omissions during action performed (Muller, 2003). Accountability also implies conditional liability for the nurse's own acts and omissions and willingness for him or her to be judged against professional rules, norms or expectations that have been set and thus to bear the consequences for such judgment. Nurses are responsible and accountable for their actions and are expected to be willing to accept the consequences of their behaviour. However, when full authority is granted to a nurse, it officially signifies permission to fulfil the role alone with the responsibility to inform the immediate supervisor whenever the nurse is uncertain about his or her ability to perform a particular activity or competence required to do the work. The ICN (Styles & Affara, 1997:44) defines a competence as "a level of performance demonstrating the effective application of knowledge, skills, and judgment". Until the time a nurse has reached the desired level of competence, accountability for practice rendered rests in the hands of others. When a nurse has demonstrated the relevant competencies and related judgment, she or he has satisfied the conditions necessary for professional accountability (Muller, 2003).

Accountability comes with experience as it is based on judgment. Figure 2.2 illustrates Bergman's three conditions for accountability (1982, cited in Muller, 2003). These conditions, namely ability, responsibility, and authority, lay the ground for determining the consequences derived from a nurse's acts or omissions. Each is described briefly.

Figure 2.2: Conditions for professional accountability

(Source: Bergman, 1982, cited in Muller, 2003)

a) Ability

A nurse must demonstrate the abilities or competencies (KSVA and judgment) to perform a given action. The knowledge required for nursing practice is implicitly identified in legislation (Muller, 2003; ICN, 2003). Competencies required of a nurse include:

- advanced scientific principles specific to selected areas and applied to nursing practice;
- relevant knowledge of human anatomy, physiology, biochemistry and physics;
- principles of human behaviour (psychology), social behaviour of humankind, family and community, child and adult education, as well as spiritual and cultural practices;
- professional and personal values and norms;
- self-directed learning;
- communication skills;
- self-responsibility skills in group work and multidisciplinary teamwork;
- decision making, and critical analytical skills in the application of the scientific principles of assessment, planning, implementation, evaluation and documentation;

- research skills; and
- current technology and advanced literacy.

The most obvious knowledge and skills that the nurse practitioner needs are identified in the educational programme of a specific course, whether it is basic, post-basic, specialised, or advanced practice. Curriculum for nursing education is approved by the respective country's regulatory board (e.g. by the SANC). A country's nursing regulatory board or council certifies the practitioner as having achieved prescribed competencies.

The second condition of accountability is responsibility.

b) Responsibility

The allocation of responsibility must be in place before liability for a nursing act can be accepted. The professional-ethical responsibilities are identified in a country's nursing scope of practice regulation (Muller, 2003). Nurses carry out these responsibilities throughout the course of their nursing practice. If the nurse neglected to carry out prescribed professional responsibilities and her/his acts or omissions resulted in harm to the patient, he/she could be disciplined by the respective regulatory board and, depending on the severity, through the legal system.

The third condition that must be granted is authority.

c) Authority

Authority is the right to perform a task or make a decision. Boundaries for nursing practice are found in legislation (Muller, 2003) as an act which authorises certain work to done by a registered nurse. The nurse must also abide by the principles underlying laws such as informed consent and/or different acts (e.g. the narcotics act). A nurse receives her/his job authority or responsibilities in terms of a job description or contract from their employer.

The last condition in the pyramid is accountability.

d) Accountability

Only after the other three conditions are met can a nurse be held personally and solely accountable for their practice. Before being delegated responsibilities she/he must demonstrate the necessary competencies. Nurses who have not yet demonstrated competencies required to perform a certain task (such as medication administration) cannot be held solely accountable, as the supervisor is also professionally accountable for the task performed. However, if the nurse is not competent to perform the task, he or she is personally accountable for seeking expert help from the supervisor whenever performing the task (Muller, 2003). Muller identifies six levels of accountability (see Table 2.1).

Table 2.1: Levels of accountability (Source: Muller, 2003)

Accountability levels	Explanation
Public	▪ Require acceptable and adequate services ▪ Trust professional nurses to implement correct nursing actions
Employer	▪ Liable for quality health care services to patient/client ▪ Responsible for health care facility (e.g. hospital or community) ▪ Partner in continuing professional development
Government	▪ Responsible for health care and legal systems ▪ Laws of the country established to protect the public ▪ A nurse who violates laws is answerable and must accept consequences ▪ A nurse may not take over job of other health professionals (e.g. giving or changing medication without valid physician prescription)
Other professionals	▪ Provide similar/auxiliary services (i.e. physicians, pharmacists, nutritionists, social workers, physiotherapists)
Professional Council/ Board	▪ Responsible for fulfilling social mandate and continuing professional development required for quality public services
Practitioner (nurse)	▪ Demand high quality education within professional framework ▪ Depend on profession for social status and credibility ▪ Responsible and accountable for continuing professional development and maintaining and enhancing competencies

As noted, competent practice does not simply entail knowledge and skills. Nurses are competent when they have demonstrated the necessary knowledge, skills, values and attitudes (KSVA) reflected in their judgment (ICN, 2003). It is imperative that values and attitudes and therefore judgment be included. Ensuring judgment in nursing practice takes time and thus experience; therefore until such time that a nurse has demonstrated competence required for the role she or he should not be granted full authority. Furthermore, self-regulation of nursing practice by the nurse and the profession is critical to provide quality care and thus protect the public from harm (ICN, 2003; CNA, 2001a).

2.4.1.2 iii) Self-regulation

As mentioned, the nursing professional has a social agreement with the public which is fulfilled through responsive and responsible self-regulation (Van der Merwe, 2002). Donabedian (1976, quoted in Affara & Styles, 1992:ii) describes self-regulation as follows: "There is a social contract between the society and profession. Under its terms, society grants the professions authority over functions vital to itself and permits them considerable autonomy in the conduct of its affairs. In return the professions are expected to act responsibly always mindful of the public's trust. Self-regulation to assure quality is at the heart of this relationship. It is the authentic hallmark of a mature profession." It also includes "…self-control and trustworthiness (maintaining standards of honesty and integrity)" (Mezirow, 2000:11).

The ICN (Styles & Affara, 1997) refers to self-regulation as self-governance or governance of nurses and nursing by nurses in the public's interest. The ICN developed a conceptual framework (see Figure 2.3) through which to study occupational regulation. This framework could be used when examining internal and external relationships of any system of professional governance (Styles, 1986; Affara & Styles, 1992; Styles & Affara, 1997). With regard to the internal aspects, what are the features of the system that regulated education and practice? Are these features in accord with one another and consistent with their purpose? From an external perspective, the ICN (Affara & Styles, 1992) recommends that the profession take note of the effects of the regulatory systems regarding the following:

- quality and goal of health services;
- accessibility and cost of health services;
- public policies (health, education, labour, social welfare, economy);
- other health workers;
- goals of the nursing profession; and
- status and welfare of nurses.

Nursing self-regulation is based on the premise that the profession has acquired the knowledge and skills to set its own standards for the practice and conduct of its members (Muller, 2003). Although historically professional self-regulation referred only to the nursing regulatory body's work, today it

also includes the individual nurse's practice (CNA, 2001a). For nurses, self-regulation encompasses fitness to practise and maintenance of competence. For the regulatory board it entails standards (credentials) for professional practice and conduct (Van der Merwe, 2002). Nursing credentials are defined as an established set of standards, such as licensure or certification, which determines that an individual has achieved professional recognition in a specific field of practice (Styles & Affara, 1997). The primary threat is that if self-regulation is not effectively conducted, "the functions of a nursing regulatory authority could be transferred to either other professions or to bureaucrats" (Bryant, 2005:11).

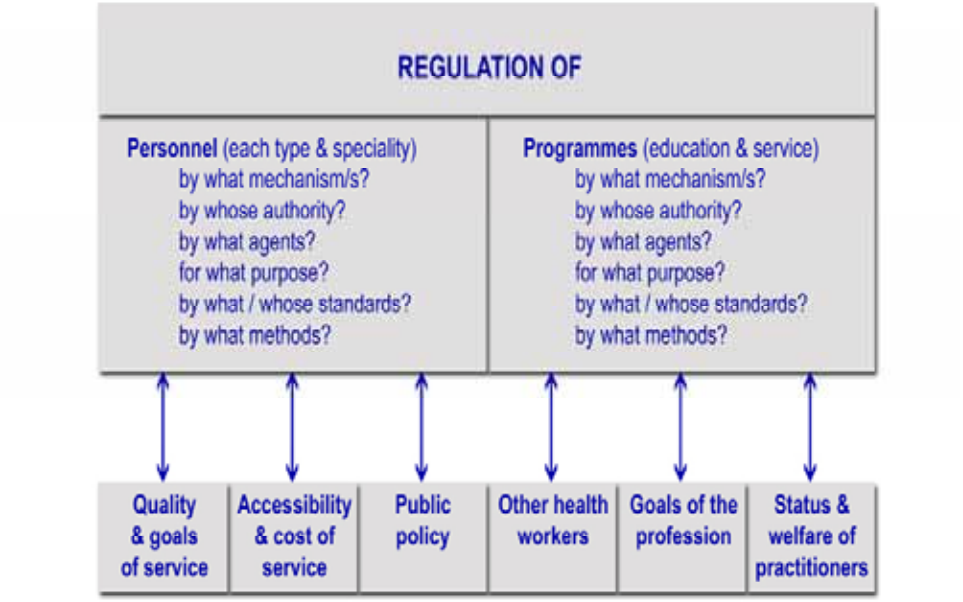

Figure 2.3: A conceptual framework for studying occupational regulation (Source: Styles, 1986)

Through continuously learning from practice, nurses acquire and enhance competencies required to fulfil their roles. The ICN (2003) has called for standardisation and credentialing of nursing practice. For nurses to maintain competence and professional commitment, a proactive and comprehensive nursing regulatory system is required.

2.4.1.2 iv) Nursing professional regulatory system

The obligation of the nursing profession is to put a regulatory system in place, maintain it all the time and strive for the ideal. Under the regulatory system standards can be identified, implemented, maintained and evaluated. Standards are defined by the "desirable and achievable level of performance against which actual practice is compared" (ICN, 2003:28). The Registered Nurses Association of British Columbia (RNABC, 2002) emphasises that governments, employers, and nursing organisations and schools of nursing are jointly responsible for creating and maintaining a nursing practice environment necessary for safe and appropriate care. Key aspects of nursing regulation are identified by the ICN (Styles, 1986; Styles & Affara, 1997). These aspects are represented in Table 2.2.

According to the ICN (Styles & Affara, 1992) the various dimensions of professional regulation include the fundamental objectives, the target group, the mechanism of the regulation, the authorities involved, the standards and work methods (instruments). Each is explained in Table 2.3 below.

Table 2.2: Key aspects of nursing regulation (Source: Styles & Affara, 1997)

Key aspects	Description
Nursing schools	▪ Students - pre-defined qualifications ▪ Prescribed basic and ongoing education programme based on practice standards, code of conduct ▪ Accreditation from external authority (e.g. nursing board/ council)
Nurses	▪ Qualified to provide services to public ▪ Given compensation and title ▪ Certified specialists - advanced education / experience - additional responsibilities / authority ▪ Bound by a code of ethical conduct ▪ If a nurse violates code, laws or regulations, it may lead to disciplinary action – by professional regulatory body and / or through legal system
Nursing practice	▪ Set boundaries defined in scope of practice ▪ Directed by governmental rules and regulations ▪ Educational programmes and roles / responsibilities reflect practice scope and standards
Health care agencies/ Organisations	▪ Responsible to protect the public ▪ Health care agencies accredited ▪ Standards set by specific external authority ▪ Standards include qualifications and health care personnel ▪ Designated roles / responsibilities ▪ Supervision of lesser prepared auxiliaries by qualified nurses
Government	▪ Set health care and civil services policies (e.g. health care priorities, financing, health care systems, qualifications, rights / responsibilities, working conditions and compensation) ▪ Shape overall professional practice framework

In Canada and other countries, nursing regulatory bodies have developed and implemented standards to regulate the practice of nurses. Standards represent criteria against which the registered nurses' practice can be measured by the public, patients/clients, employers, colleagues and nurses themselves. Practice standards reflect the value of the profession and clarify what is minimally expected of registered nurses (Brunke, 2005). One criticism of a minimum approach is that it may not provide adequate incentive for continuous performance improvement (Finnie & Usher, 2005). Employers may also impose policies and procedures onto its employees which may conflict with professional standards (Bryant, 2005).

In the next section the ICN principles of regulation are highlighted.

Table 2.3: Dimensions of professional regulation (Source: Affara & Styles, 1992)

Dimensions	Explanation
Fundamental objectives: Why the regulatory system was established. For what purpose?	Regulatory board/council's objectives include: ▪ Protect public from unsafe practices ▪ Set professional-ethical standards ▪ Confer accountability ▪ Identify and confer professional status ▪ Utilise country's policy statement ▪ Ensure nursing services acceptable and accessible
Target group: Who is being regulated?	▪ Practitioner – provides services ▪ Education system - establish educational programme - practitioner education/preparation ▪ Health care services system hires qualified educators
Professional regulation mechanism: What forms does regulation take?	Credentials assessed, standards met and practice approved - ▪ Require formal regulatory system with routine assessment: - reliable record keeping system of each member - monitor standards - remedial action when standards not maintained ▪ Credentialing mechanisms include: - education agency standards e.g. building and classrooms - approval and assessment credentials - basic and graduate levels - situational analysis of learning opportunities available - teaching staff credentials - educational programme standards - examination of students - meet education objectives licensed/ registered - professional-ethical guidelines conduct of practice - formal practice authorisation (registration and credentials)
Authorities and agencies: Inside and outside of profession	▪ External regulation - government authority ▪ Internal profession itself – autonomous / independent regulation ▪ Autonomous regulation - public trusts profession ▪ Agent - organisation performs / administers regulation ▪ Authorised by government - national or provincial / state level ▪ Authorisation in legislation – e.g. proclaimed as a nurses' act
Standards	▪ Acceptable to all role players ▪ Provide minimum achievable level to ensure quality ▪ Reflect practice scope and demands ▪ Evidence knowledge and performance described ▪ Relate to education, health care services and resources
Work methods	▪ Compile curricula / education programmes ▪ Develop valid and reliable competence instruments ▪ Visits to nursing schools, educational institutions and health care organisations for the purpose of evaluation ▪ System for examination and certification ▪ System for continuing professional development and accountability ▪ System for disciplining when required

2.4.1.2. iv) Principles of nursing regulation

As the global mouthpiece for nurses the ICN has cultivated an international network of nursing experts in regulation and has developed and improved techniques and principles for nursing regulation. The wide disparity among nations regarding the purposes, standards and procedures of regulation necessitated fundamental agreement on these issues, therefore the ICN adopted the following rationale and resolution: "Health is a vital social asset. 'Health for All' is a global objective. The nursing profession offers its utmost to this world-wide social purpose. Fulfilling this promise calls for influencing and responding to changing health needs and priorities; and developing and mobilising the fullest potential of the profession" (Styles & Affara, 1997:11). The ICN (Styles, 1985; Styles & Affara, 1997) stresses that a nursing governance system must provide for the following:

- high standards for the personal and professional growth and performance of nurses;
- public sanction for nurses to perform to the full extent of their capabilities;
- participation of the profession in the development of public policy;
- accountability of the profession to the public for the conduct of its affairs on behalf of the public; and
- proper recognition and remuneration for the contribution of the profession and opportunity for self-actualisation of its members.

This rationale forms the basis for the ICN 12 principles of professional regulation (Styles & Affara, 1997). The principles attempt to distinguish between governmental and professional responsibility as well as the common ground in between. It is important that a "distinction needs to be made between the right to practice which is a provision of the law and the standards of practice which are determined by the profession" (ICN, 1969, quoted in Styles, 1985:40). These principles underscore the responsibility of the profession to prepare its own code of ethics and to establish standards of practice (Percival, 2001). They relate to purposefulness, relevance, definition, professional ultimacy, multiple interest and responsibility, representative balance, professional optimacy, flexibility, efficiency and congruence, universality, fairness and inter-professional equality and compatibility (Styles, 1985). [See Table 2.4].

Table 2.4: The International Council of Nurses' regulation principles (Source: Styles, 1985)

Principles	Description
Purposefulness	Regulation be directed toward an explicit purpose
Relevance	Regulation be designed to achieve the stated purpose
Definition	Regulatory standards be based upon clear definitions of professional scope of practice and accountability
Professional ultimacy	Regulatory definition and standards promote fullest professional development commensurate with potential social contribution
Multiple interests and responsibilities	Effective regulatory system incorporate legitimate roles and responsibilities of interested parties – public, profession, government, employers, other professions – aspects of standard-setting and administration
Representational balance	Regulatory system's design acknowledge and appropriately balance interdependent interests
Optimacy	Regulatory system provide limited controls and restrictions necessary to achieve objectives
Flexibility	Regulation practice standards are sufficiently broad and flexible to achieve objectives and permit freedom for innovation, growth and change
Efficiency and congruence	Regulatory system operate in most efficient manner, ensuring coherence and co-ordination among parts
Universality	Regulatory system promote universal performance standards and foster professional identity and mobility compatible with local needs and circumstances
Fairness	Regulatory processes provide honest and just treatment for parties regulated
Inter-professional equality and compatibility	Regulatory system practise standards incorporate equality and interdependence of various professions

The ICN has also set out guidelines and principles for professional regulation in the form of position or policy statements. These statements are to protect the public and support the profession to fulfil its responsibility to the public. The ICN calls for representation of all role players in the process of professional regulation and the maintenance of certain standards. The role of the professional board/council is to act in the interest of the public by regulating nursing education and the practice of

the nurse. The quality of nursing education and practice, protection of the public, and the mobility of nurses can be greatly enhanced when countries and nursing regulatory bodies adhere to regulatory principles and guidelines of the ICN.

The next section summarises the researcher's personal and professional philosophy.

2.4.1.3 Researcher's personal and professional philosophy

Philosophy enables "…individuals to better understand and appreciate the activities of everyday life" (Elias & Merriam, 1995:5). Living and working as a nurse educator in Saudi Arabia, the world centre for the Muslim religion, provided a rich learning environment for such explorations. For over 30 years, Saudi Arabia has been a crossroads for nurses from between 50 and 55 nations. Practising nursing in the midst of a multicultural workforce situated in a different culture from my own has provided an opportunity for me to consider more deeply how I know what I know and why I value what I value. I became very focused and self-directed in my learning and continuing professional development. As an educator, I guided learning, facilitated teachable moments, and created positive learning environments. I was also mindful of potential ethical and cultural considerations involved in helping adults achieve transformational learning, including value conflicts and sociological and psychological adjustments that might include questioning social and cultural norms.

My primary philosophical foundation is that of a Christian. I believe in the importance of contributing to the common good and living a life that matters. I try to maintain a holistic perspective and I believe that caring (Bevis & Watson, 1989) is the essence of nursing, whether nurses are promoting health, supporting and nurturing those who are sick, dying or in a state of grief. If one expects nurses to care for others holistically, one must also care for nurses and treat them holistically.

I appreciated the privilege of being able to enhance my personal and professional development and thoroughly enjoyed facilitating learning for others. As an adult educator, I utilise experiential learning, interactive group tasks and discussions, team teaching and self-directed learning and strive to be consistent in applying these elements. I prefer to work collaboratively within nursing as well as with

other disciplines to support the betterment of the human condition. I remain respectful to all human beings while supporting their right to learn and develop.

I believe everyone has the potential for continuous growth and development. In nursing there are large bodies of concrete facts to internalise and integrate into practice. One method for keeping up to date is to learn and develop continually. From my personal experience, growth included specific practice competencies, critical and reflective thinking, ethics, communication and leadership. Prior to coming to Saudi Arabia, I had practised at the bedside in critical care areas for 15 years and another 15 in management. Assuming an educator role required me to enhance my nursing education competencies. To assist in this learning process, I pursued a PhD in higher education. My educational goal was to build on my knowledge and experiences to enhance my abilities to teach and support others to learn. From my mentor, I learned the importance of a well developed study guide which can also serve as a learning contract with learners. Study guides and course readings are, of course, just the basics of what should be covered to achieve significant exit learning outcomes. Essential as well are practical ways for learners to internalise, achieve mastery and integrate their learning into their nursing practice. For example, I read extensively, shared my learning while teaching and engaging in dialogue, wrote about my experiences and critically reflected on my experiences. Through this constructivistic process, I internalised and integrated my learning thereby transforming personally and professionally (Diekelmann & Magnissen, 1998; Merizow, 2000; Brookfield, 2000).

The relationships created within my current research were unique. Firstly they were contrived for my benefit in pursuing my PhD, and secondly for the benefit of all nurses working within Saudi Arabia and for other parties who may be interested in the research results. In conducting the research, I used a variety of skills to encourage information disclosure – some of which may otherwise not have been told. The situation of openness in communication might have posed risks for the subjects and placed me in a position of power. To guard against misuse of this power, written approval for the research was requested and granted by a senior executive from the organisation where I was employed. Additionally, in making a commitment to investigate the phenomenon of continuing professional development of nurses working in Saudi Arabia, my intent was to influence the quality

of nursing practice in Saudi Arabia and ultimately to enhance the overall outcomes of health in the Saudi Arabian population.

While working within Saudi Arabia, I was accountable to the society of Saudi Arabia in particular to support and promote quality nursing practice. As an employee, I was accountable to my sponsor organisation, to the government of Saudi Arabia, and ultimately to the Saudi public. Morally I was also responsible for my research and as such accountable to those who were my research participants, and who were also engaged in learning. Thus, in accepting these various levels of responsibility, I had three major stakeholders: the nursing community and profession, the people of Saudi Arabia and the research participants.

The focus of the next section is the practice of nursing education, the domain in which I am currently practising. Nursing education practice was the second component of the literature review conceptual framework (see Figure 2.1).

2.4.2 Nursing education practice

As previously mentioned, each professional nurse has a responsibility to maintain and continually enhance his or her knowledge to ensure quality nursing practice. Furthermore, nursing education is a major determinant in the development and enhancement of quality practice (Muller, 2003; CNA & CASN, 2004a). There has been significant shift in the ways in which we think about learning (Finnie & Usher, 2005; Pratt, 1998). This heightened consciousness necessitates change in the way nurse educators approach learning. The shift from teaching content to outcomes-based education, in particular, is in keeping with standards, quality improvement and evidence-based practice (Van der Merwe, 2005). In this section nursing practice, specifically the domain of education, is explored by focusing on the following topics: nursing education; curriculum development; outcomes-based education; and quality practice environments.

2.4.2.1 Nursing education

Nursing education is achieved in a wide variety of settings. As educators, nurses need to be proactive, take risks where necessary, use critical thinking and creativity liberally and continue to embrace caring as the essence of their practice (Bevis & Watson, 1989). “Based on needs and values, learners determine the type and extent of learning activities. Educational activities are directly influenced by an organisation’s mission, goals, values, priorities and resources” (American Nurses Association [ANA], 2000b:7). Further, as the quality of nursing practice ultimately influences patient outcomes, nurse educators and health and educational institutions have a professional responsibility to support the ongoing professional development of nurses in a flexible and accessible format (CNA & CASN, 2004b). Nurse educators assume roles that are uniquely different from their clinical, manager or research counterparts, such as that of educator, facilitator, designer, change agent, consultant, researcher, leader and lifelong learner (see Table 2.5). Continuing professional development contributes to the quality of nursing education practice, enabling nurses to base their practice on the most recent and strongest evidence to produce or contribute to quality patient outcomes, assist in preventing poor practice and protect the public (CNA & CASN, 2004b; Heath, 2002).

Table 2.5: Educator's roles and specific activities
(Sources: American Nurses Association, 2000b; Southern Regional Education Board, 2002)

Educator's roles	Specific activities
Educator	▪ Provide an appropriate climate for learning ▪ Facilitate the learning process ▪ Ensure learners are actively involved in process of assessment of needs and outcomes ▪ Demonstrate ability to support and empower learners ▪ Evaluate the effectiveness of outcomes ▪ Collaborate with learners to enable them to develop portfolios
Facilitator	▪ Assist learners to identify their learning needs and effective learning activities ▪ Provide sufficient time for learners to meet their needs, re-mediating as necessary ▪ Serve as a role model for continuing learning and education ▪ Foster positive attitude about benefits and opportunities of lifelong learning
Designer	▪ Identify learning requirements within specific context ▪ Develop, plan and present educational activities within areas of expertise ▪ Design original programmes ▪ Select and prepare suitable learning resources ▪ Select, sequence and pace resources sensitive to the holistic needs of the learners
Change Agent	▪ Serve as a change agent - organisational, community, national and international levels ▪ Facilitate initiation of, adoption of and adaptation to change ▪ Participate in strategic planning, committees, projects to identify needed changes ▪ Influence the necessary policy, procedures to create and support the change process
Consultant	▪ Act in a formal or informal consultant role ▪ Assist in the integration of new learning into practice or practice environment ▪ Assist nurses to identify and design needed educational experiences ▪ Provide feedback to the learners and organisations related to effectiveness of learning and learning activities
Researcher	▪ Design and implement research ▪ Integrate relevant research outcomes into practice through effective learning activities ▪ Help others utilise the research process in their practice ▪ Foster the use of systematic evaluation research with regard to data ▪ Evaluate outcomes of educational endeavours ▪ Track learner outcomes
Leader	▪ Support organisational and administrative structures to achieve departmental and organisational goals ▪ Manage programme activities, including human and material resources ▪ Ensure educational activities are congruent with organisation's mission, vision and goals ▪ Evaluate the effectiveness of the overall educational programme ▪ Communicate effectively and efficiently with all levels of organisation ▪ Use problem solving skills ▪ Model behaviour to reflect participation and leadership in activities
Lifelong learner	▪ Continue developing competencies including teaching and learning theories, curriculum design, measurement evaluation, research and technological options ▪ Demonstrate ongoing personal, academic and professional growth ▪ Utilise reflective practice techniques ▪ Maintain a professional portfolio to document results

The link between education and service is essential if nursing education programmes are to meet service demands. Flexibility in education so that the nurse can continually adapt to changing needs is also important (Bryant, 2005). Kenny (2004) recommends a closer relationship between academic nursing education and clinical education. “One way to ensure that nursing education programmes are reflective of the needs of employers and the practice environment is through curriculum development…” (Bryant, 2005:18). According to the WHO (2001), nursing education accreditation systems should support capacity development in nursing educational institutions, through:

- linkages with institutions of higher education and educational authorities;
- integration with hospitals and health services;
- collaboration with health-related and governmental bodies; and
- collaboration with international organisations, developed through appropriate channels.

Further such systems should build capacity to prove broad learning programmes as a basis for meeting the lifelong learning needs of the nursing workforce. Success requires a comprehensive approach and the help of multiple stakeholders to establish:

- a legal framework for nursing education and practice;
- a regulatory system and standards for educational programmes;
- accreditation (validation) of programmes; and
- a high calibre nursing workforce (WHO, 2001).

Practice standards should be based on Saudi Arabia health care needs as well as global requirements; adequate resources (human and material); and a comprehensive education process that includes a philosophy, curriculum, extracurricular activities and comprehensive outcomes to guide teaching-learning strategies with adequate hours for clinical/field work (Van der Merwe, 2005). Initial education standards refer to those necessary to develop generalist nurses who are competent to provide quality care in all types of settings, for example in hospitals, primary care, homes, schools and industry and for all ages, from womb to tomb, so that nurses can become active as citizens and members of the community, sensitive to what and how health is determined (Wilkinson & Marmot, 2003). It is important that they have the competence to impact and improve the health of the people and develop and promote nursing as a profession (WHO, 2001).

In the next section curriculum development is explored.

2.4.2.2 Curriculum development

To support quality learning the methods and forms that are used to teach are extremely critical and require careful and deliberate selection (Conti & Kology, 1998). To achieve learning outcomes, educators must carefully select and know why one methodology is better than another within a given learning situation. Basing the selection on careful experiential reflection and theory adds to one's professional approach (Elias & Merriam, 1995). As particular teaching methods have distinct characteristics, using them may make it easier to facilitate learning. While some methods are more compatible with a certain philosophical premise for learning, they are not necessarily restricted to a specific philosophy (Conti & Kology, 1998). Rather the difference lies in how the individual teacher uses the method, including for example, what activities are used, the purpose for using the specific method, and the desired outcomes. Curriculum design refers to the way in which educators conceptualise an educational programme and arrange its major components (subject matter content, teaching and education methods and materials, learner experiences and activities) to provide direction and guidance towards outcomes (Muller, 2003). Curriculum steps are dynamic and interrelated (see Table 2.6). Outcomes of curriculum and learning go beyond the institutional walls and extend to the building of better citizens who are productive in the workforce and community (Kegan, 2000; Boyer, 1990). An outcomes-based education (OBE) curriculum provides a comprehensive transformational approach to adult learning which is in keeping with continuing professional development requirements of nurses.

Table 2.6: Curriculum planning: interrelated steps and design components with specific actions
(Source: Muller, 2003; Vella, 2002)

Interrelated steps	Design components	Specific actions
Educational philosophy (why?)	▪ Learning ▪ Education	▪ Identify educational philosophy determining beliefs of adult learning ▪ Identify professional practice standards (national and international) ▪ Determine how learning is to take place and education to be offered
Target group (who?)	▪ Essential and specific learning needs	▪ Identify learner (target) group ▪ Clarify roles and responsibilities ▪ Prepare assessment strategy
Situational analysis (how?)	▪ Learning needs ▪ Resource assessment ▪ Budget	▪ Assess needs of learners and organisation ▪ Use assessment results to inform programme design ▪ Identify human and material resources ▪ Prepare educational budget
Formulate outcomes (why?)	▪ Critical and specific	▪ State programme purpose ▪ Ensure outcomes are measurable and realistic and within a timeframe ▪ Formulate competencies (knowledge, skills, values and attitudes)
Learning content (what?)	▪ Classify and group	▪ Prepare main modules and learning units ▪ Sequence content from simple to difficult, easy to complex ▪ Incorporate adequate time for knowledge development, comprehension (internalisation) and integration into practice
Educational principles and strategies (how?)	▪ Principles / methods / strategies	▪ Create a safe, open and respectful learning environment ▪ Build sound relationships with and among learners and educators ▪ Engage adults in their own learning, moving towards self-directed learning ▪ Incorporate cognitive, affective and psycho-motor learning aspects ▪ Repeat facts, skills and attitudes in diverse, engaging ways ▪ Include teamwork and small group activities ▪ Have learners practise what is taught to gain confidence ▪ Facilitate critical and reflective thinking through praxis ▪ Direct learners to implement career plan and professional portfolios
Curriculum implementation strategies (when, where?)	▪ Venue / dates / time ▪ Communication	▪ Extend invitations and negotiate dates / times and remuneration ▪ Communicate details with target group and relevant others
Assessment / evaluation strategies (so what, now what and then what?)	▪ Theoretical and practical assessment ▪ Feedback ▪ Presenter's assessment ▪ Curriculum assessment ▪ Ongoing research	▪ Assess validity / reliability of content (evidence-based practice) ▪ Provide continuous constructive feedback (verbal and written) ▪ Assess learners, educator(s) and curriculum content continually ▪ Ensure that what was proposed in learning programme was taught ▪ Remediate as necessary to enhance learning outcomes ▪ Analyse contributing factors that impact learning results ▪ Assess organisational improvement as a result of learning ▪ Formulate improvement based on analysis, research and critical reflection ▪ Write report and share findings and recommendations

2.4.2.3 Outcomes-based education

The primary aim of outcomes-based education (OBE) is to facilitate desired changes within the learners, by increasing knowledge, developing skills and/or positively influencing attitudes, values and judgment. OBE embodies the idea that the best way to learn is first to determine what needs to be achieved. Once the end goal (product or outcome) has been determined, the strategies, processes, techniques, and other ways and means can be put into place to achieve the goal. Bryant (2005:18) says that learning outcomes and competencies are synonymous: "the competency based approach to health professional education has grown in response to concerns about patient safety".

2.4.2.3 i) Definitions of outcomes and outcomes-based education

Outcomes describe the results of learning over a period of time – the results of what is learned versus what is taught; and what learners are able to do with what they know and have learned. Geyser (1999) says when learners do important things with what they know they have taken a significant step beyond knowing itself. Outcomes assessment helps learners know what they know and demonstrates accountability in teaching (Vella, Berardinelli & Burrow, 1998).

Outcomes-based education (OBE) is defined as a "…comprehensive approach to organizing and operating an education system that is focused in and defined by the successful demonstrations of learning sought from each student" (Spady, 1994:191). OBE involves restructuring curriculum, assessment and reporting practices in education to reflect the achievement of high order learning and mastery rather than accumulation of course credits (Tucker, 2004). Having decided what are the key things students should understand and be able to do or the qualities they should develop, both structures and curricula are designed to achieve those capabilities or qualities. Educational structures and curriculum are regarded as means not ends (Willis & Kissane, 1995).

OBE and outcomes-focused education (OFE) are often confused or used synonymously. An OBE system is one in which the outcomes drive the whole course content and assessment structure. OFE is one in which learner outcomes (the result of student learning) are specifically identified in

discipline-based courses and units. The assessment processes are designed specifically to assess the learners' achievement of the outcomes (Tucker, 2004). In this research OBE and OFE are used interchangeably. Behind these definitions lie an approach to planning, delivering and evaluating instruction that requires administrators, teachers and learners to focus their respective attention and efforts on the desired results of education (Killen, 2000) and to be accountable for what transpires (Spady, 1994; Vella et al., 1998). Proponents of OBE assume there are many ways in which to arrive at the same results. OBE is currently favoured internationally in countries such as Canada, South Africa, New Zealand and the United States (Malan, 2000). The roots of OBE go back a long way in history.

2.4.2.3 ii) The roots of outcomes-based education

An outcomes-based approach to education dates back some 500 years to the craft guilds of the Middle Ages in Europe in the form of apprenticeship training models. There are many examples still in place today (Spady, 1994). Several authors (King & Evan, 1991; Malan, 2000) analysed past educational reforms that influenced OBE and identified the following:

- In 1950, Tyler identified fundamental issues that are important when developing and planning instruction, including purpose, content, organisation and evaluation. He believed that objectives were essential for systematic planning and identifying the required learner behaviour post instruction as well as the content and context within which to apply it. His curriculum design approach continued to influence teaching for several decades and the basic philosophy for outcomes -based design is rooted there (Arjun, 1998, cited in Malan, 2000)
- Bloom's taxonomies for educational objectives emerged in the 1950s and helped to determine whether learners had attained acceptable standards compared to desired learning outcomes. His mastery learning theory was based on the premise that with sufficient opportunities and support from an appropriate learning environment most learners are successful in their learning tasks. This notion is reflected in OBE. Other characteristics of mastery learning include:
  - ascertaining prerequisite knowledge or skills to attain goals (outcomes);
  - a flexible time frame to attain goals (outcomes);
  - using different media and materials to create enriched teaching/learning contexts; and
  - formative evaluation to provide feedback for both teaching and learning improvement.

- Competency-based education was introduced in the 1960s in North America in response to growing concerns that students were not being taught what they required after they left school. Malan (2000) summarises the following components from the literature on competency-based education, noting their prominence in OBE:

  - explicit learning outcomes with respect to the required skills and concomitant proficiency (standards for assessment);
  - a flexible time frame to master skills;
  - a variety of instructional activities to facilitate learning;
  - criterion-referenced testing of the required outcomes;
  - certification based on demonstrated learning outcomes;
  - adaptable programmes to ensure optimum learner guidance; and
  - support for the notion that the learner is accountable for his or her own achievement.

- In 1963, Glaser described criterion-referenced measurement as that which locates a student's test behaviour on a continuum ranging from no proficiency to perfect performance. Criterion-referenced instruction and assessment is based on attaining specific outcomes and on testing for competence in terms of stated criterion. This form of instruction compares a learning outcome or mastery of competencies with a predetermined external standard. Success is measured by demonstration of standards followed by remedial intervention as required. Criterion-referenced assessment is the preferred mode of assessment in OBE.
- Spady's (1994) outcomes-based education approach closely resembles Mager's (1984) guidelines in terms of expected performance, conditions under which it is attained and standards for assessed quality. OBE learning programme assessment and learners' competence can be compared to specific criteria. Competence in the required outcome (learner behaviours) is demonstrated within a specific time frame and context.

OBE is explored in greater detail in the following sections.

2.4.2.3. iii) Outcomes-based education philosophy

Outcomes-based education can be regarded as a theory (or a philosophy) of education (Killen, 2000). Within OBE there are a certain set of beliefs and assumptions about learning, teaching and

the systemic structures within which activities take place. Spady (1996) proposes three basic assumptions: all learners can learn and succeed; success breeds success; and teaching institutions (schools) control the conditions of success.

Killen (2000) defines two basic types of outcomes. The first includes performance indicators which may be measured in terms of test results, completion rates, and post-course employment. It also emphasises learner mastery of traditional subject-related academic outcomes/content and some cross-discipline outcomes (such as problem solving or working cooperatively). The second is less tangible and is usually expressed in terms of what the learners know, are able to do or are like as a result of their education. It stresses long-term, cross-curriculum outcomes which relate to future life roles of the learner (such as being a productive worker, a responsible citizen or parent). These two approaches are what Spady (1994) respectively calls traditional/transactional (content-based) and transformational (outcomes-based) learning systems (see Table 2.7). The latter is the focus of this research and includes standards to be consistently demonstrated by the learner at the end of a significant learning experience (Spady, 1996).

Table 2.7: Content-based learning versus outcomes-based learning (Source: Spady, 1996)

Content-based learning system	Outcomes-based learning system
Passive students	Active learners
Assessment process – examination and grade driven	Continuous assessment
Rote learning	Critical thinking, reasoning, reflection and action
Content-based/ broken into subjects	Integration of knowledge, learning relevant / connected to real life situations
Textbook/worksheet-focused and teacher-centred	Learner-centred and educator / facilitator uses group / teamwork
See syllabus as rigid and non-negotiable	Learning programmes are designed to allow for innovation and creativity when designing programmes / activities
Teachers/trainers responsible for learning Learners motivated by personality of the teacher	Learners take responsibility for their learning Learners motivated by constant feedback / affirmation of worth
Emphasis is on what teacher hopes to achieve	Emphasis is on outcomes – what learner becomes and understands
Content placed in rigid time frames	Flexible time frames - learners work at own pace
Stay in single learning institution until complete	Learners can gather credits from different institutions until they achieve qualification
Previous knowledge and experience in learning field is ignored Each time attends whole course	Recognition of prior learning: after pre-assessment Learners are credited with transfer credits elsewhere

2.4.2.3. iv) Principles of outcomes-based education

Four principles guide the transformational OBE approach. Taken together, they strengthen the conditions for both learner and teacher success: clarity of focus; design down; high expectations; and expanded opportunities (Spady, 1994). Clarity of focus infers that curriculum development, implementation and evaluation should be geared by the outcomes which are expected as the culminating demonstrations of the learners. The principle clearly delineates that the articulation of the desired end point is essential for successful outcomes (Willis & Kissane, 1997). Curriculum planners and educators have to identify a clear focus on what they want learners to be able to demonstrate at the end of significant learning time. Once these outcomes have been identified, the curriculum is constructed by backward mapping of knowledge and skills. The design down aspect infers that all curricular and educational activities should be designed back from the point where the exit outcomes are expected to happen. The principle of high expectations elicits a higher level of standards than would normally be set, as only those can be labelled completed (Spady, 1996). Expanded opportunities provide for a flexible approach in time and teaching methodologies matched against the needs of the learner allowing more than one opportunity to succeed (Killen, 2000). The principles of OBE, and their application, are summarised in Table 2.8 below.

Table 2.8: Outcomes-based principles – explanation and application to practice (Source: Spady, 1996; Killen, 2000)

OBE principles	Explanation	Application to practice
Clarity of focus	▪ Focus on what teachers want learners to be able to do successfully	▪ Help learners develop competencies ▪ Enable predetermined significant outcomes ▪ Clarify short- and long-term learning intentions ▪ Focus assessments on significant outcomes
Design down	▪ Begin curriculum design with a clear definition of the significant learning that learners are to achieve by the end of their formal education	▪ Develop systematic education curricula ▪ Trace back from desired end results ▪ Identity learning building blocks ▪ Link planning, teaching and assessment decisions to significant learner outcomes
High expectations	▪ Establish high, challenging performance standards	▪ Engage deeply with issues they are learning ▪ Push beyond where learners would normally have gone
Expanded opportunities	▪ Learners do not all learn same thing in same way in same time	▪ Provide multiple learning opportunities matching learners' needs with teaching techniques

2.4.2.3. v) The purpose of outcomes-based education

Spady (1996) emphasises that the decision of what and whether the learners learn is more important than when it happens and through what means (how) they learn it. He therefore identifies two key aims for OBE.

While all learners can learn and succeed, they cannot all do so on the same day because learners have different learning rates and learning styles. Furthermore, since successful learning breeds more successful learning, the importance of having a stronger cognitive and psychological foundation of prior learning cannot be underestimated. Since the conditions directly affecting learning are under the educational system's control, learning is dependent on the willingness of teachers and others to believe in the approach, and to support learners in their learning. As educators focus more broadly on accomplishing results as opposed to simply providing a service, OBE differs greatly from more traditional forms of education, most notably in its overall approach (framework); perception of time; what and how standards are assessed; and how performance is determined (Spady, 1994) (see Table 2.9). It is also important that conditions and opportunities be established that enable and encourage all learners to achieve the essential outcomes (Spady, 1996).

OBE educators are facilitators of learning who support the learners to become independent thinkers and ultimately manage themselves and their careers (Killen, 2000; Wallace, 1997). The OBE educator also acts as an experienced mentor advising learners about learning and their approaches to life (Geyser, 1999). There are many positive aspects to OBE, particularly from a transformational viewpoint. OBE supports a rational approach to education as a means to an end rather than an end in itself and promotes cooperative as opposed to competitive learning. It demands that those who plan, manage and account for what happens, will focus their efforts on learning and attainment of desired outcomes as opposed to curriculum content and achievement of grades. Learning is no longer time and teacher dependent. Learners, educators and others who support learning have to become more attuned to creating the conditions that support learning and to the attainment of desired outcomes. Part of the success of OBE lies in its inherent encouragement of continuous

growth and ongoing improvement (Spady, 1994). Assessment of outcomes-based learning is described in the next section.

2.4.2.3 vi) The assessment of outcomes-based learning

A range of instruments can be used to assess learning outcomes. Assessment instruments for outcomes-based learning, however, should be directed to the prescribed evidence-based criteria that are acceptable to the professionals (Shumway & Harden, 2003). The four most common criteria to take into account when choosing instruments are the following:

- *Validity.* The instrument should be valid in that the assessment instrument (e.g. test or case study) measures what it is suppose to measure. It is not the instrument but the score that is the concern. Shumway and Harden (2003) note that validity includes three aspects:
  - *Content validity* is determined by a review of the assessment instrument and the extent to which it measures what it is suppose to measure.
  - *Criterion-related validity* is the comparison of a test score against a known criterion of the expected performance.
  - *Construct validity* is the collection of indirect assessment that the assessment instrument measures what it purports to measure, including the different levels of learning.
- *Reliability.* The reliability of an assessment instrument is determined by its consistency, generalisability and reproducibility and the extent to which scores would be similar if retested. If the assessment results cluster around each other, it can be said the evaluation is reliable (Shumway & Harden, 2003).
- *Impact.* The impact of the assessment instrument on the learner is driven by the content, structure (or format); what is asked and its frequency; timing; and the number of repeat examinations (Van der Vleuten, 1996).
- *Practicality.* The assessment practicality depends on the resources and expertise available and the cost incurred when undertaking it. Costs include the start-up and continuing resources required for development, implementation, monitoring and evaluation. It should also be assessed against the benefit it adds to learning and teaching (Shumway & Harden, 2003).

Table 2.9: Characteristics of learning systems: content-based versus outcomes-based (Source: Spady, 1996)

Learning system characteristics	Content-based (traditional/transactional)	Outcomes-based (transformational)
Framework	▪ Predefined curriculum, assessment and credentialing in place ▪ Structures ends, no defined learners' outcomes	▪ Curriculum, instructional strategies, assessment and performed standards ▪ Structures support outcomes, flexible and a means to define learning ends
Time	▪ Inflexible constraint for educator and learner schedule controls learning	▪ Used alterable source – match needs of educator and learners
Performance standards	▪ Comparative and competitive approach ▪ Linked to predetermined curve or quota of possible successes	▪ Learners potentially able to receive credit for achieving performance standards ▪ No quotas / standards pursued
Learning assessments	▪ Continuous testing and permanent grading ▪ Mistakes on permanent record: best grades and records fast and consistent performers ▪ Slower learners never catch up ▪ Never assesses/ documents what learners can ultimately do successfully	▪ Macro view learning and achievement ▪ Mistakes inevitable steps in developing, internalising and demonstrating high level of performance capabilities ▪ Ultimate achievement is what able to do

Shumway and Harden (2003) have classified assessment instruments in the following way:

- *Written assessments* – e.g. short essays, short answer questions, multiple choice questions, patient management problems (also referred to as problem-based learning) reports; critique of documentation (nursing notes, incident reports, performance evaluations, policies and procedures); research proposals and project reports;
- *Clinical or practical assessment* – e.g. objective structured clinical examinations (OSCE); classroom or clinical teaching; management round;
- *Observation* – e.g. competence checklist; performance / evaluation rating scales; competence assessment – patient care provision and management; management functions; teaching; evidence-based / research practice;
- *Portfolios and other records of performance* – e.g. content and format of professional portfolios; nursing patient care plans; structured curriculum (learning programme); strategic, operational and disaster plans; minutes of meetings; management reports.
- *Peer and self-assessment* – e.g. peer report and self-report; reflective practice report; career management plan.

A quality practice environment is another essential element.

2.4.2.4 Quality practice environments

Quality practice environments enable quality care (Lowe, 2000; CNA, 2001b; RNABC, 2002). Conversely, when practice environments do not support nurses' practice, their patients are more likely to have adverse health outcomes (Baumann, O'Brien-Pallas, Armstrong-Stassen, Blythe, Bourbonnias, Cameron, Irvine Doran, Kerr, McGilles Hall, Vezina, Butt, & Ryan, 2001; Aiken, Clarke, Sloane, Sochalski, Busse, Clarke, Giovanetti, Hunt, Rafferty, & Shamian., 2001; Aiken, Buchan, Sochalski, Nicholes & Powell, 2004). Various authors (Upenieke, 2003; Buchan, 1999; Aiken, Clarke, Sloane, Sochalski & Siber, 2002) state that nurses prefer to work in environments (conditions) which:

- maintain well qualified nurse executives;
- decentralise the work environment;
- emphasise open, participatory management organisational structures;
- offer an autonomous, self-managed, self-governing climate;
- allow nurses to fully practise their clinical expertise;
- provide flexible staffing and adequate staffing ratios;
- provide planned staff orientation;
- emphasise service/ continuing education; and
- provide clinical career opportunities and management development.

Lowe, Schellenberg and Shannon (2003) found a strong correlation between a healthy work environment and good communication and social support. Employees in self-rated healthier work environments also have higher job satisfaction, commitment and morale, and lower absenteeism and intent to quit. Thus, for the overall sustainability of a high quality health care workplace, many elements are needed. However, no single discipline can capture the processes and structures to facilitate quality patient care outcomes (Lowe, 2000).

One study (Aiken et al., 2001) included more than 43 000 nurses from 700 hospitals in five different countries: the United States, Canada, England, Scotland and Germany in 1998-1999. Despite distinctly different health care systems, the participants reported similar shortcomings in their work

environments and the quality of hospital care. Fewer than half of the nurses in each of the five countries confirmed that management in their hospitals was responsive to their concerns, provided opportunities for nurses to participate in decision making and acknowledged nurses' contribution to patient care.

Motivation at work is believed to be an important factor for individual performance and a significant predictor of the intent to quit the workplace. Job dissatisfaction, lack of motivation and intention to quit are empirically linked (Zurn, Dolea & Stilwell, 2005). Three factors play a key role in nurses' performance: the ability (knowledge, skills and experience) to do the job; adequate motivation for them to apply their abilities; and the organisational support (availability of resources, presence of policies and practices conducive to performance, physical and social environment) or opportunity to do the job well and make choices about how their job is done (Zurn, et al., 2005; Rafferty, Maben, West & Robinson, 2005). The ICN (2002) states that negative factors in the workplace, such as stress and violence, conflict, occupational health and safety hazards, as well as isolation from others could further exacerbate a hostile work environment. Recently much has been written on the subject of workplace (horizontal) violence (Kelly, 2003; Chalmers, 2004). The term *horizontal violence* is defined in the literature (Kelly, 2003) as bullying or intimating behaviour in the workplace. Hastie (2004:2) expands the definition to include "…systems and cultural issues, a symptom of an emotionally, spiritually and psychologically toxic and oppressive environment…"

Many of the workplace stress factors (e.g. an enclosed atmosphere, time pressures, excessive noise, unpleasant sounds and having to stand for long periods) are easily recognised by nurses as daily occurrences (ICN, 2002). Workplace stress is aggravated by inadequately defined roles and responsibilities, poor communication methods, policies and practice and the lack of decision making. Under-utilisation of skills or failing to reach full potential, limited or no opportunities to learn, and physical and emotional demands further breed job stress (ICN, 2002). The International Labour Office, International Council of Nurses, World Health Organisation and Public Services International (ILO, ICN, WHO & PSI, 2002) designed a joint programme, including guidelines on workplace violence in the health sector.

Attending to the needs of workers may increase trust and further work commitment, improve communication and in general promote healthy work relationships. Organisational trust and commitment are deepened when the nurse perceives that the employer is taking her or his interests and well-being into account. Excessive workloads, job insecurity and strain, and a top-down approach to job design can have negative implications for job satisfaction, morale and staff turnover. Studies show that autonomy, improved communication, and respect are positively associated with job satisfaction, recruitment and retention, and positive evaluation of the workplace (Kangas, Kee & Waddle, 1999; Gillies, Franklin & Child, 1990). Strong employment relationships are linked to good human management practices including open communication and constructive feedback, and treating nurses with respect. Such practices are not only low-cost, but importantly they are highly effective (CPRN, 2002). Furthermore, quality workplaces can enhance critical outcomes such as job satisfaction, commitment, a lack of absenteeism, and performance (Lowe & Schellenberg, 2001).

The American Association of Colleges of Nursing (AACN]) identified work environments that support professional practice and include strategies such as the Magnet Hospital Recognition Programme (Bliss-Holtz, Winter & Scherer, 2004). This Programme recognises excellence in:

- nursing services management, philosophy and practices;
- adherence to standards for improving the quality of patient care;
- leadership of the chief nurse executive;
- competence of the nursing staff; and
- attention to cultural and ethnic diversity of patients, their significant others and the care of providers in the health care system.

Given the increased health care environment complexity, favourable clinical practice experiences have become extremely critical for the successful transition of students and new graduate nurses into the workplace (Van der Merwe, 2003). The CNA (2004d) recommends preceptorship and mentoring programmes to support continuing professional development and practice experiences. Students and newly appointed professional nurses who work closely with experienced senior nurses can increase their competence and improve their role socialisation and confidence (Myrick & Yonge, 2004; CNA, 2004d). Internship programmes have also proven to be effective in transitioning the new nurse into the practice setting, facilitating recruitment, increasing retention and furthering commitment (AACN, 2002).

The nursing community in Canada has articulated a vision of the ideal professional practice environment. Nurses who participated in a CNA workshop (Lowe, 2002) thought quality of work-life indicators (QWI) should be an evolving process guided by shared learning and continuous improvement becoming catalysts for action. They identified five overall QWI dimensions (see Table 2:10). Thus the creation of a quality work environment requires a fundamentally different approach, one in which there is shared responsibility between different players inside and outside health care organisations. Some aspects of the practice environment are beyond the control of the individual nurse, such as manageable workloads, supportive managers, non-violent workplace, and opportunities for continuing professional development. When these factors are absent, it is difficult for nurses and other health care professionals to provide quality patient care.

Table 2.10: Quality of work-life indicators (QWI) (Source: Lowe, 2002)

QWI dimensions	Key QWI for 2004 accreditation programme	Additional QWI for development
Leadership and culture	▪ Span of control ▪ Leadership	▪ Value and respect ▪ Influence in decisions
Control over workload	▪ Overtime hours ▪ Full-time/part-time/casual ratios	▪ Workload ▪ Peer competence
Control over practice	▪ Autonomy / scope of practice	
Resource adequacy	▪ Professional development opportunities	▪ Supplies and equipment
Organisational and individual outcomes	▪ Absenteeism ▪ Grievances	▪ Job satisfaction ▪ Stress ▪ Work-life balance ▪ Joint initiatives involving management and professional associations ▪ Turnover ▪ Error rate

The next section focuses on continuing professional development, which relates to the final component of the literature review conceptual framework (see Figure 2.1).

2.4.3 Continuing professional development

As noted in Chapter 1: Section 1.1 continuing professional development (CPD) is one mechanism through which nurses fulfil the obligation of public trust, as it is a strategy by which nurses

strengthen their practice base. It is also an integral part of quality nursing and quality work environments (Lowe, 2002; RNABC, 2002). Kegan (2000) believes that lifelong learning is necessary for individual success as well as for economic development and social cohesion.

The American Nurses Association (ANA, 2000b:24) defines professional development of nurses as "the lifelong process of active participation in learning activities that assist in developing and maintaining their continuing competence, enhance…professional practice and support achievement of their career goals". The ANA definition reflects a similar path now being taken by other countries such as the United Kingdom (Furze & Pearcey, 1999), Canada (CNA & CASN, 2004a) and South Africa (Muller, 2003). Continuing professional development entails the learning experiences organised by the nurse, a facility, agency or an educational institution and undertaken by the nurse to enhance his or her nursing competencies. It is critical to assert that various players, besides nurses, share responsibilities with regard to CPD (Nelson & Purkis, 2004) (see Table 2.11).

Furze and Pearcey (1999) found that experiential and practice-based learning are essential to demonstration of competent practice. These researchers discovered that nurses who were engaging in CPD were motivated and self-directed, but they noted a bias in the literature, as there was very little on those who had chosen not to participate in CPD. Mackereth (1989) discovered while 64% of staff nurses rated CPD as important, 18% had no intention of furthering their education.

Mandatory CPD was implemented in the USA 20 years ago (Thurston, 1992) and American nurse researchers have since developed a large body of literature regarding its effect on nursing practice (Barriball, White & Norman, 1992). Two authors (Hutton, 1987; Thurston, 1992) found in those states where it was implemented, that more nurses favoured mandatory CPD. They also found that since implementation nurses had had a shift in attitude in favour of it being mandatory. Another bias that was apparent in the literature was the failure to report negative findings (Barriball & White, 1996).

Table 2.11: Continuing professional development groups and their responsibilities (Source: Canadian Nurses Association & Canadian Association of Schools of Nursing, 2004b)

Groups	Responsibilities
Individual nurses	▪ Demonstrate commitment to lifelong learning, reflective practice and integrating learning ▪ Ensure competencies are relevant and up to date ▪ Seek quality relevant educational experiences ▪ Support development of others ▪ Work with employers to support quality practice workplaces ▪ Meet regulatory requirements of continuing competence
Regulatory body	▪ Promote competent practice throughout career of nurses ▪ Promote, develop, maintain and monitor/evaluate high quality CPD programmes ▪ Establish effective, flexible CPD programmes
Nurse educators	▪ Provide multiple opportunities for CPD ▪ Work with others to promote and sustain high quality CPD
Employers	▪ Put mechanisms in place to promote identification of practice competencies ▪ Maintain quality practice workplaces to support and foster CPD ▪ Establish structured programmes to support CPD ▪ Foster collaborative practice and learning
Governments	▪ Facilitate collaboration among nursing profession, educational institutions and respective ministries (e.g. health and education) to support CPD

Furze and Pearcey (1999) found that CPD, self-directed learning and motivation seem to be interconnected. However, Darbyshire (1993) argues against the assumption that adults are self-directed learners (Knowles, 1980), believing that some individuals are more so than others. Furze and Pearcey (1999) questioned whether self-directed learners may be more proactive and motivated to learn. Echoing other researchers, they called for further research into nurses' self-directed learning. In one study (Wildman, Weale, Rodney & Pritchard, 1999), research subjects who had completed a diploma in professional studies, reported they were more questioning, better researchers, and had a broader knowledge practice base. Whyte, Lugton and Fawcett (2000) discovered that the preparation for study towards a master's degree contributed to personal and professional development in all domains of nursing practice: clinical, educational, management and research. Spence (2004) found evidence of increased cognitive capacity, confidence, and clinical credibility. Furthermore, nurses seemed to think and articulate differently and be more proactive at local and national levels in relation to health policy. Spence, however, concluded that factors within the environment could constrain nurses' advanced practice. She advised nurses to seek support from management, other health professionals and the public to enable them to utilise their advance practice and contribute effectively to public health outcomes.

Growing interest in continuing professional development and competency-based practice has been fuelled by increased public demands for greater accountability, changing practice and practice roles of health professionals, changing in scientific knowledge, technology, trade agreements and professional legislation (Percival, 2001). The challenge for licensing boards and employers is to ensure that nurses are competent throughout their careers, not just with their initial licensure. Competency-based practice has been adopted as a mechanism through which to assess, maintain and enhance practice standards and quality patient care.

2.4.3.1 Competency-based practice

The development of nursing practice competencies must begin with undergraduate nursing education (Bryant, 2005). Once competence has been demonstrated the regulatory board and the employer have an obligation to assess and hold nurses accountable for their practice. To achieve this outcome all concerned need to take an active role in assessing, maintaining and enhancing nurse practice competence (CNA & CASN, 2004b). According to Affara (2002), countries have adopted different models to promote continuing competence, but the model which presents the most comprehensive overview was developed by the Canadian Nurses Association (CNA, 2000b). The CNA model illustrates the linkage of continuing competence with the Code of Ethics, practice standards and other activities undertaken as part of continuing professional development and lifelong learning (see Figure 2.4). The International Council of Nurses (ICN, 2003) identifies CPD as an essential component of competency-based practice.

Nursing competencies have as their basis a strong foundation of nursing sciences, biological sciences, psychological sciences, sociological sciences, the humanities, the liberal arts, research and ethics (RNABC, 2000b). Such competencies form the basis of nursing practice, preparing nurses to care for patients of all ages across the whole continuum of care in multiple settings, both within and outside of tertiary hospitals. When met, these competencies ensure that nurses have the foundational knowledge in health promotion and illness prevention as well as acute and chronic disease management. Furthermore, they support nursing practice in education, management, research as well as in evolving areas such as informatics, infectious diseases, genetics, environmental health and immunology. Nursing competencies should reflect the nurse's own belief,

ethical values, attitudes, accountability and knowledge, matching the expected outcomes (Whittaker, Carson & Smolenski, 2000). Competencies are the direct link between education and regulation, although development of systems for continuing competencies is relatively recent. According to Bryant (2005:21), "Employers of nurses, nurses themselves, providers of continuing education and nurse regulatory bodies all have a stake in continuing competence." Employers have a responsibility to identify the competencies necessary for a given nursing position and to provide education programmes to enable their staff to meet these competencies (Bryant, 2005; Muller, 2003; CNA & CASN, 2004b).

CPD is crucial to nurses who wish to enhance their nursing careers and who want to be members of a profession, and especially in ensuring that nursing practice is congruent with the health needs of the society. Competence to practise is dependent on the continuous updating of knowledge and skills and the personal and professional growth of the individual nurse. Since CPD is a career-long process, nurses are encouraged not only to maintain and enhance their competence but to manage and plan their career as well. As depicted in Figure 2.4, CPD is also a dynamic and complex process.

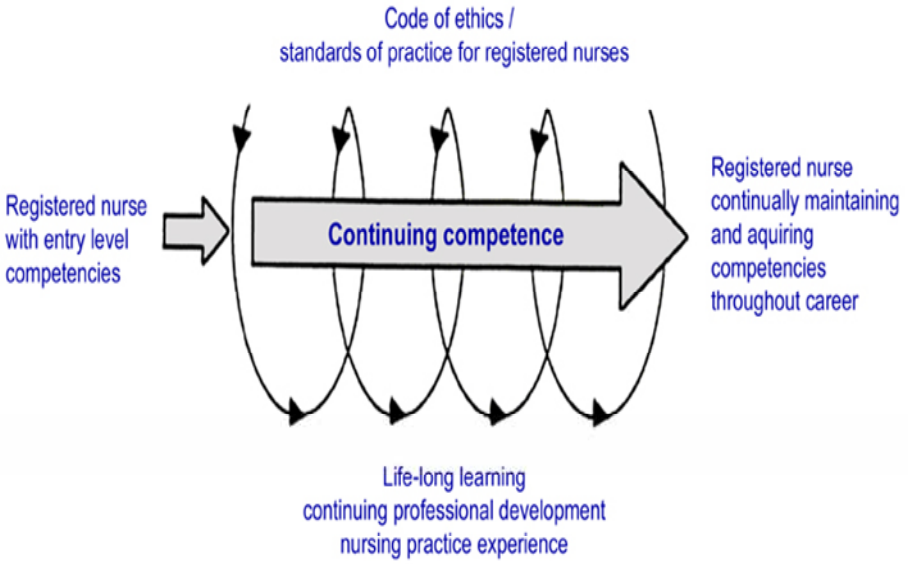

Figure 2.4: Continual linkage process to continuing competence
(Source: Canadian Nurses Association, 2000b)

2.4.3.2 Career management

Career management is a stage of the journey through professional life that is guided by a vision/mission of how the nurse chooses and expects to use his/her time in employment (Donner & Wheeler, 2001). Moves may be planned or may come about as opportunities arise. In any new job it is likely that there will be new learning which will be ongoing. New learning will mean new qualifications, thus meaning validation of the learning process and practical skills (Alsop, 2000). To optimise career opportunities it is essential for nurses to identify their strengths, weaknesses, opportunities and threats and to seek future promotion or employment (Donner & Wheeler, 2004). However, it is imperative for nurses to understand that a career management plan is only a structured method to goal achievement and does not signify definite success (Van der Merwe, 2004a). While it is still up to the individual and the availabilities of opportunities to be successful, due to the great diversity of needs and availability of choices, career pathways are recommended (Heath, 2002).

2.4.3.2. i) Career pathways

Nursing career pathways need to be structured so as to demonstrate the diversity within nursing, including clinical, educational, management and research. Career pathways should be based on the individual's choice, outcomes to be achieved and strategies by which to reach them. They also need to be flexible to accommodate individual differences and experiences, as well as emergent changes within the health care system and the health needs of the community and population (Price, Heartfield & Gibson, 2001). An Australian review of nursing education (Heath, 2002) concluded that there is a lack of pathways or positions that lead to strong career development for nurses. Price et al .(2001) recommend a framework for developing nursing career pathways, which includes:

- nursing practice roles – clinical, education, management and research;
- employment opportunities;
- qualifications requirements;
- ongoing learning options;
- registration requirements;
- nursing classifications;

- integration of nursing practice with other health care professional practice; and
- diversity of educational practice placements.

In the United Kingdom, and in most Canadian provinces nurses have to maintain a professional portfolio to document results of career planning, learning and continuing competence, including professional credentials, continuing educational activities, leadership activities and a narrative of self-reflection of practice as well as a peer review summary linking competence in practice to quality of care.

2.4.3.2. ii) Professional portfolio

Calman (1998) defines a portfolio as a personal professional development tool aimed at encouraging reflection and self-direction in identifying training needs. A portfolio is a collection of professional and personal documents purposefully assembled to illustrate an individual's talents and accomplishments. Maintaining a portfolio provides an opportunity to reflect on one's practice, identify learning needs and stay in charge of one's career. Hence it is a dynamic process that needs to be updated so as to reflect ongoing learning needs and opportunities. It can include the following:

- picture and personal history of the individual;
- career management plan;
- current practice assessment;
- current professional development plan;
- evidence from professional activities; and
- assessment of learning.

A portfolio can also be a place to bring together evidence of how a nurse evaluates and self-regulates his/her practice, identifies ongoing learning needs and professional achievements, and contributes to quality patient care and goals of the organisation. Portfolios are presented differently in ways reflecting the interests, priorities and intentions of those individuals who compiled them (Alsop, 2000). A portfolio is a vehicle for individual nurses to record learning and to plan how to integrate what has been learned into practice. It can be generic or specific to competencies in an area of practice. Compiling a portfolio requires skills of recording, analysing and reflecting on

experience to inform CPD (Hyde, 2003). In essence, portfolios demonstrate the achievements and capabilities of the respective owner. A high quality portfolio provides evidence of the nurse's continuing professional development.

The next section presents an overview of the opportunities and challenges of adult learning as adult learners have different requirements from those of children.

2.4.3.3 Adult learners

Ideal adult learners are described as autonomous individuals who are able to identify their own learning needs and plan, carry out and assess their learning activities (Sork, 2000). Knowles (1980) believes that adult learners move from dependency towards increasing self-directedness as a normal part of maturity. Mezirow (1991), however, says adults are caught in their histories regardless of how good they are at making sense of experiences. He reminds us that formative learning occurs in childhood both through socialisation (informal or tacit learning of norms from parents, friends and/or mentors, allowing us to fit into society) and through schooling and learning provided by one's particular culture. Ways of seeing and understanding are shaped by language, culture and personal experience. All factors join together to set limits to future learning, and social structures form the basis of conceptual categories, rules, tactics and criteria for judging implicit habits of perception, thought and behaviour (Mezirow, 1990). In other words, individuals must not be viewed separate from their respective society, which includes cultural norms, beliefs and values. Mackeracher (2004:25) emphasises that field research has shown "adults of all levels of intelligence, all ages and all stages of development up to the moment of death are capable of learning".

2.4.3.3. i) Definition of learning

Learning is defined (Mackeracher, 2004:7-8) "as a process of making sense of life's experiences, and giving meaning to whatever sense is made; using these meanings in thinking, solving problems and making choices and decisions…" It also includes "acting in ways that are congruent

with those choices and decisions as a means of obtaining feedback to confirm or disconfirm meanings and choices". The change is permanent in meaning and behaviours and "in the ways one goes about making sense, making meaning and thinking, making choices and acting".

2.4.3.3. ii) Assumptions about learning

Learning is a process in which the learner engages; it is not done to or done for the learner. It is a function of the central nervous system. Individuals have preferred ways to learn, and emotions affect the learning process. Learning is cyclical, it involves learning how to learn and it takes place within a particular context and culture. Learners interpret and filter what is taught through their own model of reality. Those who have learned how to learn are more productive than learners who have not. Input from others is critical in the learning process. In general, adults learn more effectively when what is being learned is relevant and possible (Mackeracher, 2004).

2.4.3.3. iii) Assumptions about adult learners

Although adults and children learn differently, these differences are not universal nor are they absolute (Mackeracher, 2004) (see Table 2.12). In the next section theories on pedagogy and andragogy are explored and contrasted.

Table 2.12: Major differences between adult and child learners
(Source: Mackeracher, 2004)

Adult learners	Child learners
▪ Extensive pragmatic life experience ▪ Learning transforming or extending meanings, values, skills and strategies from previous experiences	▪ Fewer pragmatic life experiences ▪ Learning on forming, accumulating basic meanings, values, skills and strategies
▪ Experience major pressures for change from factors related to family, work and community roles and expectations and personal needs for continuing productivity / self-definition, responsibility and connection to others	▪ Experience major pressures for change from factors related to physical growth and socialisation, and preparation for future family, work, and community roles
▪ Learning needs related to current life situations	▪ Learning needs related to development and future
▪ Capacity for using generalised abstract thought	▪ More likely to use specific, concrete thought
▪ Express own needs and describe learning processes ▪ Negotiate and collaborate in planning learning programmes	▪ Express own needs and learning processes via non-verbal activities ▪ Learning planned by experts, observers and interpreters
▪ Organised and consistent self-concept / self-esteem ▪ Participates as a self separate from others ▪ Capable of acting independently of others	▪ Relatively less organised and consistent self-concept ▪ Perceives self separate but dependent on others
▪ Assigned a responsible social status ▪ Expected to be productive	▪ Assigned a non-responsible social status ▪ Expected to play and learn

2.4.3.3. iv) Differences between pedagogy and andragogy

Pedagogy is derived from the Greek words “paido” meaning “child” and “agogus” meaning “leader of” (Merriam-Webster’s Collegiate Dictionary, 2003). Hence pedagogy literally means the art and science of teaching children. Conversely, andragogy is a term that denotes the teaching of adults. The andragogy model is a system of assumptions and is not an ideology (Knowles, Holton & Swanson, 1998). An ideology is defined as sets of values, beliefs, myths, explanations and justifications seeming to be both true and morally desirable. Ideologies are manifested in language, social habits and cultural forms and provide legitimacy to certain political and organisational structures and educational practices accepted as the normal order of things.

Knowles et al. (1998) describe the dominant pedagogical education model as an ideology based on assumptions about teaching and learning that evolved between the seventh and twelfth centuries.

They say that until quite recently this ideology formed the basis of all education for children and adults alike, with teachers having full responsibility for making the decisions of what is to be learned; how it is to be learned; when it will be learned; and for determining whether learning has happened.

In teacher-directed learning, which was the norm until recently, learners only need to know that they must learn what the teacher teaches in order to pass. As they do not have to apply what is learned to their lives, they can assume a dependent personality and need never learn how to self-direct their learning. Experience is not used as a resource for learning. Instead the learner remains a subject in the learning process; driven by external motivating factors (grades, parental pressures, teacher's approval or disapproval).

Knowles (1980) introduced andragogy as an alternative approach to learning, identifying several assumptions about adult learners: self-concept; prior experience; readiness to learn; learning orientation; and motivation to learn. Knowles assumes that adults want to know why they need to learn something prior to learning it. Furthermore, he believes that when adults undertake learning on their own they are apt to put more energy into it especially when learning is linked to their self-concept of being responsible for their own lives. In addition, adults have experiences to draw from, and when they apply new knowledge they are more likely to retain it. Thus adults' most important motivators for learning are internal (Knowles et al., 1998). Knowles et al. (1998) recommend that regardless of age it may be more prudent to use a pedagogical assumption at least as a starting point. For example, when learning is taking place in a new content area, the learner is dependent and/or there is no prior learning experience. These authors believe that adults who are willing and able to learn are resources to society and those not willing to learn or have difficulty learning are not able to maintain or improve their social and economic status. Nevertheless, they stress that all adult learners can benefit by being assisted in their learning. They offer their "Andragogy in Practice…as a new approach to more systematically applying andragogy across multiple domains of adult learning practice" (Knowles et al, 1998:181) (see Figure 2.5).

Pratt (1993) writes critically of Knowles' five assumptions, viewing them rather as characteristics of adult learners. These assumptions, he says, emphasise the psychological and individualistic nature of the learner and thus learners are assumed by nature to be autonomous and desiring self-

improvement with the capacity to be self-directing. Pratt (1993) concludes that Knowles did not deal effectively with social structures that might influence personal characteristics, aspirations and learning. He defines social structures as those societal institutions and systems that produce and reproduce rules and resources influencing the communication of meaning, exercise of power, legitimate and judgment of conduct (for example, the family, the religious institutions, systems of education, economic policies, cultural tradition, historical events). Another criticism of andragogy is that it does not acknowledge the influence on the formation of the person, ways of interpreting the world and the historical context in which a life is lived (Pratt, 1993). Mezirow (1997) and others (Freire, 1970; Daloz, 1986; 2000) believe real learning requires transformation.

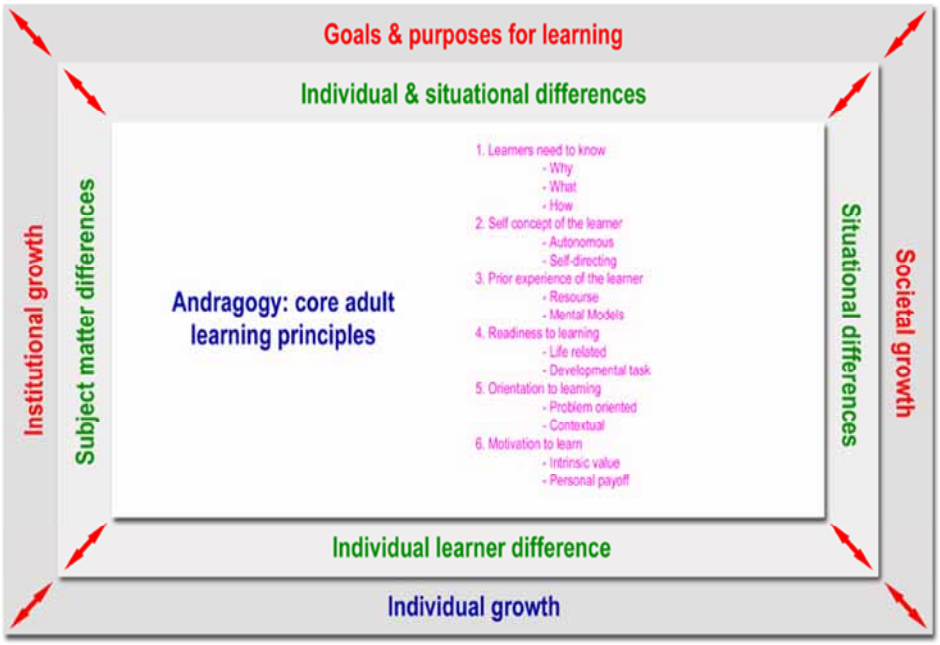

Figure 2.5: Andragogy in practice
(Source: Knowles, Holton & Swanson, 1998)

2.4.3.3 v) Transformational learning

To transform is to change oneself, but while transformational learning produces change, its effect is much more far-reaching. Mezirow (2000), a distinguished transformative learning theorist, says that although the context and terminology were different, understanding of transformative learning was influenced by Kuhn's (1962) concept of paradigm and that of conscientisation made popular by Paulo Freire (1970). Transformational learning is also a process of moving toward more complex ways of viewing oneself and one's situation and perhaps leading learners to take on more active responsibility for the world in which they live (Taylor, Marieneau & Fiddler, 2000). Mezirow labelled this process *emancipatory learning,* which frees individuals from limiting beliefs, to be better informed and reflective in their decision making (Mezirow, 2000). Transformational changes have a profound impact on the learner's subsequent experiences. Transformational learning shapes people so that they are forever different afterwards, in ways they and others can recognise. The change process can be gradual or sudden and it can either occur in a structural education environment or in ordinary life. Hence transformational learning is a normal part of life intimately connected to the human developmental process through cognitive processes (Clark, 1993). Changes result in a major shift in the way the individual perceives, remembers, and thinks about the world (Mackeracher, 2004). Kegan (2000) concluded that cognitive processes and structures development proceeds through two basic processes: analysing (differentiating) and synthesising (integrating). When the integrating process expands concepts without changing their essential meaning it is called assimilation. When the results lead to wholly different meaning, the process is called transformation (Mezirow, 1991). Exploring the latter makes it possible to understand transformational learning (Clark, 1993).

There are differing approaches to transformational learning in the literature. Clark (1993), for example, compares the work of three authors: Mezirow, Freire and Daloz. Mezirow used a theoretical approach, arguing that all human beings function within meaning systems, complex and dynamic structures of beliefs, theories and psycho-cultural assumptions. Transformations occur through differentiation (separating, distinguishing) and integration (connecting, combining)

(Mackeracher, 2004). Transformations involve changes in meaning schemes as well as in perspectives or frames of reference (Cranton, 2000; Mezirow, 2000).

Mezirow (2000) believes that meaning systems function as a lens or filter through which personal experience is mediated and by which it is interpreted. Perceptions can become distorted through habits of expectation. Meanings can be transformed by modifying knowledge, skills, values and attitudes. How we know what we know and why we value what we value (our premises) can be transformed by reflecting and modifying the processes underlying our meanings. Premise transformation also transforms our meanings (Mackeracher, 2004). Changes in meaning can happen incrementally or more suddenly, but central to the change process is critical reflection where the underlying assumptions of the meaning perspective are identified, critically assessed and reformulated to permit the development of a more inclusive and permeable meaning perspective (Clark, 1993). The general framework and cultural understandings which underlie a person's reality can also be transformed by reflecting on and modifying perspectives or underlying assumptions (Mackeracher, 2004). Mezirow's theory keeps the focus on the learner.

Unlike Mezirow, Freire's (1970) ultimate goal is social change. Frieire believes that liberating learning occurs through a process he calls conscientisation or consciousness-raising. His view is that people come to a conscious awareness of social forces that lie at the root of their oppression. Freire also believes that learning and critical reflection should be linked with collective action and uses the term *praxis* to describe the fusion of reflection and action (Farquaharson, 1995). Freire seeks to liberate adults through a dialogic, problem-posing pedagogical style that challenges students to become aware of oppressive social structures in their world, to understand how those structures have influenced their own thought, and finally to recognise their own power to change the world. This style of education is collaborative rather than passive, a movement away from the traditional model which Freire calls *banking education* and toward a model that supports freedom and the autonomy of learners (Freire, 1970). Freire acknowledges the political nature of teaching, arguing that education is never politically neutral. He believes education either domesticates by giving the learners the values of the dominant group or liberates by enabling them to reflect on their world and to act in order to change it. Fundamental to his vision is a just society where all people

can live freely and with dignity. Freire understands transformational learning as the means through which to realise this vision.

Daloz (1986) deals with transformation within a particular setting of formal education. Daloz researched the impact education has on adult learners, exploring development as facilitated by a relationship of care between the teachers and their students. Students, he says, must be challenged to let go of old conceptualisations of self and their world and to embrace new understandings. The presence of a knowledgeable and caring teacher or mentor makes such transformation less frightening. The role of the educator / mentor is to facilitate the learners' growth process by providing support, challenge and vision. Daloz (2000) challenges teachers to think about their teaching not so much in terms of developing competence, but rather in terms of fostering personal development.

Although these three authors tackle transformational learning somewhat differently, they hold several aspects in common. They:

- share humanistic vision, believing human beings are capable of change and free to act on the world;
- understand knowledge as a construction that human beings make rather than an objective truth they discover; and
- presume a democratic vision of society in which individuals are responsible for their collective futures (Clark, 1993).

Mezirow believes that society is made up of autonomous, responsible individuals who, having chosen to change their meaning perspectives, are thus able to change their world. According to Mezirow (1991), the individual's perspective must be transformed before social transformation can occur. He sees change as incremental and reformist, not revolutionary. The individual stands at the centre of Mezirow's concept of society and power and is understood not in terms of structural relationships, but rather in terms of human agency. This viewpoint is a thoroughly liberal democratic one. Freire appears to have a more radical view, yet he argues passionately for democracy while viewing his type of education as a basis for the development of true democracy. Daloz approaches

the question of the relationship between the individual and society in a less political fashion, but he too is guided by a fundamentally democratic vision (Clark, 1993).

Critical reflection is central to all three perspectives of transformational learning as is change in consciousness. Critical reflection enables learners and teachers to correct distortion in beliefs and errors in problem-solving techniques. Freire (1970) further defines critical reflection as a process whereby individuals achieve a deeper social-cultural reality that changes their ability to transform their lives. He argues that the level of critical consciousness cannot be reached through a traditional banking approach to teaching which he compares to depositing knowledge into an empty vessel (the student). Freire sees learning as a product of problem posing in which learners pose problems and the teacher becomes a co-investigator into the nature of reality (Farquaharson, 1995). Thus transformational learning provides new insights into the learning process. However, as Clark (1993) notes, at the root of transformational learning are three humanistic principles:

- a view of human beings as free and responsible;
- an understanding of knowledge as personal and social construction; and
- a belief in a liberal democratic vision of society.

Further, while transformational learning theories have widened our understanding of learning in adulthood by constructing it in terms of meaning formation, they also underscore the importance of critical thinking and consciousness awareness for all involved (Clark, 1993). Underlying the learner characteristics is the assumption that learning in adulthood means growth in self-direction and autonomy.

2.4.3.3 vi) Self-directed learning

One of Knowles's (1980) major tenets of andragogy is that generally adults have a deep need to be self-directed. Adult educators who use an andragogical approach commonly focus on this learner characteristic as one of the major goals of their instructional processes: allowing, and in some cases, teaching adults how to take more responsibility and control in the learning process (Caffarella, 1993). Philosophical assumptions also underlie self-directed learning and are primarily humanistic in their orientation, particularly when the focus is on the individual learner. From a humanistic perspective learners are expected to assume primary responsibility for their own

learning. Hence the learning design and processes are centred on the learners' needs rather than on content, and the educator's role is facilitative as opposed to his/her being the content expert (Elias & Merriam, 1995).

The humanistic philosophical orientation can be contrasted with that of the progressive and behaviourist philosophical stances. In the progressive orientation the learner and the learner's experience are central to the learning process. The learner is responsible for ensuring that learning has taken place. Educators act as guides, encouraging learning in a practical and pragmatic manner. Conversely, behaviourists focus mostly on how the learner should go about the process of self-directed learning, developing plans (learning contracts) and stressing the importance of learning objectives. Evaluation of learning is in terms of whether or not the objectives were met (Elias & Merriam, 1995).

A central assumption in self-directed learning is that learning in adulthood means growth and autonomy coupled with interdependence and interconnectedness (Caffarella, 1993). Individuals do not move toward self-directed learning at the same rate nor are they necessarily self-directed in all aspects of their lives. According to Caffarella (1993:30), variables that have an influence on whether adult learners are autonomous in learning situations include: "their level of technical skills; their familiarity with the subject matter; their sense of personal competence as learners and the content of the learning event". Caffarella (1993:25-26) defines self-directed learning as a process, a characteristic, and/or an instructional design: "a process of learning that stresses the ability of individuals to plan and manage their own learning; an attribute or characteristic of learners with personal autonomy as its hallmark, and a way of organising instruction in formal settings that allows for greater learner control". In formal settings, the learner's willingness and ability, the content to be learned and the situational context influence the amount of self-direction and learner control that learners are willing to take and instructors are willing to allow. Learners and teachers may have difficulty in making the transition from teacher directed to self-directed learning. Caffarella (1993) cautions against idealising self-directed learning as the true marker of a mature adult learner, as there are a number of unanswered questions about what constitutes self-learning. Garrison (1992) advocates for the merger of critical thinking and self-directed learning frameworks

using the concepts of control and responsibility to offer a more integrative and explanatory perspective of adult learning. Self-directed learning is also a key aspect of reflective practice.

2.4.3.3 vii) Reflective practice

Reflection is defined as thinking and feeling activities in which individuals engage in exploring their experiences leading to new understandings and appreciations (Boud, Keogh & Walker, 1985). Reflective practice is a process of learning and development through examination of one's own practice, including experiences, feelings, action and knowledge (Atkins, 2004). Skills necessary for reflection include self-awareness, description, critical analysis, synthesis, judgment and evaluation (Atkins & Murphy, 1993). Additional skills necessary when engaging in reflective practice with others include active listening, empathy, assertiveness, supporting and challenging and the planning and management of change (Atkins, 2004).

Higher levels of skills necessary for critical thinking are harder to develop and take longer (Duke & Appleton, 2000). Atkins (2004:27) draws attention to the similarities between skills underlying reflective practice and those required for academic work, adding, "With the exception of self-awareness these skills are the higher level of order cognitive or thinking skills identified by Bloom, et al.'s (1956) taxonomy of educational objectives." She advocates developing these academic skills as they may enhance the integration of theory with practice and understanding of work-based learning and continuing professional development.

Dewey (1933) was one of the first and perhaps most influential educational theorists to explore the concept of reflective thinking. He believed that reflective thinking arose out of situations of doubt, hesitation, perplexity and/or mental difficulty, prompting the individual to search for ways to resolve or clear the situation, often using past experiences (Teekman, 2000). Schon (1987), who conversely focused primarily on outcomes, coined the term *reflective practice*, emphasising the importance of the role of practice for professional knowledge development. He also developed two key concepts quoted regularly in the literature:

- reflection-in action – thinking that an individual does while doing the action; and

- reflection-on-action – thinking that occurs once the action is completed.

Teekman (2000) discovered from a literature review that some researchers insist nurses are reflective practitioners, and they emphasise this talent as an effective tool by which to reduce the practice theory gap. However, he uncovered other research which did not substantiate these claims: "(T)here is little evidence that an objective review of reflective practice and its implications for nursing and nurse educators has ever occurred..." (Mackintosch, 1998:553). Teekman provides a summary of the nursing literature in terms of reflective thinking in learning versus reflective thinking in critical inquiry (see Table 2.13).

Table 2.13: Reflective thinking for learning and critical inquiry (Source: Teekman, 2000)

Reflective thinking for learning	Reflective thinking for critical inquiry
Make sense of and learn from specific situations	Go beyond questions and technical proficiency
Focus is on immediate situation versus learning	Reflect how context influences health and nursing
Apply professional nursing interventions and skills	Concern for ethical / moral issues - justice and equality

Teekman wanted to know whether nurses engaged in reflective thinking, and if so, what their thinking focus was and how the process altered their practice. Using a qualitative approach called sense-making, he tried to determine whether 10 nurse research participants utilised reflective thinking in their practice. Examining three levels of reflective thinking (action, evaluation and critical inquiry), he found that all participants in fact used reflective thinking to create meaning and plan nursing actions. While they demonstrated reflection for evaluation (the second order), none used it for critical inquiry. This led Teekman to recommend self-questioning to be encouraged and extended to routine situations so that nurses might shift from problem solving to problem posing. Unlike problem solving, which tends to be reactionary, problem posing is more anticipatory and does not require an active problem as such. Knowledge developed from problem posing is more likely to be transferred to other situations and settings than those acquired from problem solving (see Figure 2.6).

Reflective thinking at the evaluation level enabled study participants to monitor their personal and professional performance. As these nurses' self-questioning centred on the "here and now", they mostly focused their efforts on addressing gaps in their practice. Respondents reported that self-questioning helped them with their thought processes, enabled them to think ahead, to clarify issues and to make meaning. In all cases the questions asked of the self were action oriented. The study showed that anticipatory questions were a part of reflective thinking for action. Figure 2.6 demonstrates the dynamic process involved in reflective thinking and action.

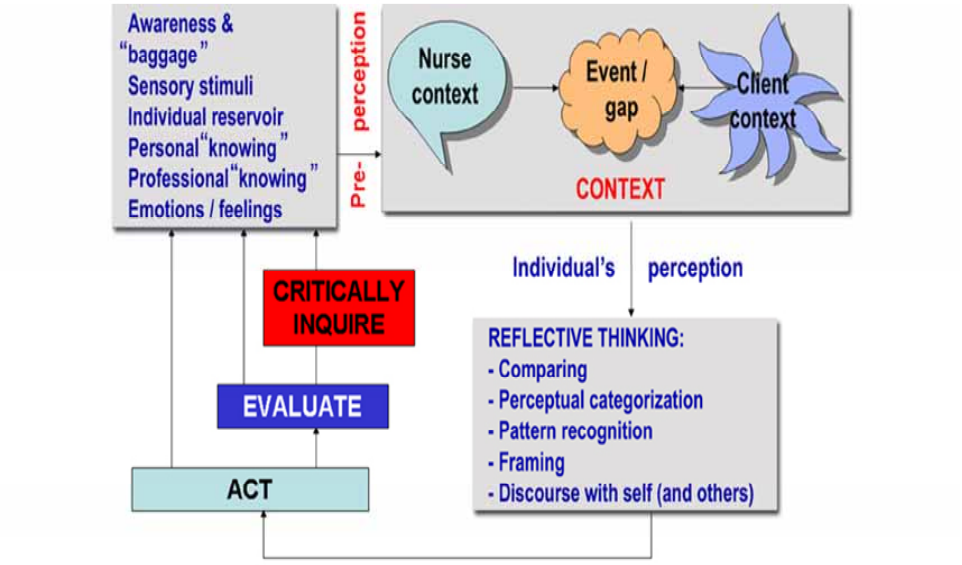

Figure 2.6: Reflective thinking as a dynamic process
(Source: Teekman 2000)

Reflective thinking for evaluation differs from that of action, since in the former the primary focus is to understand the whole situation. It only occurs after the reflection-for-action had taken place. Reflective thinking for evaluation is concerned with analysing and clarifying individual experiences, meanings and assumptions in order to evaluate both the actions and the beliefs. Teekman (2000) found that nurses focused on two aspects of reflective thinking for evaluation: the situation and the self. At this level reflections were deeper and not limited to the situation at hand. However, the purpose of their reflection was primarily to describe and plan nursing actions rather than to learning or to build theories. Furthermore, according to Teekman (2000), while discourse with self and posing

questions to self can help some to make sense out of situations, these activities do not compensate for gaps which are caused by lack of information, inexperience, or dealing with information overload. Self-questioning does not work in situations where the individual is unable to recognise patterns or where there is a knowledge deficit.

Brookfield (2000) clarifies the important point that reflection is not by definition critical, as it is quite possible for adults to work reflectively while focusing solely on technical or routine decisions. He stresses that the fact that it is not critical does not necessarily lessen its importance. According to Brookfield (1995), reflective practice allows us to stand outside of ourselves and come to a clearer understanding of what we do and who we are by freeing ourselves of distorted ways of reasoning and acting. Brookfield (2000:126) believes the word "critical" is sacred and "…for something to count as critical learning, critical analysis or critical thinking, the individual concerned must engage in some sort of power analysis of the situation or context in which the learning is happening. They must try to identify assumptions they hold dear that are actually destroying their sense of well-being and serving the interest of others; that is hegemonic assumptions". Brookfield (2000) says the focus of critical reflection is around three interrelated processes:

- questioning and replacing or reframing previously held assumptions, some of which may represent commonsense wisdom;
- taking alternative perspective on ideas, action, forms of reasoning and ideologies that were previously taken for granted; and
- recognising the hegemonic aspect of dominant cultural values and understanding power and self-interest of unrepresentative minorities.

Brookfield (2000) is convinced that the only focus critical reflection can take is investigation of assumptions. He also identifies three common assumptions for critical reflection:

- paradigmatic assumptions that structure the world into fundamental categories (which he says are the most difficult ones to identify in oneself);
- prescriptive assumptions about what we think ought to be happening in a specific situation; and
- causal assumptions about how the world works and how it may be changed (the easiest to identify).

When critical reflection stimulates a different order of abstraction, it can effect change in an individual's frame of reference (Mezirow, 2000). From Brookfield's (2000) perspective the language and concepts used in reflection are culturally framed, transmitted and learned, representing power formations. He sees ideology critiquing as the overarching domain of critical reflection.

When we create stories, for example, we use socially familiar narrative forms that were culturally learned (e.g. language, metaphors and concepts). With regard to this view, Brookfield (2000) maintains that to reflect critically we must learn how these forms are socially constructed and distorted. He further argues that we must uncover power dynamics and relationships that are hidden within us. Being aware of power dynamics helps us realise that forces within the wider society do intrude. Awareness of pervasiveness of power is the first step in exploring how "power over" can be transformed into "power with". Brookfield (2000) recommends that critically reflective efforts should not be undertaken alone, but in the company of critical friends to serve as critical mirrors highlighting our assumptions and reflecting them in unfamiliar, surprising and disturbing ways.

Becoming critically reflective of assumptions underlying content, process or premise is a challenging process. However, modelling critical reflection about one's assumptions may influence the way others derive meaning (Mezirow, 2000). Learning to use reflective thinking skills effectively is a competence that can be acquired through transformational learning and dialogue. As Brookfield (2000) reminds us, critical reflection is an ingredient of and not a synonym for transformational learning. As Mezirow (2000:31) states "In fostering transformational learning efforts, what counts is what the individual learner wants to learn". Teaching does not ensure learning has taken place.

In Tables 2.14 a, b and c, the empirical indicators derived from the literature research are indentified. In the next section, a Chapter summary is provided.

Table 2.14 a): Empirical indicators for the continuing professional development learning programme – professional, ethical and legal practice

Regulation and credentialing	Ethical and legal foundations	National nursing associations

▪ Primary purpose –inherent in self-regulation public protection
▪ Goals
  ▪ serve public's interest
  ▪ define profession and members – use of title
  ▪ determine practice scope
  ▪ set education standards
  ▪ establish accountability
  ▪ establish credentialing
  ▪ facilitate effective working relationships with other providers
  ▪ provide for mobility of competent nurses
▪ Code of ethics
▪ Practice standards
▪ Key regulation components:
  ▪ nursing schools and education programmes
  ▪ nurses
  ▪ nursing practice
  ▪ health care system / agencies / organisations
  ▪ government / governance / regulation system
▪ Regulation dimensions:
  ▪ purpose
  ▪ target group
  ▪ mechanism
  ▪ authorities and agencies
  ▪ standards
  ▪ work methods
▪ ICN principles (12)
▪ Continuing competence requirements for nurses
	▪ Laws – nurses' act
	▪ Code of ethics
	▪ ICN goals
	  ▪ advance nurses / nursing worldwide
	  ▪ health policy
	▪ Practice standards
	▪ Scope of practice
	  ▪ competencies
	  ▪ responsibility
	  ▪ authority
	  ▪ accountability
	  ▪ acts and omissions
	▪ Self-regulation
	  ▪ nursing profession
	  ▪ nurses
	  ▪ lifelong learning
	▪ Personal and professional experiences
		▪ Protect public
		▪ Goals
		▪ Code of ethics
		▪ Scope of practice
		▪ Practice standards
		▪ Qualifications / credentials
		  ▪ basic
		  ▪ advanced or specialised
		▪ Discipline
		▪ Approval
		▪ Professional accountability
		  ▪ levels
		  ▸ public
		  ▸ employer
		  ▸ government
		  ▸ other professionals
		  ▸ professional board
		  ▸ practitioner
		  ▪ continuing competencies
		  ▪ ongoing professional development
		  ▪ self-regulation
		▪ Health policy

Table 2.14 b): Empirical indicators for the continuing professional development learning programme – nursing education practice

Nursing Education	Curriculum Development	Outcomes Based Education (OBE)

▪ Nurse educator roles:
  ▪ educator
  ▪ facilitator
  ▪ designer
  ▪ change agent
  ▪ consultant
  ▪ researcher
  ▪ leader
  ▪ lifelong learner
▪ Competence based practice
  ▪ novice to expert
▪ Teaching what was promised
▪ Evaluation
▪ Continuing professional development
▪ Quality practice environment
  ▪ supportive factors
  ▪ enhance critical outcomes
  ▪ quality continuous process with
  ▪ quality work indicators
  ▪ resources adequate
  ▪ strategies to support practice excellence
  ▸ Magnet hospitals
  ▸ preceptorship
  ▸ mentoring
	▪ Design
	▪ Educational philosophy
	  ▪ learning
	  ▪ education
	▪ Target group (who)
	▪ Situational analysis (how)
	▪ Outcomes (why)
	▪ Learning content (what)
	▪ Educational principles and strategies (how)
	▪ Implementation strategies (when and where)
	▪ Assessment/ evaluation strategies (so what, now what, then what)
		▪ Outcomes
		  ▪ Clear learning results
		  ▪ Learning experiences
		  ▪ Demonstrations
		  ▪ Integrated into practice
		  ▪ Accountability in teaching
		▪ Comprehensive
		▪ Successful learners
		▪ Process, structures
		▪ Quality improvement
		▪ Supported internationally
		▪ Roots
		  ▪ Tyler's objectives
		  ▪ Bloom's taxonomies and mastery learning theory
		  ▪ Competency based education
		  ▪ Glaser's criterion referenced
		  ▪ Mager's guidelines, expected performance
		  ▪ Spady's OBE approach
		▪ Principles
		▪ Purpose
		▪ System's characteristics

Table 2.14 c): Empirical indicators for continuing professional development learning programme – continuing professional development (CPD)

Personal and professional development	Career management	Transformative learning

▪ Lifelong (formal / informal)
▪ Different groups accountable and responsible
  ▪ individual nurses
  ▪ regulatory body
  ▪ nurse educators
  ▪ employers
  ▪ governments
▪ CPD intertwine with
  ▪ self-regulation; and
  ▪ motivation
▪ CPD based on continuous improvement process
	▪ Scientific process
	▪ Vision / mission
	▪ Structured
	▪ Professional portfolio
	  ▪ Encourage reflection
	  ▪ Collect documents of talents and accomplishments
	  ▪ Dynamic process
	  ▪ Evidence of CPD
		▪ Worldwide more complex
		▪ Profound impact on learner
		▪ Different person – can be sudden or gradual
		▪ Cognitive process
		▪ Mezirow's meaning schemes
		  ▪ Complex, dynamic and holistic
		▪ Premise changes
		▪ Learning and critical reflection linked
		▪ Educator's role to challenge learner and facilitate change
		▪ Fundamental democratic vision
		▪ Self-directed learning

Competency-based practice	**Adult learners**	**Reflective practice**

▪ Based in sciences, liberal arts, research and ethics
▪ Demonstrate and internalise
  ▪ knowledge
  ▪ skills
  ▪ values
  ▪ attitudes
  ▪ judgment
▪ Competence
  ▪ initial licensure; and
  ▪ throughout nursing career
  ▪ assessed best in practice
  ▪ can erode if not used
  ▪ greater emphasis on employer to ensure nurses competent
	▪ Adults' learning needs are different from those of children
	▪ Pedagogical approach used when they had no prior self-directed learning
	▪ Adults caught in history
	  ▪ Formulate learning habits in childhood
	  ▪ Culture approves and rewards
	  ▪ Seeing and knowing shaped by language, culture, experiences
		▪ Learning process
		▪ Examination of practice
		▪ Skills required
		▪ Time to develop
		▪ Enhance theory integration
		▪ Arise during situation of doubt
		▪ Prompt search new ways
		▪ Reflection in / on action
		▪ Critical thinking / reflection
		▪ Critical reflective assumptions
		▪ Uncover power dynamics

2.5 SUMMARY

In this Chapter the literature research was described based on three components: professional, ethical and legal practice, nursing education practice and continuing professional development. These components were adapted from the competencies framework of the ICN. From this review empirical indicators (see Tables 2.14a, b and c) were identified for utilisation in Phase 1: Outcome 1: development and implementation of a provisional learning programme. In Chapter 3, the research methodology for the continuing professional development learning programme for nurses in Saudi Arabia is described.

CHAPTER THREE: RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

The whole universe of science is built upon the world as directly experienced, and as we want to subject science itself to rigorous scrutiny and arrive at a precise assessment of its meaning and scope, we must begin by reawakening the basic experience of the world of which science is the second order of experience. Science has not and never will have by its nature, the same significant qua (capacity) form of being as the world which we perceive, for the simple reason that it is a rationale or explanation of that world (Merleau-Ponty, 1962). "Since we have come to the understanding that science is a metaphorical ordering of experiences, the new science does not impugn the old. It is not a question of which view is true in some ultimate sense. Rather, it is a matter of which picture is more useful in guiding human affairs" (Harman, 1977:39).

Research is a complex process laden with values, and at times, complicated by a variety of expectations. Given this complexity, perhaps it is not surprising that researchers based their endeavours on different beliefs about how research should be conducted and what the results of research should accomplish (Cavana, Delahaye & Sekaran, 2001). We are living in a fast-moving global nursing marketplace where nurse migration is a reality. At the same time it is being scrutinised by the scientific community (Buchan, Kingma & Elegado-Lorenzo, 2005).

International nursing shortage is both a reality and a confounding variable in the pursuit of quality patient care. Regulatory boards and councils as well as health care employers have an obligation and a legal responsibility to protect patients from unsafe care, thus their role in ensuring that employees are competent to practise is paramount. There are changes in how education is perceived, with greater emphasis on quality and continuous performance improvement related to a particular role and responsibilities (JCI, 2003).

Throughout the world, hospitals are the greatest employers of nurses. However, the role of the nurse is not limited to the hospital environment, but extends into the community. The World Health

Organisation (2001) has called for a shift of focus to primary health and public health particularly in a country such as Saudi Arabia, where half of the population are under the age of 20 years. Such changes demand visionary transformative leadership and necessitate that employers, educators and health professionals will respond in a timely and considerate manner. Within this context, collaboration and uniform implementation are crucial elements. Bryant (2005) reminds us of the difficulty of finding evidence on the linkages between competence development, education, regulation and safety and quality. To obtain a better understanding of these global and local issues, including their interrelatedness, research is imperative.

In this chapter the research design and methodology for the development, operationalisation, validation, and evaluation of a learning programme for the continuing professional development of nurses working in Saudi Arabia is described. The design and methodology should complement both the human perception and the scientific process in creating solutions related to problems arising from the international nursing migration whose population has been subjected to differing educational standards as well as to basic preparation of nurses and requirements for their continuing professional development. Establishing a framework for the development of the research design and methodology was an attempt to integrate all the information in a logical manner, so that the reason for the research problem could be conceptualised and tested in reality. The framework development was guided by the life and nursing experiences and intuition of the researcher as well as by the research scientific process (Cavana et al., 2001). The framework development followed the Botes' Model (1998), which entailed structuring and outlining different theories and concepts in the research design and methodology (see Chapter 1: Section 1.8). In the next section, the research purpose is outlined.

3.2 THE PURPOSE OF THE RESEARCH

In Chapter 1 the research overview was briefly described and the purpose was stated as the design, implementation and evaluation of a learning programme for the continuing professional development of nurses working in Saudi Arabia. The learning programme was inductively developed emerging from the researcher's personal and professional experiences while working in a tertiary hospital in Saudi Arabia, and validated by experts from South Africa, Canada, the United

States of America (USA), Australia, Egypt and Saudi Arabia. The central theoretical assumption for this research, as stated in Chapter 1: Section 1.4, was that the implementation of a continuing professional development learning programme in Saudi Arabia for nurses should

- facilitate quality nursing practice;
- facilitate personal and professional development; and
- support the implementation of nursing legislation.

At the root of this research was an obligation of all professional nurses to protect the public by promoting and implementing quality nursing practice wherever they may work and live. Thus the outcomes of the research were to

- design a provisional learning programme for the continuing professional development of nurses working in Saudi Arabia;
- operationalise the provisional learning programme;
- validate the provisional learning programme;
- evaluate the final learning programme;
- prepare the research findings for publication in a peer reviewed journal; and
- submit the paper to a peer review journal.

To explore the field of research, the Botes' Research Model (1998, 2000) was utilised. This model, which is also referred to as the Botes' Model, also assisted the researcher to identify research assumptions prior to finalising research decisions. The application of the three orders of the Botes' Research Model is described in Section 3.3.

3.3 APPLICATION OF THE BOTES' RESEARCH MODEL

The methodology for the development of the learning programme was described according to the Botes' Model (1998). This model supported a holistic approach to the research process rather than a detailed description of research methods and techniques. Thus the Botes' Model lends itself to both quantitative and qualitative research methodologies (Botes, 1998, 2000) (see Table 3.1).

Table 3.1: Botes' (1998) research model applied to nursing practice

Research orders	Relationship between	Application to research
First	Research field - pre-scientific / lay interpretation	Nursing education
Second	Applied in practice– scientific (empirical) process	Qualitative and quantitative research approaches
Third	Philosophical – paradigmatic perspective	Researcher's experience and philosophy

The rationale for the Botes' Model is straightforward and practical, while at the same time allowing a comprehensive research approach to be undertaken. The Botes' Model consists of the three interacting orders which will now apply to the research:

- *The first order* (see Section 3.3.1) is the nursing practice which includes four domains – clinical practice, management, education and research. Hence, nursing is both the activity and the field of research. Researchers have to be active in the field of research and the research has to be practice-focused. In this research, the researcher, as a nursing educator, inductively developed a learning programme for the continuing professional development of nurses in Saudi Arabia with guidance from one of her academic advisers who also acted as her mentor. The researcher drew upon her professional and personal experiences of working and living in Saudi Arabia and Canada, visiting South Africa and working and associating with nurses from South Africa while in Saudi Arabia. She was enrolled in a doctorate programme of higher education from South Africa. One of her academic supervisors, an eminent South African nursing leader, lived and worked in Saudi Arabia. The researcher and the mentor's workplace was a tertiary hospital and research centre. The second adviser was a professor in the Faculty of Education where the researcher was enrolled.
- *The second order* (see Section 3.3.2) includes a theory of nursing, namely King's Theory of Goal Attainment (King, 1995) hereafter also called King's Theory, and the research methodology was based on the determinants for research decisions. King's Theory was derived from a system's framework concerning human transactions in different types of environments (King, 1981, 1995; Creasia & Parker, 2001). The theory deals with outcomes and was therefore apt, as the research entailed using an outcomes approach when developing the learning programme.
- *The third order* (see Section 3.3.3) is the paradigmatic perspective, including meta-theoretical, theoretical and methodological assumptions. The paradigmatic theoretical assumptions were

derived from King's Theory. King perceives the individual as an open system, living and transacting with groups within interpersonal and societal systems. According to King, nurses promote health through their transactions with their clients, interacting with them through shared environments (see Chapter 1: Figure1.2). Their transactions lead to the attainment of mutually agreed upon goals and thus influence health outcomes. The Botes' Model and King's Theory complement each other as both recommend a comprehensive dynamic scientific approach focusing on health outcomes while at the same time grounding nurses in their respective practice.

Using the three orders of the Botes' Research Model (1998, 2000), the methodology for the research is described in detail below.

3.3.1 First order: nursing practice

As mentioned, the first order of this model included the field of nursing practice, specifically education in a tertiary care hospital in Saudi Arabia. The field of research was composed mostly of hospital-based nurses who were predominately migrants, originating from 50 to 55 countries. The remainder were Saudi nurses. In this particular hospital, the long-standing policy had been to employ only highly skilled professionals with a minimum of two years' previous nursing experience. Over the period of the research, the profile of the nurses changed dramatically with significantly fewer nurses from western countries. As of June 2005, there were approximately 80 Saudi nurses, mostly with minimal to no experience, in a population of over 1500 nurses. Approximately seven percent of the total population of nurses was westerners. When the researcher came to the hospital in 2001, the Canadian nursing population was 18 percent. Four years later it was less than three. Western nurses were replaced with those who generally speaking, practised from a narrower scope, and many spoke English as a second language. English was the official working language. Table 3.2 depicts the first order of the Botes' Model in the particular tertiary hospital.

Table 3.2: Application of Botes' first order to nursing practice (Source: Botes, 2000)

Critera	Application
Field of research	▪ Conducted in a tertiary care hospital in Saudi Arabia

Attributes	Included:
	▪ Employer: tertiary government-sponsored hospital with an adjacnt research centre
	▪ Multinational nursing workforce from 50-55 different countries
	▪ Employees
	  ▪ Registered nurses
	  ▪ Newly graduated nurses with less than two years of experience
	  ▪ Other disciplines
	  ▪ Administrative and support staff
	▪ Service hours: varied from 10-12 hours per shift
	▪ Service provision: 24 hours, Hirjira (based on lunar cycles) and Gregorian (based on sun) calendars were used simultaneously
	▪ Service delivery
	  ▪ Hospital
	  ▪ Home and community
	▪ All professional nursing staff were responsible and accountable for the quality of nursing services rendered
	▪ New graduate and nurses who had just begun working at the hospital were required to demonstrate competence prior to receiving authority to practise alone
	▪ All professional nursing staff were voluntarily committed to quality nursing practice
	▪ Scope of practice was derived from a western perspective and driven and primarily controlled by the needs of the organisation as there was no national nurses' act by which to establish the boundaries for practice
	▪ Ethical foundations and relevant legal acts applicable to nursing (see Chapter 2: Section 2.4.1.2)

Pre-scientific	▪ Implemented continuing professional development as a method through which nurses can improve their practice and thus the care they render in general to the public and specifically to patients and their families ▪ Supported quality nursing practice by advocating for and creating a quality practice environment by developing, implementing, validating and evaluating a learning programme for the continuing professional development of nurses working in Saudi Arabia

During the period of the research, the Saudi Nursing Board (SNB) was still emerging. Thus non-Saudi nurses working in Saudi Arabia were still required to acquire a country of origin registration. Proof of continuing professional development prior to renewing a licence was primarily a requirement from western nursing regulatory boards. The SNB had notified health organisations that all nurses had to register and that they were required to have verified continuing education for renewal of licence (Abu-Zinadah, 2004).

The focus of Section 3.2.2 is the application of Botes' second order, beginning with an overview of the research methodology.

3.3.2 Second order: research methodology

The orientation for this research was mixed methods which included qualitative with quantitative research techniques used to strengthen the outcomes/results (see Figure 3.1). Rallis and Rossman (2003:494) state that methods are "ways, techniques or tools for generating thoughtful, accurate and ethical data about a programme and also ways, techniques or strategies for manipulating the data". Creswell (2003) recommends mixed methods be used in social and human sciences research as these research practices lie somewhere in the continuum between qualitative and quantitative, with some studies favouring one over the other. Researchers are increasingly recognising the advantages of mixing both quantitative and qualitative data collection in a single study. There are now more clear definitions of mixed methods, including procedures identified for critical design elements such as a visual model of procedures; a notation system; the explication of the designs; and specific criteria useful in deciding what type of design to use given the study (Creswell, Plano-Clark, Gutman & Hanson, 2003). There is a growing consensus in the literature that mixed methods can strengthen research outcomes (Teddlie & Tashakkori, 2003).

In qualitative research humans are viewed as complex, largely unpredictable beings with differences and needs that override predictable natural laws of behaviour. The role of research is to deepen the understanding of human behaviour through detailed study of human thought and behaviours. Thus the aim of the qualitative research is to discover how individuals construct meaning in their contextual setting by exploring their values, interpretative schemes, mind maps, belief systems and rules of living (Cavana et al., 2001).

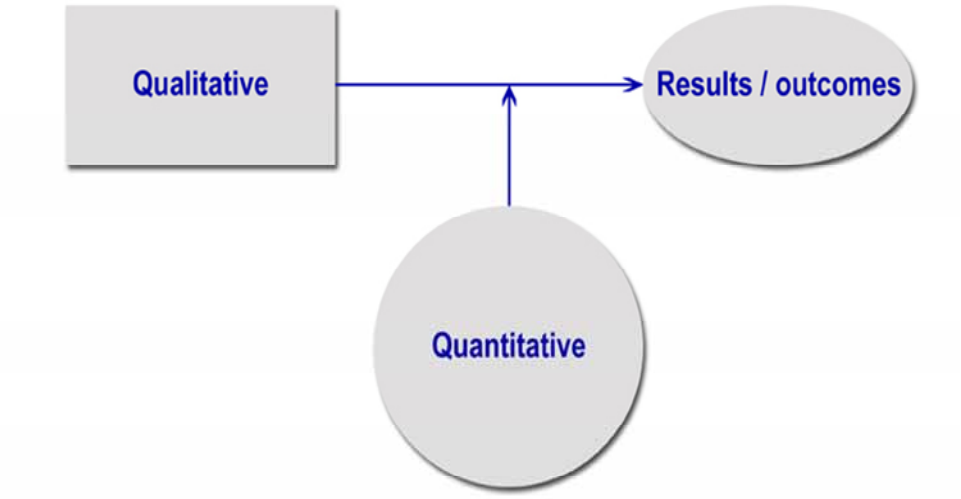

Figure 3.1: Mixed methods: quantitative research to strengthen qualitative results (Source: Creswell, 2003)

Conversely, quantitative research is based broadly on the ideals of positivism derived from the work of Auguste Compte (1789-1857). Such ideas espouse data precision, and value rigorous and exact measures. Good research is seen as objective observation, precise measurements, statistical analysis and verifiable truths with careful analyses of the data using the statistics to test the hypothesis. Through the research universal laws of human behaviour are uncovered to control and predict events. It is assumed that reality can be discovered and nature will operate according to the natural laws discovered through deduction and logical reasoning. Ideally the researcher identifies an expected solution to a problem (hypothesis) and then attempts to prove that the hypothesis is not correct; that is, to prove the null hypothesis (Cavana et al., 2001). Table 3.3 provides a comparison of these two orientations.

A number of authors (Creswell, 2001, 2003; Cavana et al., 2001; Morse, 2003; Tashakkori & Teddlie, 1998; Teddlie & Tashakkori, 2003) recommend combining qualitative and quantitative methods, as together they can generate a synergistic energy providing unique and important

insights. The synergy is created by the fundamental difference between the two approaches with quantitative research based on deductive reasoning, and qualitative research on inductive reasoning. These authors argue that as quantitative and qualitative methods are compatible, investigators should utilise both in their research rather than being wed to a particular theoretical style and its most compatible method. Tashakkori and Teddlie (1998) further argue that both research methods share many similarities in their fundamental values and underlying beliefs including:

- the value ladenness of inquiry;
- the theory ladenness of facts;
- that reality is multiple and constructed;
- the fallibility of knowledge;
- the under-determination of theory by fact;
- the importance of understanding and improving human condition;
- the importance of communicating results to inform decisions; and
- that the world is complex and often difficult to understand.

Table 3.3: Comparison of quantitative and qualitative research

(Source: Cavana et al., 2001)

Quantitative research	Qualitative research
Reality is objective and singular and apart from the researcher	Reality is subjective and multiple, as seen by participants in a study
Researcher is independent of that being researched	Researcher interacts with that being researched
Research is assumed to be value free and unbiased	Research is value-laden and biased, with values generally made explicit
Theory is largely casual and deductive	Theory can be causal or non-casual, and is often inductive
The hypothesis with which the researcher begins, is tested	Hypothesis is replaced by the central theoretical assumption (Botes, 1998) Meaning is captured and discovered once the researcher becomes immersed in the data
Concepts are in the form of distinct variables	Concepts are in the form of themes, motifs, generalisations and taxonomies
Measures are systematically created before data collection and are standardised	Measures are created in an ad hoc manner and are often specific to the individual setting or researcher
Data are in the form of numbers from precise measurement	Data are in the form of words from documents, observations and transcripts
There are generally many cases of subjects	There are generally few cases or subjects
Procedures are standard, and replication is assumed	Research procedures are particular, and replication is rare
Analysis proceeds by using statistics, tables or charts and by discussing how that which they show relates to hypotheses	Analysis proceeds by extracting themes or generalisations from evidence and by organising data to present a coherent, consistent picture

Morse (1991) shortened the terms quantitative and qualitative to “quan” and “qual” respectively, implying that both approaches to research are legitimate and equal in stature (Creswell et al., 2003). Morse (2003) also designed a coding system to further differentiate possible combination of multi- and mixed methods designs (see Table 3.4). Morse (2003) defines the primary way the researcher thinks as the theoretical drive; clarifying that the theoretical drive may be inductive (for discovery) or deductive (for testing). The former is most commonly used in qualitative research, particularly when the researcher is trying to answer questions such as: “What is going on?” “What is the meaning of__?”

Deductive thinking can be used with mixed methods research, but Morse (2003) argues that the researcher’s theoretical drive should remain constant even when aspects of the research process

are confirmatory or deductive. She adds that it is critical for the researcher to be continually aware of whether she or he is working inductively or deductively at any stage to ensure that assumptions of each method are not violated. As noted in Chapter 1: Section 1.5, the research method used in this research was primarily qualitative, with quantitative method used to validate the learning programme. Using Morse's multi-/mixed methods design typology, the approach used in this research was QUAL + quan, as the qualitative aspect was dominant and both were used simultaneously, employing an inductive theoretical drive (see Table 3.4).

Table 3.4: Morse's (2003) multi-/mixed methods and design types

Approaches	Multi-/mixed method and design types
QUAL + qual	Simultaneously use two qualitative methods – one is dominant or forms basis of whole project
QUAL → qual	Sequentially use two qualitative methods – one is dominant
QUAL + quan	Simultaneously use a qualitative and quantitative method with an inductive theoretical drive
QUAL→ quan	Sequentially use a qualitative and a quantitative method with an inductive theoretical drive
QUAN + quan	Simultaneously use two quantitative methods, one of which is dominant
QUAN→ quan	Sequentially use two quantitative methods, one of which is dominant
QUAN + qual	Simultaneously use a quantitative and a qualitative method with a deductive theoretical drive
QUAN → qual	Sequentially use a quantitative and a qualitative method with a deductive theoretical drive

The term *mixed methods design* refers to data collection techniques and analyses, given the type of data collected, as both aspects are intertwined. Originally the mixed methods design was also called the triangulation method with triangulation defined as the convergence of research results (Tashakkori & Teddlie, 1998; Teddlie & Tashakkori, 2003). Creswell et al. (2003) state that the mixed methods design serves purposes beyond triangulation. Greene, Caracelli and Graham (1989) identified five purposes for the mixed methods design:

- triangulation or convergence of results;
- examining different facets of a phenomenon;
- initiating or discovering paradoxes, contradictions, fresh perspectives;
- developing or using the methods sequentially so that the first method informs the use of the second; and
- adding breadth and scope to research through expansion.

While the research design was exploratory, descriptive, and partially explanatory (see Section 3.3.2.1 iv), it also fulfilled the four criteria devised by Creswell et al. (2003) for a sequential transformative mixed methods design:

- The implementation is either quantitative, followed by qualitative, or qualitative followed by quantitative. In this case qualitative was followed by quantitative.
- Priority is quantitative or qualitative or equal. For this research it was qualitative.
- The stage of data integration is to be identified. In this research it was during the interpretative stage.
- An overall theoretical perspective is used. For this research it was King's Theory.

The ultimate goal of a transformative design – regardless of ideological perspective, or domain of inquiry – is change (Creswell et al., 2003). In this design the transformative element began with a vision that all nurses who were working in Saudi Arabia would demonstrate their commitment to protecting the public through continuing their professional development. To be transformative, such a commitment would have to go beyond individual action to include relevant legislation and regulation enacted via different levels of policy development, implementation, monitoring and assessment of outcomes.

When a research design provides opportunities for dialogue across ideological differences, it has the potential to restructure professional practice. A mixed methods design is transformative when it includes a broader set of interests in the resulting knowledge claims and when it strengthens the likely effectiveness of action solutions leading to practice (Greene & Caracelli, 2003). Having the results of a provisional learning programme critiqued by a group of international experts partially fulfilled this aspect. Continuous mentoring from a transformational nurse leader provided further support for the researcher, both personally and professionally. Moreover, a transformative design / mixed methods approach encouraged the researcher to explore and integrate differences in theoretical perspectives and give voice to such differences, thereby demonstrating her competence in developing, implementing, remediating and evaluating the learning programme. Boyer's Scholarship Model (1990) and the American Association of Colleges of Nursing (AACN, 1999d) scholarship standards were used to triangulate the research results, thereby providing evidence of scholarship achievement (see Chapter 4: Table 4.19).

A research method describes a flexible set of guidelines which connect the theoretical paradigms first to strategies of inquiry and second to methods for collecting empirical material. It also situates a researcher in the empirical world while connecting her or him to specific sites, persons, groups, institutions and bodies of relevant interpretive materials from practice (Denzin & Lincoln, 2000). Thus the mixed method was the strategy of inquiry that the researcher employed as she moved from the paradigmatic to the empirical work. Strategies of inquiry put paradigms of interpretation into motion (Creswell, 2003). Strategies of inquiry also connected the researcher to specific methods of collecting and analysing empirical material (Botes, 1998). Research strategies allowed the researcher to implement and anchor paradigms to specific empirical sites or incorporate them into specific methodological practices (Denzin & Lincoln, 2000).

The second order of the research model represented a theory of nursing and research methodology. The activities in this case were research and theory development. Theory development emerged from the continuing and extended process of research (Bowman, 2001). The aim of the research was development, implementation, validation and evaluation of a learning programme for continuing professional development of nurses in Saudi Arabia. The goal of the research was functional by nature in that the knowledge of continuing professional development in nursing was generated and applied to nursing practice in Saudi Arabia. Research methodology was described as the research decisions that were taken within the determinants of the research framework (Botes, 1998; 2000).

3.3.2.1 Determinants of research decisions

All determinants of research decisions were based on the initiation of the problem statement as described in Chapter 1: Section 1.2. The second order of the research methodology emerged from King's Theory of nursing and was structured by the determinants of the research decisions (see Chapter 1: Figure 1.1). As visualised in Figure 1.1, the determinants included the attributes of the research domain/field; the research context; the researcher's assumptions and the research purpose. The research design formed the basis for the research decisions and the research

decisions included the research formulation, the research conceptualisation and the research implementation (Botes, 1998, 2000). The determinants of the research decisions were briefly described in Chapter 1: Section 1.5 and are expanded upon below. Conceptualisation of the research methodology was visually depicted in Chapter 1: Tables 1.1, 1.2, 1.3, and 1.4 and they are further explained below.

3.3.2.1. i) Attributes of the field of research

Botes (1989) identified a number of characteristics that affect all nursing research and thus the research decisions the researcher must make. She refers to these characteristics as attributes of the field of research, identifying them as interpersonal relationship attachment; intent; value and context attachment; dynamics and multi-dimensionality (Botes, 1995). Each is applied to the researcher's particular situation and explained below:

- *Interpersonal relationship attachment* was determined by the structure of nursing practice (see Table 3.1) in a tertiary care hospital in Saudi Arabia.
- *Intent* meant the nurse researcher had the responsibility and accountability to provide quality nursing education according to her Nurses' (Registered) Act, 1996 as per the legislative authority of the province of British Columbia, Canada.
- *The value and context attachments* were also influenced by the Nurses' (Registered) Act of British Columbia as well as by the quality of the nurse's work environment (e.g. leadership, professional practice standards, and culture, legislation and political influences). The nurse researcher's practice was regulated by her nursing board in one country (Canada) while she worked in a tertiary hospital in another country (Saudi Arabia) and continued her professional development in a university in a third country (South Africa). As such she was expected to comply with the laws of Canada and to respect those of Saudi Arabia. The nurse researcher was responsible and accountable for her acts and omissions in the rendering of her practice regardless of country. She was also expected to subscribe to quality (excellence) in her nursing practice and support and promote quality practice environments (CNA, 2003b).
- *Dynamics and multi-dimensionality* were influenced by: the dynamic process of nursing in Saudi Arabia, Canada and South Africa; the nurse researcher's contribution; her personal/professional development; and her personal commitment to quality practice.

3.3.2.1 ii) Research context

According to Botes (1995), the researcher must clarify that the research design is inclined towards both a universal and a contextually specific approach. The researcher implemented an international approach, drawing upon her nursing experiences from Canada and Saudi Arabia, and her academic experience from Canada and South Africa. To develop a learning programme for the continuing professional development of nurses working in Saudi Arabia, she undertook a global research of the literature pertaining to the following areas of study:

- Professional, ethical and legal practice:
  - regulation and credentialing;
  - ethical and legal foundations;
  - nursing regulatory boards.
- Nursing education practice:
  - curriculum development;
  - outcomes-based education;
  - quality practice environments.
- Continuing professional development:
  - competency-based practice;
  - career management;
  - adult learners and learning theories;
  - reflective practice.

In the next section, which begins with a definition of health, the researcher's assumptions are stated.

3.3.2.1 iii) Researcher's assumptions

The World Health Organisation (1948) defines health as a dynamic state of physical, mental, spiritual and social well-being that is culturally influenced and practised by individuals, groups and communities. In this research context the state of health implied the individual nurse's well-being and optimal functioning in Saudi Arabia. Health and illness lie somewhere along a continuum as people interact with their family, friends and others within a variety of environmental conditions. Individuals and/or communities realise aspirations and satisfy needs within their cultural, social, economic and physical environments. As a community resource, healthy people are important to daily living and societal productivity. Health is influenced by circumstances, beliefs, customs and cultural norms and practice and other health determinants such as education, income, employment, safe environments, social support and community connectedness. Hence nursing practice is also derived from a unique understanding of the influence of the environmental context of health (Community Health Nurses' Association of Canada [CHNAC], 2002).

It is the nurse's professional responsibility to promote, protect and preserve the health of the individuals, nurses, families, groups, communities and populations wherever they live, work, learn, worship and play. Nurses promote health through strategies of health promotion, health education, illness or injury prevention, and health protection, health maintenance, restoration and palliation.

At the base of nursing practice is caring (Bevis & Watson, 1989). Caring is essential when developing a relationship that values the individual as unique and worthy. Nurses enact this basic belief whenever they act to preserve, protect and enhance human dignity holistically for individuals and as well for groups and communities (CHNAC, 2002). It is, therefore, critical for the individual/community to be an active partner in the control of the decisions that affect health and well-being. Active participation includes defining health needs, setting priorities among health goals, controlling the choice(s), using various actions to improve health and evaluating outcomes. Furthermore, participation is the basis of therapeutic, caring relationships promoting empowerment and building capacity (CHNAC, 2002).

Whether working mainly with individuals and families, groups and/or communities, nurses identify and promote care decisions that build on the capacity inherent within the individual/family or community. Thus, within the context of primary health care, nurses also contribute to the population's health. A nurse's basic education preparation, therefore, needs to include primary health care to capture the quality of nursing practice required to promote, protect and preserve the health of individuals and communities. Furthermore, since every nurse, regardless of practice focus or setting, is accountable for her/his nursing practice, standards are required to ensure adequate basic education and preparation at a generalist level, then to support ongoing competent practice and continuing professional development so as to enable a nurse to practise to the fullest extent of his or her scope of practice (ICN, 2003).

As nursing practice contributes to and complements other health disciplines, collaborative practice is paramount to achieve quality patient care and strive for healthy people living in healthy communities. Hence, a continuing professional development programme is needed to maximise the unique contribution of nursing while facilitating collaboration with other disciplines working in the particular health system.

The research purpose is described in the next section.

3.3.2.1. iv) Research purpose

The purpose of the research was to design a continuing professional development learning programme for nurses working in Saudi Arabia. Following the direction provided by Botes (1998, 2000), the researcher utilised three research strategies, namely exploratory, descriptive and explanatory research. The exploratory research began with a phenomenon of interest in continuing professional development, but the researcher decided to investigate the full extent of the research problem to gain insight and understanding (Pilot & Beck, 2004) rather than simply to observe and describe the phenomenon.

Pilot and Beck (2004) note that qualitative methods are especially useful in exploring a phenomenon that is not understood, because this helps to shed light on the various ways in which it is manifested and on underlying processes. As a strategy of inquiry, exploring improved the researcher's insight and understanding of the research problem. The exploratory process was initiated inductively during the time the researcher was a nurse educator at a tertiary hospital in Saudi Arabia. Under the guidance of one of her academic supervisors, an expert nurse educator, a provisional learning programme for continuing professional development was inductively developed (Phase 1: Outcome 1; see Chapter 1: Table 1.1; and Chapter 4: Section 4.4.1).

During Phase 1, the researcher read and synthesised selected literature (see Chapter 2: Section 2.4; and Chapter 4: Section 4.4.1), familiarising herself with the research phenomenon and searching for hidden structures and models (Burns & Grove, 2001). The researcher also explored and analysed the literature on nursing theories and models and consulted experts in the fields of nursing practice, adult education, curriculum development, outcomes-based education, continuing professional development and regulation and legislation (see Chapter 4: Section 4.4.3). Thus a descriptive research strategy was also followed.

Descriptive research is defined as a study that accurately portrays the characteristics of persons, situations, groups and/or the frequency with which a certain phenomenon occurs (Burns & Grove, 2001). The purpose of the descriptive design was to discover new meaning, to describe what existed, and to determine the frequency with which something occurred while categorising information. The descriptive strategy was used to gain more information about characteristics within continuing professional development of nurses working in Saudi Arabia to develop a picture of what was actually happening. This strategy was also used to develop theory, identify problems from current practice, justify current practice, make judgments, and determine what other countries were doing (Waltz & Bausell, 1981). The descriptive strategy supported the formation of the provisional learning programme, the process of implementing the final learning programme and the assessment (evaluation) of the programme implementation.

It was important to delineate the research phenomenon before causality could be examined (Burns & Grove, 2001). Causality is linked to explanatory research. The purpose of an explanatory strategy (validation of the learning programme) is to understand a specific natural phenomenon and to explain systematic relationships underlying the phenomenon (Pilot & Beck, 2001). Explanation is achieved when the research process has helped to clarify the relationship between the phenomenon and when certain identified events occur. Judgments or conclusions were made during the data analysis and were carefully considered, linking information from the research to each conclusion (Burns & Grove, 2001). This research study, however, partially explained the phenomenon since there were 14 experts who validated the learning programme which was implemented in one hospital in Saudi Arabia. In the next section, the research design based on the research decisions is further explored. Data on the provisional learning programme were collected by utilising a semi-structured questionnaire (see Appendix A) consisting of biographical data and evaluation of the learning programme's content and format.

3.3.2.2 Research decisions

The research decisions included the design, formulation, conceptualisation and implementation of the research design. Each of these aspects is briefly described below.

3.3.2.2 i) Research design

The purpose of the research design was to achieve greater control and thus improve the validity of the study in examining the research problem. The procedures for collecting, analysing and reporting the research are included in the design. The specific design aspects are a) general research methods; b) research strategies; c) sampling methods and target population; d) data collection and analysis and coding; e) strategies of reasoning; and f) trustworthiness. Each of these design aspects is subsequently explained in the respective sections.

a) General research methods

Qualitative, quantitative and mixed methods frame the research approach differently (Creswell, 2003). Borrowing from Crotty (1998), Creswell provides a framework combining the elements of philosophical ideas, strategies and methods into the three approaches to research (see Figure 3.2). He identifies three questions that when explored together demonstrate the interrelated levels of decisions that go into designing the research process:

- What knowledge claims were made?
- What strategies of inquiry informed the procedures?
- What methods of data collection and analysis were used?

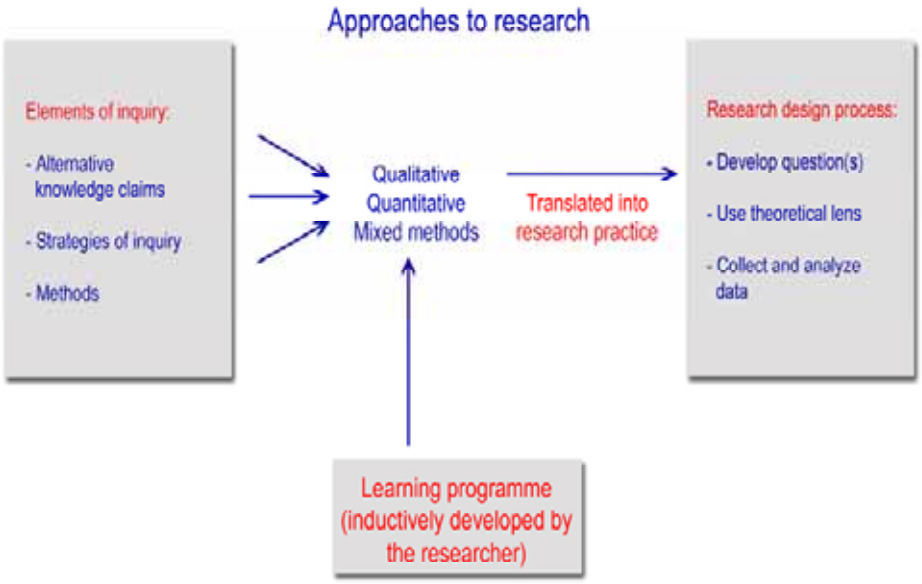

Figure 3.2: Elements of inquiry, research approaches and design process (Source: Creswell, 2000)

When stating a knowledge claim about the research, the researcher identified certain assumptions about what was to be learned and how. Such claims are sometimes called paradigms (Creswell, 2003; Lincoln & Guba, 2000), philosophical assumptions, epistemologies and ontologies (Crotty, 1998); or research methodologies (Neuman, 2000). Creswell (2003) cautions, however, that truth is what works at the time of the research, providing the best understanding of the research

problem. According to Creswell (2000) a paradigm is sometimes stated as a knowledge claim in which the researcher begins his/her research with certain identified assumptions about how and what he/she will learn during the inquiry. He further notes that pragmatism opens the door to multiple methods, different worldviews, and different assumptions, as well as to different forms of data collection and analysis in the mixed methods study.

b) Research strategies

By combining and increasing the number of research strategies used, the researcher was able to broaden the dimensions and thus the scope. Using more than one research method within a research programme meant a more complete picture was likely to emerge, thus hastening the achievement of understanding and research goals (Morse, 2003). Outcomes research is an emerging form of inquiry propelled by policymakers, insurers and the public's demand for greater accountability. Outcomes research sometimes uses different strategies from the accepted scientific methodology, incorporating evaluation methods, epidemiology and economic theory. Florence Nightingale was among the first to conduct outcomes studies (Burns & Grove, 2001).

Burns and Grove (2001) identify the theoretical base for outcomes research as coming from evaluation research with quality as the overriding construct. Evaluation is the systematic assessment of the learning programme for the purpose of effectiveness and improvement (Mouton, 2001; Weiss, 1998). The mixed methods approach focused on formative and summative aspects. King's Theory was utilised in establishing relevant beliefs about nursing practice (Weiss, 1998). By using programme evaluation research, the researcher was able to establish rapport and trust with her subjects, to enhance construct validity and to provide an insider (emic) perspective. Mouton (2001:162) warns that typical errors that can ensue include observer and interviewer bias and a lack of rigour control over the selection of subjects. If the researcher does not systematically and rigorously evaluate the programme outcomes, "…strong causal inferences regarding …benefits and impact are difficult…to make"(Mouton, 2001:162).

Donabedian (1986) developed a theoretical base for evaluation research. He identified three objects of quality: structure, process and outcome. His theory requires that outcomes be identified and clearly linked with the process that caused the outcomes. The researcher followed Donabedian's (1986) theoretical framework (outcomes, structure and processes) integrating this framework with the scientific nursing process which were then applied to the particular aspects of the research phenomena and linked to relevant research outcomes and processes (see Table 3.5).

It was essential to develop and implement a structured learning programme inductively in order to facilitate the continuing professional development of nurses. Moreover, a structured programme would ensure that the researcher would be able to meet the requirements of a regulatory board, including accreditation processes. While the learning programme was developed from the first order of the Botes' Model, it was continuously adjusted to the changing needs of individual learners and organisational circumstances. The provisional learning programme was validated by national and international experts using a Delphi technique, thereby strengthening the scientific aspects. The Delphi technique is "a method of measuring the judgment of a group of experts for assessing priorities or making forecasts" (Burns & Grove, 2001:795). The judgments of experts were measured with regard to the validity and reliability of the learning programme. The criterion used to select the experts was that they would be individuals who would be able to assist with the validation of a provisional learning programme for continuing professional development. The minimum selection requirement was a Master's degree in the content validation of the provisional learning programme.

The evaluation inquiry process was an iterative learning process (see Chapter 4: Section 4.4.1, and Figure 4.1) with one phase informing another and looping back to reframe an earlier phase (Rallis & Roosman, 2003). During the quantitative aspect of the research, the researcher collected the data from the experts who validated the provisional learning programme and simultaneously analysed the data, following which conclusions were drawn and evaluated in terms of quality of inferences (internal validity) and generalisability. Qualitative methods required data analysis simultaneously with data collection, making inferences/conclusions, collecting more information and making further inferences/conclusions until the data were saturated (Tashakkori & Teddlie, 1998). Qualitative data were collected from multiple sources. This included regular observations,

interviews, and documents. Field notes included written notes from class and formal memos and reports and reading from relevant literature; meetings; curriculum discussions; informal gatherings; and a survey of experts' opinion, supplemented with formal and informal mentoring sessions with one of the academic supervisors. Some notes were taken during a specific time while others were recorded later. Data were analysed simultaneously or as close to the data collection as possible. Experts were asked to validate the provisional learning programme utilising a semi-structured questionnaire (see Appendix A).

Table 3.5: The research strategy: using the scientific nursing process, steps in scientific process, research application and research outcomes and processes

Scientific nursing process	Steps in process	Application	Outcomes and processes
Standard I: Assessment	▪ Identify problem ▪ Gather data ▪ Analyse data ▪ Identify alternative ▪ Write report	Problem statements: ▪ Saudisation within an emerging regulatory system ▪ Multinational regulation systems ▪ Varying scopes of practice, standards of practice and requirements for licensure renewal	Outcome I – design and implement provisional learning programme Outcome II – validate learning programme
Standard II: Planning	▪ Choose an alternative from the assessment / analysis process	▪ Continuous professional development as integral aspect of the learning programme ▪ Learning programme validated by experts in nursing practice, health education continuing professional development, career management and outcomes-based education, regulation and accountability	Outcome I Outcome II
Standard III: Implementation	▪ Implement alternative approach	▪ Provisional continuing professional development learning programme implemented in two nursing diplomas and a new graduate programme	Outcome I
Standard IV: Evaluation	▪ Evaluate implemented alternative ▪ Remediate and assess	▪ Continuously evaluated (formative and summative) ▪ Remediated as required ▪ Prepared an article for peer review based on research conclusions	Outcome III - learning programme continuously evaluated Outcome IV – published research findings in a peer review journal

Teddlie and Taskhakkori (2003) propose inference quality as a mixed methods term to incorporate the QUAN term *internal validity* and the QUAL terms *trustworthiness* and *credibility of interpretations*. These authors define credibility as "the degree to which the interpretation and conclusions made on the basis of the results meet the professional standards of rigor, trustworthiness, and acceptability as well as the degree to which alternative plausible explanations for the obtained results can be ruled out" (Teddlie & Taskhakkori, 2003:709). The reliability of the learning programme was validated to ensure the quality of the data collected (results of measurement and/or observations) and the practice standards utilised were considered valid (trustworthy) and dependable (reliable) by the respective experts (Teddlie & Taskhakkori, 2003; Punch, 1998). Reliability of the research findings was determined by experts from six countries: South Africa, Canada, the USA, Egypt, Australia and Saudi Arabia. A statistician-researcher was asked to verify data obtained from experts.

The next section describes the target population and explores techniques for decreasing sampling bias.

c) Sampling methods and target population

The sampling of individuals, settings or literature has consequences for internal validity of research findings and thus some inferences made on the basis of the results might have low or no credibility if improperly selected (Tashakkori & Teddlie, 1998). The purposeful sampling method, also referred to as theoretical or judgmental sampling, was employed in this research. It involved the conscious selection of certain subjects or elements to include in the study. Purposeful sampling is often used in qualitative research. This sampling method provided a way to gather initial ideas about an area not easily examined with the use of other sampling techniques.

When using purposeful sampling, it was important for the researcher to identify criteria to replace the principle of cancelled random errors (Kemper, Springfield & Teddlie, 2003) and on the basis of information about these individuals (Tashaskkori & Teddlie, 1998). Confidence in generalisation from the sample to population depended on the degree to which the whole population was represented within the sample. Sampling error is random and might occur whenever an individual,

text, situation or unit of observation is selected from within the respective population. Relatively large samples are required for sampling error to be low or nil. Thus if the researcher cannot select a relatively large sample, he/she will increase trustworthiness and credibility of results by selecting units on the basis of available information regarding their characteristics instead of on the basis of random selection (Tashakkori & Teddlie, 1998). Sampling bias, on the other hand, is systematic rather than random. A biased sample is not representative of the population and therefore research findings have a low transferability or external validity. Tashakkori and Teddlie (1998) advise researchers to employ purposeful sample selection based on characteristics chosen ahead of time.

The following criteria were used for the purposeful selection of the four research sample populations:

- nurses who were enrolled in one of two diploma programmes during September 2002 and April 2005 (see Chapter 4: Section 4.4.1: Table 4.2);
- new graduate nurses with minimal to no experience who were enrolled in a transition programme between August 2004 and June 2005 (see Chapter 4: Section 4.4.1 and Table 4.2);
- literature research with articles primarily between 1998-2005 (see Tables 3.6 a, b and c); and
- experts from South Africa, Canada, the USA, Egypt, Australia and Saudi Arabia who had a minimum of a Master's degree with expertise in selected content fields (see Chapter 4: Section 4.4.3).

Table 3.6 a: Target population from the literature review:

Professional, ethical and legal practice

Literature population	Literature sources	
Regulation and credentialing	Affara, & Styles (1992) Brunke (2003) CIHI (2001) CNA (2001a, 2002a, 2003a) Finocchio, et al. (1995) Khofa (n.d.) ICN (1996; 2001, 2003, 2004)	Lemire-Rogers (2003) Muller (2003) Percival (2001) Styles, & Affara (1997) Van der Merwe (2002) WHO (2002)
Ethical and legal foundations	Bergman (1982) CNA (1993, 2003a, 2003b) CNO (1995) Hardingdam (2003) ICN (2002)	Muller (2003) SCHS (2003) Styles & Affara (1997)
Nursing professional regulatory system	Affara, & Styles (1992) Bryant (2005) CNA (1993) ICN (1986,1994, 2003)	Percival (2001) RNABC (2002, 2003b) Styles & Affara (1997)

Table 3.6 b: Target population from the literature review: nursing education practice

Literature population	Literature sources	
Nursing education	ANA (2000b) Bevis, & Watson (1989) Billings, & Halstead (1998) CNA (2004a) CNA & CASN (2004a, 2004b)	Heath (2002) Muller (2003) Pratt (1998) SREG (2002) WHO (2001)
Curriculum development	Conti, & Kology (1998) Elias, & Merriam (1995) Kegan (2000)	Muller (2003) Vella (2001, 2002) Zinn (1998)
Outcomes-based education	Arjun (1998) Geyser (1999) Finnie, & Usher (2005) Harden (n.d.) Harden, et al. (1999) Killen (2000) King, & Evan (1991) Malan (2000)	Shumway, & Harden (2003) Simpson et al. (2002) Spady (1994, 1996) SREB (2002) Tucker (2004) Vella, et al. (1998) Wallace (1997) Willis, & Kissane (1995, 1997)
Quality practice environments	AACN (1995, 2002, 2003) Aiken, et al. (2001, 2002, 2004) Baumann et al. (2001) Bliss-Holtz, et al. (2004) Buchan (1999) Buchan, & Calman (2005) CNA (2002b, 2004d) Chalmers (2004) Cooper (2003) CPRN (2002) ICN (2002) ILO, ICN, & WHO (2002) Kelly (2003)	Hastie (n.d.) Lowe (2000, 2002) Lowe & Schellenberg (2001) Lowe et al. (2003) Myrick (2002) Myrick, & Yonge (2004) O'Brien, et al. (2004) Rafferty, et al. (2005) RNABC (2002) Stokes (1998) Upenieke (2003) Van der Merwe (2003) Zurn et al. (2005)

Table 3.6 c: Target population from the literature review: continuing professional development

Literature population	Literature sources	
Professional development	Affara (2002) ANA (1994) Barriball, et al. (1992) Barriballi, & White (1996) Bryant (2005) CNA (2000b; 2004d) CNA & CASN (2004a, 2004b) Darbyshire (1993) Donabedian (1976, 1987) Furze, & Pearcey (1999) Guskey, & Hubberman (1995) Hutton (1987)	ICN (2003) Kegan (2000) Knowles (1980) Lowe (2002) Mackereth (1989) McMullan et al. (2003) Muller (2003) RNABC (2002) Spence (2004) Thurston (1992) Whyte et al. (2000) Wildman, et al. (1999)
Competency-based practice	Benner (1984) Byrant (2005) CNA (1997, 2000b, 2004c) CNA ,& CASN (2004a, 2004b)	ICN (2003) RNABC (2000) Mustard (2002) Whittaker et al. (2000)
Career management	Affara (2002) Alsop (2000) Calman (1998) Cooper, & Emden (2001) Donner, & Wheeler (2001, 2004)	Heath (2002) Hyde (2003) Price, et al. (2001) Van der Merwe (2001)
Adult learners and learning theories	Brookfield (1987, 2000) Caffarella (1993) Clark (1993) Cranton (2000) Daloz (1986, 2000) Dewey (1916, 1933) Elias, & Merriam (1995) Friere (1970. 1985) Kegan (2000)	Knowles (1980) Knowles et al., (1998) Kuhn (1962) Mackeracher (2004) Mezirow (1990, 1991, 1997, 2000) Pratt (1993) Schon (1987, 1992) Taylor et al. (2000)
Reflective practice	Atkins (2004) Atkins, & Murphy (1993) Boud, et al. (1985) Boyer (1990) Brookfield (1995, 2000) Brown, & Gilles (1999) CNO (2004) Dewey (1933) Duke, & Appleton (2000) Freire (1970, 1985) Jarvis (1992)	Johns (2000) Kemper (2001) McIntosh (1998) Mezirow (2000) Price, et al. (2001) Reid (1993) Saylor (1990) Schon (1987, 1992) Simpson, & Courtney (2003) Teekman (2000)

d) Data collection, analysis and coding

As a mixed methods approach was used, data gathering and analysis were conducted in two phases. Techniques for obtaining qualitative data were through dialogue, formal evaluation, practice experiences and a review of select literature. The quantitative component of the design was implemented to gather data from experts regarding their opinions and recommendations on the provisional outcomes-based learning programme for continuing professional development of nurses working in Saudi Arabia. There were two distinct research phases (see Chapter 1: Section 1.3) and within each, data analysis was conducted simultaneously relevant to data source and triangulation techniques. (See Table 3.7 for a summary of data analysis/interpretative and reporting procedures linked to the mixed methods, research phases and outcomes.)

Making sense out of raw data involved transcribing and preparing the data for analysis, completing the analyses, and gradually coming to understand the data at an increasingly deeper level. Then it was possible for the represented data to be interpreted for more extensive meaning, at which point inferences could be drawn (Creswell, 2003:190). In this research, data analysis was intertwined with data collection, as an ongoing process, involving continual reflection, asking analytic questions and writing findings as reports, memos and field notes. This process also required that the researcher continually asked questions and analysed participants' responses. Open-ended information necessitated generating categories, selecting one of the categories and positioning the open-ended information within a theoretical model (axial coding). A story had to be explicated from the interconnection of the categories (selective coding) (Creswell, 2003).

A general sense of the information was obtained and initial impressions of what was being said were reflected upon to assess the credibility and use of information. Information then was coded. Coding is the process of organising materials into categories and labelling those categories with a term before deriving meaning (Rossman & Rallis, 1998:171). The terms used in the research were descriptive and based in the language of the participants. Like categories were grouped and interrelationships between categories discovered. When the data were assembled a preliminary analysis was made and where necessary recoding was done (Creswell, 2003). Coding was used

to identify themes or major findings from the various categories, displaying multiple perspectives from participants and supported with diverse quotations and specific evidence.

Table 3.7: Mixed methods, research phases, research outcomes and data analysis/ interpretation and reporting procedures

Mixed methods	Research phases	Research outcomes	Data analysis/interpretation and reporting procedures
Qualitative (Assess, plan and implement)	Phase I	*Outcome I:* Provisional learning programme	▪ Implemented continuing professional development learning programme during September 2002-June 2005 utilising outcomes-based education ▪ Continuously assessed progress ▪ Observed participants ▪ Collected qualitative data – field notes, literature review ▪ Debriefed (ongoing) with adviser/mentor ▪ Explored characteristics within data ▪ Analysed data for themes and issues ▪ Described results and drew initial conclusions / inferences ▪ Prepared the provisional learning programmes
Quantitative (Evaluate)	Phase II	*Outcome II:* Learning programme validation	▪ Designed a questionnaire ▪ Questionnaire reviewed by one of the academic adviser and an independent nurse researcher ▪ E-mailed to experts along with a copy of the provisional learning programme ▪ Analysed data of questionnaires ▪ Described and reported results (see Chapter 4) ▪ Made changes in learning programme
Mixed methods (Assess, plan, implement and document)		*Outcome III:* Evaluation of final learning programme	▪ Implemented revised programme ▪ Evaluated programme and remediated as required ▪ Finalised programme and triangulated results ▪ Drew conclusions/ inferences and recommendations ▪ Completed research study (June 2005)
Mixed methods (Document)		*Outcome IV:* Results publication	▪ Wrote article for peer reviewed journal ▪ Submitted article to peer-reviewed journal

A semi-structured questionnaire was developed in order to gain written documentation of experts' opinion regarding the learning programme. A letter was sent with reassurance that the participants' responses would not be linked with either their names or other identifiable personal data (see Appendix B). The questionnaire was composed of three sections: Section A requested biographical data; Section B focused questions on the content of the learning programme and Section C included questions related to the format of the learning programme. In Sections B and C

a four-point Likert scale was used, and in Section B some questions required a yes or no response. Space for additional comments was also included (see Appendix A).

Data themes were initially grouped using knowledge, skills, values and attitudes, judgment and quality improvement. The themes were further grouped to tell a story and thereafter developed into a theoretical model. Descriptive information was included in narratives, tables, figures and visuals. Findings from a literature review, extant theories, and expert validation of the learning programme were subsequently triangulated and further meaning was derived. The final step was interpretation of the meaning of the triangulated data to discover what lessons could be learned from the research. As King's theoretical lens was used, interpretations formed the basis for a call for action and change (Creswell, 2003:195) with regard to continuing professional development of nurses working in Saudi Arabia. Validity of the research referred to ensuring high quality research that was plausible, credible, trustworthy and defensible. In general terms, the key issue of research validity was whether experts considered the research to be well done and worthy of readers' attention (Johnson & Turner, 2003). Validity (trustworthiness) of the research was at stake.

In the next section strategies of reasoning are explored and then trustworthiness of the research is overviewed.

e) Strategies of reasoning

Mixed methods researchers can follow either deduction or induction strategies, or a combination of induction and deduction when designing their research. Morse (2003), however, encourages researchers who use mixed methods to maintain their primary orientation (deductive for quantitative and inductive for qualitative) when reasoning. The strategies of reasoning used in this research were analysis, deduction, induction, derivation, synthesis and critical reflection.

- *Analysis* is defined as the process of organising and synthesising data in order to answer either (a) research question(s) or to test a hypothesis or hypotheses (Pilot & Beck, 2004). This reasoning process is useful when clarifying and refining objects, assumptions, and theories (Wolcott, 1994). In this research an analysis was conducted based on the different approaches to continuing professional development in practice and in the literature. The

results of the questionnaire were analysed to draw the conclusions, make changes and derive recommendations.

- *Deductive* reasoning (see Figure 3.3) moves research from the general to the specific or from a general premise to a particular situation (Burns & Grove, 2001). This method was utilised to draw from an already formulated theoretical statement or observable empirical facts (Teddlie & Tashakkori, 2003) and specific predictions from general principles (Abdellah & Levine, 1979). Deductive strategies were implemented when reviewing the literature and analysing the experts' written opinions, after inductively developing a provisional learning programme.
- *Induction* refers to a mode of logic whereby a general rule is inferred from a number of cases where a certain result is observed (Erzberger & Kelle, 2003). It is the logical process whereby probable conclusions, depending on the external confirmation, are reached (Creswell, 1998). Induction came from the researcher's personal experiences and ways of knowing and her continued interactions within the field of research and nursing education. Figure 3.3 illustrates the differences between using deductive and inductive reasoning in research. The provisional learning programme was inductively developed and implemented by the researcher under the guidance of her two academic advisers who were both experts in the field of research and higher education.
- *Derivation* implies analogies and metaphors that were used during the redefinition of concepts, statements or in applying theories from one context to another (Walker & Avant, 1988). Concepts were taken from the literature and were redefined for the learning programme to suit the multinational and Saudi nursing workforce in a tertiary hospital in Saudi Arabia.
- *Synthesis* is a process of combining isolated parts of theoretical information to combine a new concept or statement (Walker & Avant, 1988). Synthesis was used to summarise the theoretical information from the literature to support the design, implementation and evaluation of the learning programme and in the preparation for this chapter. Synthesis was used during the triangulation of the research results and in Chapter 5.
- *Critical reflection* is also a reasoning process and according to Brookfield (1995) it is supported by the following interrelated aspects: questioning and replacing or reframing previously held assumptions – some representing commonsense wisdom; taking an alternative perspective on ideas, action, forms of reasoning and ideologies that had previously been taken for granted;

and recognising hegemonic aspects of dominant cultural values and understanding power and self-interest of unrepresentative minorities.

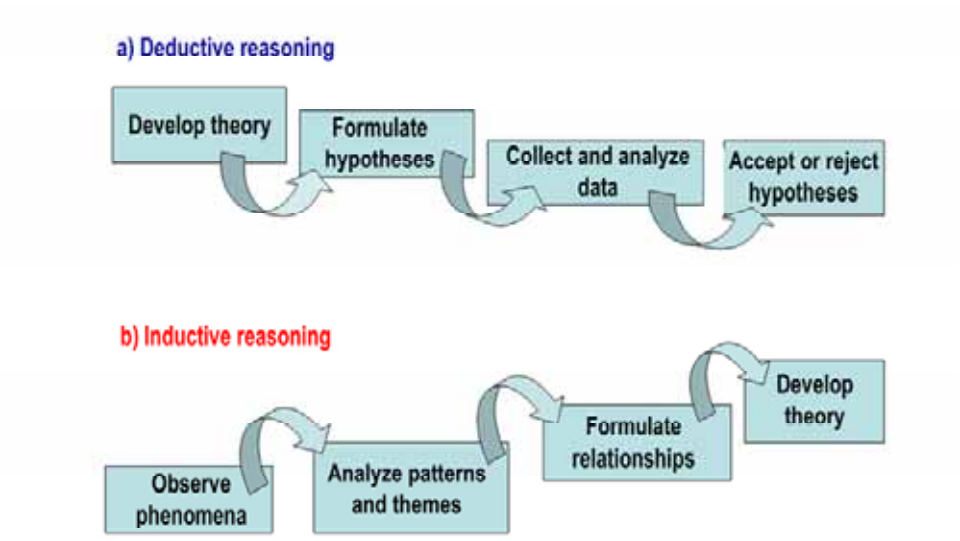

Figure 3.3: Deductive and inductive reasoning in research
(Source: Cavana et al., 2001)

By using the above strategies of reasoning within a mixed methods design, it was possible to create a multifaceted perspective of the research question (Kemper et al., 2003). The researcher also triangulated the data (see Chapter 4: Table 4.18) allowing for stronger inferences to emerge than with a single method research study (Tashakkori & Teddlie, 1998). Nevertheless, mixed methods research engenders a crisis of representation, particularly in capturing the real lived experiences into fieldwork text and finalising the research report (Denzin & Lincoln, 2000). Therefore, one of the most important research aspects was the researcher's ability to persuade her readers (and herself) of the validity or trustworthiness of the research report.

f) Trustworthiness of research

Lincoln and Guba (1985) conceived the concept of trustworthiness, identifying the need of the researcher to persuade his/her readers (and him/herself) that the findings of a research inquiry are worthy of attention. To do so the researcher must mount an argument and invoke criteria in order to be persuasive with regard to trustworthiness, credibility and validity. Maxwell (1992) identified five types of validity in qualitative research:

- *Descriptive validity* is defined as the factual accuracy of the account as documented by the researcher. The data and results from the questionnaires were validated by an independent statistician / researcher.
- *Interpretive validity* is defined as the extent to which a researcher's interpretation of an account represents an understanding of the perspective of the group members under study and the meanings attached to their words and actions. Interpretations were analysed and validated by both supervisors and an independent researcher.
- *Theoretical validity* is the degree to which a theoretical explanation developed from the research fits the data. Theory application was according to recent (1998-2005) global references.
- *Evaluative validity* is the extent to which an evaluation questionnaire can be applied to the objects of the study rather than to a descriptive, interpretative or explanatory framework.
- *Generalisability* is the extent to which a researcher can generalise the account of a particular situation or population to other individuals, times, settings or contexts:
  - *internal generalisability* refers to the conclusions within the setting or group studied; and
  - *external generalisability* pertains to what is beyond the group, setting, time or context. The same learning programme was utilised for the two diplomas as well as for a new graduate programme (see Chapter 4: Sections 4.4.1 and 4.4.2).

In qualitative research, internal validity refers to a more general concept, namely the match between the researcher's categories and interpretations of what is actually true. In other words, whether the pattern was real, whether it had had limitations in the data gathering; or whether the situation had distorted the findings (McMillan & Schumacher, 1997). Thus the researcher must be confident that the relationship between variables or events is real and that it does not occur for

other reasons. The internal validity was determined through careful examination of the inference drawn from the research. Krathwol (1993) summarised the evaluation of internal validity into five judgments to which Tashakkori and Teddlie (1998) added a sixth, namely inferential consistency audit:

- *Explanation credibility* is the degree to which the explanations for the relationship between variables are theoretically and conceptually sound and acceptable. King's Theory was utilised.
- *Translation fidelity* is the degree to which the conceptual framework of the study is translated into the element of the design with appropriate sampling, measurement/observation and other procedures. The literature research findings and the researcher's own experiences were utilised for the learning programme.
- *Demonstrated result is* the judgment required to assess whether some results occurred and whether they were the ones that had been expected. The questionnaire results were analysed with confirmation from an independent statistician/researcher.
- *Alternatives explanation* eliminates concerns for the evaluation of the degree to which there is no other plausible explanation for the relationship. The results from the evaluation questionnaires provided evidence for this aspect.
- *Credible result* is the evaluation of the degree of consistency of the results with previous findings in the literature. A strong study that met the above criteria might be internally valid even if there were unexpected results, providing the inferences/conclusions followed the findings. In the quantitative research credibility of the conclusions was assessed by the results of experts. In the qualitative research the credibility of the conclusions (the provisional learning programme) was assessed to ensure that they were credible to the individuals whose multiple realities were reconstructed or described. Using mixed methods allowed the researcher the flexibility to evaluate the credibility of the results according to either or both criteria as appropriate. Saturation was reached as the same results occurred.
- *Inferential consistency audit* is the degree to which inferences and interpretations are consistent with the analysis of data obtained and inferences/conclusions made in the same study. It is similar to Lincoln and Guba's (1985) confirmability audit. The content for the learning programme was validated internationally through utilising a semi-structured questionnaire.

The next section describes the research formulation.

3.3.2.2 ii) Research formulation

Formulation of the research process is described as the problem, purpose, hypothesis and assumptions. Formulation of the research problem was outlined in Chapter 1: Section 1.2 as the problem statement. The research purpose was described in Section 3.2 where it was noted that the central theoretical assumption replaced the hypothesis (Botes, 1998, 2000).

A proactive approach to the development of the health personnel in Saudi Arabia is essential if the realisation of the Saudisation Policy is to be effectively implemented. This is particularly relevant in the case of Saudi Arabia where there is a limited supply of nurses. The country is dependent on a foreign workforce during the global shortage of nurses which has already begun to affect their availability and retention.

3.3.2.2 iii) Research conceptualisation

As discussed in Chapter 2: Section 2.3, the conceptual framework for this research was based on King's theory, the literature research and the researcher's personal and professional experiences. King's theory informed and influenced the research, including the inductive integration of the literature research and pertinent information emerging inductively from the researcher's nursing practice. Strategies for reasoning were discussed in Section 3.3.2.2 (i-e) as a component of the research design. This included the aspect of inductive reasoning.

The next section highlights the research implementation.

3.3.2.2 iv) Research implementation

As noted previously, the research was implemented at a tertiary hospital in Saudi Arabia. The provisional learning programme was implemented during the period of April 2002 to December 2004. Validation of the learning programme occurred during December 2004 to March 2005 and was carried out by 14 experts from Saudi Arabia, South Africa, the USA, Australia, Egypt and Canada. Recommendations with regard to the learning programme were implemented and communicated to the two academic advisers. The learning programme was continuously evaluated and changes made according to recommendations. The results of the research were prepared for publication in peer reviewed journals in South Africa, Canada and in international nursing journals.

Philosophical assumptions (ideas) are used to explain what knowledge claims were constituted within the research. In Section 3.3.3 the third order, the paradigmatic perspective of Botes' model, is explored and applied to the research.

3.3.3 Third order: paradigmatic perspective

Researchers approach their research with a certain paradigm or worldview (Creswell, 1998; Tashakkori & Teddlie, 1998). The term *paradigm*, initially defined by Thomas Kuhn (1965), refers to a basic set of philosophical beliefs or assumptions about the nature of the world. Paradigms are deeply embedded in the socialisation of individuals, helping them to determine what is important, legitimate and reasonable. A paradigm is useful in the research process in relation to guidelines and principles to direct the research.

The positivist and post-positivist paradigms underlie quantitative methods while the constructivistic paradigm underlies qualitative methods (Guba & Lincoln, 1994; Creswell, 1998; Tashakkori & Teddlie, 1998; Cavana et al., 2001). More recently the pragmatic paradigm has emerged as a consequence of blending quantitative and qualitative methods (Creswell, 2003; Tashakkori & Teddlie, 1998). Regardless of the methods utilised, each should flow from its corresponding paradigmatic perspective (Ticehurst & Veal, 1999; Morse, 2003; Teddlie & Tashakkori, 2003). The

paradigmatic perspective is described by Botes (1998, 2000) according to the philosophical basis for research. She also described the metatheoretical, theoretical and methodological assumptions.

3.3.3.1 Philosophical basis for the research

As explained in Section 3.1, research is a complex process, laden with values, and oftentimes complicated by a variety of expectations. Researchers bring different beliefs with them about how research should be conducted and what the research results will achieve. These different beliefs can be categorised under different schools of thought or paradigms: positivist, interpretivist and critical research (Cavana et al., 2001). The work of Creswell (1998, 2003) and Tashakkori and Teddlie (1998) were combined to explain the fourth, namely pragmatism.

3.3.3.1 i) Positivist research

Cavana et al. (2001) state that the positivist research grew out of the natural sciences which generally examine elements of the natural world, while the social sciences focus on people. Positivist research is usually associated with quantitative data requiring precise, objective measures and deductive reasoning. It requires a linear strategy for formulating a statement of the relationships between the observed phenomenon (a hypothesis) attempting to disprove the assumed relationships of the hypothesis through a null hypothesis. The data gathering steps are rigorous, with statistical methods being employed during data analysis. Should another researcher replicate the research, he or she should come up with comparable results. Positivist researchers use deductive reasoning beginning with a theoretical position and moving toward concrete empirical evidence based on the assumption that there is a universal law waiting to be discovered. To ensure objectivism, positivist researchers are expected to remain aloof and separate from their research subjects and to employ deductive reasoning processes.

3.3.3.1 ii) Interpretivist research

Interpretivist researchers assume that people share similar systems of meaning, while experiencing physical and social realities in different ways. These meaning systems or patterns of conventions are created out of social interactions between people using inductive reasoning. Interpretivist research is based on the assumption that people's perception of the world is largely what provides meaning. The role of the researcher is to identify what was meaningful to the individuals or the group being investigated. Thus interpretivist research provides a rich and complex description of how people think, react and feel under certain contextually specific situations (Cavana et al., 2001).

3.3.3.1 iii) Critical research

The aim of critical research is to empower people to create a better world by uncovering, and going beyond the surface. Critical researchers uncover myths and reveal hidden meanings, using both deductive and inductive reasoning. Critical researchers assume once people see these hidden meanings they will be empowered and motivated to make changes in their lives. Hence the role of the critical researcher is to present findings in such a way that they become a catalyst for transformation (Cavana et al., 2001). While social theory provides a map or guide to the social sphere, critical social theory is concerned in particular with issues of power, and justice and the ways that the economy, matters of race, class, and gender, ideologies, discourses, education, religion and other social institutions and cultural dynamics interact to construct a social system (Kinchloe & McLaren, 2000). In general, the critical researcher explores the scientific study of social institutions and their transformations through interpreting the meanings of social life, historical problems of domination, alienation and social struggles and a critique of society and the envisioning of new possibilities. As Creswell (1998) notes, such themes have methodological implications.

Morrow and Brown (1994:242) postulate that "...critical theory is distinguished...by a distinctive approach to methodology as a set of meta-theoretical assumptions and privileged research design strategies, a core set of substantive commitments related to the analysis of crisis tendencies in

advanced capitalism, and an explicit approach to normative theory and its relation to critique of ideologies". The end goal of the research is to comprehend and perhaps transform through praxis the underlying orders of social life – those social and systemic relations that constitute society. Critical researchers are coming to understand that people's view of themselves and the world is greatly influenced by social and historical forces in particular today with the mass media-saturated Western culture. No individual is completely free from the socio-political context.

Individuals adopt the values and perspectives of their social group and such factors help them determine what is important and not, and what must be attended to and what should be ignored (Dewey, 1916). People interpret from within their particular orientation, including boundaries and blinders (Kinchloe & McLaren, 2000). These authors question the arrogance that comes with efforts to emancipate others and they urge researchers to respect those who have different conclusions about how life should be lived.

Differences in paradigmatic perspectives are commonly discussed in the research literature (Denzin & Lincoln, 2000; Creswell, 1998; Tashakkori & Teddlie, 1998; Teddlie & Tashakkori, 2003). These authors identify the fact that a number of new paradigms are growing daily, creating a blurring of genres. According to Guba and Lincoln (1994), worldview difference can only be resolved when a new paradigm emerges that is more informed and sophisticated. There have been numerous attempts to make peace between the two major paradigmatic positions beginning with Howe (1988), who posited the use of a different paradigm, pragmatism (Teddlie & Tashakkori, 2003).

3.3.3.1 iv) Pragmatic research

Pragmatism is defined as "…a deconstructive paradigm that debunks concepts such as truth and reality and focuses instead on what works as the truth regarding the research questions under investigations. Pragmatism rejects either/or choices associated with the paradigm wars, advocates for the use of mixed methods in research and acknowledges that the values of the researcher play a large role in the interpretation of the results" (Teddlie & Tashakkori, 2003:713). These authors

emphasise that the discussion and debate regarding paradigms and mixed methods continue and include great differences of ideas among scholars in the field of research generally, and mixed methods in particular. They believe the third methodological movement (mixed methods) will eventually be established alongside the other two (quantitative and qualitative).

An important philosophical issue in any research concerns the relative importance of paradigms, research methods and research questions (Tashakkori & Teddlie, 1998). Pragmatists consider the research question to be more important than either the worldview or the method used. Their view of reality consists of two parts: an external world independent of the mind; and uncertainty of one reality being better than another. The pragmatist choice of one explanation over another relates simply to one approach being better than another at producing anticipated or desired outcomes (Tashakkori & Teddlie, 1998). For the pragmatist, truth, like good, is a normative concept; it is what works at the time and hence knowledge claims can not be separated from one's beliefs, interests and work (Howe, 1988). From a pragmatist's perspective causal relationships exist but can never be pinned down as such (Tashakkori & Teddlie, 1998).

Nevertheless, through higher consciousness and self-criticism, the researcher may gain insight into how ambiguous and closeted interpretative processes operate and come to appreciate that facts do not demand particular interpretations. Furthermore, as Kinchloe and McLaren (2000) remind us, the researcher's consciousness and interpretative frames are historically situated, ever changing and evolving in relation to both the cultural and ideological environment. It is essential, therefore, that the researcher identifies her/his philosophical assumptions.

3.3.3.2 Philosophical assumptions

All research is interpretative. It is guided by a set of beliefs and feelings about the world and how it should be understood and studied (Creswell, 2003). Embedded within the researcher's paradigmatic perspective is a set of beliefs (assumptions) about the world. Some beliefs may be taken for granted, while others are highly problematic and controversial. Nevertheless, these beliefs shape how the researcher sees the world and reacts within it (Denzin & Lincoln, 2000).

According to Creswell (1998), there are five philosophical assumptions that guide the researcher's inquiries in relation to the nature of the reality (ontology issue), the relationship of the inquirer (researcher) to that being researched (epistemological issue), the role of values in a study (axiological issue), how we know the world or gain knowledge from it (methodological issue), and the language and terms of qualitative inquiry (rhetorical issue) (see Table 3.8).

3.3.3.2 i) Ontological assumptions

An ontological assumption addresses the nature of the reality for the researcher. Multiple realities exist that are constructed by those involved in the research situation. The researcher is responsible for reporting such realities, and advancing evidence of each theme. Reality in this research is the practice of nursing education in a multicultural tertiary care hospital environment.

3.3.3.2 ii) Epistemological assumptions

From an epistemological vantage point, the researcher tries to minimise the distance between him/herself and those being researched (Guba & Lincoln, 1985), shifting from an outsider (etic) to an insider (emic) role during his or her field research. Both have been associated with differing research methods, etic referring to a trained (outsider) observer's analysis of raw data and emic an insider's interpretation (Currall & Towler, 2003). Emic researchers tend to use observational techniques within one organisation, immersing themselves in the setting while developing relationships. Etic researchers use surveys from a wide range of organisations and then form inferences on quantitative data. When researchers combine the two types, they can conduct exploratory and confirmatory research (Currall & Towler, 2003).

Table 3.8: Categories of assumptions, questions arising, characteristics and implications for practice (Source: Creswell, 1998)

Assumption categories	Questions arising	Assumption category characteristics	Implications for practice
Ontological	What is the nature of reality?	Reality was subjective and multiple, as seen by participants in the study	Researcher used quotes and themes in words of population sample/research participants and provided evidence from different perspectives
Epistemological	What is the relationship between the researcher and that being researched?	Researcher attempted to lessen distance between him/herself and that being researched	Researcher collaborated, spent time in field with participants and became an insider (emic) as she developed, implemented and evaluated the learning programme
Axiological	What is the role of values?	Researcher acknowledged that research was value laden and that biases were present	Researcher openly discussed values that shape the narrative and included her interpretation in conjunction with interpretation of participants (see Chapter 4: Section 4.4.4)
Methodological	What is the process of the research?	Researcher used inductive logic, studied the phenomenon within a specific socio-political context utilising an emerging research design	Researcher worked with particulars (details) before generalisations, described in detail the context of the study and continually revised questions from experiences in the field and she inductively designed the provisional learning programme
Rhetorical	What is the language of the research?	Researcher wrote in a literary, informal style, occasionally using the personal voice, and used qualitative terms and limited definitions	Researcher used an engaging style of narrative, and employed the language of qualitative research

The researcher was involved in the following programmes and time frames: leadership and management and education diplomas, 2002-2005; and new graduate transition 2004-2005. The two diplomas were designed by one of the academic supervisors, with input from the researcher. The researcher taught in both programmes. The researcher assisted with the design of the new graduate transition programme and taught non-clinical (e.g. regulation and credentialing, continuing professional development and reflective practice). Her education responsibilities

included programme evaluation, supporting a learning environment, counselling and consultation, researching and continuing her own professional development. During this period, she inductively developed a provisional learning programme.

3.3.3.2 iii) Axiological assumption

Several authors (Cavana et al., 2000; Creswell 2003; Denzin & Lincoln, 2000) stress that the researcher's interpretations and reports are value-laden and biased. Thus the closeness between the researcher and participant(s) with a shift to the emic role has implications for the axiological assumption. Creswell (2003) recommends the investigator report values and biases as well as the value-laden nature of information gathered from the field. By so doing ethics are embedded rather than remain external to paradigms and thus contribute to the consideration of and dialogue about the role of spirituality in human inquiry (Denzin & Lincoln, 2000). The researcher sought written permission to conduct the research, and authority was granted by a senior administrator from the hospital where the research was conducted. The researcher described her personal and professional philosophy (see Chapter 2: Section 2.4.1.3), assumptions that she held (see Section 3.3.2.1 iii) and subjective research experience (see Chapter 4: Section 4.4.4.5).

3.3.3.2 iv) Methodological assumptions

Methodological assumptions have their origin in science philosophy (Botes, 1995). They deal with purpose, methods and criteria for the validity of the research. Methodological assumptions concerned the researcher's view of the nature and structure of science and research within nursing (see Chapter 2: Section 2.4.1.3). Through the rhetoric of the study methodological assumptions emerged and the research process was conceptualised.

3.3.3.2 v) Rhetorical assumptions

Basing research on a rhetorical assumption means that the author uses specific terms and a personal and literary narrative in the study (Creswell, 1998). Rather than using quantitative terms

such as internal validity, external validity, generalisability and objectivity, qualitative researchers employ terms such as credibility, transferability, dependability, trustworthiness, and confirmability (Lincoln & Guba, 1988). The language of qualitative research is more personal, evolving over the course of the study, including terms defined by participants. Concepts also contain built-in assumptions and statements about the nature of things that are not observable or testable. Concepts and theories are built on assumptions about the nature of human being, social reality or a particular phenomenon (Neuman, 2000). Validation of the learning programme by international experts served to increase the trustworthiness of the research and credibility was increased with a review by an independent statistician/researcher (see Section 3.3.2.2 i – f).

In general, qualitative researchers work inductively, and through the process, the research design emerges (Creswell, 1998). It was the duty of the researcher to identify assumptions from her paradigmatic perspective including those that emerged in the literature research. The researcher's assumptions (see Section 3.3.2.1 iii) were influenced by specific paradigmatic assumptions. The researcher had no preference for a particular method. Therefore she utilised mixed methods, the one that best suited the research problem. Botes (2000) identified the following categories of research assumptions: meta-theoretical, theoretical and methodological. Each of these categories of assumptions is subsequently discussed.

3.3.3.3 Meta-theoretical assumptions

Botes (2000) describes meta-theoretical assumptions as non-testable axioms, with origins in philosophy. Thus meta-theoretical assumptions reflect the researcher's view of human beings and society. The researcher approached this study from a Christian perspective within a Muslim society (in Saudi Arabia). She viewed each human being as unique and a creature of God and believed that each person makes decisions based on his/her world-view within the availability or limitations of his/her life circumstances. One reason why the researcher engaged in this research was to contribute to the quality of nursing practised in Saudi Arabia, ultimately with the desire to impact the health of the population within Saudi Arabia positively (see Chapter 2: Section 2.4.1.3).

3.3.3.4 Theoretical assumptions

Unlike meta-theoretical assumptions, theoretical assumptions are testable, providing epistemic statements of the research field and forming part of the existing and accepted theory of nursing (Botes, 1995). Theoretical assumptions gave structure to the central theoretical assumption (see Chapter 1: Section 1.4) as well as to the conceptual framework of the study. In some qualitative studies the theoretical assumptions can only be made after the data gathering and data analysis processes have been completed (Botes, 1995). The theoretical assumptions were based on King's theory as described below.

3.3.3.4 i) The nature of King's theory

The fundamental assumption of King's theory is a nurse's focus on the human being and human acts within a particular system or environment. Other assumptions found within this theory are that the roles and responsibilities of nurses include assisting individuals and groups in society to attain, maintain and restore health. Nurses also assist individuals to meet their basic needs at every point of the life cycle (Fawcett, 1995), thus nursing education assists learners to function optimally in nursing practice. Theoretical assertions were derived from a thorough literature review (see Chapter 2: Section 2.4) in particular with regard to professional, ethical and legal practice, nursing education practice and continuing professional development. Based on this review and the researcher's personal and professional experiences, theoretical assumptions were formulated by using King's Goal Attainment theory (1981) for nursing.

3.3.3.4 ii) The rationale for using King's theory

From King's perspective (her assumption base), people are open systems in transactions with the environment conceptualising as social, sentient, rational, perceiving, controlling, purposeful action oriented outcomes (Creasia & Parker, 2001). As open systems, individuals interact with stressors

originating from both the internal and the external environment. Hence King's theoretical framework provided a way of thinking about the real world of nursing practice. The concepts are represented in the fundamental knowledge in nursing practice, offering a way of organising a multitude of facts into meaningful wholes while providing a common theoretical basis for communication about perceived relationship directing attention to processes and relationships (Creasia & Parker, 2001). Although King's framework is abstract, the concepts within can be used in practice to create a common language across all four nursing domains. The framework exemplifies a way of thinking both inductively and deductively, helping those who use it to value their own thinking and feelings (King, 1995). In this research the nurse learner was seen as a holistic human being within a new multicultural environment.

According to King's theory, all systems have an end product (outcome) and in nursing practice the outcome is either health or peaceful death (Sieloff-Evans, 1991). Nursing education is the demonstration of international nursing concepts into practice in Saudi Arabia. King's theory is arranged in three open systems: the personal, interpersonal and social (see Chapter 1: Figure 1.1.) The personal system deals with the individual who is either the nurse or the client. The interpersonal system focuses on how people interact among themselves, either one to one or within a group. Finally, the social system deals with the dynamics of socio-political system, how it is organised and how it affects the environment and the people.

Specific beliefs and values about human beings, health and the environment are also included in King's theory (King 1995). King regards human beings holistically and analyses the concept of the human being as mentioned within three dynamic interacting open systems. The individual (personal system) is constantly interacting with other human beings and their environment. She also views interpersonal relationships as being affected by the individual perceptions, which in turn influence the individual's life and health. From King's perspective the most important aspect of social systems is the environment (King, 1995). The research environment was Saudi Arabia within a multicultural workforce in tertiary care hospital. For nurses to understand the variety of social systems within which people grow and develop, knowledge of the environment is absolutely essential. The goal in this research was the rendering of quality (excellence) nursing education

reflected in practice which was a pre-determinant to the quality of client/community health outcome (see Figure 3.4).

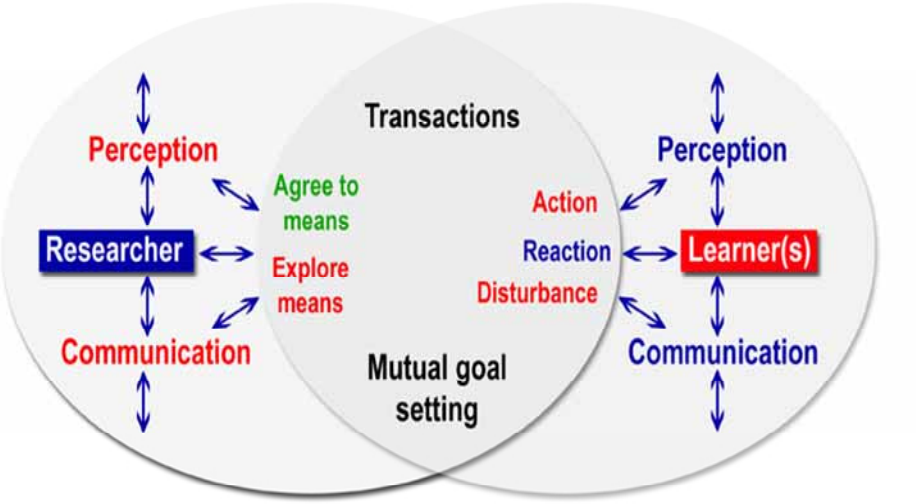

Figure 3.4 Schematic diagram of King's theory of goal attainment
(Applied to nursing research practice)
(Source: Sieloff-Evans 1991)

Nurses play a key role in the health-related life events of individuals. As such, they require a broad understanding of the worldviews of others, including how health is interpreted. Health has different meaning in different cultures (Leininger & McFarland, 2002) and often has different meanings for individuals in the same culture. In this research health was the optimal functioning of the nurse in a tertiary hospital in Saudi Arabia. Optimal functioning was viewed from a holistic perspective and thus included bio-psycho-social-spiritual aspects.

As mentioned above, King (1995) draws her concept for the environment from the general systems theory. In terms of this theory, energy, matter, and information were exchanged through multi-national nurses, working and living in internal and external environments in Saudi Arabia which is a Muslim country. These environments were multiple, dynamic, and integrally linked to health

outcomes. The environment also included countries from which nurses migrated and those where experts resided, and the organisational system in which the learning programme was developed, implemented, validated and evaluated. The rationale for utilising King's theory was that it focuses on interactions/processes and identifies outcomes (McQuiston & Webb, 1995). The outcomes of King's theory are within the formulated outcomes for this research. King's theory emphasises that

- research has to deal with the process. In this research the researcher developed, implemented and evaluated a learning programme for the continuing professional development of nurses in Saudi Arabia;
- research has to deal with outcomes. This research focused on the quality of education and ultimately on nursing practice rendered to the public in Saudi Arabia;
- research strategy implies that decision-making is a shared collaborative process. In this research, the researcher followed predetermined steps developed in the scientific process (assessment, planning, implementation and evaluation). She took into account the opinions of experts as she engaged in the process of analysing and evaluating the inductively developed learning programme;
- research focused on the interaction in the social and nursing system through collaboration with experts on a process of validating the learning programme for the continuing professional development of nurses in Saudi Arabia. The research brought together six distinct social systems: Saudi Arabia, South Africa, the USA, Australia, Egypt and Canada.

3.3.3.4 iii) Utilising King's theory

As King's theory (1981) deals with paradigms, it is part of the third order of the Botes Model (1998). A basic theoretical assumption within King's theory is that a nurse and his/her client communicate information, set goals through a process of mutual interaction and then act to attain those goals or outcomes (King, 1995). King purposefully created a practice relationship between her theory and the scientific nursing process. In this research, the goals were replaced by outcomes. The nurse was the researcher/educator and the client was the learner (nurse and other) undertaking continuing professional development.

In the next section, Chapter 3 is summarised.

3.4 SUMMARY

In Chapter 3, the research design and methodology were described according to the three orders of the Botes' Research Model (1998; 2000). The Model allowed the researcher to order research findings from the perspectives of nursing practice; theory; and the paradigm. Research, however, is a complex process laden with values and complicated by the unexpected. Therefore it was imperative for the researcher to state her values and beliefs, to clarify how the research was conducted, and importantly, to explain what was expected from the research outcomes.

As research is an interpretation of the phenomenon under study, perspectives of experts were integrated into the research so as to increase trustworthiness of the findings and to shape the empirical inquiry outcomes. Mixed methods support the use of experts. Experts provided necessary experiences to ensure that the learning programme met the requirements of continuing professional development of nurses working in Saudi Arabia. The research outcomes would ultimately serve to protect the public from being treated by unqualified nurses. In Chapter 4 the research data collection, analysis and results are featured.

CHAPTER FOUR: PRESENTATION, ANALYSIS AND INTERPRETATION OF RESULTS

4.1 INTRODUCTION

Senior administrators within any health organisation are responsible and ultimately accountable for the quality of the services rendered, be they in the clinical, educational, management or research area. The Joint Commission International (JCI, 2003) recommends that health organisations implement a comprehensive education programme based on practice standards beginning at orientation and continuing throughout the employment period to support continuing professional development and quality patient care. It is also essential that nurses participate in continuous professional development in partial fulfilment of their professional responsibility to provide competent patient care continually and to respond to changing community health needs. In turn, nurse educators have a responsibility to provide quality education.

If quality has to be provided, Galbraith (1998) proposes that the educator understand self, as well as adult learners; provide a climate conducive to learning and exploring new ideas, skills and resolutions; encourage critical reflection, problem solving; and support practice decision making. The educator must be prepared to assist adults with the process of learning how to change perspectives, shift paradigms and replace one way of interpreting the world by another. Vella (2001, 2002) recommends engaging in dialogue with learners and using effective learning tasks. She describes the latter as those that: connect learners with what they already know and with their unique context; invite learners to examine input (cognitive, skills and attitudes) – the content of the course; get learners to do something directly with new content, somehow implementing it; and integrate this new learning into their lives.

Course content of continuing educational and professional development activities are influenced by the organisation's mission, goals, values, priorities and resources, both human and material (JCI, 2003). Additionally, access to orientation and continuing education is fundamental to the provision

of quality nursing practice (Murphy, 2003; CNA & CASN, 2004b). A comprehensive orientation can ease the adjustment into the organisation by clarifying practice expectations and where necessary providing decision support for practice. Furthermore, a favourable perception of the work environment may increase job satisfaction, organisational commitment and retention and performance, which in turn affect patient outcomes (CNA, 2002b; RNABC, 2002; Lowe et al., 2003).

The type, extent and content of learning activities require flexibility in the design to meet the diverse needs of learners working within an organisational or particular practice context (Spady, 1996; Killen, 2000). Van der Merwe (2003) suggests using a constructivistic learning approach embedded within outcomes-based education. She also advocates for nurse educators and managers to assess their learners (nursing staff) holistically and to improve learning (practice) outcomes through remediation. Further she actively promotes and supports applied research (evidence-based nursing) as an effective method to improve practice constantly and thus to foster continuous performance improvement and quality patient care.

In Chapters 1, 2, and 3, an overview of the research, a literature research and the research design and methodology respectively were described. In the next section, the central theoretical assumption for the research is identified.

4.2 CENTRAL THEORETICAL ASSUMPTION FOR A CONTINUING PROFESSIONAL DEVELOPMENT LEARNING PROGRAMME

The central theoretical assumption formulated for the research stated that the implementation of a continuing professional development learning programme for nurses working in Saudi Arabia should

- facilitate quality nursing practice;
- facilitate personal and professional development; and
- support the implementation of nursing legislation (Chapter 1: Section 1.4).

The purpose of the chapter is described in the following section.

4.3 THE PURPOSE OF THE CHAPTER

The purpose of this chapter is to describe the development, operationalisation, validation and evaluation of a continuing professional development learning programme for nurses working in Saudi Arabia. In the next Section (4.4), the research design and methodology are described. Section 4.4.1 focuses on Phase 1: Outcome I of the research, the inductive development of a provisional learning programme. The structure used to design the learning programme is described and analysed. In Section 4.4.2 the operationalisation of the learning programme (Phase 1: Outcome I) is described and analysed. In Section 4.4.3, the process for validating the learning programme (Phase 1, Outcome II) is identified and the results are analysed. Evaluation aspects (Phase II, Outcome III) are the focus of Section 4.4.4. A triangulation technique is utilised to analyse key results simultaneously and to finalise the learning programme (see Section 4.4.5). The conclusions of the chapter are formulated in Section 4.5.

4.4 THE INDUCTIVE DEVELOPMENT OF THE PROVISIONAL LEARNING PROGRAMME: RESEARCH DESIGN AND METHODOLOGY

The researcher has over 30 years of experience in nursing. She spent the majority of this time in Canada, but she has been in Saudi Arabia for four years. Her decision to complete her doctoral studies arose out of an interest in contributing to continuing professional development research and to the nursing profession in Saudi Arabia. Prior to writing her research proposal, she worked with one of the academic advisers in preparing a report for the nursing director in the hospital where both worked. The report focused on professional development and included the following aspects:

- a summary of regulation and credentialing;
- an analysis and evaluation of the importance of competence-based practice;
- a set of basic practice competencies required for a new nurse to make the transition into the workplace and to progress from being a novice to achieving a competent level of practice (RNABC, 2000);

- an outline and rationale for the development of career management and planning; and
- guidelines for the compilation of a professional development portfolio and reflective practice.

From March 2003 to February 2004, the researcher was responsible for the coordination of the nursing orientation programme. This experience provided a foundation for her doctoral research and is therefore summarised as part of her proposal preparation.

The monthly orientation programme followed a two-day hospital-wide orientation focusing primarily on clinical nursing practice. The programme was conducted over two weeks, from eight in the morning to five in the afternoon, with a hectic schedule. Programme topics did not always flow sequentially (general to specific) nor were they attached to specific learning outcomes or objectives. The overall purpose of the programme was to orientate the nurses to practice expectations as well as hospital policies.

The majority of presenters were clinical instructors, responsible for clinical education and orientation. Most had minimal to no practical experience in designing curriculum. Their first teaching experience generally began when they assumed positions as clinical instructors. One noticeable teaching style was the predominant use of the lecture format with PowerPoint overheads. Usually there was little dialogue during the lectures as most educators had to adhere to their allocated time line. Lecturers followed a predefined content format, rarely taking time to find out what their learners knew. There was no assessment method to identify knowledge gaps or uncover what had been learned from the teaching (Vella, 2001). In the words of Freire (1970) teachers were using banking education rather than constructivistic or transformational learning (Mezirow, 1997). Further, teaching philosophy and methods were primarily behavioural (Elias & Merriam, 1995) and unfortunately adult learning principles were constantly violated.

The researcher instigated practice change through role modelling and constructivistic learning by engaging educators in dialogue and building their trust and respect and encouraging them to adopt more effective methods. Through conversations and written feedback they identified benefits and outcomes from more active learning. When they implemented more active teaching methods, educators were surprised by the difference, in particular by the fact that new employees were

ready to begin work when they got to the unit (Vella, 2002). While no educators stopped lecturing, they did update their lectures and referenced their evidence sources. Learning activities were more practical than content-based and educators enjoyed teaching as it was different each time. Several, who identified gaps in their practice, enrolled in distance learning courses.

Whenever possible the researcher engaged new nurse employees in group discussion and reflective exercises. They analysed and compared their country's professional regulation and legislation, scopes of practice and their accountability and responsibilities for continuing professional development in order to maintain competent practice. The two-week period was sequenced to flow from general topics such as professional development responsibilities to more specific unit-based practice such as safe medication administration. The orientation curriculum was re-focused onto the organisation's problem prone, high volume and low volume, high-risk problems. A request was put forward for a skills laboratory so that new employees could be given more specific unit orientation rather than sit through orientation sessions that were not applicable to their area of practice.

In general, the majority of the nurses adjusted and adapted to their new environment, different culture, norms and sometimes very great differences in (western versus non-western and North American versus British norms) and different practice expectations (e.g. transcription of medications). Inherent within the adaptation process were many stressors, including having to communicate and learn in English. Nurses who spoke English as a second language were expected to have passed an English examination prior to being recruited. In reality, some did not have an adequate level of language skills. Moreover, English speakers not only had different accents, but their use of words and phrases was often country specific. Problems with language were uncovered during the orientation and verified when they went to the nursing units. Although English was the working language of the hospital, as more Arabic-speaking employees were hired the practice shifted, particularly as patients and their families also spoke Arabic. Being assessed in relation to their respective nursing practice was stressful. Besides having clinical competencies assessed, staff nurses and clinical educators had to achieve a minimum of 80% on a pharmacology test and were required to complete a written clinical assessment based on a predefined case scenario. Those without a valid American Heart basic life support (BLS) certificate

were expected to complete this process shortly after they got to the nursing units. Other stressors included suffering from jet-lag; feeling overloaded with information and change; sharing accommodation with a total stranger; missing family and friends; and dealing with anxiety, particularly during times of bombings and other forms of societal unrest.

Some new employees were pleasantly surprised by the structured orientation programme, having expected to go straight to work. They evaluated the sessions as being professionally delivered and appreciated the different types of teaching. They said that their orientation experience was memorable and that it had helped them to broaden their minds and settle into their new environment. Some acknowledged their responsibility to continue their professional development while in Saudi Arabia. They also appreciated sharing experiences with other nurses and expressed an interest in learning about and supporting Saudi nurses. They wanted to learn more about different cultures, especially as they were now working in a multicultural environment. They assessed the educators as being knowledgeable, approachable, friendly, humorous and loyal to the hospital. There were a few presenters who did not demonstrate respect for the new nurse employees' knowledge/experience and some were unable to hold their attention. Some sessions contained too much information, leaving them feeling overwhelmed, which led them to recommend shorter days with more activities with a follow up once they had been in their respective units for a few months.

Over the 11-month period, there were 354 new nurse employees, from 15 different countries. Of these, 19 were from Saudi Arabia and most were newly graduated. It was the individual unit head nurse, preceptor and clinical instructor's responsibility to assess competencies and to assist in the transition into the unit. Having new graduates on the unit was a new phenomenon and there was a general lack of knowledge and experience with regard to responsibility and accountability. Many managers, educators and staff nurses assumed that new graduates were accountable for their practice even though they had not yet demonstrated competent practice (Muller, 2003). Similarly to staff nurses, new graduates were expected to complete their probationary period within a 90-day probationary period as per hospital and nursing policy. According to the literature, such a timeline is unrealistic (RNABC, 2000). Moreover, as all nurses were to have a minimum of two years of clinical experience, it was assumed all had acquired basic competencies. With an increased

number of non-western nurses, limited English language skills and variation in practice standards were evident. Remediated educational methods such as structured English classes, skills laboratory and extended preceptor periods were required. A new graduate programme was implemented in August 2004 (see Section 4.4.2.2).

Almost all of the orientation and education focused on clinical practice with minimal orientation and education in place for educators and managers, regardless of level (e.g. unit or programme). Both groups were expected to attend the nursing orientation programme, but not necessarily for all aspects. The researcher recommended putting learning plans in place. Several were developed for specific managers, but as there was no follow through it was difficult to gauge their impact. During this period, the department where the researcher was working was undergoing a significant staff turnover including five different programme managers in a two-year period. New educators and managers seldom used curriculum and teaching resources left from an earlier era. Instead, individuals designed their own lectures in the absence of a curriculum.

During this same period the researcher was reading and synthesising selected literature on continuing professional development, using her up to date knowledge in her practice and as well in presentations at conferences in Saudi Arabia and internationally. She worked with a group of head nurses to plan and implement two workshops with regard to reflective practice and portfolio development. These experiences were reflected in the research proposal and carried over into the provisional learning programme design. In April 2004, the researcher was transferred from the nursing orientation programme to work in the department where her mentor was the director. She continued to co-teach in two diploma programmes, shared responsibilities for the new graduate transition programme, counselled and remediated, and during times when the director was away, stepped into that role. By this time, she had completed the first two chapters of her doctoral research.

As noted in Chapter 3: Section 3.3.2, the orientation of the research design and methodology was a qualitative-quantitative mixed method with the quantitative aspect used to confirm research results. The theoretical drive remained inductive. Qualitative methods deepened the researcher's appreciation of constructing meaning in relation to implementing continuing professional

development in a tertiary hospital where nurses, who come from 50-55 countries, continued to function under the regulatory system of their country of origin as the country where they worked (Saudi Arabia) emerged its own regulatory board and prepared its own nurses (albeit slowly) for the workplace. This context was in contrast with the researcher's years of nursing experience in Canada where professional nursing regulatory and educational structures have been in place for approximately 100 years (founded in 1908). This contrast helped her to reflect critically on different aspects of the same phenomenon (continuing professional development of nurses) and thus to broaden her research scope. In Section 4.4.1, the emergence of the provisional learning programme is described.

4.4.1 Emergence of the provisional learning programme: Phase I, Outcome I

With guidance from her two academic advisers, the researcher inductively developed a provisional learning programme from her practical teaching experiences (2002-2005) and conducted an extensive literature review (see Chapter 2: Section 2.4). She also collected and analysed research data from an insider's (emic) perspective by observing, participating, critically reflecting and analysing both her teaching and learning experiences (see Section 4.4.4.5). Other data sources included written reports; questionnaire results; and ongoing discussions with academic advisers, programme learners, other nurses and professionals. Figure 4.1 illustrates the inductive development of the learning programme which was for the most part an iterative and continuous learning process.

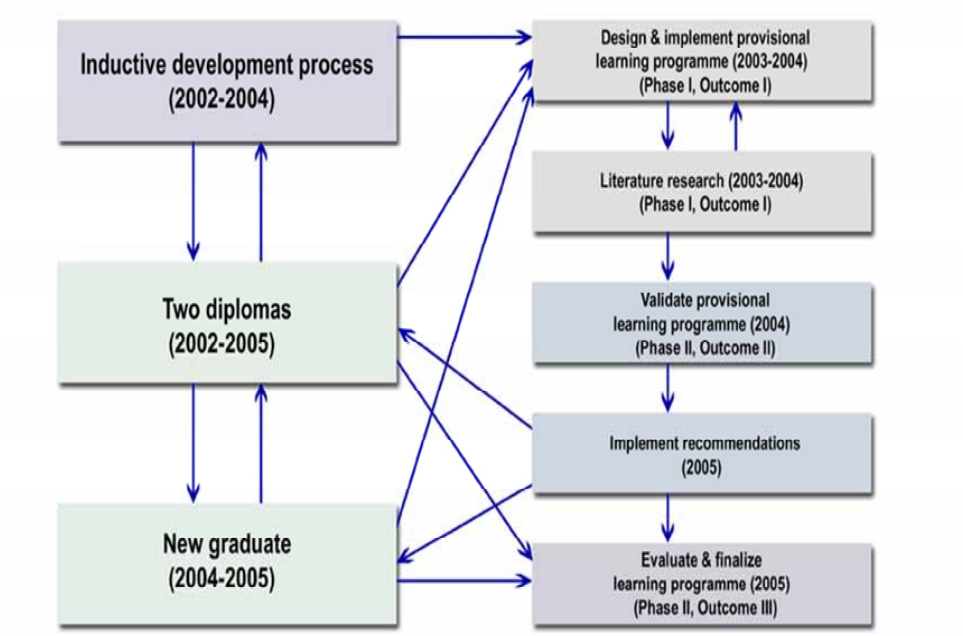

Figure 4.1: Learning programme development process and outcomes

The provisional learning programme was completed in November 2004 and followed a similar format as the one taught by her mentor, incorporating standards, constructivistic learning and outcomes-based education as well as evidence from the literature and practical experiences. The programme design utilised three overarching components: professional, ethical, legal practice (accountability; ethical and legal practice); quality nursing practice (key principles of practice; care provision and management); and professional development (professional enhancement; quality improvement; continuing education). These components (see Figure 4.2) were adapted from the Framework for Competencies of the International Council for Nurses (ICN, 2003).

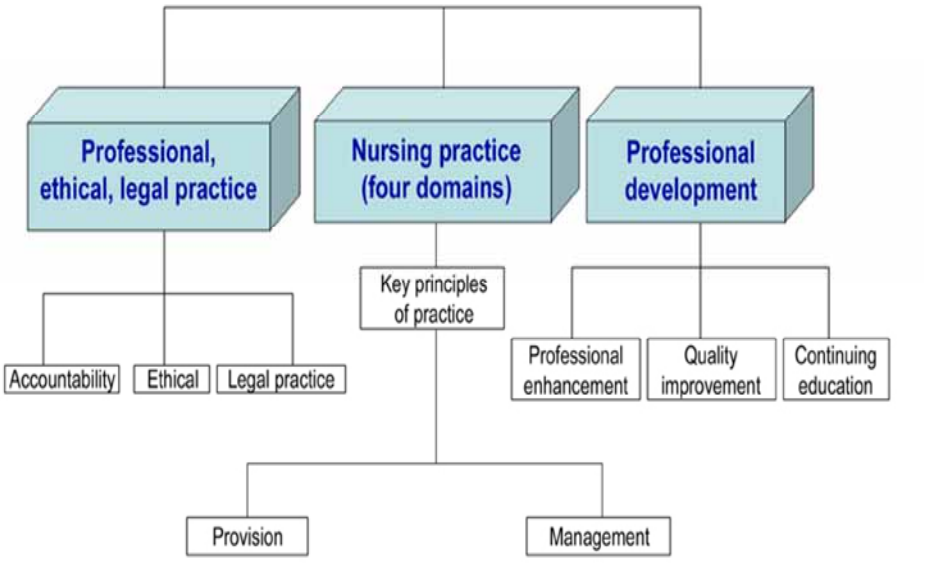

Figure 4.2: Adapted from the International Council for Nurses' Framework of Competencies

While planning the research proposal and designing the learning programme, the researcher co-taught with one of her advisers in two nursing diploma programmes (from 2002 to 2005) and later in the new graduate programme (2004-2005), thus she not only gained practical teaching experience but also had a natural laboratory for her research. An outline of the programme and summary of the content is provided in Table 4.1. The process and structure used to create the provisional learning programme are explained in the next section.

Table 4.1: Provisional learning programme outline and content summary	
Outline	Content summary
Introduction	▪ Nursing profession is undergoing transformation worldwide ▪ Many countries have nursing shortage ▪ Government of Kingdom of Saudi Arabia (KSA) directed nationalised workforce - policy called Saudisation ▪ Saudi nurses were granted professional self-regulation in 2004 under Saudi Council for Health Specialties (SCHS) ▪ Nurses working in KSA must now register with Saudi Nursing Board (SNB) and are to be held responsible and accountable for their continuing professional development (CPD) ▪ CPD validates nurse's commitment to public accountability ▪ Continuing education of staff has been identified as an accreditation standard
Context for practice	Kingdom of Saudi Arabia (KSA) ▪ Distinct social, cultural and religious practices based on Islamic principles and values, Shariah law ▪ Centre for Muslim religion and millions of pilgrims visit yearly ▪ Achieved high level of socio-economic development including advanced tertiary hospitals ▪ Over 30 years crossroads for 50-55 nations of nurses – hence very diverse nursing workforce ▪ Nurses from different countries bring different standards, practices, approaches ▪ Not all countries require their nurses to continue their professional development ▪ Native language Arabic but English is working language of many health organisations – accents and word usage vary, as does individuals' ability to speak, comprehend and express self ▪ As of January 2005, all nurses working in the Kingdom of Saudi Arabia must register under the SNB and maintain CPD showing verified proof whenever they registered thereafter
Competencies Framework of the International Council for Nurses	▪ Developed for generalist nurse and based on international professional development literature ▪ 3 components – professional, ethical, legal; care provision and management; professional development ▪ Structured undergraduate programme with practical experience essential for competence development ▪ International researchers recommend programme to support new graduate transition into workplace ▪ ICN competencies framework adapted to include all domains and levels of nursing practice ▪ Having demonstrated initial competence, professional nurse responsible and accountable to continue professional development ▪ Government, regulatory boards and health organisations share in responsibility for CPD and maintenance of education standards
Learning programme	▪ Flexible, adaptable and based on ICN Framework for Competencies, international practice standards, empirical indicators derived from the literature research and learning outcomes and can be applied to meet diverse needs of learners, health organisation and community
Practice standards	▪ Standards, adapted from Canada, are the following: responsibility and accountability; code of ethics; self-regulation; competent application of knowledge, skills and judgment; professional relationship and advocacy; professional leadership; continuing professional development; and quality improvement and evidence-based practice
Learning outcomes	▪ Overall outcome: nurse integrates and internalises practice standards as well as specific standards and concepts into nursing practice ▪ Critical outcomes: facilitate personal and professional development (principles in practice; communication skills; CPD; self-regulation and competencies; multi-disciplinary teamwork; decision and critical analytical skills in application of scientific nursing process, evidence based practice and quality improvement) ▪ Exit outcomes: specify to what the nurse is expected to demonstrate (maintain standards and professional conduct; maintain and continuously improve competence; participate in quality improvement; gather evidence of CPD; and perform a yearly review of practice)

Table 4.1: Provisional learning programme outline and content summary (continued)

Outline	Content summary
Duration	▪ Begins with a structured orientation and extended to end of first year with ongoing professional development opportunities thereafter
Essential responsibilities	▪ Learners prepare self and demonstrate responsibility for learning; actively participate in learning to master skills; verbalise learning needs; and insist on feedback
Teaching approach and methods	▪ Constructivistic, positive teaching and learning standards based on principles of adult learning, two-way communication and mutual respect
Personnel	▪ Programme coordinator and guest teachers
Nurse learner assessment	▪ Continuous – during class participation; assignments and reflective practice sessions ▪ Presentation (clinical case study, education programme, management strategy or research results) ▪ Demonstrate ongoing competence in nursing practice
Programme coordinator and presenter assessment	▪ Learners assess programme content, teachers and self at the end of session, after respective probationary period and yearly thereafter as part of their annual performance appraisal process ▪ Learner feedback to be assessed for suggestions to improve or enhance learning programme
Learning programme reviewers	▪ National and international experts asked to assess provisional learning programme to determine and ensure content validity (see Section 4.4.3). ▪ Expert fields included: nursing practice; adult education; curriculum development; outcomes-based education; regulation and credentialing; and continuing professional development
Specific standards	▪ ICN competencies framework (see Figure 4.2) provided overall learning programme structure ▪ Specific standards based on those from three Canadian nursing regulatory councils (boards)
References	▪ Identify supporting literature used in the compiling the learning programme – derived from Chapter 2 (literature research)
Appendices	▪ Contain additional information to support programme implementation and learning, entitled as: ▪ Appendix 1: Definitions ▪ Appendix 2: Empirical indicators from continuing professional development literature ▪ Appendix 3: Regulation and credentialing ▪ Appendix 4: Scope of practice ▪ Appendix 5: Accountability and responsibility ▪ Appendix 6: Continuing professional development ▪ Appendix 7: Competence-based practice ▪ Appendix 8: Culturally sensitive care for Saudi patients ▪ Appendix 9: Career management ▪ Appendix 10: Evidence-based practice ▪ Appendix 11: Reflective practice ▪ Appendix 12: Professional portfolio

4.4.1.1 The provisional learning programme process and structure

The provisional learning programme was designed from an outcomes-based educational (OBE) approach. OBE curriculum and education decisions are driven by what the learners are to achieve (learning outcomes). This approach is closely related to performance assessment and

competency-based practice (see Chapter 2: Section 2.1.2.3 ii). (For the interrelated steps in the curriculum design process see Chapter 2: Table 2.6.) In OBE expected learning outcomes are communicated to all involved and they determine curriculum content, teaching methods and assessment (Spady, 1994, 1996). Thus "the clearer the learning outcomes the more effective the assessment process can be planned and implemented" (Shumay & Harden, 2003:5). In the United Kingdom, the medical schools in Scotland have adopted a three circle model to classify practice learning outcomes (Simpson, Furnace, Crosby, Cumming, Evans, Freidman-Ben, Harden, Lloyd, McKenizie, McLachlan, McPhate, Percy-Robb, & MacPherson, 2002.) which also reflects what is expected in the respected ICN (2003) component (see Figure 4.2). The three identified learning outcomes are the doctor (nurse) as a professional (professional, ethical, legal component of practice); what the doctor (nurse) is able to do or the expected performance (nursing practice component); how the doctor (nurse) approaches her/his practice (professional development component) (Shumway & Harden, 2003; ICN, 2003). The level of performance expected from each learner should be explicit. The competent level (Benner, 1984) was used as a minimal requirement for learning outcomes. The learning outcomes are statements of what is to be accomplished (mission). They are also important with regard to accountability for teaching and learning (Vella et al., 1998). Learning outcomes can be used as the standard against which an internal and external judgment of success can be made (Harden, Crosby & Davis, 1999). Particular learning outcomes guide each phase of the programme (curriculum) including teaching methods and strategies (Spady, 1996). They clarify the educator's contribution to and role in the programme and are used when assessing each phase of the curriculum. Assessments should reflect the learning outcomes. The learners should:

- be familiar with the criteria to be used;
- be able to judge their progress;
- know whether they have achieved the learning outcomes; and
- be held accountable for demonstrating achievement of outcomes (Harden et al., 1999).

Professional portfolios were used in the provisional learning programme. The rationale for using a portfolio was to increase interaction and support reflective practice related to the learning outcomes. Specific assignments were prepared by individuals and groups of learners and when their quality did not reach the required standard they were returned for remediation. Further (expanded) learning

opportunities were provided where necessary in the form of dialogue and debate during and after class time. Reflection on and in action (Schon, 1992) was also encouraged during discussions, after class presentations and in relation to praxis.

As mentioned, the structure for the provisional learning programme was built from the Framework of Competencies of the International Council for Nurses (2003) for the generalist nurse and Canadian practice standards (RNABC, 2003b; CNO, 2002; College of Registered Nurses of Nova Scotia [CRNNS], 2004). The eight practice standards (classified under the respective component and learning outcomes) are as follows:

I. *Professional ethical and legal* - *how* the professional nurse approaches her or his practice has three practice standards -

- responsibility and accountability;
- code of ethics; and
- self-regulation.

II. *Nursing practice* (provision and management) describes what the nurse is *able to do* in his/her practice. There are three practice standards -

- competent application of knowledge, skills and judgment;
- professional relationship and advocacy; and
- professional leadership.

III. *Professional development* - directs the nurse's *continuing development.* It has two practice standards -

- continuing professional development; and
- quality improvement and evidence-based practice.

Empirical indicators (see Chapter 2: Tables 2.14 a, b, and c) were identified from the literature population (see Chapter 3: Tables 3.6 a, b, and c) and used in the development and operationalisation of the provisional learning programme as described in the next section.

4.4.1.2 The literature population – empirical indicators: Phase I, Outcome I

As noted in Chapter 3: Section 3.3.2.2. i c the literature was one of the four research populations. (See Chapter 3: Tables 3.6 a, b and c.) Empirical indicators also emerged from the literature (see Chapter 2: Tables 2.14 a, b and c) and were grouped under the three ICN components described above. The empirical indicators were also used in the design of the provisional learning programme. In particular, these indicators were captured under the range statements (programme content). As mentioned, the structure of the provisional learning programmes was summarised in Table 4.1. The operationalisation of the provisional learning programme is described and analysed in Section 4.4.2.

4.4.2 Operationalising the provisional learning programme: Phase I, Outcome I

The structure for the provisional learning programme evolved over a period of two years (2002-2004) emerging primarily from the researcher's practical experiences of teaching in three programmes, with one of her academic advisers. In this section these programmes are described and analysed from the perspective of operationalising the provisional learning programme.

4.4.2.1 Two diploma programmes

There were two diploma programmes: one in leadership and management and the other in education. They were developed by one of the academic advisers. The programmes incorporated standards of practice, followed a constructivistic, outcomes-based learning approach, were grounded in adult learning principles and established two-way communication. Learners were viewed holistically and mutual respect was encouraged. Learners were responsible and accountable for their learning. The respective academic adviser also obtained approval from the Saudi Council for Health Specialties (SCHS), the Saudi Arabian health professions' regulatory board for continuing education units for both programmes.

Initially the leadership and management programme was implemented alone (September 2002-July 2003) and in 2003-2005 the two diplomas were run simultaneously. In the first year, besides the coordinator, there were four other educators teaching in the programme. One had doctorate preparation and was responsible for all research aspects and the other three (one of whom was the researcher) had a master's degree and taught particular aspects of the programme. For the second and third year, the coordinator and the researcher co-taught both programmes including the research component.

Both programmes had three modules taught over three 15-week periods. The core module was the same and focused on ethical, legal and professional practice and continuing professional development. There were three specific standards in the core. Standard 1 focused on Saudisation (affirmative action) and professional development and included the following units: nursing regulation credentialing; career management; professional portfolio; and competence in nursing practice. Standard 2 dealt with research in nursing practice and Standard 3 with contemporary issues in nursing. Under each standard and unit there were specific outcomes followed by criteria and range (content) statements. The criteria statements all began with high level action verbs (Vella, 2001). The range statements contained empirical indicators as found in the literature and were verified with practical experience. For each standard there were graded assignments, three objective-based tests (a requirement of the SCHS) and when necessary remediation to improve learning outcomes (Diekelmann & Magnissen, 1998).

The fourth standard, similar for both programmes, served to bridge the core with the foundations of professional practice (history of nursing, ethical values, traditional norms and regulatory systems) and the particular area of specialty. The remaining standards focused on specific aspects of the specialty practice. In the leadership and management programme, Standards 5, 6 and 7 focused on foundations of leadership and management including the four management functions – planning, organising, leading/directing and controlling; human and resources management; and practical application of leadership and management theories and concepts. While in the education programme, Standards 5 and 6 focused on structure and process of nursing education and quality improvement in nursing education. Quality improvement was covered under the control function of

the leadership and management programme. A research pilot project was required for both diplomas with a presentation of the results to invited guests as part of the celebration of nursing research day. These projects were based on identified needs within a particular workplace and thus were practical and adhered to Botes' Model (see Chapter 3: Section 3.3.1).

The overall outcome for these programmes was for the professional nurse at a post-graduate level to integrate and internalise the specific content into his/her nursing practice. Critical outcomes for both programmes were based on the premise that learning (knowledge development combined with practical experiences or praxis) should facilitate personal and professional growth, with reference to specific areas in nursing practice, through the implementation and integration of:

- professional and personal values and norms;
- self-directed learning;
- communication skills;
- self-responsibility skills in group work;
- advanced scientific principles specific to selected areas;
- multidisciplinary team work;
- decision-making and critical analytical skills in the application of the scientific principles of assessment, planning, implementation, evaluation and documentation;
- research skills; and
- technology and advanced literacy.

Learner responsibilities were clearly identified in the study guides, reviewed at the beginning and reinforced as required. Although some reading materials were provided, learners were expected to search for additional information when preparing for class and completing assignments. Learners were also expected to accept and demonstrate responsibility for her/his learning. They were to complete written assignments and make required changes. Assignment dates were set, but were negotiable in view of work and vacation schedules. Assignments were reviewed by the educators and returned with written feedback and required changes to facilitate learning outcomes. Active participation and critical reflection were deemed necessary to master skills. Learners were continually asked for feedback with regard to their practicum, assignments and general progress,

and assessed via their written assignment, in class participation and results of multiple choice examinations at the end of the semester.

Additionally, a collaborative approach was utilised to optimise teaching and learning and to identify areas for improvement for the learners, course content and teaching. Learners received their respective study guides as part of their learning package. Each guide identified assignments with fixed dates, and explained how learners would be assessed (evaluated) and graded.

The diploma programmes were held once a week over a period of one year with pre-defined times and allocated classrooms. Learners were for the most part nurses, although during the second year there were three non-nurses. There was also one in the third year. All were required to have a bachelor's degree with a minimum of two years' practical experience. Most worked at the hospital where the research took place but several came from other hospitals within the city and five travelled from another region each week to attend classes. In the first year there were no Saudi nurses or non-nurses but in the second and third year there were 18 (39% of the total population sample). In the third year the ratio of Saudi to non-Saudi was 50%. Before entering the programme they met with the educators and acquired written approval from their immediate supervisor to attend.

In Table 4.2 the programme focus, population size, duration and research data collection period are identified for the two diplomas and the new graduate programme. In Section 4.4.2.2 the new graduate programme is described.

Table 4.2: Programme standards, population size, duration and data collection period

Programme	Standards	Population sample	Duration	Data collection period (2002-2005)
Diplomas	Core and specialty practice standards	53	1 year	September 2002 - April 2005 (34 months)
New graduates	Overview of core standard with emphasis on clinical practice standards	36	6-24 months	August 2004 - April 2005 (8 months)
	Total	89		

4.4.2.2 The new graduate programme

In August 2004, a new graduate programme was implemented to support the transition of bachelor prepared Saudi nurses who had little to no prior clinical practice, into the workforce. The programme standards were identified in a clinical practice assessment portfolio (CPAP), and incorporated in the new graduate's job description and yearly performance appraisal instrument. A copy of the CPAP was given to each new graduate and served as a guide to structure clinical practice and acquisition of competencies. The overall learning outcome for the new graduates was to integrate and internalise unit specific goals into their nursing practice.

Learners in the new graduate programme were from Saudi Arabia. All were bachelor prepared, some had received their nursing education outside of the country (in Jordan and the USA) and all had minimal to no previous clinical practice experience. The intent was that the CPAP be used to facilitate personal and professional growth with reference to specific clinical practice through the implementation and integration of

- professional and personal values and norms;
- self-directed learning;
- communication skills;
- self-responsibility skills in group work;
- advanced scientific principles specific to selected areas;
- multidisciplinary team work;
- decision-making and critical analytical skills in the application of the scientific principles of assessment, planning, implementation, evaluation and documentation;
- research skills; and
- technology and advanced literacy.

New graduates were to accept and demonstrate responsibility for their learning and assume responsibility to practise and demonstrate competence related to the fundamentals of nursing practice. They were to participate actively in all unit activities so as to master skills, and to reflect critically on issues concerning nursing practice through verbal or written case studies and reflective

practice groups. They were to be active partners in their own learning, verbalising their learning needs to their preceptor and/or clinical instructor. They were also to evaluate the management of patient care on the unit while providing direct services to their patients and families, while insisting on feedback with regard to their progress and clinical practice. Moreover, they were to be professional role models adhering to the dress code and to other hospital policies.

The new graduate programme followed a two-week hospital and general nursing orientation with an extended orientation. There were a variety of educators in the extended orientation process, including the mentor, the researcher, two clinical educators (one of whom coordinated the two weeks) and a number of invited speakers (e.g. infection control experts, dieticians and a pain management specialist).

On the first day educators provided an overview of the portfolio content, focusing on the key concepts including ethical foundations of nursing practice, professional responsibility and accountability, practice standards, reflective practice and clinical practice assessment. In addition, overall responsibilities and key policies (e.g. dress code, leave and sick time) were reviewed. The emphasis of the CPAP was primarily for the new graduate to practise how to become a professional nurse (the second component of the ICN framework; see Figure 4.2). During the remainder of the two weeks the new graduates reviewed key concepts and practised in a simulated skills laboratory under the supervision of a clinical educator. Following the orientation, new graduates were assigned to non-critical care units for a period of six months to two years depending on their ability to demonstrate competencies. Those wishing to go into critical care eventually or who were uncertain of where they wanted to practise were rotated through select units. The rest were assigned permanently to a unit of their choice. As the new graduates were not yet competent, they were not granted full authority for their practice (see Chapter 2: Section 2.4.1.2 ii). Rather they were under the supervision of a preceptor who along with the clinical instructor and head nurse maintained accountability for the particular new graduate's practice (Muller, 2003).

When they first started, most new graduates lacked clinical experience. Therefore, their head nurses and clinical instructors were asked to wait for at least three months before sending them to courses and then to be selective with regard to the course so as to increase the likelihood of their

using their new knowledge upon returning to their respective unit. Until such time as basic competencies were demonstrated, new graduates were to be continuously supervised for all invasive procedures, including all forms of medication administration.

New graduates were held responsible and accountable for their action and were expected to accept the consequences of their behaviour. Hence a critical aspect of their learning was for them to inform their supervisor whenever they were uncertain about their ability to perform a particular activity or competence. Authority for practice was gradually granted. First they were required to gain practical experiences and thus required competencies. When they had demonstrated the relevant competencies contained in the CPAP and related judgment they were deemed ready to be staff nurses and thus given the authority to self-regulate their own practice (see Chapter 2: Section 2.4.1.2 iii).

A four-hour workshop was offered to all staff nurses (in particular those who precept nursing students and new graduates), head nurses, clinical educators and programme managers to prepare them to work with the new graduate programme. There were seven workshops between August and November 2004, with 151 attendees. Each workshop catered for 15-30 participants. The workshop outcome was that the learner/supervisor facilitates a quality nursing workplace environment for the new graduate through the utilisation and optimisation of the CPAP. The workshop criteria were to

- analyse and debate the overall outcome for the new graduate;
- demonstrate the practical implementation; and
- summarise and engage in reflective practice.

During the workshop the format and content of the CPAP was reviewed and constructivistic teaching strategies were utilised to engage the participants in learning activities (e.g. dialogue and specific group exercises). Follow-up was largely dependent on the availability of time and for the most part tended to occur when problems arose.

The three programmes were assessed for evidence of the identified empirical indicators. Exceptions were contemporary issues in nursing, research and career management in the new graduate programme, and basic life support (BLS) in the two diploma programmes. The rationale for leaving the three empirical indicators out of the new graduate programme was that the emphasis was on the integration of nursing fundamentals into practice. While all three were touched upon, more in-depth discussion and analysis were deemed more appropriate when the new graduate had demonstrated basic (fundamentals of nursing) standards. For the diploma learners the BLS education was captured elsewhere. Otherwise selected empirical indicators were evident in all three programmes. (See Tables 4.3 a, b, and c.)

Table 4.3 a): Professional, ethical, legal practice empirical indicators in the two diploma and new graduate programmes

Professional, ethical, legal practice Empirical indicators	Two diploma programmes	New graduate programme
Regulation and legislation	✓	✓
Accountability to public	✓	✓
Code of ethics	✓	✓
Promotion and protection of patients' rights	✓	✓
Scope of practice	✓	✓
Self-regulation	✓	✓
Registration responsibilities	✓	✓
Proof of licence	✓	✓
Personal and professional experiences	✓	✓
Internal policies and procedures	✓	✓
Trans-cultural nursing	✓	✓
Characteristics of a profession	✓	✓
Saudi culture and legal framework	✓	✓
Saudisation policy in nursing	✓	✓

Table 4. 3 b): Nursing practice empirical indicators in the two diploma and new graduate programmes

Nursing practice Empirical indicators	Two diploma programmes	New graduate programme
Competency-based practice	✓	✓
Job description and performance appraisals	✓	✓
Scientific (nursing) practice	✓	✓
Practice standards	✓	✓
Transition into the workplace	✓	✓
Demonstration of knowledge, skills, values, attitudes and judgment	✓	✓
Prevention and infection control	✓	✓
Patient safety and consent	✓	✓
Basic life support certification		✓
Evaluation of self and others	✓	✓
Quality of workplace environment	✓	✓
Communication	✓	✓
Risk management	✓	✓
Conflict management	✓	✓
Patient and family education	✓	✓
Managing personal stress	✓	✓
Promoting health of self and others	✓	✓
Professional leadership and role modelling	✓	✓

Table 4.3 c): Continuing professional development empirical indicators in the two diploma and new graduate programmes

Continuing professional development Empirical indicators	Two diploma programmes	New graduate programme
Personal vision and mission	✓	✓
Career management	✓	
Professional portfolio	✓	✓
Lifelong (self-directed) learning	✓	✓
Reflective practice	✓	✓
Critical thinking	✓	✓
Quality improvement	✓	✓
Research process and project	✓	
Evidence based research	✓	✓
Contemporary health issues	✓	

The research participants came from 14 countries: Saudi Arabia, South Africa, the USA, the United Kingdom, Malaysia, the Philippines, Palestine, Egypt, Lebanon, Columbia, Australia, Ireland, South Korea and Canada. The focus of Section 4.4.3 is the validation of the provisional learning programme (Phase II, Outcome II).

4.4.3 The validation of the provisional learning programme: Phase II, Outcome II

The goal of the research was functional in that knowledge of continuing professional development in nursing was generated and applied to nursing practice in Saudi Arabia. Experts who had lived in four different countries, Saudi Arabia, South Africa, Canada and the USA validated the provisional learning programme content. Having the programme critiqued by international experts strengthened its potential effectiveness, content validity, rigor, trustworthiness and credibility and while the research was conducted in Saudi Arabia, the validation in three other countries provided both a global and a local context. Nurse expert registrations were from South Africa, Canada, Saudi Arabia, Australia, Egypt and the USA.

The provisional learning programme and a semi-structured questionnaire (see Appendix A) were sent to 14 experts by e-mail while two were given hard copy. These questionnaires were distributed from mid-December (2004) to late March (2005) for the purpose of gathering the opinions of the selected experts in relation to the content of the provisional learning programme. A promise was made not to link any name or identifiable data to the research results. The questionnaire had three sections: the first was the experts' biological data (see Section 4.4.3.1 a); the second focused on the content and the third related to the format of the provisional learning programme (see Section 4.4.3.2). In the following section, the process for choosing the experts is explained.

4.4.3.1 Choosing the experts

Lynn's (1986) criteria for validity and reliability of experts were used. A minimum selection requirement needed for an expert participating in this research was that the person had to have a master's degree. Lynn advises that a maximum number of 10 experts be used and a minimum score of three has to be obtained when using a four point Likert scale.

Based on Lynn's research, experts who were prepared at the master's or doctoral level were purposefully selected from the fields of education, curriculum design, outcomes-based education, regulation and legislation, and continuing professional development. The purposeful sampling method replaced the principle of cancelled random errors (Kemper et al., 2003). Of the 16 individuals contacted, one declined after she had reviewed the questionnaire and provisional learning programme stating she did not believe she was competent to respond. She was prepared at the master's level and was chosen because of her experience and writing in the field of nursing and career planning and management. The second person who was also prepared at a master's level and who had worked internationally agreed to respond, but due to workload was not able to do so in the allotted time frame. Thus a total of 14 (n=14 or 87.5%) completed the questionnaire. In the next section the expert biographical data are identified (see Table 4.5).

4.4.3.1 a) Biographical data summary

Table 4.4 contains the biographical data for the 14 respondents (N=14). All worked in the health sector, eight (n=8 or 57%) were prepared at the doctoral level and six (n=6 or 43%) at the master's. Thirteen (n=13 or 93%) were nurses. One (n=1) was registered as a nurse in Saudi Arabia, six (n=6) in Canada, three (n=3) in the USA, one (n=1) in Australia, one (n=1) in Egypt, and one (n=1) in South Africa. The non-nurse (n=1) held her professional registration in South Africa. Four (n=4) respondents lived and worked in Saudi Arabia, two (n=2) in South Africa, one (n=1) in the USA and the remaining six (n=6) in Canada.

Table 4.4 Biographical data of the respondent experts

Respondent	Highest and specific qualifications as identified	Nursing registration	Country working in	Organisation/area of work
One	Master Science of Nursing Neonatal practitioner	United States	Saudi Arabia	Hospital Private consultant
Two	RN, BScN, MSc (Community Health)	Canada	Canada	Health region Hospital
Three	Bachelor of Nursing, Master of Public Administration	Canada	Canada	Private consultant
Four	Master of Science Nursing	Canada	Canada	Regulatory body
Five	Master of Science Nursing	Canada	Canada	Nursing council/ association
Six	Doctorate	Canada	Canada	Health region
Seven	Doctorate Nursing Administration	Saudi Arabia	Saudi Arabia	Private consultant Nursing council/ association
Eight	Doctorate	United States	Saudi Arabia	Hospital
Nine	RN, MSN, DNSc	United States	United States	University Private consultant Nursing council/ association
Ten	PhD (Didactics)	South Africa	South Africa	Health region Private consultant Dept of Health
Eleven	Bch Health Science (Nursing), Grad Diploma Critical Care, Grad Diploma Education, Master Nursing	Australia	Saudi Arabia	Hospital
Twelve	Doctorate	South Africa	South Africa	Private consultant
Thirteen	BSN, Master of Education (Adult) Doctorate in Education (Educational Administration in Higher Education)	Canada	Canada	University
Fourteen	Doctorate, Medical-Surgical Nursing Gerontology	Egypt	Saudi Arabia	University

Section 4.4.3.1 b) Areas of expertise

Five (n=5 or 36%) individuals identified more than one place of work; four worked at a hospital; six were private consultants; three (n=3) worked in health regions; four worked with regulatory bodies;

three (n=3) at a university; and one (n=1) in a health department. Of the 13 (n=13) nurse experts, only eight (n=8) identified nursing practice (NP) as a field of expertise. Of those who did not choose NP, three (n=3) worked at universities, and three (n=3) worked with regulatory bodies.

Five (n=5) identified themselves as being an expert in higher education (HE), six (n=6) in curriculum development (CD); and five (n=5) in outcomes-based education (OBE). Four (n=4) chose continuing professional development (CPD); and three (n=3) said they were experts in career management (CM). Seven (n=7) considered themselves expert in regulation (R) and five (n=5) in accountability (A). (See Table 4.5) Under the other category, respondent two indicated that her expertise was nursing administration and leadership; respondent nine considered herself an expert in international education; and respondent 13 identified herself as an expert in health care delivery systems. Respondent two also included the following caveat: "…I am a Chief of Nursing in both the (name of hospital removed) and the (name of health region removed), hence the dual check marks above." In the next section responses from Sections B and C of the questionnaire are highlighted.

Table 4:5 Respondents' self-identified areas of expertise with percentage by area

Respondent	Highest qualifications	Areas of expertise								
		NP	HE	CD	OBE	CPD	CM	R	A	Other
One	Master Science of Nursing	✓					✓	✓	✓	
Two	MSc (Community Health)	✓					✓	✓	✓	✓
Three	Master of Public Administration	✓				✓			✓	
Four	Master of Science Nursing							✓		
Five	Master of Science Nursing	✓						✓	✓	
Six	Doctorate	✓							✓	
Seven	Doctorate			✓		✓	✓	✓		
Eight	Doctorate	✓								
Nine	DNSc		✓	✓	✓			✓		✓
Ten	PhD – Didactics	✓	✓	✓	✓			✓		
Eleven	Master of Nursing	✓		✓	✓					
Twelve	Doctorate		✓		✓	✓				
Thirteen	Doctorate		✓	✓	✓	✓				
Fourteen	Doctorate		✓	✓						
	Total respondents	8	5	6	5	4	3	7	5	2
Percentage (%) of respondents		57	36	43	36	29	21	50	36	14

4.4.3.2 Description of the experts' responses

As mentioned, the questions of Sections B and C focused on the content and format of the provisional learning programme respectively. Two scales were used in the questionnaire: a) Likert 1- 4 with 1 being the least and 4 being the most; and b) a yes or no response. Space was also provided for additional comments under most questions. All but three respondents (seven, 12 and 14), provided additional comments. Expert responses are displayed in 11 tables (Table 4.7 to Table 4.17) and described in the following sections. Under each section, conclusions are derived. These comments are located in Appendix C. According to Lynn (1986), a mean score ($\overline{X}$) of 3 on

a 4 point Likert scale is regarded as valid. In the following section, a description of the results is provided.

Section 4.4.3.2 a): Questions 1, 3 and 4

Table 4.7 contains responses to Question 1 (introduction); Question 3 (practice context); and Question 4 (relevance of the International Council of Nurses' [ICN] Competencies Framework). Five (n=5) respondents assessed the introduction (Question 1) at a 3 and nine (n=9) respondents rated it at a 4 with a mean score ($\overline{X}$) of 3.6. Question 2 asked for comments if the respondent rated the introduction (Question 1) as a 2 or less. Four (n=4) respondents rated the relevance of the ICN Competencies Framework (Question 4) as a 3 and 10 (n=10) rated it as a 4 (see Table 4.7). The mean score ($\overline{X}$) was 3.7. Thus the introduction, practice context and relevance of the ICN Competencies Framework are valid for the Learning Programme.

Table 4.6: Scores for Questions 1, 3 + 4 from the expert questionnaires

Respondents	Introduction				Practice context		Relevance of ICN Competencies Framework			
	1	2	3	4	Yes	No	1	2	3	4
One			✓		✓				✓	
Two				✓	✓					✓
Three				✓	✓					✓
Four				✓	✓				✓	
Five			✓		✓				✓	
Six				✓	✓				✓	
Seven			✓		✓					✓
Eight				✓	✓					✓
Nine				✓	✓					✓
Ten			✓		✓					✓
Eleven				✓	✓					✓
Twelve				✓	✓					✓
Thirteen				✓	✓					✓
Fourteen			✓		✓					✓
Total responses			5	9	14				4	10
Mean score ($\overline{X}$)	3.6						3.7			

Section 4.4.3.2 b): Question 5.2 i

Respondents rated the four overall outcome characteristics (clear, understandable, realistic and demonstrable) in Question 5.2 i (Table 4.7) as follows:

- clear – one (n=1) as a 2, three (n=3) as 3 and ten (n=10) as 4 with a mean score ($\overline{X}$) of 3.6;
- understandable – one (n=1) as a 2, five (n=5) as a 3 and eight (n=8) as a 4 with a mean score ($\overline{X}$) of 3.5;
- realistic – one (n=1) as a 2, six (n=6) as a 3 and seven (n=7) as a 4 with a mean score ($\overline{X}$) of 3.4; and

- demonstrable - two (n=2) as a 2, four (n=4) as a 3 and eight (n=8) as a 4 with a mean score ($\overline{X}$) of 3.4.

In conclusion, as the mean score for each of the characteristics of the overall outcome ranged from 3.4 to 3.6 this aspect of the Learning Programme is valid.

Table 4.7: Scores for Question 5.2 i: the overall outcome characteristics

Respondents	Clear				Understandable				Realistic				Demonstrable			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
One				✓			✓				✓				✓	
Two				✓				✓				✓				✓
Three				✓			✓					✓				✓
Four				✓				✓			✓			✓		
Five				✓				✓				✓				✓
Six			✓				✓				✓				✓	
Seven			✓				✓				✓				✓	
Eight				✓				✓				✓				✓
Nine				✓				✓				✓				✓
Ten			✓				✓				✓				✓	
Eleven				✓				✓				✓				✓
Twelve				✓				✓			✓					✓
Thirteen		✓				✓				✓				✓		
Fourteen				✓				✓				✓				✓
Total responses		1	3	10		1	5	8		1	6	7		2	4	8
Mean score ($\overline{X}$)	3.6				3.5				3.4				3.4			

Section 4.4.3.2 c): Question 5.2.ii

The respondents scored the critical outcomes characteristics (Question 5.2 ii, see Table 4.8) as:

- clear – two (n=2) as a 2, five (n=5) as a 3 and seven (n=7) as a 4 with a mean score ($\overline{X}$) of 3.4;
- understandable – two (n=2) as a 2, six (n=6) as a 3 and six (n=6) as a 4 with a mean score ($\overline{X}$) of 3.3;
- realistic – two (n=2) as a 2, nine (n=9) as a 3 and three (n=3) as a 4 with a mean score ($\overline{X}$) of 3;
- demonstrable – two (n=2) as a 2, five (n=5) as a 3 and seven (n=7) as a 4 with a mean score ($\overline{X}$) of 3.2.

In conclusion, the critical outcomes are valid as the mean scores ($\overline{X}$) ranged from 3 to 3.4.

Table 4.8: Scores for Question 5.2 ii: critical outcomes characteristics

Respondents	Clear				Understandable				Realistic				Demonstrable			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
One				✓			✓				✓					✓
Two				✓				✓				✓				✓
Three			✓				✓				✓				✓	
Four			✓				✓				✓				✓	
Five		✓				✓				✓				✓		
Six			✓				✓				✓				✓	
Seven			✓				✓				✓				✓	
Eight				✓				✓			✓					✓
Nine				✓				✓				✓				✓
Ten			✓				✓				✓				✓	
Eleven				✓				✓				✓				✓
Twelve				✓				✓			✓					✓
Thirteen		✓				✓				✓				✓		
Fourteen				✓				✓			✓					✓
Total responses		2	5	7		2	6	6		2	9	3		2	5	7
Mean Score ($\overline{X}$)	3.4				3.3				3				3.2			

Section 4.4.3.2 d): Question 5.2.iii

Table 4.9 provides responses in relation to the characteristics of the exit outcomes (Question 5.2 iii). Scoring for the four characteristics was as follows:

- clear - four (n=4) as a 3, and ten (n=10) as a 4 with a mean ($\overline{X}$) score of 3.7;
- understandable –four (n=4) as a 3 and ten (n=10) as a 4 with a mean score ($\overline{X}$) of 3.7;
- realistic –two (n=2) at a 2, seven (n=7) as a 3 and five (n=5) as a 4 with a mean score ($\overline{X}$) of 3.2;

- demonstrable –six (n=6) as a 3, seven (n=7) as a 4, with a mean score ($\overline{X}$) of 3.3. One did not check a score.

In conclusion, the mean scores ($\overline{X}$) ranged from 3.2 to 3.7 in relation to the characteristics exit outcomes. These outcomes were therefore valid.

Table 4.9: Scores for Question 5.2 iii: exit outcomes characteristics

Respondents	Clear				Understandable				Realistic				Demonstrable			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
One				✓				✓		✓					✓	
Two				✓				✓				✓				✓
Three				✓				✓				✓				✓
Four			✓				✓				✓				✓	
Five				✓				✓				✓				✓
Six			✓				✓				✓				✓	
Seven			✓				✓				✓				✓	
Eight				✓				✓			✓					✓
Nine				✓				✓				✓				✓
Ten			✓				✓				✓				✓	
Eleven				✓				✓				✓				✓
Twelve				✓				✓			✓					✓
Thirteen				✓				✓		✓			No response			
Fourteen				✓				✓			✓				✓	
Total responses			4	10			4	10		2	7	5			6	7
Mean scores ($\overline{X}$)	3.7				3.7				3.2				3.3			

Section 4.4.3.2 e): Question 6

One respondent scored the duration of the provisional learning programme as a 2, while five respondents scored it as a 3 and eight as a 4 with a mean score ($\overline{X}$) of 3.5. The remaining aspects of the provisional learning programme identified under Question 6 (see Tables 4.10 a and b) were rated as follows:

- learner responsibilities – one (n=1) as a 2, three (n=3) as a 3 and ten (n=10) as a 4 with a mean score ($\overline{X}$) of 3.6;
- teaching approach and method – one (n=1) as a 2, three (n=3) as a 3 and 10 (n=10) as a 4 with a mean score ($\overline{X}$) of 3.6;
- personnel involved - five (n=5) as a 3 and nine (n=9) as a 4 with a mean score ($\overline{X}$) of 3.6;
- learner/nurse assessment – one (n=1) as a 2, five as a 3 and eight (n=8) as a 4 with a mean score ($\overline{X}$) of 3.5;
- coordinator and presenter assessment – one (n=1) as a 2, seven (n=7) as a 3 and six (n=6) as a 4 with a mean score ($\overline{X}$) of 3.4; and
- learning programme reviewers – one (n=1) as a 2, two (n=2) as a 3 and 11 (n=11) as a 4 with a mean score ($\overline{X}$) of 3.7.

In conclusion, as the mean scores ($\overline{X}$) for the learning programme aspects ranged from 3.4 to 3.7, all were valid.

Table 4.10a: Scores for Question 6: learning programme aspects

Respondents	Duration				Learner responsibilities				Teaching approach and methods				Personnel involved			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
One				✓			✓				✓				✓	
Two				✓				✓				✓				✓
Three				✓				✓				✓			✓	
Four		✓						✓			✓				✓	
Five				✓				✓				✓				✓
Six			✓					✓				✓				✓
Seven			✓				✓				✓				✓	
Eight			✓					✓				✓				✓
Nine				✓				✓				✓				✓
Ten				✓				✓				✓				✓
Eleven			✓					✓				✓				✓
Twelve				✓				✓				✓				✓
Thirteen			✓			✓				✓						✓
Fourteen				✓			✓					✓			✓	
Total responses		1	5	8		1	3	10		1	3	10			5	9
Mean scores ($\overline{X}$)	3.5				3.6				3.6				3.6			

Table 4.10b: Scores for Question 6 - learning programme aspects

Respondents	Learner/ nurse assessment				Coordinator and presenter assessment				Learning rogramme reviewers			
	1	2	3	4	1	2	3	4	1	2	3	4
One			✓				✓					✓
Two				✓				✓				✓
Three				✓			✓					✓
Four			✓				✓					✓
Five				✓				✓				✓
Six			✓				✓					✓
Seven			✓				✓				✓	
Eight				✓			✓					✓
Nine				✓				✓				✓
Ten				✓				✓				✓
Eleven			✓					✓			✓	
Twelve				✓				✓				✓
Thirteen		✓				✓				✓		
Fourteen				✓			✓					✓
Total Responses		1	5	8		1	7	6		1	2	11
Mean Scores ($\overline{X}$)	3.5				3.4				3.7			

Section 4.4.3.2 f): Question 7

All respondents scored the relevance of the eight practice standards (Question 7) as either a 3 or a 4 (see Tables 11 a and 11 b) with mean scores ($\overline{X}$) of 3.9. The practice standards were valid.

Table 4:11a: Relevance of the eight practice standards (Question 7)

Respondents	Responsibility and accountability				Code of ethics				Self-regulation				Competent application of knowledge, skills and judgment			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
One				✓				✓				✓				✓
Two				✓				✓				✓				✓
Three				✓				✓				✓				✓
Four				✓				✓				✓				✓
Five				✓				✓				✓				✓
Six				✓				✓				✓				✓
Seven			✓				✓				✓				✓	
Eight				✓				✓				✓				✓
Nine				✓				✓				✓				✓
Ten			✓					✓				✓				✓
Eleven				✓				✓				✓				✓
Twelve				✓				✓				✓				✓
Thirteen				✓				✓				✓				✓
Fourteen				✓				✓				✓				✓
Total responses			2	12			1	13			1	13			1	13
Mean scores ($\overline{X}$)	3.9				3.9				3.9				3.9			

Table 4:11b: Relevance of the eight practice standards (Question 7)

Respondents	Professional relationships				Professional leadership				Continuing PD				Quality improvement and evidence-based practice			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
One				✓				✓				✓				✓
Two				✓				✓				✓				✓
Three				✓				✓				✓				✓
Four				✓				✓				✓				✓
Five				✓				✓				✓				✓
Six				✓				✓				✓				✓
Seven			✓				✓				✓				✓	
Eight				✓				✓				✓				✓
Nine				✓				✓				✓				✓
Ten				✓				✓				✓				✓
Eleven				✓				✓				✓				✓
Twelve				✓				✓				✓				✓
Thirteen				✓				✓				✓				✓
Fourteen				✓				✓				✓				✓
Total responses			1	13			1	13			1	13			1	13
Mean scores ($\overline{X}$)	3.9				3.9				3.9				3.9			

Section 4.4.3.2 g): Question 8

Responses to Question 8 (Table 4.12) related to four characteristics of the specific outcomes and were rated as follows:

- clear – one (n=1) as a 2, three (n=3) as 3 and 10 (n=10) as a 4 with a mean score ($\overline{X}$) of 3.6;
- understandable – one (n=1) as a 2, three (n=3) at a 3 and ten (n=10) as a 4 with a mean score ($\overline{X}$)of 3.6;

- realistic – one (n=1) as a 2, seven (n=7) as a 3 and six (n=6) as a 4 with a mean score ($\overline{X}$) of 3.4;
- demonstrable – one (n=1) as a 2, five (n=5) as a 3 and eight (n=8) as a 4 with a mean score ($\overline{X}$) of 3.5.

In conclusion, the mean scores ($\overline{X}$) for specific outcomes characteristics ranged from 3.4 to 3.6, thus they were valid.

Table 4:12: Scores for Question 8: specific outcomes characteristics

Respondents	Specific outcomes															
	Clear				Understandable				Realistic				Demonstrable			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
One				✓				✓			✓				✓	
Two				✓				✓				✓				✓
Three				✓				✓				✓				✓
Four				✓				✓			✓				✓	
Five				✓				✓				✓				✓
Six			✓				✓				✓				✓	
Seven			✓				✓				✓				✓	
Eight				✓				✓			✓					✓
Nine				✓				✓				✓				✓
Ten			✓				✓				✓				✓	
Eleven				✓				✓				✓				✓
Twelve				✓				✓			✓					✓
Thirteen		✓				✓				✓				✓		
Fourteen				✓				✓				✓				✓
Total responses		1	3	10		1	3	10		1	7	6		1	5	8
Mean scores ($\overline{X}$)	3.6				3.6				3.4				3.5			

Section 4.4.3.2 h): Question 9

- Three (n=3) respondents scored the content of the standard criteria (Question 9) as a 2, five (n=5) scored it as a 3 and six (n=6) scored it as a 4 with a mean score ($\overline{X}$) of 3.2 (see Table 4.13). Thus the experts validated the content as fulfilling the standards criteria.

Table 4.13: Scores for question 9: content fulfils standard criteria

Respondents	Standard criteria			
	Content fulfils			
	1	2	3	4
One				✓
Two				✓
Three			✓	
Four		✓		
Five		✓		
Six			✓	
Seven			✓	
Eight				✓
Nine				✓
Ten				✓
Eleven			✓	
Twelve				✓
Thirteen		✓		
Fourteen			✓	
Total responses		3	5	6
Mean score ($\overline{X}$)	3.2			

Section 4.4.3.2 i): Questions 5.1, 5.3, 10, 11 and 12

Questions 5.1, 5.3, 10, 11 and 12 were grouped together in Table 4.14 due to their requiring yes or no responses. Thirteen (n=13) respondents thought the practice standards (Question 5.1) were

inclusive; one (n=1) did not. All 14 (n=14) responded affirmatively to the provisional learning programme facilitating learning outcomes. In relation to whether the standard range was complete two (n=2) did not response and 12 (n=12) said yes. One (n=1) individual did not provide a response to Question 11 (learner embed knowledge) and the other 13 (n=13) respondents marked yes. There were two (n=2) no responses to whether the demonstration of competence (question 12) and the remainder (n=12) said yes it did.

Table 4.14: Responses to questions 5.1, 5.3, 10, 11 and 12

Respondents	Practice standards inclusive		Facilitates learning outcomes		Standard range complete		Learner embedded knowledge		Demonstration of competence	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
One	✓		✓		✓		✓		✓	
Two	✓		✓		✓		✓		✓	
Three		✓	✓		✓		No response		✓	
Four	✓		✓		No response		✓		No response	
Five	✓		✓		✓		✓		✓	
Six	✓		✓		✓		✓		✓	
Seven	✓		✓		✓		✓		✓	
Eight	✓		✓		✓		✓		✓	
Nine	✓		✓		✓		✓		✓	
Ten	✓				✓		✓		✓	
Eleven	✓		✓		✓		✓		✓	
Twelve	✓		✓		✓		✓		✓	
Thirteen	✓		✓		No response		✓		No response	
Fourteen	✓		✓		✓		✓		✓	
Total responses	13	1	14		12		13		12	

Section 4.4.3.2 j): Question 13

All respondents (n=13) with the exception of one (n=1) responded affirmatively to the references and appendices being current and relevant (see Table 4.15). Respondent 13 said yes and no (see comments in Appendix C).

Table 4:15: Responses to question 13: current and relevant references and appendices

Respondents	Current		Relevant	
	Yes	No	Yes	No
One	✓		✓	
Two	✓		✓	
Three	✓		✓	
Four	✓		✓	
Five	✓		✓	
Six	✓		✓	
Seven	✓		✓	
Eight	✓		✓	
Nine	✓		✓	
Ten	✓		✓	
Eleven	✓		✓	
Twelve	✓		✓	
Thirteen	✓	✓	✓	✓
Fourteen	✓		✓	
Total responses	14	1	14	1

Section 4.4.3.2 k) Question 1: Section C

Respondents' assessment of the technical format (Section C- Question 1, Table 4.16) was as follows:

- clear – one (n=1) did not respond, five (n=5) rated it as 3, and eight (n=8) as 4 with a mean score ($\overline{X}$) of 3.4;
- logical and organised – one (n=1) did not respond, six (n=6) rated it as a 3 and seven (n=7) as a 4 with a mean score ($\overline{X}$) of 3.3; and
- overall – one (n=1) did not respond, five (n=5) rated it as a 3 and eight (n=8) as a 4 with a mean score ($\overline{X}$) of 3.4.

In conclusion, the technical format of the learning programme was regarded as valid by the experts as the mean scores ($\overline{X}$) ranged from 3.3. to 3.4.

Table 4.16: Scores for Section C: Question 1 - assessment of technical format

Respondents	Clear				Logical and organised				Overall			
	1	2	3	4	1	2	3	4	1	2	3	4
One			✓					✓				✓
Two				✓				✓				✓
Three			✓					✓				✓
Four			✓				✓				✓	
Five				✓				✓				✓
Six			✓				✓				✓	
Seven			✓				✓				✓	
Eight				✓			✓				✓	
Nine				✓				✓				✓
Ten				✓				✓				✓
Eleven				✓			✓					✓
Twelve				✓				✓				✓
Thirteen	No response											
Fourteen				✓			✓				✓	
Total responses			5	8			6	7			5	8
Mean scores ($\overline{X}$)	3.4				3.3				3.4			

Section 4.4.3.2 l) Respondents' comments

The respondents' comments (see Appendix C) primarily asked for clarification or further information in relation to specific concepts or issues within the learning programme. The comments were reviewed carefully and the respective ideas were incorporated in the changes made to the Provisional Learning Programme. The only major change was that two appendices were added. The content of the first one (Appendix 2) was the Empirical Indicators (see Chapter 2: Tables 2.14 a, b, and c) and the second (Appendix 8) contained cultural information for nurses who were caring for Saudi patients. The latter content was verified by two experienced professional Saudi nurses. The experts' comments were also reviewed prior to formulating the recommendations (see Chapter 5: Section 5. 4). One of the experts had suggested using Boyer's Scholarship Model (1990). This model was subsequently utilised in the data triangulation (see Section 4.4.5).

Expert responses are summarised in the next section.

Section 4.4.3.2 m) Conclusion of responses

In conclusion, the experts' mean scores ($\overline{X}$) ranged from a high of 3.9 to a low of 3. Of those questions which asked for a yes or no response, all experts (n=14) agreed with the practice context relevance and concurred that the learning programme facilitated learning outcomes. The next highest agreement was Question 7 (relevance of practice standards, see Tables 4.12 a and b) with a mean score ($\overline{X}$) of 3.9. Respondent seven rated all standards as a 3, but also marked yes in Question 5.1 (practice standards are inclusive). Respondent 10 rated the responsibility standard as a 3 while responding yes to question 5.1. Conversely, respondent three scored the practice standards as a 4 while responding no to question 5.1. Respondent three's no response was in relation to inclusiveness of "nurses working in community or clients homes would not identify themselves as clinical practice. You may want to use clinical/community." Respondent seven and respondent 10 did not provide any comments.

The lowest score was in relation to 5.2 ii (critical outcomes characteristic, see Table 4.8), specifically the realistic aspect of the critical outcomes mean score ($\overline{X}$) of 3. Two respondents scored this aspect as a 2. Respondent five's comment was not found (see Appendix B). Respondent 13 scored almost all aspects (with the exception of standards) as a 2. The majority of the respondents scored this question as 3. The respondents may not have understood the language of outcomes -based education as the mean score ($\overline{X}$) for the practice standards was 3.9 which are the intended critical outcomes. Finally, of interest as mentioned above (Section 4.4.3.1), are the number of nurse experts who did not select the category of nursing practice even though they are credentialed in that profession. Comments were reviewed and recommendations culled from the comments were utilised when finalising the learning programme (see Appendix F). In the next section, the evaluation of the learning programme and the way in which the above recommendations were utilised in the learning programme are described.

4.4.4 Evaluation of learning programme

Constructivism can be used to characterise the philosophical logic of qualitative evaluations, particularly when telling stories about individuals and groups living within a particular socio-political context. An emic (insider) perspective is by its very nature value-based and requires direct engagement of the researcher (evaluator) with those being studied. On-site observations and personal interviews and discussions are the main ways in which data are gathered (Greene, 2000).

Interpretation of events is dependent on a number of factors, including the evaluator's prior experience, knowledge and expertise, cultural sensitivity, insightfulness, critical/reflective thinking abilities and values and attitudes. As there is vested interest in evaluation results, an evaluator is morally obligated to identify whose interest is to be served. Moreover, as evaluation is about valuing and judging, it is best if the evaluator identifies criteria and standards upon which judgments of quality are made (Greene, 2000). When quantitative methods are used to validate the research results, trustworthiness in the content validity and reliability is more likely to increase (Creswell, 2003).

As described in Section 4.4.2, the learning programme (see Figure 4.1) was developed for the specific purpose of completing doctoral studies. The researcher's philosophical stance is described in Chapter 2: Section 2.4.1.3 and the underlying assumptions and ideological stances are described in Chapter 3: Section 3.3.3. The purpose of this section is to describe and analyse the results of the formative and summative evaluation data. The data were gathered from the following sources:

- diploma learners' evaluation data (see Section 4.4.4.1);
- new graduate research conducted by two diploma students (see Section 4.4.4.2);
- assessment of diploma and new graduate programmes (see Sections 4.4.4.3 and 4.4.4.4); and
- the researcher's subjective experiences (see Section 4.4.4.5).

When describing and analysing the data, the researcher was mindful of how she constructed meaning and drew conclusions about the learning programme. In the sections that follow, evaluation results are described initially from the perspective of the diploma learners, then from new graduates; next from the educators; and finally from the researcher's subjective experiences. In Section 4.4.4.1, the diploma programme learner evaluation is overviewed.

4.4.4.1 Learners' evaluation results from two diploma programmes

As noted in Section 4.4.2, Table 4.2, there were 53 learners in the two diploma programmes, three of the initial seven learners completed the first year (2002-2003), 22 of the 27 completed the second year (2003-2004) and 16 of the 19 completed the third year (2004-2005). These learners came from a total of 14 countries: Saudi Arabia, South Africa, the USA, the United Kingdom, Malaysia, the Philippines, Palestine, Egypt, Lebanon, Columbia, Australia, Ireland, South Korea and Canada. The research was an exploratory, descriptive, and partially explanatory design for the evaluation of the central theoretical assumption. The evaluation data were derived from an open ended semi-structured questionnaire (see Appendix D) completed by 18 (n=18) of the 22 (2003-2004) learners. These 18 learners completed their respective questionnaires immediately after their final examination. They were asked to evaluate the following: the course content;

presenters and themselves. Their responses are described in the next sections and include verbatim comments.

4.4.4.1 i) Course content

During the first semester, learners were discovering what they did not know: “I really like the first term as there was a lot that I never knew I did not know”. The learners were also forming relationships with classmates: “Through the process of completing assignments, I have made...good professional relationship with colleagues and it was a very valuable opportunity”. “(I enjoyed) the “actual practice of learning”. By the end of the first term, they had “a better understanding of standards and how they can be incorporated into an individual practice or unit” while “learning and understanding standards and self regulation”. “…The lecture on the nursing board and association (was) so helpful; it had a significant impact on me…” Two other comments highlighted the importance of “addressing core values of self-development, regulation, continuing development …” and “developing a mission statement”. One person acknowledged that the evaluation provided “…a good opportunity to look back at myself” while another said “it was like sitting in front of a mirror to re-evaluate my work as a nurse manager and having a chance to refine my work and myself”.

Suggestions for change included more balanced assignments and projects particularly at the beginning. Management students asked for greater emphasis on leadership, personnel management, time management and conflict resolution with specific examples from the hospital. Educators wanted more teaching practice and a little more on how to teach others. One person asked for less emphasis on examinations and more on individual presentations. Fixing the classroom was also requested. (Due to problems regarding teaching space it was not possible to use the same classroom all the time.) In the next section the evaluation of the presenters is described.

4.4.4.1ii) Evaluation of presenters

The learners were asked to briefly reflect on the presenters (educators) and comment on their knowledge, skills, values and attitudes. The following sections provide a summary of their feedback (see Appendix E for a copy of the questionnaire).

a) Presenters' knowledge

In relation to presenters' knowledge, the learners wrote the following. "Each time they present was very wise knowledge with the content of each class even with the small details. Both presenters know their fields." "Both…know a lot (of) very useful things"…the "information flows easily" and "…it looked like a sea of knowledge". They "…were very knowledgeable….very confident"…"Both had knowledge which we benefited from" They had "unlimited knowledge and experience which made us…visualise the contents and apply it in our daily work tasks." They "are competent role models…I hope…I could follow you…" "It was excellent with preparation, presentation (which) influenced our …practice". Their "excellent knowledge base … was presented in an easy manner"… One "had very good integration of theory and practice" and the other had "…good knowledge base, clear and concise". "They are more than knowledgeable."

b) Presenters' skills

"They practised very high standards skills"…They were "…able to bond the group"… "to extract from us and encourage group participation". "As educators their techniques are excellent." It was "...very interactive". "Both have the right skills of communication and…practice." They were "…especially skilful when teaching and facilitating and pulling information from students". "The teaching skills of the presenters are optimum which enabled them to attract the attention of their students and make the education process very enjoyable." One had "…excellent teaching skills, got the message across simple and easy, teleconference was marvellous!!" and the other used "methods of teaching… (that were)…insightful and interesting". "They are great."

c) Presenters' values

Three learners said the presenters had "excellent values". They had "excellent application and dissemination"… "They made it clear for the group what values mean when they taught us about

their values and shared it with us." They were "committed"… "tried to help everybody"… were respectful of "…everyone's input". "Both are good, wonderful, loving and caring persons to know and have in my life." They "…always (practise from) the highest standards". They understood the "…Kingdom of Saudi Arabia values and culture" and held "very strong belief towards Saudisation" and were "very respectful to their culture and other people's culture especially the Saudi culture". One "has a passion for her work and shows in her interventions, has a deep seated love for her students" and the other was "dedicated and committed to her work, very respectful and loving towards students".

d) Presenters' attitudes

"They showed (a) very respectful attitude to the group." Both were "…inspiring, motivational and transformational"…"very professional and very friendly they are special…" They were "helpful"… "very competent presenters" and had "positive attitudes to students, their ideas, opinions and beliefs". They were "… professional and so considerate and understanding for us"… "we had a wonderful time together as colleagues and friends". Their "attitudes make learning easy to understand". It was a "pleasurable experience". One presenter was "motivating and stimulating, most time thought provoking" and the other was "kind, caring and supportive". "Thank you both for the memorable experiences, created in this course and for the beautiful experience of the conference." In the next section, learner evaluation feedback is described.

4.4.4.1 iii) Self-evaluation

Learners were then asked to assess their learning from the perspective of knowledge, skills, values and attitudes. The following is a summary of their feedback.

a) Learners' knowledge

"(I am surprised) how much the diploma added to my knowledge and widen my mentality and changed my thinking for the better." It helped … "(me to gain a) greater understanding and respect for colleagues outside my profession". "I became more aware about and have a lot of knowledge and information." One manager realised her responsibility included running the entire unit, not just the human and material resources. Others said the programme had added to their knowledge and

had improved their thinking (although there were some confusing times). One now appreciated how important competent staff members were to the delivery of quality patient care.

For another "it was a good opportunity to build my ground firm and steady". "I have the tools of my trade and can work more competently and confidently." One person had started to look at things in different ways, building her vision from broader thinking. She said it broadened "…my vision and enabled me to analyse and see the whole picture". The programme "increased my knowledge and a desire to do more study". "It broadened (my)… knowledge base (from which I can build)… my practice." "Doing (well) in the interview was a significant reflection of this program in my career and life." "This year has changed me and I have learned so much." The programme "broadened my knowledge and helped me cope with my job as educator" and it "improved my teaching skills". "I now understand the changes that (are) going through the health care."

b) Learners' skills

"I am not the same person I was before I enrolled in the diploma." Several learners evaluated improvement in a number of skills: presentation and research (previously unexplored area of practice). It helped others to enhance and better utilise management and leadership skills and styles; and improved interact with multi-cultural staff. One learner said she was more accountable and responsible in her practice and "now … my skills and performance (have improved) and (I) keep… evaluating my skills". Several were more confident. One said she was "…more competent, confident than before" while another reported "I am better able to cope with anything they throw at me" and a third individual felt she had "improved also and it appears in my area but I need more". One was now able to apply APIE (assessment, planning, intervention and evaluation) to "all the tasks which make things more successful" while another said "I have read more, I have learned more and so I can write more…"

c) Learners' values

The programme made an impact on learners' beliefs and values: "It affects on my beliefs and how I think." "(It) has made me think more about my values and what they mean." "I know very well my values and (am) working on it." I know that values (are) part of being competent." "(I have learned that (a) holistic approach is the best (when dealing) with people around me." "I appreciate what I

have learnt and intend to incorporate many elements into my day to day practice." The programme "helped me to improve my values ... I became more responsible and committed." It also helped to improve self-respect; job commitment; judgment; and broaden understanding of differences and respect for others. It added other positive things such as the value of teamwork; helped one person to recognise she was not the only one with good values and attitudes. One believed that a "brighter future will be made by us". "I am very much empowered and influenced by the excellent presentations, moments and atmosphere."

d) Learners' attitudes

There was evidence of attitudinal changes in the learners' comments. "As a unit manager, I am applying now what (the educators) demonstrated to us – knowing the staff, including their personal life, family and what is important to them and always show to them that you are there to help and not to criticise (do not set them up for failure). Smile, be nice to others and be professional just like (the educators)." The programme "…becomes very basic in my life…". "(I) respect (the) need (for) continuing self development." It helped to create "…a positive attitude toward learning and new information". "(My attitude) improved also in a professional way because it affects my thinking so it affects my attitudes – thanks." It "has changed my attitude to work and ongoing education". "It has allowed me to reflect on many aspects of my personal and professional life and hopefully allowed me to improve in many aspects." "I am encouraged to (improve continually) … thank you!" "(I have a) positive change to (the)…role (and) leadership." "(I am able to) draw a nice picture for a nice future and work for it" and "(I have) confidence in imparting knowledge". "(I am) improved 100% …" "I can now think upper management and try to understand what they are trying for."

In the next section, results from a new graduate research study are described.

4.4.4.2 New graduate research study results

Two months after implementation, two learners from the diploma programmes did a descriptive quantitative research study of the new graduate programme as part of their studies. The researchers were guided by the mentor/academic adviser. They used a two part semi-structured

questionnaire to gather their data. Questions from Part A consisted of four items, rated on a Likert Scale of 1 to 4 and two open ended questions. Part B included nine items with the same Likert Scale and three open ended questions. The questions were based on themes gathered from the literature. A total of 20 new graduate Saudi nurses with less than two years' experience were randomly selected. Six had recently completed their orientation and of these, four had worked as nurse interns (the final year of nursing school) in the hospital during a period where there was no structured programme for new graduates. In the next section, the research findings are summarised (see Appendix E for a copy of the questionnaire used to gather the data).

4.4.4.2 i) Research findings summary

Overall new graduates appeared to be satisfied with the orientation programme as 55% (n=11) agreed and 35% (n=7) strongly agreed that their extended orientation had helped them to adapt to the work environment. Two (10%) disagreed. Fifteen (n=15) respondents agreed (75%) and four (n=4) strongly agreed (20%) that the theory content on the extended orientation was related to their work requirements. One individual (n=1) disagreed with this statement. The majority of new graduates appreciated having practical learning sessions rather than just lecturing – 12 (n=12) agreed and 7 (n=7) strongly agreed. The majority (60%)) either disagreed (15%) or strongly disagreed (45%) with 10 days being enough orientation time. Respondents suggested more practical sessions in the skills laboratory as well as on the units and more connection with the internal policies and procedures to their practice. In general, the new graduate respondents found that the programme supported them in connecting theory to practice.

Support from their preceptors had the greatest impact on their clinical experience compared with head nurse, clinical instructor, and the nursing department that delivered the programme and coordinated their practical experiences. Similar findings are identified elsewhere (Myrick, 2002; CNA, 2004d). Almost all of the respondents (95%) believed that they needed the programme and the clinical practice assessment portfolio provided more structure to their practice. They asked for more follow-up and evaluation of their practice in the clinical setting. The researchers concluded that the programme was assisting the transition of the new graduate nurse to the role of a

professional nurse. They also concluded that because the new graduates were guided and were provided with learning opportunities, it was safer for patients. The 10 day orientation gave the new graduates additional time to familiarise themselves with the nursing practice and adjust to the hospital expectations. The portfolio provided greater structure for learning how to implement and assess the practice standards. One aspect that was not measured was whether the programme had any effect on new graduates' critical and reflection thinking. In the next section, the educators' assessment of the diploma programme is described.

4.4.4.3 Educators' assessment of the diploma programme

As noted in Section 4.4.2.1, during the first year of the programme the adviser/mentor was responsible for most of the course content with the exception of the research component which was taught by another doctoral prepared nurse educator. Three master's prepared educators, one of whom was the researcher, taught individual classes and participated in the assessment and examination process. During the second and third year, the adviser/mentor (with assistance from the researcher) led the programme. Data for the educators' assessment comes from years two and three and were taken from reports and memos to senior managers.

The focus of the next section is the educators' assessment of the programme content.

4.4.4.3 i) Programme content

The educators met on a regular basis to plan and discuss the weekly content and required remedial action. Their assessment of the programme content data revealed the following:

- Programme content was valid, appropriate, and current and could effectively be utilised in practice.
- The multiple choice examination was a requirement of the Saudi Health Specialties Council and hence was mandatory. Therefore, at the end of each trimester students completed a multiple-choice examination, for a total of three examinations.

- Validity and reliability of examination papers were ensured by means of an external moderator/examiner who critiqued and gave feedback for changes and on the quality of the content. The moderators also evaluated the marked papers for correctness and fairness. The pass mark was set at 70% and all learners passed all three examinations in all three years.

Learner assessments and results are described in the next section.

4.4.4.3 ii) Assessment of learners

The two educators utilised a continuous assessment and remediation process with regard to the programme learner assessments. Before, during and after class time, the educators solicited verbal feedback from learners on specific content and how it was being applied to practice. They used a problem-solving approach to analyse feedback, remediated learning and planned future actions. Ongoing learner assessments included the following:

- written or verbal assignments;
- homework remediation;
- multiple choice objective examinations (this particular aspect was a formalised requirement of the SCHS; and the learners had to have a pass mark of 70% in order to complete the particular diploma); and
- course evaluations.

Learners were eager to learn. They enjoyed the class, formed a cohesive group and over the course of the year submitted well developed and thoughtful assignments. By the end of the first and the beginning of the second semester, all were thinking globally as well as locally, and demonstrating in their assignment and in class feedback that they were transferring their learning into their practice.

Weekly assignments were reviewed and graded according to criteria identified in the diploma learning programme. Assignments that did not meet the criteria were returned with feedback for remediation. Assignments were returned until such time that a grade of 80-85% or above was met. The rationale for this approach was based on the principle that some learners require multiple

opportunities to learn and by critically reflecting on what they wrote and correcting their assignments they deepen their analysis and thus their knowledge (Van der Merwe, 2005; Diekelmann & Magnissen, 1998).

As learning progressed in the course of the three semesters, roles were expanded and learners were provided multiple opportunities to work in groups and reflect on their learning. Outside of class time educators held periodic counselling and remediation sessions. During all three years, learners (either as individuals or groups) facilitated one-hour theoretical learning sessions. Learners were coached beforehand by the educators and their teaching sessions were evaluated by fellow learners and the educators. After class their presentation was reviewed by themselves and the educator and a summary of their competencies (knowledge, skills, values and attitudes), specific areas for improvement; and in class evaluation data were provided. In the period 2004-2005, learner presenters were also asked to reflect on

- what they liked about their presentation;
- what they had learned from teaching the session;
- what they would do differently next time;
- how they knew their learners knew; and
- what they intended to take from the session to their nursing practice.

Posing questions encourages and facilitates reflective thinking. During one learner-teaching session, one of the learner teachers facilitated a brainstorming session in which she asked what motivated the participants in their work. When it came to the adviser/mentor's turn, she said she was motivated by the need for change. The learner-teacher proceeded to write CHANGE in the middle of the board. Later when asked by the adviser/mentor why she had done this, the learner-teacher replied because she now believed change was the basis of motivation. She had written the word in capitals to emphasise this point. The learner-presenter had deduced an important conclusion from her reading on motivational theories. By asking her learners for their ideas, she was able to draw from their experiences rather than imposing her new-found belief.

Later in the same class, the adviser/mentor asked all the learners (16 of the 18 diploma learners were present) to think back to the beginning of the programme and identify significant personal

changes. During their reflection they identified increased knowledge and self-confidence and the enjoyment of learning from and with others, both in class and through group assignments. One person who only wanted to work with a few people at the beginning said she had stepped outside of her comfort zone and now found it much easier to work with the others. Reading to understand, completing assignments and understanding one of the educator's spoken English became easier. There was noticeable change in the learners' body language, greater cohesion, more laughter and joking and in general the number of interactions with teachers and among each other had increased. Some said they had a strong commitment to learning (e.g. one said she was taking leave (holiday) to attend the class). The non-nurse said she had once felt like an outsider but that she no longer felt that way. She had considered giving the class up but when she realised three fellow learners travelled over 300 kilometres each week, she decided against it. There was increased passion and ability to cope in their work because of what they were learning in the classroom. Learning within a multicultural environment was also identified as an important aspect. A male learner said he was not used to expressing feelings, seeing himself more as a practical man not needing to speak about feelings. Prior to attending the diploma programme, he mainly taught in lecture format using PowerPoint presentations. When he talked about the energy in a recent workshop he had facilitated he was more animated than usual and smiled when asked about the changes in his body language. The adviser/mentor said she believed when she taught the class about standards, all demonstrated learning had taken place. For her it was a day when group change had happened.

During the first year, there were no research projects, as the educator who was responsible for this aspect taught from a theoretical rather than a praxis perspective. In 2003-2004, all 22 learners completed their research projects andl presented them during a research day celebration. In 2004-2005, the 16 learners again are implementing pilot projects and were scheduled to present their findings in mid-September 2005. In the next section, assessment of the presenters is highlighted.

iii) Presenters

With the exception of the first year, the two educators were the primary presenters for most of the programme content. During the second year guest presenters were invited to discuss recruitment and retention and budgeting and in the third year there was a guest lecturer for the budgeting process. These presenters were purposefully selected because of their expertise. Evaluation data from the learners revealed that the presenters were knowledgeable, that they were experts on the particular subject, that they could apply theory to practice and that they were always prepared (see Section 4.4.4.1 ii). In the next section the new graduate reflective practice sessions are assessed.

4.4.4.4 New graduates' reflective practice sessions

New graduates came together as a group once a month for two hours. During this time they engaged in reflective practice learning activities. Because they were working on two different teams, half met on one day and the other half the next day. BSN prepared nurse interns were included in both groups. These nurse interns were rotating through various units in the hospital for a year and when they graduated some would be offered fulltime positions. As these nurses and nursing students got to know one another, they engaged more in learning together and thus made better use of the time. Moreover, when these sessions were structured and they were required to work in a group rather than individually, learning was more effective. Two examples are provided to demonstrate these conclusions.

During one session, the new graduates were divided into two groups and a case study was read to them. They were then asked to draw a picture depicting how they would complete their holistic nursing assessment and plan their nursing care. At the end of the session, they were surprised at how much they had learned from one another. When asked what they had learned, many were shy to speak and even those who did gave very basic level responses. In the following reflective practice session they were given photos and asked to use them in their group to develop a story about the individual's health status. Having their story identified, they were then to develop a nursing care plan and bring it back to the group for discussion. Later they returned to their group

and reflected together on what they had learned from the exercise. This time their responses were more animated, better thought out and included greater detail. They said they enjoyed working together, sharing information, listening to each others' different ideas and using their imagination. The exercise helped them to think critically, but the next time they said they would be more organised and be more confident about working together. One group said they had had found it difficult to create their stories at the beginning. They said they felt shy as they did not know one another. Another group said that although they were not used to learning this way, they enjoyed it. From their discussion and feedback there was evidence that the new graduates were not only learning what to think but how to think (Myrick, 2002) as they had created a common story and worked together to identify a plan of care.

All learners were continually assessed, but new graduates in particular required counselling and follow-up in the clinical setting. As they transformed and transitioned through the various stages, some either found their own way or were sent by the head nurse for counselling. Some new graduates, for example, found it extremely difficult to deal with death, to work with people of the opposite gender and/or to wear the required white head scarf. Some new graduates and nurse interns exhibited signs of cultural shock; they were tearful and found it difficult to deal with the work situation on an emotional level. Nurturing and treating each of them as individuals and engaging them in dialogue eased the learning process.

There was evidence from the evaluation of the two diploma programmes to indicate that the concepts in the three central theoretical assumptions were being maintained. In the new graduate programme, although the first two assumptions were upheld, many new nurses did not fully grasp self-responsibility in nursing practice (see Table 4.17). During annual performance when new graduates were asked questions in relation to professional, ethical and legal aspects of their practice, most did not know. Hence it was generally a time when these aspects were re-explained.

Table 4.17: Evidence of central theoretical concepts being upheld in learners

Central theoretical concepts	Diploma programmes	New graduate programme
Facilitate quality nursing practice	✓	✓
Facilitate personal and professional development	✓	✓
Support the implementation of nursing legislation	✓	

The focus of the next section is the researcher's subjective experience.

4.4.4.5 Researcher's subjective experience

As this section reflects the researcher's personal experience, I wrote in the first person. I am forever grateful that my two academic advisers agreed to supervise my research. Without their guidance my learning would not have been such an enriching experience. One adviser was accessible through e-mail and telephone. I met regularly with my second adviser, engaging in dialogue, practicing together with her and critically reflecting on achievements, next steps and areas for improvement.

In the next section I reflect on my professional development.

4.4.4.5 i) Reflecting on my professional development

Engaging in doctoral research gave me an opportunity to continue my professional development which was a nursing licensure requirement (RNABC, 2002). The research process stimulated my critical and reflective thinking, which made my nursing practice more interesting. Reading and presenting on recent scientific knowledge provided an opportunity for me to role model research-based (evidence-based) nursing practice. In addition, I continually learned and constructed meaning from my nursing education experiences (Botes' (1998, 2000), first order, see Chapter 3: Section 3.3.1) and from this constructivistic learning process I inductively developed a learning programme (see Appendix F). Developing a learning programme and co-teaching with an expert teacher for three years transformed me professionally and personally. Because I was engaged in

reading, writing, thinking and dialogue as a doctoral student in higher education, my transformation was scholarly (Diekelmann & Magnusson, 1998).

As I collected and analysed the research results and derived new meaning, I embedded this knowledge into my practice and used it when I taught or engaged in related dialogue. My thinking became much clearer and it was easier to analyse critically and to teach, because I was able to retrieve relevant concepts and theories in relation to continuing professional development quite easily. I learned how to implement education standard-based practice and I enhanced my ability to practise reflectively. These changes were in keeping with the application of the first and second order of Botes' Research Model (see Chapter 3: Sections 3.3, 3.3.1 and 3.3.2). The transformation also enabled me to reflect and engage in dialogue from a metatheoretical perspective (Botes' third order, see Section 3.3.3). I flourish in an environment where I am accepted and valued for who I am and when I am a member of a progressive, professional team. I believe my doctoral research (i.e. CPD learning programme) was progressive in meeting the requirements of a higher education institution while at the same time applicable to the realities of being part of a multicultural workforce of nurses (myself included) who were working in Saudi Arabia. In the next section, the results of the research are triangulated.

4.4.5 Data triangulation

A definition of data triangulation is provided in Chapter 1: Section 1.8. Triangulation was used so that the results (see Table 4.18) could be viewed simultaneously as opposed to sequentially, enabling the researcher to finalise the learning programme (see Appendix F). The provisional learning programme was authenticated by 14 experts. The researcher had planned to use the Delphi technique (see Chapter 3: Section 3.3.2.2 i b) to ask the respective experts to confirm the findings. As the first round of respondent results (with the exception of one respondent's) validated the learning programme, data saturation was reached (see Section 4.4.3). Hence a second round was not necessary.

One of the experts suggested using Boyer's scholarship research noting it encourages creativity and diversity into higher education and by extension society. In his seminal work Boyer (1990)

broadened the scope of scholarship by identifying four overlapping scholarship dimensions: scholarship of discovery; scholarship of integration; scholarship of application; and scholarship of teaching. In a posthumously published article, Boyer changed the dimension of application to engagement explaining that "the scholarship of engagement means connecting the rich resources of the university to our most pressing social, civic and ethical problems, to our children, to our schools, to our teachers, and to our cities" (Boyer, 1996: 20).

Later, Glassick, Huber and Maeroff (1997) defined standards which could be applied to each of the categories of scholarly activity identified by Boyer. They suggested that academic institutions had to make fundamental changes in order to tap the full range of academic talent and to keep abreast with changing needs of society. Further, they described how scholarship could be fairly evaluated. A major contribution of these authors was the way in which they identified the common sequence of the unfolding stages of all scholarly activity. They maintained that scholarly work of any kind can be appraised by qualitative standards that need to be explicitly articulated.

Davis and Chandler (1998) who extended the discussion of scholarly roles and the resulting impact, argue that even though Boyer fostered debate about scholarship, he ignored the socio-economic contexts and historical purposes of universities. They further criticised Boyer saying he assumed a reward system to be part of scholarship and ignored the body of research and theory which indicates that rewards and punishment are more closely connected to control than to increase quality. In contrast to Boyer, Davis and Chandler emphasised the intrinsic motivational aspects of scholarly work and environments where real academic freedom and socio-economic security prevail. They believed that these are more appropriate ways to foster scholarly quality.

Although Boyer's model was developed for higher education within academic (university) settings, it is relevant to nursing in general and continuing professional development in particular, as the work of nurses is extremely complex, practice-based and accountable to a variety of stakeholders (the public, government, regulatory boards, employers and nurses themselves). As King's Theory (1998) incorporates a comprehensive (biological, sociological, psychological and spiritual) system's (personal, family, group and society) approach to nursing practice (see Chapter 1: Section 1.5.1

and Chapter 3: Section 3.3.3.4 i) the above criticisms of Boyer's work (Glassick, et al, 1997; Davis & Chandler, 1998) have been addressed in this research.

The American Association of Colleges of Nursing (AACN, 1999d) utilized Boyer's research to develop scholarship standards for nursing education. In Table 4.18, Boyer's four scholarship dimensions are defined and the AACN standards are applied to the research findings and thus the results were triangulated. The data triangulation was based on feedback from the experts (see Appendix C) who validated the learning programme; the synthesis of the literature (see Chapter 2) and empirical indicators that were subsequently derived (see Chapter 2: Tables 2.14 a, b, and c); and the constructivistic learning that occurred while teaching in the three programme (see Section 4.4.2) with the mentor/adviser.

Provision of initial and ongoing competence education requires a structured curriculum (learning programme) including specific standards, exit learning outcomes and detailed assessment and evaluation strategies and methods (Van der Merwe, 2005). Nurse managers and educators have a leadership responsibility to establish continuing professional development programmes to achieve organisational outcomes including quality patient care and effective human resources management (JCI, 2003). Additionally, to protect the patients, respective students, recent graduates and peers who are new to the organisation or assume a new role require active teaching as well as continuous assessment and evaluation. Furthermore, educators, preceptors, mentors and managers also require education (Van der Merwe, 2005; Muller, 2003). A quality workplace environment (Lowe, 2000; 2002) is very important for learning, retaining motivated and competent staff, delivering quality patient care and achieving positive outcomes (O'Brien-Pallas, Thomson, McGillis-Hall, Pink, Kerr, Wang, Li & Meyer, 2004; Bryant, 2005).

Table 4.18: Boyer's scholarship model and AACN standards utilised to triangulate research findings (Sources: Boyer, 1990; AACN, 1999d)

Scholarship	Boyer's definition and AACN standards	Research findings triangulated

Discovery	Educator incorporates new and unique knowledge:
	- Reflect expanded view of health, emphasising health promotion, restoration, and rehabilitation and commitment to caring and comfort
	- Take the form of research:
	  - Primary empirical
	  - Historical
	  - Theory development
	  - Methodological studies
	  - Philosophical inquiry
	- Use a variety of quantitative and qualitative designs
		- Began with a vision of healthy population and a commitment to quality nursing practice
		- Reflected uniqueness of nursing, broad view of health within the Saudi Arabian context – a Muslim country
		- Answered the question "what should the contents be of a CPD learning programme?"
		- Was an original investigation and empirical indicators were identified (e.g., quality of workplace environment) and verified
		- Drew together scientific and experiential knowledge, assumptions, and principles
		- Utilised Botes' Research Model outside of South Africa generated scientific knowledge
		- Sought to answer questions about the best educator/learner practices to support quality nursing/ patient care
		- Utilised mixed methods to inductively develop the provisional learning programme

Integration	Educator discovers the relationship among disciplines: - Refer to writing and other products that use concepts and original works from nursing and other disciplines to create new patterns, placing knowledge into a larger context for benefit of society	- Shared research findings when teaching, at conferences, in workshops, meetings - Included other disciplines as learners - Validated by 14 experts from six countries
Application	Educator places emphasis on using new knowledge in solving society's problems: - Encompass all aspects of nursing service delivery where evidence of direct impact in defining and solving health care problems - Base on competence in practice	- Included all aspects of nursing practice at all levels and settings (hospital, home and community) - Tested in three specific programmes - Facilitated praxis in learners - Supported CPD and thus competence - Verified results

Teaching	Educator creatively builds bridges between his/her understanding and that of the learner:
	- Produce knowledge to support transfer of science/ art of nursing from expert to novice
	- Build bridges between educator and learner, teaching and learning
	- Accept diverse learning styles, focus education on learner
	- Increase the effectiveness of:
	  - transfer of discipline specific knowledge
	  - development of innovative teaching and evaluation
	  - programme development and learning outcomes evaluation
	  - professional role modelling
		- Targeted all nurses in four practice domains and all levels and settings
		- Based programme on needs of learner, employer, patients/ community
		- Used content specific to practice field
		- Co-taught with adviser/mentor
		- Continuously evaluated self and learners
		- Developed, implemented and evaluated learning programme
		- Mentored new graduates, novice educators and managers
		- Implemented research process
		- Finalise research and then disseminate findings broadly (e.g. regulatory boards, employers, peer review journals)

Employers have a very important role to play in helping to establish and maintain positive workplaces. They are also well placed to identify continuing competency required for quality patient care and thus have a role in identifying outcomes, processes and structures for a continuing professional development learning programme. According to Mustard (2002), workplace competence assessment is possibly the most reliable method for determining whether health professionals are competent within a particular practice context. A professional portfolio with verified evidence of current practice can aid the assessment process and help nurses when they register with the SNB.

The primary responsibility of a nursing council (e.g. SNB) is to protect the public from potential harm if unqualified workers were to provide nursing care (Bryant, 2005; Styles & Affara, 1997; WHO, 2001; CNA, 2001a; Muller, 2003). Under the respective country nurses' act, nursing leaders have a legislated responsibility to establish a fully functioning regulatory system, and diligently to maintain it, all the while striving for the ideal. Regulation encompasses credentialing processes, including registration, licensure, qualification, and education accreditation, certification, and endorsement. A code of ethics (conduct), scope of practice, standards of practice, competence requirements and continuing professional development opportunities are also required. The ICN has established 12 principles for regulation (Styles, 1985) which underscore the responsibility of the profession to prepare its own code of ethics and to establish standards of practice (Percival, 2001). (See Chapter 2: Section 2.4. 1.)

Practice standards are used to direct basic education and preparation of the generalist nurse and support ongoing competence development so as to enable a nurse to practise to the fullest extent of her /his scope of practice (ICN, 2003). Standards influence the nursing profession's ability to meet the challenge of changing health needs of the population as well as the complexity inherent in the health care delivery system (Bryant, 2005; ICN, 2003; WHO, 2001). A quality nursing education approval system assures that nursing graduates have met specific criteria and that nursing education is current, progressive and responsive to the changing needs of the public (ICN, 1997). It also requires standards based on Saudi Arabian health care needs and global requirements; adequate resources (human and material); and a comprehensive education process (Van der Merwe, 2005; Styles & Affara, 1997).

In the next section, this Chapter is summarised.

4.5 SUMMARY

As nursing is a practice-based profession, competencies (knowledge, skills, values, attitudes and judgment) are best demonstrated when the nurse applies them in the practice setting rather than in a classroom or skills laboratory (Myrick, 2002). A purposefully designed and organised continuing professional development learning programme was carefully sequenced and validated through practical implementation in three learning programmes and by 14 national and international experts. Evidence from practical application of what was taught was identified to illustrate that improvement in nursing practice had occurred. Finally, Boyer's scholarship research and AACN scholarship standards were used to triangulate the research results and scholarship was verified. In Chapter 5 the research synthesis is provided, conclusions are drawn and recommendations are made.

CHAPTER FIVE: RESEARCH SYNTHESIS, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

In Saudi Arabia, the public's discourse with regard to the nursing profession and professional nurses is relatively young, particularly as far as Saudi nurses are concerned. It is also formed within a particular socio-political-economic context, which includes the integration of the Muslim religion within the people's culture, norms and beliefs, as well as certain expectations of gender roles and behaviours and a long-term dependency on a multinational nursing workforce. This discourse is further influenced by globalisation, in particular exposure to the information revolution, new medical technologies, health care reform, demands from international bodies (e.g. the International Council of Nurses, the Gulf Cooperative Council, the World Health Organisation, the World Trade Organisation, the International Standards Organisation and Joint Commission International), and more knowledgeable consumers of health services.

Throughout the world there is a growing interest in and demand for evidence-based decisions in health care, particularly with regard to patient safety, quality improvement and consumer involvement in health policy. Recommendations coming from international organisations such as those mentioned above are generally based on the latest research. Nurses and other health professionals are very much part of this scenario. The public expects them to provide quality services, continue their professional development and use evidence to support their decisions. The language of accountability, transparency and evidence-based outcomes is increasingly found in the documents of regulatory boards, conference presentations and day to day practice. Working as a nurse educator and researcher in Saudi Arabia has therefore provided a unique perspective from which to research the problem with regard to the learning programme for continuing professional development for nurses working in Saudi Arabia.

This dissertation is divided into five chapters. In Chapter 1 an overview of the research was described. The findings of a literature review in relation to continuing professional development of

nursing were presented in Chapter 2. In Chapter 3, the research design and methodology was outlined. The development, operationalisation, validation and evaluation of a continuing professional development learning programme for nurses working in Saudi Arabia was articulated in Chapter 4. The purpose of this final chapter (Chapter 5) is to synthesise the research, draw conclusions, and offer recommendations.

5.2 RESEARCH SYNTHESIS

The Saudi government has implemented a nation-wide policy to prepare its people for the workforce and has directed that the Saudi Council for Health Specialties (SCHS) be established. Under the SCHS umbrella the Saudi Nursing Board (SNB) has been formed for the purpose of regulating the nursing profession. Henceforth, the Saudi nursing profession has a responsibility to develop its social mandate and provide a full range of services to the Saudi public. Systems and education programmes are required for all aspects of the regulatory process, including continuing professional development (see Chapter 1: Section 1.2). Effective regulation systems are not based on a "one size fits all" approach. Furthermore, nurses need to insist on high quality education to develop both basic and ongoing competence and should be able to depend on the profession for social status and credibility (see Chapter 2: Section 2.4.1.1).

It is an opportune time in which to establish a Saudi Arabian nursing regulation system, as according to Bryant (2005) health professional regulatory systems are being examined worldwide. The primary function of the SCHS is to protect the public. Some researchers (Moore & Picherack, 2003) argue for a balance between the broader public interests and the public protection mandate. In the case of Saudi Arabia, broader public interests include the role and behaviours of women and men within the society. As SNB and other health professional regulators are ultimately responsible and accountable for health professionals' practice, they need to balance social interests with requirements for competent practice to ensure that quality services are available to match the population's health needs (WHO, 2001). Simultaneously, the respective regulatory boards/councils and employers are responsible and accountable to ensure that the public (patients) are protected from unsafe health professional practices (see Chapter 2: Section 2.4.1.2 ii).

As explained in Chapter 1: Section 1.1, Saudi Arabia has for many years been dependent on the international community for its nursing workforce. One downside to international migration is that nurses are not all educated from the same or similar standards of practice nor are they all held equally accountable for their continuing professional development. Thus one challenge for the SCHS and SNB is to ensure that practice standards are developed and maintained and competency development continues, since ultimately nursing practice affects the quality of patient services (see Chapter 2: Section 2.4.3.1).

The purpose of the research was to develop, implement, validate and evaluate a continuing professional development learning programme for nurses working in Saudi Arabia. The learning programme was built from a vision of nurses (regardless of country) engaging in lifelong learning for the purpose of ensuring quality patient care (population health). Implementation of the full research strategy is represented in Figure 5.1. Research outcomes are summarised in the next section.

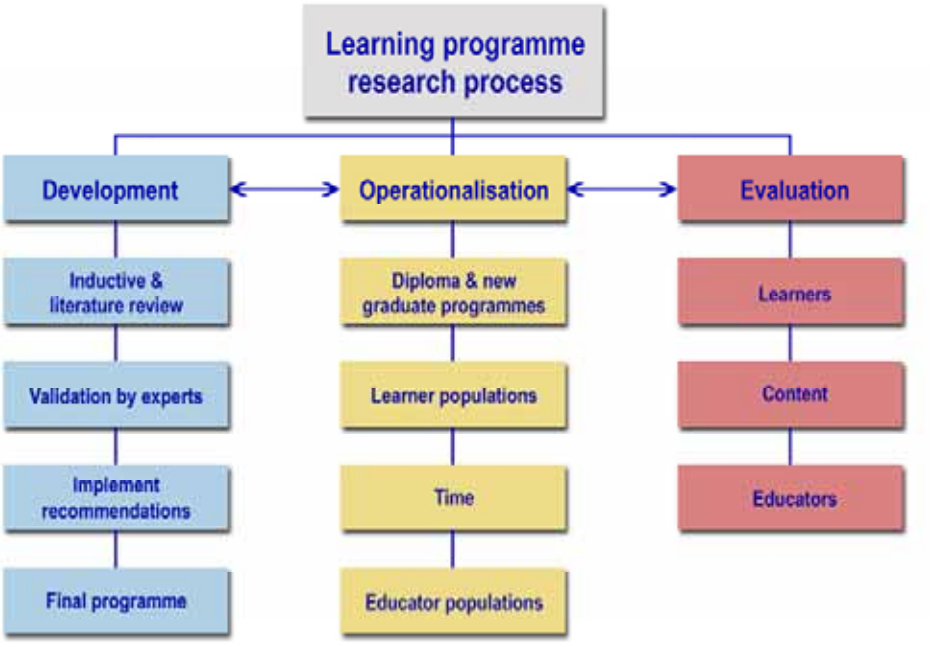

Figure 5.1 Research process – learning programme

5.2.1 Research outcomes

The research was conducted in two phases with the aim of accomplishing four outcomes. In the initial phase, the outcome (Phase I: Outcome I) was the inductive development and implementation of a provisional continuing professional development learning programme. A provisional learning programme was designed between September 2002 and November 2004, using a continuous iterative learning process (see Chapter 4: Figure 4.1). The programme arose from Botes' (1998, 2000) first order (see Chapter 3: Section 3.3.2), and specifically entailed nursing education practised within a tertiary hospital in Saudi Arabia. It was operationalised through three different programmes (the leadership and management diploma, the nursing education diploma, and the new graduate programme) and continuously evaluated (see Chapter 4: Section 4.4.2).

An extensive literature research on the phenomenon of continuing professional development in nursing was undertaken (see Chapter 2: Section 2.4). The structural base of the provisional learning programme was formed by using the ICN (2003) competencies framework for the generalist nurse (see Chapter 4: Figure 4.2), Canadian practice standards (see Chapter 4: Section 4.4.1.1), learning outcomes (see Chapter 4: Sections 4.4.1 and4.4.1.1) and empirical indicators (see Chapter 2: Tables 2.14 a, b and c).

Validation of the provisional learning programme (Phase II: Outcome II) was achieved. A semi-structured questionnaire (see Appendix A) was e-mailed to 14 experts (one of whom declined and the other was unable to respond within the required timeframe) and a hard copy was given to the last two experts who participated in the validation process. Expert respondents rated the programme's content and format using either a four point Likert scale or a yes or no response to structured questions. Their mean scores ($\overline{X}$) ranged from a low of 3 to a high of 3.9 (see Chapter 4: Section 4.4.3.2). As a mean of 3 is regarded as acceptable (Lynn, 1986), the collective results authenticated the learning programme. The experts' comments were compiled (see Appendix C) and analysed in relation to data results and triangulation of findings (see Chapter 4: Section 4.4.3.2 j) and required changes to the programme.

The third outcome (Phase II: Outcome III) was the learners' evaluation of the programme content and teachers and the completion of the learning programme. Suggestions from the experts were considered when conducting the evaluation, finalising the learning programme and analysing research results. With the exception of one, the experts' comments were primarily at the level of clarifying and explaining terms and concepts (see Appendix C). Based on the experts' feedback, two additional appendices were added: one containing the empirical indicators identified in the literature research (see Chapter 2: Tables 2.14 a, b and c) and the other in relation to the provision of culturally sensitive nursing care to Saudi patients (see Appendix F). The latter was reviewed by two professional Saudi nurses who worked at the hospital where the research was conducted.

King's Theory was used to holistically frame the learning programme within an open national and global system consisting of individuals, groups and communities (see Chapter 3: Section 3.3.3.4 i, ii and iii). The ICN framework for competencies (see Chapter 4: Figure 4.2) was also used to: organise the literature review (see Chapter 2: Figure 2.1); identify the empirical indicators (see Chapter 2: Tables 2.14 a, b and c); and synthesise the literature population (see Chapter 3: Tables 3.6 a, b and c).

The final outcome (Phase III: Outcome IV) was the preparation of an article, on the research outcomes, which is to be submitted to a peer review journal. The overall outcome (goal) of the research was functional by nature in that the knowledge of continuing professional development in nursing was generated and applied to nursing practice in Saudi Arabia. In the following section the research design and methodology is summarised.

5.2.2 Research design and methodology

The research was undertaken to answer the question: What should the contents be of a learning programme for the continuing professional development of nurses working in Saudi Arabia? Due to the nature of the question, a mixed methodology was selected (see Chapter 3: Section 3.3.2). As the qualitative aspect was dominant and both qualitative and quantitative methods were used simultaneously, the design was QUAL + quan (Morse, 2003). The design included exploratory and descriptive aspects. The researcher employed qualitative methods to develop, implement and

evaluate the learning programme, and quantitative methods to validate the provisional programme This resulted in a partial explanation of the research phenomenon (see Chapter 4: Section 4.4.4). The primary theoretical drive was inductive, as the purpose was to discover rather than to test the learning programme contents (Morse, 2003). In his model for scholarship, Boyer (1990) identified discovery as the initial step. Mixed methods design supported the convergence of the different facets of the research phenomenon enabling a fresh perspective, while broadening and transforming the research scope (see Chapter 4: Section 4.4.5 and Table 4.18).

Donabedian's (1986) theoretical base (outcomes, structure and process) was integrated with the scientific nursing process steps (assessment, planning, implementation and evaluation) and linked to the respective research outcomes and processes to realise the research strategy (see Chapter 3: Section 3.3.2.2 and Table 3.5). The researcher utilised the Botes' Research Model (1998, 2000) (see Chapter 1: Figure 1.1) and King's Theory of Goal Attainment (1995). King's Theory entails a holistic open system perspective of the health of individuals, groups and communities within dynamic and interacting environments (personal, interpersonal and societal). Within these open systems, learners and educators interact with the internal and external stressors and utilise various transactions (e.g. assessing, teaching, preceptoring, evaluating, counselling, mentoring, reflective practice, and celebrating) to reach mutually agreed upon learning outcomes (goals). (See Chapter 3: Figure 3.4.) The Theory was used to describe Botes' first order (see Chapter 3: Section 3.3.1 and Table 3.2), second order (see Chapter 3: Section 3.3.2), and third order (see Chapter 3: Section 3.3.3). It was also used to identify paradigmatic assumptions and to guide the design of the learning programme. The Model and Theory complemented each other as they support a comprehensive, dynamic scientific approach to learning (health) outcomes influenced by the quality of nursing practice and practice environment (personal, interpersonal, and societal).

The research was outcomes-based with the quality of patient care (population health) and nursing practice situated within a context of an emerging nursing regulatory system as overriding constructs. Outcomes-based education did not appear to be understood by all of the experts (see Chapter 4: Section 4.4.3.2). King's theoretical paradigm helped the researcher connect strategies of inquiry with the empirical indicators. She was thus able to move between Botes' (1998, 2000) three orders – the paradigmatic, empirical (research) and practice spheres (see Chapter 1: Figure

1.1). The researcher read extensively (see Chapter 2: Section 2.4) and through dialogue with her mentor, learners and others and a continuous process of reasoning (inductive, deductive, derivation, analysis, synthesis, and critical reflection) came to a deeper realisation of what should be included in the learning programme. Theory development occurred as knowledge of continuing professional development was generated and applied to practice.

Throughout the design and writing processes, the researcher incorporated fundamental values, beliefs and assumptions (Tashakkori & Teddlie, 1998). The researcher is a Canadian nurse and a Christian, practising as an educator while conducting her doctoral research in a multinational health organisation (tertiary hospital) in Saudi Arabia, which is a Muslim country.

There were 89 research participants. While the majority in the two diplomas was nurses, a small minority (four) was from three different disciplines and had varied personal and professional experiences. All learners in the new graduate programme were from Saudi Arabia. All were bachelor prepared, some had received their nursing education outside of the country (in Jordan and the USA) and all had minimal to no prior experiences. Altogether, the research participants came from a total of 14 countries: Saudi Arabia, South Africa, the USA, the United Kingdom, Malaysia, the Philippines, Palestine, Egypt, Lebanon, Columbia, Australia, Ireland, South Korea and Canada. The 14 experts came from a total of six countries (Saudi Arabia, the USA, South Africa, Australia, Egypt and Canada). The two academic advisers came from South Africa. One worked at a university in that country, while the other worked in the hospital where the research was conducted (see Chapter 4: Section 4.4.2). Thus there were multiple realities, since the researcher, learners, experts and academic advisers came from and worked in multiple environments, had differing education preparation and were from varying cultures and had been exposed to different cultures and various kinds of life experiences. Their collective professional practice experiences varied from novice to expert (Benner, 1984). Additionally, the hospital where the research was conducted was built from a western care delivery model and had recently (March 2005) been accredited for the second time by the Joint Commission International (JCI), which is an external accreditation body based in the USA.

The original plan to continue using the Delphi technique to reconfirm the provisional Learning Programme content and format was not necessary as the data findings were similar (see Chapter 4: Section 4.4.3 and 4.4.5). Research data were integrated at the interpretative phase and axial and selective codings (see Chapter 3: Section 3.3.2.2 i d) were used in the data analysis. While the research was conducted from an emic (insider) perspective, an outsider (etic) perspective was used when deducting and synthesising the literature and quantitative data. King's Theory (1995) was utilised to explain the relationships between variables and thus increased the explanation credibility (McMillan & Shumacher, 1997). Translation fidelity (McMillan & Shumacher, 1997) was increased with the incorporation of the empirical indicators and the researcher's experiences teaching in the three programmes (see Chapter 4: Sections 4.4.1, 4.4.2 and 4.4.4).

As the researcher established rapport and trust with the research participants, she enhanced content validity from an emic perspective. As the programme evaluation was formative and summative (Mouton, 2001) and the programme was validated by 14 experts, it was easier to achieve the four research outcomes (see Chapter 4: Section 4.4). Boyer's Model (1990) and AACN (1999d) standards were used for results triangulation (see Chapter 4: Section 4.4.4 and Table 4.18.), enabling the scope of the research to broaden and evidence of scholarship to emerge. The data results were reviewed by a statistician/researcher, and an English language consultant reviewed the language and format of the thesis. Initially the dissertation was scrutinised by the academic advisers and later examined by an examination panel. Ethical approval was granted by a senior hospital administrator as the research was educative in nature and did not directly involve any patients. As data saturation was reached within the similarity of the questionnaire results (see Chapter 4: Section 4.4.3), trustworthiness (truth value/credibility, applicability/transferability, consistency/data dependability, neutrality/reliability confirmabiltiy) (Lincoln & Guba, 1985) of the research findings was confirmed. Limitations from the research are identified in the following section.

5.2.3 Limitations of the research

From an emic perspective, the researcher was not a disembodied observer in the research process and this could have been a limitation of the research. Her presence influenced the interactions and

thus bias may have occurred due to her involvement. Whenever the Arabic-speaking learners found it difficult to communicate in English, the learning experiences were curtailed.

As the Arabic-speaking learners became more confident and proficient in English and were able to understand the various accents (including the researcher's), they shared stories of not being understood and how they were unable to explain their actions or decisions to non-Arabic speakers. This difficulty with language may have been one reason why new graduates had problems internalising and integrating ethical, legal and professional aspects of nursing practice (see Chapter 4: Section 4.4.4.4 and Table 4.18). In the next section, conclusions are drawn and recommendations are offered.

5.3 RESEARCH CONCLUSIONS AND RECOMMENDATIONS

The purpose of this section is to draw conclusions from the research findings and to identify recommendations. Future research hypotheses are also offered.

5.3.1 Nurses' (individual) self-regulation and leadership responsibilities

The onus is on nurses to practise within the boundaries of ethical, legal and professional standards thereby demonstrating their professionalism (see Chapter 2: Section 2.4.1). Nurses who are working in the Kingdom of Saudi Arabia are required to register with the SCHS, to continue their professional development and have verified proof when re-registering. Non-Saudi nurses must maintain the professional nursing registration of their home country. Although the SNB has adopted the Gulf Cooperation Council (GCC) Code of Conduct for Nursing (Khoja, nd), practice standards have yet to be formulated (see Chapter 1: Section 1.2). Achieving and sustaining competence-based practice require structured-practice-based learning programmes (see Chapter 2: Section 2.4.2). Such programmes must include all four domains (clinical/community, educational, management and research) of nursing practice and ideally support nurses to implement learning into their daily practice rather than simply teaching them theory (see Chapter 4: Section 4.4.3.2).

Additionally, Saudi nurses have a number of barriers to overcome, including communicating in English. Mixing of the genders is very uncommon in Saudi society, therefore it can be (and often is) very stressful for Saudi nurses to care for patients of the opposite sex as they learn how to become professionals in a mixed gender workforce. Another finding from the research was that new graduates were not fully ready in relation to ethical, legal and professional aspects of their practice and thus the legislative aspect of the central theoretical assumption was not upheld for them (see Chapter 4: Section 4.4.4.4). New graduates benefited from the transition programme (Chapter 4: Section 4.4.4.2). However, it was important when designing, implementing and evaluating the Learning Programme not only to respect the local culture and resulting social relations, but to critically analyse the impact of these relations on the workplace and to determine how best to manage them within a particular organisation and specific nursing department.

Further, as the majority of nurses in Saudi Arabia are employees, nurse managers and educators have a leadership responsibility to establish continuing professional development programmes to achieve organisational outcomes including quality patient care and effective human resources management. Nursing leaders are obliged to act as active role models in continuing professional development and career management. Structured learning programmes supported initial and ongoing competent practice (see Chapter 4: Section 4.4.2). However, nurses providing direct patient care in the clinical or community settings, educators, preceptors, mentors and managers need to be educated with regard to their particular role and responsibilities for continuing professional development (CPD) (see Chapter 4: Sections 4.4.3, 4.4.4, and 4.4.5; and Table 4.18). Based on the authentication of the provisional Learning Programme and the research conclusions, the following recommendation is made. (See Table 5.1 for an overall summary of the conclusions, supporting evidence and recommendations.)

Recommendation One:

- *It is recommended that the Continuing Professional Development Learning Programme be utilised by all nurses working in Saudi Arabia.*

Table 5.1: Research conclusions, supporting evidence and recommendations

Research conclusions	Supporting evidence	Recommendations	Future research hypotheses
▪ The onus is on the nurse to practise within boundaries of ethical, legal and professional standards ▪ SCHC and SNB require nurses to continue their professional development and acquire verified proof when re-registering ▪ Competency-based practice requires structured-practice-based learning programmes ▪ CPD programme should be designed to support nurses to implement theory into their respective practice (praxis) ▪ New graduates benefit from a structured transition programme ▪ Regardless if nurses are clinicians, managers, educators or researchers, they need to be professionally educated and held accountable for fulfilment of their CPD responsibilities	▪ Chapter 2: Section 2.4.1 ▪ Chapter 1: Section 1.1 ▪ Chapter 2: Section 2.4.2 ▪ Chapter 4: Section 4.4.4.1 ▪ Chapter 4: Sections 4.4.3, 4.4.4, 4.4.5; and Table 4.18 ▪ Chapter 2: Section 2.4.1.2	▪ *The CPD Learning Programme be utilised by all nurses working in Saudi Arabia*	▪ *When OBE is used to deliver CPD Learning Programmes, it leads to improvement in the nurse learner's competence* ▪ *Such programmes equip nurses with the ability to self-direct their learning and self-regulate their practice* ▪ *Sharing research evidence inter-professionally regarding nurses' contribution to patient care (population health) vastly improves the image of nurses in the organisation, community and country increasing the retention and recruitment of Saudi nurses into the profession and workplace*
▪ SNB have not yet articulated practice standards ▪ Currently new graduates are prepared at varying levels of standards ▪ Educational standards are essential in assessing programme outcomes, determining levels of expected performance (novice to expert) and protecting the public and remaining responsive to their changing health needs	▪ Chapter 1: Section 1.2 ▪ Chapter 4: Section 4.4.4.1 ▪ Chapter 2: Section 2.4.2.1	▪ *Based on the research findings and Learning Programme, additional structures including practice standards be implemented to support initial and continuing professional development*	▪ *Implementation of the Learning Programme as part of professional regulation and quality improvement processes improves the quality of nursing education thus indirectly influencing patient and organisational outcomes*

▪ Quality workplaces are critical for:
  ▪ learning
  ▪ retaining motivated and competent staff
  ▪ delivering quality patient care and
  ▪ achieving positive organisational outcomes
	▪ Chapter 2: Section 2.4.2.4
	▪ Chapter 2: Table 2.14 c
	▪ Chapter 4: Section 4.4.4.1
		▪ *All health sector employers promote and support healthy workplaces as a priority, incorporating the concept as part of the organisation's vision and mission, strategic outcomes, related policies, mechanisms and human and material resources*	▪ *Patient care and organisation outcomes are improved when there is a quality workplace and linkages are made between standards, competency development, evidence based practice, CPD, healthy workplace and effective regulation systems.*

In the next section, recommendations are made for the nursing profession self-regulation responsibilities, in particular full establishment of the regulatory system of the SNB.

5.3.2 Nursing profession's self-regulation responsibilities

Currently (Decemeber 2005), there are no national standards for nursing practice, hence curricula and hours of practical experience for nursing students vary greatly. Without national practice standards, there is no uniform approach to assessing nursing education and nurses' practice and ensuring that the public will receive competent nursing care throughout Saudi Arabia. New graduates, for example, who participated in the research, were prepared in three different countries with differing lengths of studies, practice hours and academic requirements (see Chapter 4: Section 4.4.4.1).

Multiple types of programmes without a common set of practice standards can have a negative effect on patient care delivery (WHO, 2001). Nursing curricula based on the medical model stressing individual and curative hospital care, fail to prepare nurses to respond to the holistic and changing health needs of the Saudi population. A quality nursing education approval system assures that nurse graduates have met specific criteria and that their nursing education remains current, progressive, and responsive to the changing needs of the public (ICN, 1997). Further educational standards can be used to assess professional educational programmes outcomes and thus protect the public (see Chapter 2: Section 2.4.2.1). Based on the above research conclusions and the authenticated Learning Programme, the following recommendation is made.

Recommendation Two:

- *It is recommended that additional structures including practice standards be implemented to support initial and continuing professional development.*

In the next section, conclusions regarding the importance of a healthy (quality) workplace environment are drawn and a third recommendation is identified.

5.3.3 Healthy (quality) workplace environments

Quality workplaces are critical for learning, retaining motivated and competent staff, delivering quality patient care and achieving positive organisational outcomes. Quality practice environments were identified in the literature review (see Chapter 2: Section 2.4.2.4) and surfaced as a key empirical indicator (see Chapter 2: Table 2.14 c). One group in the education diploma programme (2004-2005) became interested in the concept of quality workplace and decided to do their research project on workplace violence. Their research results are forthcoming. Furthermore, diploma learners stressed that being within a supportive environment helped them in their learning and continuing professional development (see Chapter 4: Section 4.4.4.1).

Based on the above research conclusions, the following recommendation is made.

Recommendation Three:

- *It is recommended that all health sector employers promote and support healthy workplace as a priority, incorporating the concept as part of the organisation's vision and mission, strategic outcomes, related policies, mechanisms and human and material resources.*

In the next section, future research hypotheses are identified.

5.3.4 Future research

Recommendations for future research are based on the overall conclusions and include the assessment (testing) of the following hypotheses:

- When outcomes-based education (OBE) is used to deliver continuing professional development learning programmes, it leads to improvement in the nurse-learner competence, thus indirectly influencing patient and organisational outcomes. Such programmes equip nurses with the ability to self-direct learning and self-regulate practice.
- Implementation of the Learning Programme as part of quality improvement processes improves the quality of nursing education thus indirectly influencing patient and organisational outcomes.

- Sharing research evidence inter-professionally regarding nurses' contribution to patient care (population health) vastly improves the image of nurses in the organisation, community and country, thereby increasing recruitment and retention of Saudi nurses into the profession and workplace.
- Patient care and the organisation's outcomes are improved when there is a quality workplace and linkages are made between:
    - nursing practice standards;
    - competency development;
    - evidence-based practice;
    - continuing professional development;
    - healthy workplaces; and
    - effective regulation systems.

This chapter is summarised in the final section.

5.4 CHAPTER SUMMARY

This research came out of practical experiences of developing, operationalising and evaluating a continuing professional development learning programme in a health organisation (tertiary hospital and research centre). The purpose of this research was to answer the following question: What should the contents be of a continuing professional development learning programme for nurses working in Saudi Arabia?

As the Learning Programme was developed from the researcher's practice, the primarily theoretical drive was inductive. A competence framework, standards of practice, and empirical indicators were drawn from the literature research to structure the content, processes and outcomes of the provisional Learning Programme. The Learning Programme format was outcomes-based education. The researcher was mentored by one of her advisers, a nurse expert in the fields of intensive care, infection control, standard development, quality improvement, education and research. Both taught in the three programmes in the hospital where the research took place. As knowledge of continuing professional development was continuously generated and applied to

practice, theory development occurred. The provisional Learning Programme was validated by 14 international experts from six different countries. The experts collectively authenticated it, with the exception of one individual. Based on their comments minor changes were made.

The research methodology utilised was mixed methods with the qualitative aspect dominating the quantitative (QUAL + quan). King's Theory was used to move between practice, research and paradigmatic spheres found with Botes' Research Model. The research provided an opportunity to test Botes' Research Model in a country other than South Africa and added to the body of literature related in general to continuing professional development and specifically to reflective practice as a source for gathering research evidence. The provisional Learning Programme was implemented in three programmes with a total of 89 research participants. It was continuously evaluated and integrated into nursing education practice.

While the research context was local, it was also global as the quantitative component happened in four different countries. Hence the Learning Programme is adaptable and flexible enough to fit within any department and health organisation and within all domains of practice, since the learners were nurses and non-nurses, came from 14 countries and had varied levels of life experience. As the programme is comprehensive, it could be used as a planning framework within respective departments, organisations and national regulatory boards.

Boyer's model for scholarship (1990) and nursing education scholarship standards (AACN, 1999d) were utilised to triangulate the research results. The scope was expanded, the four research outcomes were realised and scholarship was demonstrated.

This research is unique in that it was conducted both locally and globally and included nurses and other professionals from 14 countries. Nurses have a profession, ethical and legal responsibility and accountability to do the right thing. It is essential for nurses to base their practice on standards and evidence in order to facilitate quality nursing practice. Nurses working in Saudi Arabia are also responsible and are held accountable for continuing their professional development. Regardless of which country they work in, nurses require quality workplaces and need to work collaboratively with

other health professionals and within other disciplines in order to provide quality service to their patients.

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7. APPENDICES

7.1 Appendix A: Semi-structured questionnaire

PURPOSE OF THE QUESTIONNAIRE: To gain your expert opinion (written documentation) on the attached Learning Programme for the Continuing Professional Development for Nurses Working in Saudi Arabia. Your responses will not be linked with your name or other identifiable personal data. Your true evaluation and recommendations are very much appreciated.

QUESTIONNAIRE SECTIONS:

- Section A asks Biographical Data
- Section B focuses on the Content of the Learning Programme
- Section C relates to the Format of the Learning Programme

INSTRUCTIONS:

- Please completed each questions using a ✓ and/or provide brief response/comment
- Your recommendation/ opinion can be given within the comment sections and/or at the end

SECTION A. BIOGRAPHICAL INFORMATION

1.1 What is your highest educational level?

	Yes	No
Master Degree Level		
Doctoral Degree Level		

1.2 Your specific qualifications:

_____

_____

1.3 If you are a nurse, in what country do you hold a current nursing registration/licensure?

Country	Yes	No
Saudi Arabia		
Canada		
South Africa		
United States		
Other (please identify)		

1.4 In which country are you currently working?

Country	Yes	No
Saudi Arabia		
Canada		
South Africa		
United States		
Other (please identify)		

1.5 Please indicate your areas of expertise

Area	Yes	No
Nursing Practice		
Higher Education		
Curriculum Development		
Outcomes Based Education		
Continuing Professional Development		
Career Management		
Regulation [Policy]		
Accountability		
Other (please identify)		

1.6 In which type of organization or area do you work?

Organization/ Area	Yes	No
Health Region		
Hospital		
Community Health Organization		
University		
Private Consultant		
Nursing Council/ Association		
Other (please identify)		

SECTION B: LEARNING PROGRAMME CONTENT

1. Using a scale from 1-4 with 1 being the least and 4 being most, do you believe the INTRODUCTION of the Learning Programme to be applicable?

Scale	1	2	3	4
Applicable				

2. If you have answered 1 or 2, please motivate your answer:

_____
_____

3. Is the CONTEXT FOR PRACTICE clearly defined?

Yes	No

Comment: _____
_____

4. Using a scale of 1 to 4 with 1 being the least and 4 being most: Is the section on the ICN COMPETENCIES FRAMEWORK relevant to the Learning Programme?

Scale	1	2	3	4
Relevant				

Comment: _____
_____

5. Learning Programme

5.1 Are the **Practice Standards** inclusive of all domains of nursing practice: clinical, management, education and research?

Yes	No

Comment: _____
_____

5.2 There are three sets of **Learning Outcomes** in the Learning Programme:

i) On a scale of 1-4 with 1 being the least and 4 being most is the **Overall Outcome**:

	1	2	3	4
Clear				
Understandable				
Realistic				
Demonstrable				

Comment: _____
_____

ii) On a scale of 1-4 with 1 being the least and 4 being most are the **Critical Outcomes**:

	1	2	3	4
Clear				
Understandable				
Realistic				
Demonstrable				

Comment: _____
_____

iii) On a scale of 1-4 with 1 being the least and 4 being most are the **Exit Outcomes**:

	1	2	3	4
Clear				
Understandable				
Realistic				
Demonstrable				

Comment: _____
_____

5.3 Do you believe that the **Programme Design** will facilitate the stated learning outcomes?

Yes	No

Comment: _____
_____

6. Evaluate the following aspects of the Learning Programme on a scale of 1-4 with 1 being the least and 4 being most:

Aspects	1	2	3	4
Duration				
Learner Responsibilities				
Teaching Approach & Methods				
Personnel Involved				
Learner/ Nurse Assessment				
Coordinator & Presenter Assessment				
Learning Programme Reviewers				

7. Using a scale from 1-4 with 1 being the least and 4 being most, determine the relevance of the Practice Standards:

Relevance of:	1	2	3	4
Responsibility & Accountability				
Code of Ethics				
Self-Regulation				
Competent Application of Knowledge, Skills & Judgment				
Professional Relationships & Advocacy				
Professional Leadership				
Continuing Professional Development				
Quality Improvement & Evidence Based Practice				

8. On a scale of 1-4 with 1 being the least and 4 being most are the Specific Outcomes:

	1	2	3	4
Clear				
Understandable				
Realistic				
Demonstrable				

Comment: _____
_____

9. On a scale of 1-4 with 1 being the least and 4 being most, does the content for the Standard Criteria fulfill the criteria for knowledge, skills, values, attitudes and judgment required for a competent nurse?

	1	2	3	4
Content Fulfills				

Comment: _____
_____

10. According to your expert opinion, is the **Standard Range** section complete

Yes	No

Comment: _____
_____

11. According to your expert opinion, would the learner **embed sufficient knowledge** to support competent practice?

Yes	No

Comment: _____
_____

12. According to your expert opinion, would the **Practice Assessment** section help to facilitate the demonstration of a competent nurse?

Yes	No

Comment: _____
_____

13. Do you consider the **References** and **Appendices** to be:

	Yes	No
Current		
Relevant		

Comment: _____
_____

SECTION C: TECHNICAL FORMAT OF LEARNING PROGRAMME

14. Please assess the **technical format** of the Learning programme using the scale 1-4 with 1 the least and 4 being most::

	1	2	3	4
Clear				
Logical & organized				
Overall				

Comment: _____
_____

Thank you for taking the time to answer this questionnaire
Your expert opinion and recommendations are greatly appreciated

7.2 Appendix B: Letter to experts

December 10, 2004

Dear Research Participant:

I am currently a PhD student at the University of Stellenbosch, South Africa. My academic supervisors are Dr. Thelma van der Merwe, RN and Dr. Chris Kapp from the Department of Higher Education, University of Stellenbosch. My research focus is to develop, implement and evaluate a "Continuing Professional Development Learning Programme for Nurses Working in Saudi Arabia". Thank you for agreeing to provide your expertise in evaluating the provisional learning programme. The selection requirement to participate in this study is an individual who has been educated at least at the master's degree level with expertise in one or more of the following fields:

- Nursing practice
- Adult education
- Curriculum development
- Outcomes based education
- Regulation and credentialing
- Continuing professional development.

Attached with this letter you will find a copy of the provisional learning programme (curriculum) and a semi-structured questionnaire to guide your evaluation of the learning programme. A nurse research colleague tested the questionnaire and reported it took one hour to complete.

The purpose of seeking your expert opinion is for validation of the programme content. Expert validation has been requested from the following countries: Canada, South Africa, Saudi Arabia, United States of America (USA) and as well at the international level.

To enhance the ethical standards for nursing research, I will endeavour to do the following:
- Respect the wishes of those who decide not to participate
- Allow all expert participants to influence the work
- Ensure the development of the learning programme remains transparent and open to suggestions from others

May I please have your opinions and recommendations back by or before the middle of February 2005, via one of the following email addresses:
- mollie_butler@hotmail.com
- mbutler@kfshrc.edu.sa

Thank you once again for supporting my PhD research, your time commitment and expertise is greatly appreciated.

Yours respectfully,

Mollie Butler
(Promovendus)

7.3 Appendix C: Compilation of experts' comments from questionnaires

On their respective questionnaires, the respondents provided the following comments.

Question 1

Although no one scored question 1 less than 3, respondents' comments were as follows:

- Respondent one: Does this apply to the new grad who may not have established a baseline knowledge base?
- Respondent three: End of 3rd paragraph please explain current level of practice.
- Respondent five: The link between CPD and continuing competence could be made more clearly. One is a professional obligation; the other is a licensing requirement. This first can exist without the second. The continuing competence program can be "one size fits all". However, the way in which the requirements are met do not have to be "one size fits all". While the design need to accommodate the individual nurse's current level of practice, its needs to provide for room for growth especially if the nurse has competence to practice issues.

Question 3

All respondents considered the practice context (question 3) to be clearly defined. Verbatim comments under this question were as follows:

- Respondent one: Suggest more discussion on the religion and geopolitical climate and its influence. Also e-education issues (as in distance education and online programs) are not currently recognized.
- Respondent two: This is very helpful context and helps the reader to place the rest of your proposal within a framework since I am not familiar with the setting or the challenges presented in such a context
- Respondent three: In the 2nd to last paragraph – please explain from whom non western nurses are waiting to take direction – Also I do not know what you mean by the statement " the norm is to initiate action from other team members". As well who has made the assumption that all nurses should be able to demonstrate western formulated competence within 90 days and how will this assumption be modified?

- Respondent four: Is it the ability to demonstrate Western formulated competence or the "90 day period" that is no longer valid?
- Respondent five: Excellent overview.
- Respondent six: May be helpful to elaborate on the type of proof required for license renewal.
- Respondent eleven: An extremely important part of this research. It is the uniqueness of this population that lends to this research. A good review.

Question 4

Verbatim comments with question 4 were as followed:

- Respondent one: I'm not clear on the adapted framework and how it includes the four domains.
- Respondent three: Found sentence top of page 3 confusing I am not sure what you mean nurses…have to be aware …prepared, competent and confident.
- Respondent four: On page 3, the statement that "health organizations also have a responsibility to define roles and competencies for nurses…" may create confusion – it might be clearer to state that the responsibility is to define roles/job descriptions that are consistent with the competencies and scope of practice of nurses. For example, one of the issues we encountered in (name of Canadian province removed from text) is employers trying to dictate scope and/or competencies – nurses need to understand that employers have the right to define jobs but it is up to the self-regulated professional to ensure that she/he had the competency and "authority" (through scope) to take on a specific role!
- Respondent five: While it is relevant, the link between the framework and OBE was not as clear as it might be in this section. It is clearer in the section on the specific standards. The ICN framework was adopted to reflect the domains of practice but it is not clear in the diagram. Also the framework now addresses "quality practice" to reflect standard of excellence whereas standards referenced to (name of regulatory body removed) relate to the minimum standard. It should be clarified as to which is the expectation.
- Respondent six: Comprehensive framework which seems relevant to an environment employing nurses from many countries.
- Respondent nine: Strong foundation with excellent adaptation.
- Respondent ten: Excellent.

- Respondent eleven: From my understanding, the ICN competency framework is the "backbone" of the learning programme. Extremely relevant.

Question 5.1

Verbatim comments to question 5.1 were:

- Respondent one: Do not see linkage between research and practice.
- Respondent two: As you know – these are very broad standards so can apply to all contexts- the trick is to get everyone to understand the concept.
- Respondent three: Nurses working in community or clients homes would not identify themselves as clinical practice. You may want to use clinical/community.
- Respondent eleven: I can not think of any you have not addressed.

Question 5.2 i

Verbatim comments for this question were:

- Respondent two: this is clear and well done.
- Respondent three: I do not know what you mean by country practice standards and suggest that you use country of origin standards or national standards.
- Respondent four: The challenge will be to design the programme in a way that allows for demonstration that the nurse has internalized standards – this may require more elaboration in the programme description.
- Respondent thirteen: Please refer to my previous comments (see section 4.4.3.2 l) in using a behaviouristic approach to setting outcomes.

Question 5.2 ii

Verbatim comments with this question (5.2 ii) were:

- Respondent one: Didn't see accountability mentioned and unclear about self regulation.
- Respondent two: Again – I find this to be very clear and logical.
- Respondent three: All critical outcomes with the exception of Principles guided by self and the profession I would score at 4. Need to be restated.
- Respondent four: The expectation regarding "self-regulation" may not be clear to everyone – it is clear in the summary on p. 12.

- Respondent five: See my comment on the document (the researcher did not find any other comments).
- Respondent thirteen: See above comments (referring to comments under question 5.2 i).

Question 5.2.iii

In relation to the exit outcomes, verbatim comments were as follows:

- Respondent two: I think this is again clear and logical from the perspective of setting learning outcomes. The challenge is that we often can only measure some of these things in their absence. Often proxy measures need to be used to determine whether this has happened and finding the right "proxies" will be interesting in a multicultural population (e.g., adhering to ethical standards is usually only observed in the negative situation where it is evident that a nurse did not do so).
- Respondent four: What is intended by "best care/service"?
- Respondent five: There is some overlap between the exit outcomes
- Respondent six: The outcomes will require evaluation tools with indicators of success

Question 5.3

Verbatim comments with question 5.3 were as follows:

- Respondent one: Theoretically yes. But realistically only if resources are provided.
- Respondent three: I do not know what you mean by the term embedded knowledge. I find the term confusing and redundant. Either individuals have knowledge or they don't.
- Respondent four: Success is highly dependent on a self-directed learning style and the individual embracing accountability for own practice
- Respondent five: Definitions of the components would facilitate easier understanding of the design.
- Respondent nine: Design is clear and concise.
- Respondent ten: Well thought through programme design.
- Respondent eleven: It will be challenging but definitely accomplishable (is that a word?) with the learning outcomes detailed.

Question 6

Verbatim comments with question 6 were:

- Respondent five: It is not clear as to most what: I've answered on the basis of most or least clear. Teaching method/ assessment – it is not clear how some of these would apply. Learner/ Nurse Assessment – self –assessment could be added to this.

Question 7

Verbatim responses to question eight were as follows:

- Respondent one: I had a little difficult navigating the table.
- Respondent two: My only comment would be that again these will be hard to measure in some instances, however, your practice assessment strategies seem relevant and appropriate – so you have addressed the issue.
- Respondent three: Preceptor/mentors missing from personnel involved, need some kind of follow-up mechanism to coordinator and presenter assessments to ensure programs are maintained or changed.
- Respondent four: See my earlier comment re ability to demonstrate.
- Respondent thirteen: In relation to previous comment about the underlying philosophy that is not in concert with where Canadian Nursing education is positioned.

Question 8

Verbatim comments in relation to this question were as follows:

- Respondent two: Mollie: This is nice work- a little outside of my expertise area when you get into educational aspects…but the regulatory approach is sound and grounded in both evidence and pragmatic reality. I will be interested in the outcome of your work, as will others interested in helping nurses to embrace self-regulation.
- Respondent three: you have placed the term Each Nurse above Specific Outcomes. I would suggest that the term Each Nurse also applies to Standard Criteria, Standard Range, Embedded Knowledge and Practice Assessment. Could the content under the Standard Range be condensed?
- Respondent four: Elaboration of Section 4.3 would add clarity. Overall, an excellent approach to ensuring individual readiness for practice and assimilation of accountability for practice!

- Respondent eight: I had some difficulty in following page 9-11 (outcomes) in relation to the lines, which belong to which.
- Respondent eleven: Could the Practice Assessment be more operationalised to make a give linear picture – excellent, well done Mollie, truly a great piece of work!!
- Respondent thirteen: It depends whom this technical format is designed for. If for students then I would suggest it is not as helpful in bringing them through the thinking processes to link from one component to the next that you have obviously gone through. If it is for teachers, it will not provide them with sufficient direction for the key conceptual underpinning you have addressed. If it is for a report on a program then in it a reasonable format.

Question 9

Verbatim comments with this question were:

- Respondent three: Standard Criteria is missing for Standard 6 Professional Leadership.
- Respondent four: Probably not enough detail to thoroughly assess content and how it will be covered.
- Respondent five: Some of the criteria are too broad, e.g., critically analyse communication skills, implement quality nursing practice
- Respondent eleven: Would past history/ experiences/ norms/ culture reflect more within the Standard Criteria in order to fulfill the above criteria?
- Respondent thirteen: Does not provide the approaches and strategies to effectively develop reasoning skills in the participants.

Question 10

Verbatim responses to question 10 were as follows:

- Respondent three: Very detailed and comprehensive perhaps could be condensed a little more.
- Respondent four: I think it is complete but I am not entirely clear what "standard range" refers to.
- Respondent thirteen: If you are asking about minimum level then it is yes; if you are asking about above then perhaps not.

Question 11

Verbatim comments with question 11 were as follows:

- Respondent one: Very good.
- Respondent three: As noted above I find the term embedded knowledge confusing and I do not know what you mean. To me it seems no different than Specific Outcomes i.
- Respondent four: as long as learning time is sufficient.
- Respondent nine: Yes – accounts for cultural differences.
- Respondent eleven: Te learner *could* but not necessarily *would*.
- Respondent thirteen: But you need to consider whether you are looking at current nursing practice or where nursing practice is heading. If the former than yes, if the latter than no.

Question 12

Verbatim comments to question 12 were as follows:

- Respondent one: But very ambitious and may not be realistic especially for the new nurse.
- Respondent two: These are very clear and realistic strategies for measuring outcomes and will be reasonably easy to apply…although some are proxy measures for behaviour. "Knowing" is not the same as "doing"- as you know well – so knowing about the codes of ethics does not mean you adhere to them in all practice. That said, when asked to explain behaviour if a nurse can situate her actions within a code of ethics it suggests that she/he uses them as a framework of reference.
- Respondent three: I would add to Practice Assessment of Standard 4 the requirement for peer review or the confirmation of self assessment by knowledgeable colleague.

- Respondent four: There may be more confidence if an observational assessment was included.
- Respondent eleven: I think it is an excellent guide
- Respondent thirteen: Again this must be qualified. If you are trying to develop reflective. practitioner with strong reasoning skills for their practice than I am not sure I could state a yes.

Question 13

Respondents' verbatim comments were:

- Respondent five: The appendices are very well done.
- Respondent eight: Some references are not current, but that depends on their value and importance.
- Respondent nine: Suggest using Ernest Boyer for Reflective Practice.
- Respondent thirteen: You have many references for the background in nursing education; however, you are missing a literature review of relevant research in nursing education that is published in the primary journal for nurse educators – The Journal of Nursing Education. Many of the issues affecting nursing curricula and teaching/learning strategies are published in this journal.

Additional Comments

Prior to returning her completed questionnaire, respondent thirteen sent an email noting she had have reviewed the learning programme and made these verbatim comments:

- The focus on both orientation of new nursing staff and ongoing is excellent. This is a major gap in most organizations. There is tremendous focus on the orientation but haphazard planning on the ongoing.
- I have some difficulty in using the focus of regulation to structure a learning program around. This is because most regulators focus on competency demonstration (behaviouristic). Hence, you use the latter in your discussion but the activities, etc are more focused on behaviouism than humanism.
- You clearly identify the complexity of having a large number of nationalities in the nursing workforce. As such you have not made allowances for the wide variance in the preparation in generalist nursing of these individuals. Those coming from less-developed countries rarely

have access to sufficient supplies and as such need assistance in navigating in a Western-style health system. Moreover, these same nurses rarely have been exposed to journal and research. Hence, you may need to develop several levels of orientation to assist all nurses to stretch to the outcomes you are proposing.

- In today's health system issues of moral distress for nurses are paramount and I don't see this mentioned. These are coming out in the research literature around retention. The ongoing learning needs to be addressing opportunities for nurses to discuss relevant practice issues (using transformative learning approach and not lectures) to work with them. Reflective practice also needs to be based on Mezirow's work. Nurses need to be able to develop the skill to be reflective. In many cultures that nurses come from their voices are expected to be silent.
- I also did not see attention to orientation to Muslim beliefs and practices. This is critical to their competent practice and assists in understanding some of the moral distress that nurses from western societies might experience.
- The program addresses knowledge, skills and professional practice but needs to be stronger in developing reasoning practices (problem solving, critical thinking, etc). In our new program standards for accreditation in Canada we identify both knowledge based practice and professional growth as key to nurses development.
- You need to balance the regulators focus on competencies with the learning development focus on knowledge development and reflective practice. At the moment it appears to be too focused on the former. You need to remember that regulators are looking for minimum practice. Your program should go beyond this to development of nurses as a professional knowledge worker.
- A couple of trends that are rapidly moving ahead are interdisciplinary practice and integration of primary health care concepts into all nursing practice. The former requires teamwork development which has not up to now been a traditional part of even Western nursing education programs.
- I hope my comments are helpful to you and I wish you well with your studies."

7.4 Appendix D: Diploma Programmes Evaluation Questionnaire

INSTRUCTIONS

- Please give us your input with regards to the positive as well as the areas for improvement in the Leadership and Management and Education courses
- No identification is required
- Evaluate the diploma according to the following

1. CONTENT

What content in the first term was useful for your practice?

What content from the second term and term terms could you utilize in your practice?

What would you recommend to change in the course content?

2. PRESENTERS

Briefly reflect on the presenters and please comment on each of the following aspects"

Knowledge

Skills

Values

Attitudes

3. YOURSELF

Briefly reflect onto yourself and how it changed you with regards to your:

Knowledge

Skills

Values

Attitudes

Thank you it was nice to have you in the course.

7.5 Appendix E: New Graduate Programme Research Study Questionnaire

The purpose of this questionnaire is to evaluate the effectiveness of the Nursing Saudization new graduate programme in supporting the transition from a novice to the competent role, and to define areas of improvement. Your input is valuable.

Part 1:

Please answer the following questions using a ✓mark and the following rating:

1 =strongly disagree
2= disagree
3= agree
4=strongly agree

New Graduates' Extended Orientation

	1	2	3	4
The extended orientation helped me to adapt to the work environment				
The theory part in the extended orientation was related to work requirements				
The practical session in the extended orientation programme supported my practice in the clinical setting				
The extended orientation period of 10 days is enough				

How do you think that we can improve the extended orientation experience?

What in the programme supported you the most in the clinical sitting?

Part 2:

New Graduate's Clinical experience

Please answer the following questions using a ✓mark and the following rating:

1 =strongly disagree
2= disagree
3= agree
4=strongly agree

	1	2	3	4
The Preceptor is knowledgeable				
The Preceptor was available forme most of the time				
The Preceptor provided me with continuous feedback about my practice				
The Preceptor encouraged me to work independently				
The Head nurses supported my learning experience				
The Clinical instructors for the units facilitated my learning experience				
Follow up made by the Nursing Saudization Department was satisfactory				
The Nursing Saudization Department supports new graduate				
The clinical practice assessment portfolio gave more structure to my practice				

For how long do you think new graduate need to work with a preceptor?

Do you think that new graduates need such a program? And why?

How can we improve the Saudization program?

7.6 Appendix F: Final Continuing Professional Development Learning Programme

A Learning Programme for the Continuing Professional Development for Nurses in Saudi Arabia

(FINAL COPY)

Prepared by:

***Mollie Butler**, PhD (Candidate)*

Faculty of Higher Education
University of Stellenbosch

Acknowledgement: ***Dr. Thelma van der Merwe, &***
Dr.Chris Kapp

Promoters

September 2005

TABLE OF CONTENTS

1. INTRODUCTION

Worldwide the nursing profession is undergoing transformation with the pace of change accelerating daily. Many countries have concerns about the international shortage of nurses (Buchan, Kingma & Elegado-Lorenzo, 2005). Recently the Saudi Arabia Government directed its workforce, including nursing, to be "Saudiised". Saudisation is a human resource development strategy through which Saudi Arabians are prepared for the workforce. In January 2004, the Saudi Government granted the Saudi Nursing Board (SNB) the responsibility to regulate nurses under the umbrella of the Saudi Council for Health Specialists [SCHS]. Although both Saudi and non-Saudi nurses are to register, the latter must also maintain country of origin registration. Under the SNB regulation, nurses must continue their professional development providing documented and verified evidence of the same when renewing their license. Currently the SCHS reviews curriculum (e.g., for short courses, specialty diplomas and conferences) and when predetermined criteria are met, approves continuing medical (education) units (Abu-Zinadah, 2004). Approved continuing education (medical) units can be used as evidence of continuing professional development (CPD). There is however, no structured learning programme in place.

Protection of the public is the primary responsibility of professional regulatory bodies. Regulation of nursing refers to the ability of the profession to act in the interest of the public (Affara & Styles, 1992). As professionals, nurses are ethical and legally responsible and accountable for the quality of care they render (Muller, 2003). Continuing competency development is recognised worldwide as essential for quality patient care (Bryant, 2005). An important aspect of a professional nurse's self-regulation responsibilities is to continue professional development so as to maintain and enhance practice competence and thereby protect the patients from unsafe practice (ICN, 2003; Muller, 2003). Self-regulation is both the hallmark (AACN, 2002) and a demonstration that the profession has the competence to set its own standards for practice and conduct of its members (Affara & Styles, 1992).

As part of its self-regulation responsibilities, the nursing profession also has an obligation to develop its social mandate and ensure nurses are competent and able to provide services of acceptable quality to the Saudi population. Patient/client outcomes are positively impacted by the rendering of quality practice (CNA, 2003; Muller, 2003). To remain competent in a particular practice domain (clinical/community, education, management and/or research), a nurse needs to work within the specialty and continually develop professionally. Nurses demonstrate self-regulation for practice when they continue to develop their competencies (knowledge, skills, attitudes, values and judgment) and apply new insights and learning to practice. Access to CPD is fundamental to the provision of quality nursing practice (Bryant, 2005; Muller, 2003; CNA & CASN, 2004b).

Senior administrators within any health organisation are responsible and ultimately accountable for quality of the services rendered regardless of the practice domain. Within a health organisation, continuing education and professional development activities are influenced by the mission, goals, values, priorities and resources (human and material). Nevertheless, a comprehensive orientation can ease the adjustment into the organisation by clarifying practice expectations and providing (where necessary) decision support for practice. A favourable perception of the work environment may increase job satisfaction, organisational commitment and retention and performance which in

turn positively affect patient outcomes (Bryant, 2005; CNA, 2002b; RNABC, 2002; Lowe et al, 2003). The Joint Commission International (JCI, 2003) recommends health organisations implement a comprehensive education programme beginning with orientation and continuing throughout the employment period with the ultimate aim to improve patient outcomes.

Although individual nurses are ultimately responsible for maintaining their CPD, many players (public, regulatory body, education institutions, health organisations, nurses) have a role to play (CNA & CASN, 2004b). One mechanism by which to support CPD is to develop, implement, monitor and evaluate a comprehensive structured learning programme. Such a programme should not be designed as a one size fits all (Bryant, 2005) but rather be flexible and sufficiently broad to accommodate the individual nurse's current level of practice and learning needs within a particular practice setting. Support within the health organisation in identifying learning requirements, accessing education and assessing practice improvement is also necessary.

This document provides a CPD learning programme for nurses who are working in the Kingdom of Saudi Arabia (KSA). The learning programme was developed in fulfillment of the author's doctorate research. It was also validated by fourteen experts living in four countries: Saudi Arabia, South Africa, Canada and the United States of America. Collectively they held registration in six different countries (Saudi Arabia, South Africa, Canada, Australia, Egypt and USA). Included in the document are references and appendices with definitions and a set of papers synthesised from the doctorate literature research. In the next section the practice context is described.

2. CONTEXT FOR PRACTICE

KSA is distinctive as its social, cultural and religious practices are based on Islamic principles and values, including Shariah law. It is also the world centre for the Muslim religion and yearly millions of people come for pilgrimage or hajj from all corners of the globe. Although it is still identified as a developing country, by the end of the twentieth century KSA had achieved a high level of socio-economic development. One positive outcome of this development has been its health sector, including very advanced state of the art tertiary hospitals. For over thirty years, Saudi Arabia has been a cross-road for more than fifty nations of nurses making it one of the most diverse, international nursing workforces anywhere in the world. Working within such diversity provides a very unique and stimulating learning environment for all concerned. [See appendix 9 for further cultural information regarding Saudi patients/clients.]

Non-Saudi nurses are generally classified as western or non-western. In the past both groups tended to stay for extended periods which provided a degree of stability and predictability within the system. Today experience nurses working in one large tertiary hospital in Riyadh remain for shorter periods and their replacements generally have less experience and originate from non-western countries. Besides cultural and experiential differences between nurses, others include language, practice styles, readiness for practice and expectations concerning CPD.

While English remains the official working language, for the majority of workers [and patients/ clients] it is not their first. When English is spoken accents and word usage may vary. The degree of independence nurses assume within their practice may also vary. An initial step is to educate nurses to SNB expectations for nursing practice assisting them to systematically plan their continuing professional development.

Under the KSA labor law, health organisations have the option to send non-Saudi nurses who are unable to demonstrate basic competencies during the first ninety days probationary period back to their home country. New Saudi nurse graduates are entering the workforce in greater numbers. According to the international literature (Consortium of Schools of Nursing [CSN], 2002), nurses with minimal or limited experience may require six months to two years before they are able to function at a competent level of clinical practice. A structured learning programme can be used to support the development of new nurses as well as those who may require extra education to function as a competent member of the health team. The International Council for Nurses' (ICN, 2003) framework for competencies was used as overarching structure when developing the CPD learning programme.

3. INTERNATIONAL COUNCIL OF NURSES' COMPETENCIES FRAMEWORK

The ICN framework for competencies, developed for the generalist nurse, has three components: professional, ethical and legal practice; nursing practice (key principles, care provision and management); and professional development (professional enhancement, quality improvement and continuing education). Importantly a structured undergraduate education programme combined with adequate practice experience is essential before the generalist nurse can acquire initial competencies (RNABC, 2000). A transition programme to support new graduates entry into the workplace is also recommended (CSN, 2002). Once initial competence is demonstrated, it is important for nurses to continue developing their knowledge and skills throughout their careers (Bryant, 2005; Muller, 2003; ICN, 2003). When initial practice competence has been mastered, career planning and management can begin.

As professionals, nurses are ethically and legally responsible and accountable for the quality of practice they render. Quality refers to the degree or standard of excellence in the service delivered (Muller, 2003). Standards of practice are set at a level (minimally) to protect the patients/clients from harm. To maintain their practice standards, nurses must know the limits of their own knowledge and skills and continually search for and utilise up to date evidence in their respective domain of practice. In this learning programme, the second component of the ICN Competence Framework includes the four domains (clinical, management, education and research) and various levels of nursing practice (novice to expert). The adapted ICN Framework is depicted in figure 1.

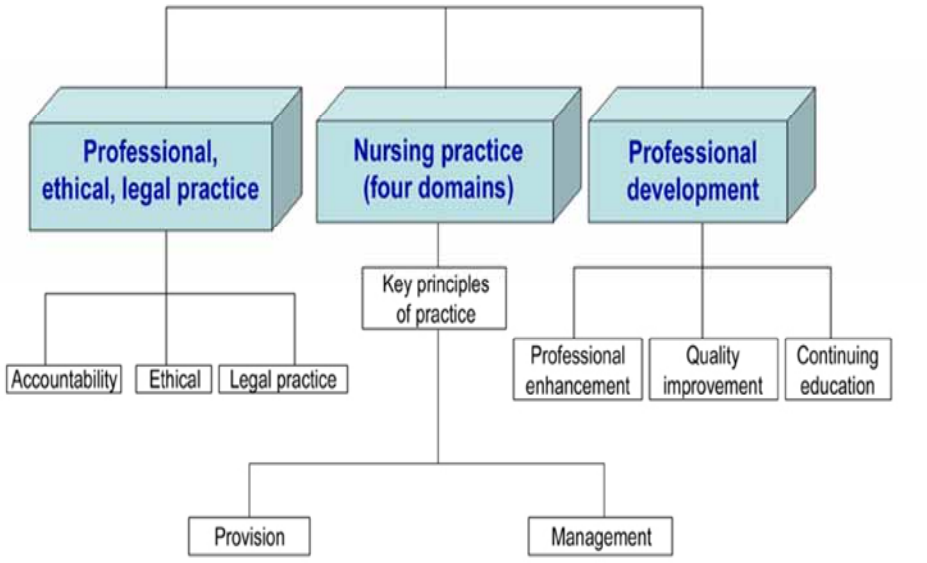

Figure 1: Adapted from the International Council for Nurses' competencies framework

All health professionals (nurses, doctors, allied health professionals, managers, educators and researchers) have a leadership responsibility to create and sustain a quality workplace environment. Quality workplaces are critical for learning, retaining motivated and competent staff, delivering quality patient care and achieving positive organisational outcomes (Lowe, 2000, 2002). Health organisations also have a responsibility to define the roles and competencies of nurses consistent within their scope of practice and support through educational and management processes those nurses who are inexperience or need to improve their competence. Education should incorporate competency based practice (CBP), constructivistic learning and outcomes based education (OBE).

Competence is a precursor to doing the job right (ICN, 2003). Personal and professional learning needs vary from nurse to nurse and within the stage of individual experiences as categorised by Benner (1984) from novice to expert. As already noted, demonstration of competence throughout one's nursing career is necessary for accountability and safe practice (Muller, 2003). To assess competence a standard has to first be set (RNABC, 2000). A standard is defined as a desirable and achievable level of performance against which actual practice is compared (ICN, 1997). Nurses need to actively promote, support and apply research (evidence-based nursing) to continually improve nursing practice and thus foster quality patient care (Bryant, 2005). Constructivistic learning is recommended.

Constructivistic learning is formed from the belief that learning is developmental and every learner constructs his or her meaning of new knowledge from their individual interpretation of the learning experience (Norton, 1998). Thus the focus is on the learner rather than the teacher. Learners build their own knowledge based on discovery and personal meaning. Learners who do not have an

appropriate background may be unable to understand what they hear or see. Thus nurse educators and managers need to holistically assess their learners (nursing staff) and remediate as necessary to improve learning (practice) outcomes.

Learning activities require flexibility and diversity in their design to meet the holistic needs of learners working within an organisational or particular practice context (Spady, 1996; Killen, 2000). OBE is a comprehensive approach to organising and operating the education system to focus on and define successful demonstrations of learning for the individual learners (Spady, 1994). Educational structures and processes are regarded as means not ends. If they do not do the job, they are rethought (Willis & Kissane, 1995). This education approach is based on standards (outcomes, structure and processes) beginning with orientation and continuing as long as the nurse practices within the particular organisation. In the next section, the learning programme is described.

4. LEARNING PROGRAMME FOR CONTINUING PROFESSIONAL DEVELOPMENT (CPD)

Vella (2001, 2002) recommends engaging in dialogue with learners and using effective learning tasks. She describes the latter as those that: connect learners with what they already know and with their unique context; invite learners to examine input (cognitive, skills and attitudes) – the content of the course; get learners to do something directly with new content, somehow implementing it; and integrate this new learning into their lives. In this section, practice standards, learning outcomes and programme design are described.

4.1 Practice standards

Practice standards are used to direct basic education and preparation of the generalist nurse and support ongoing competence development so as to enable a nurse to practice to the fullest extend of her/his scope of practice (ICN, 2003). Standards influence the nursing profession's ability to meet the changing health needs of the population as well as the complexity inherent in the health care delivery system (Bryant, 2005; ICN, 2003; WHO, 2001).

The learning programme is based on the three ICN's competencies framework components, empirical indicators derived from a literature review and practice standards from three Canadian nursing regulatory boards: the Registered Nurses Association of British Columbia (RNABC, 2002), College of Nurses of Ontario (CNO, 2003) and College of Registered Nurses of Nova Scotia (CRNNS 2004). The empirical indicators are in the appendix two. These standards are grouped under the three ICN competence framework components as seen in the table 1 below.

Table1: ICN competence framework components and adopted practice standards

ICN competence framework components	Practice standards
Professional, ethical and legal Practice	Standard one: responsibility and accountability Standard two: code of ethics Standard three: self-regulation
Nursing practice (provision and management)	Standard four: competent application of knowledge, skills and judgment Standard five: professional relationships and advocacy Standard six: professional leadership
Professional development	Standard seven: continuing professional development Standard eight:: quality improvement and evidence-based practice

In the next section, learning outcomes are identified.

4.2 Learning outcomes

4.2.1 Overall outcome

The professional nurse, either as a new employee or working in a new or expanded role integrates and internalises country practice standards as well as specific standards and concepts within this learning programme into her or his nursing practice.

4.2.2 Critical outcomes

The Learning Programme is designed to facilitate personal and professional growth and development with reference to specific areas in nursing practice, through the implementation and integration of the following:

- Principles guided by self and the profession.
- Continuing professional development.
- Communication skills.
- Self regulation and competencies relevant to domain and area of practice.
- Multi-disciplinary teamwork.
- Decision making and critical analytical skills in the application of the scientific (nursing) process of assessment, planning, implementation, evaluation and documentation.
- Evidence-based practice, quality improvement and literacy assurance including that required to utilise relevant technology.

4.2.3 Exit outcomes

Exit outcomes that each nurse is expected to demonstrate are as follows:

- Maintain standards of nursing practice and professional conduct.
- Adhere to nursing professional, ethical and legal standards.

- Assume primary responsibility for maintaining competence and fitness to practice.
- Competently apply knowledge, skills and judgment.
- Establish and maintain respectful collaborative and therapeutic professional relationships.
- Demonstrate leadership by providing, facilitating and promoting the safe and competent care/service to patients/clients.
- Maintain and continuously improve competence.
- Participate in quality improvement strategies.
- Base practice on the best evidence from nursing practice and other sciences and humanities.
- Gather verified evidence of continuing professional development and perform a yearly review of practice.

In the next section, the programme design is described.

4.3 Programme design

The programme design and practicum should facilitate the desired outcomes to meet the continuing professional development of needs of nurses working in Saudi Arabia. In outcomes based education, the outcomes are first identified and curriculum design is planned from that point backwards. See table 2 for the interrelated planning steps, components and actions recommended.

The following components were utilised to formulate the programme design:

- Practice Standards (desired outcomes to be integrated and demonstrated stated in present tense).
- Specific Outcomes (what is to be demonstrated, internalised and integrated into practice).
- Standard Criteria (begins with a verb and serves as the objective to be integrated and demonstrated).
- Standard Range (specific content for a particular standard).
- Embedded Knowledge (knowledge that is deeply internalised and integrated into practice).
- Practice Assessment (how competencies are to be measured).

For further details of implementing the specific standards see section 12. The duration of the learning programme is explained in the next section.

5. DURATION OF THE LEARNING PROGRAMME

The Learning Programme begins with orientation to the health organisation or new or expanded role, extending over the probationary period (as per hospital and/or government policy) and continuing until the end of the first year. Thereafter yearly practice standards are reviewed as an integral aspect of the nurse's performance appraisal. Ongoing educational opportunities and support are provided by the health organisation as part of its commitment to CPD and quality practice workplace. Learner's responsibilities are identified in the following section.

Table 2: Curriculum planning: interrelated steps and design components with specific actions (Source: Muller, 2003; Vella, 2002)

Interrelated steps	Design components	Specific actions
Educational philosophy (why?)	Learning Education	Identify educational philosophy determining beliefs of adult learning Identify professional practice standards (national and international) Determine how learning is to take place and education to be offered
Target group (who?)	Essential and specific learning needs	Identify learner (target) group Clarify roles and responsibilities Prepare assessment strategy
Situational analysis (how?)	Learning needs Resource assessment Budget	Assess needs of learners and organisation Use assessment results to inform programme design Identify human and material resources Prepare educational budget
Formulate outcomes (why?)	Critical and specific	State programme purpose Ensure outcomes measurable are realistic and within a timeframe Formulate competencies (knowledge, skills, values and attitudes)
Learning content (what?)	Classify and group	Prepare main modules and learning units Sequence content from simple to difficult, easy to complex Incorporate adequate time for knowledge development, comprehension (internalisation) and integration into practice
Educational principles and strategies (how?)	Principles / methods / strategies	Create a safe, open and respectful learning environment Build sound relationships with and among learners and educators Engage adults in their own learning, moving towards self-directed learning Incorporate cognitive, affective and psycho-motor learning aspects Repeat facts, skills and attitudes in diverse, engaging ways Include teamwork and small group activities Have learners practise what is taught to gain confidence Facilitate critical and reflective thinking through praxis Direct learners to implement career plan and professional portfolios
Curriculum implementation strategies (when, where?)	Venue / dates / time Communication	Extend invitations and negotiate dates / times and remuneration Communicate details with target group and relevant others
Assessment / evaluation strategies (so what, now what and then what?)	Theoretical and practical assessment Feedback Presenter's assessment Curriculum assessment Ongoing research	Assess validity / reliability of content (evidence-based practice) Provide continuous constructive feedback (verbal and written) Assess learners, educator(s) and curriculum content continually Ensure that what was proposed in learning programme was taught Remediate as necessary to enhance learning outcomes Analyse contributing factors that impact learning results Assess organisational improvement as a result of learning Formulate improvement based on analysis, research and critical reflection Write report and share findings and recommendations

6. ESSENTIAL LEARNER RESPONSIBILITIES

During the initial (orientation) phase, learners are briefed on their responsibilities. They may be required to attend classes, "skills' laboratory" and/or be precepted in their practice over a predefined period (depending on the learning needs of the individuals and health organisation). Other activities during this time include research (online or library) and specific individual or group assignments. Written or verbal feedback with remediation is provided to assist the learners to know what is expected. Some reading material is supplied by the programme coordinator, otherwise learners are expected to search the internet and utilise relevant, valid information for the preparation of class. It is essential that the learner accepts this responsibility. Fulfilment of this responsibility will make a nurse's practical experience easier and is a requirement in meeting the outcomes. Following are other essential nurse learner responsibilities:

- Come fully prepared to all classes and practical learning experiences.
- Accept and demonstrate responsibility for his/her learning. Please note teaching does not ensure learning has taken place.
- Can negotiate completion dates for the assignments when abnormal circumstances arise or when deemed necessary; this is the exception not the rule.
- Actively participate in all learning activities to master skills.
- Critically reflect on issues concerning nursing practice in the area of interest and recommend changes for improvement. This aspect can either be written or verbal feedback as per the facilitator/presenters' preference.
- Verbalise his/her learning needs to the programme presenters to facilitate a collaborative approach to optimal teaching and learning.
- Insist on feedback with regard to practicum, assignment and general progress in the programme.
- Continuously enhance own knowledge through education, experience and reflective practice.
- Decisions and actions for acquiring and maintaining competence.

In addition:

- Facilitator liaises with the appropriate programme presenters on any concerns with regard to areas of improvement for the learners.
- The goal of professional practice is the best possible outcomes for the patients/clients with no unnecessary exposure to risk of harm
- Patients/clients are the central focus of the professional service nurses provide and as partners in the decision-making process ultimately making their own decisions.
- Transition assistance comes from nursing educators, preceptors, managers, nursing colleagues and other relevant hospital personnel.

In the next section an approach and methods to adult learning are briefly described.

7. ADULT LEARNING APPROACH AND METHODS

As noted the learning approach is constructivism which includes positive teaching and learning standards based on principles of adult learning, two-way communication and a mutual respect for one another including cultural and religious beliefs and practices. Adults learn new knowledge, skills or attitudes best in relation to experience (Knowles, 1980). Vella (2002) asserts that adult learning is best achieved through dialogue. She also recommends using effective learning tasks by connecting learners with what they already know and with their unique context; inviting them to examine input (cognitive, skills and attitudes) – the content of the course; getting them to do something directly with new content, somehow implementing it; and integrating it into their lives.

Thus it is essential for the educator(s) and manager(s) to view the learner (staff) holistically, assessing and re-mediating learning opportunities as necessary to improve practice outcomes and patient care. Educators and managers actively promote, support and apply research (evidence) as an effective method to continuously improve nursing practice and foster quality patient care. The programme education coordinator liaises with the appropriate programme presenters on any concerns with regard to areas of improvement for the learners. The learner remains responsible and accountable for his/her learning. A range of teaching methods to be implemented during the programme are listed in the table 3.

Table 3: Teaching methods (Vella, 2001)

Verbal	Visual	Logical	Musical	Interpersonal	Intrapersonal	Physical	Naturalist
Report Paraphrase Listen Retell Humour	Design a story Draw Paint Observe Illustrate	Reason Collect Analyse Compare Contrast Evaluate Sort	Sing Listen Audio-tape Improvise Critique Music	Discuss Respond Dialogue Report Survey Question Paraphrase Clarify Affirm	Journal Intuitive Reflect Mediate Study Rehearse Self-assemble Express	Dance Sculpt Perform Prepare Construct Act Role-play Dramatise Pantomime Sort	Relate Discover Observe Dig Plant Design Compare Display

8. HEALTH ORGANISATION PERSONNEL

The following personnel are to be involved in the delivery of the Learning Programme:

- Programme facilitator/coordinator.
- Guest presenters to be invited to teach in areas of particular specialty or domain of nursing practice.
- Select presenters are also to be utilised in the theoretical and practice assessments.
- Preceptors/ mentors, clinical instructors, immediate supervisor (e.g., head nurse, programme director, director of nursing) assists with practical assessments and guides learning in practice.

9. NURSE LEARNER ASSESSMENT

The nurse learner is continuously assessed by:

- Programme facilitator and presenters, by means of assignments during the classes and reflective practice sessions.
- Presentation (i.e., clinical case study, education programme or management strategy).
- Immediate supervisor (preceptor, clinical instructor or head nurse) in practice setting through demonstration of competence in respective domain (clinical, management, education or research).
- Competent peers who provide constructive and timely feedback in practical setting.

A range of methods and instruments can be used to assess learning outcomes. Assessment should be directed to the prescribed evidence-based criteria acceptable to the profession (Shumway & Harden, 2003). Shumway and Harden (2003) classify these assessment methods and instruments as follows:

- Case studies - comprehensive (promotive, prevention, curative rehabilitative and palliative) and holistic (biological, psychological, sociological, spiritual)
- Written assessments (e.g., case studies, short essays, short answer questions, multiple choice, patient management problems (also referred to as problem based learning) reports; critique of documentation (nursing notes, incident reports, performance evaluations, policies and procedures); research proposal and project report).
- Clinical/ practical assessment – (e.g., objective structured clinical examinations (OSCE); classroom or clinical teaching; management round).
- Observation – (e.g., competence checklist; performance/ evaluation rating scales; competence assessment - patient care provision and management; management functions; teaching; evidence-based/ research practice).
- Portfolios and other records of performance – (e.g., content and format of professional portfolios; nursing patient care plans; structured curriculum (learning programme); strategic, operational and disaster plans; minutes of meetings; management reports).
- Peer and self-assessment – (e.g., peer report and self-report; reflective practice report; career management plan).

In the next section coordinator and presenter assessment are briefly described.

10. PROGRAMME COORDINATOR AND PRESENTER ASSESSMENT

Nurses have an opportunity to assess the programme and presenters at the end of each session, after their respective probationary period and yearly thereafter as part of their performance appraisal process. Nurse learner's feedback is to be assessed for suggestions to improve or

enhance the learning programme. In the next section the validation process for the learning programme is described.

11. LEARNING PROGRAMME REVIEWERS

To ensure content validity, the learning programme was reviewed by fourteen national and international nursing and other professional experts from Canada, South Africa, Saudi Arabia, USA, Australia and Egypt. Their self identified fields of expertise included:

- nursing practice;
- health education;
- curriculum development;
- outcomes based education;
- continuing professional development;
- career management;
- regulation; and
- accountability.

12. SPECIFIC STANDARDS

As noted above, the ICN framework for competencies provides the overall structure for the learning programme. Specific nursing practice standards were also taken from three Canadian nursing regulatory councils. Details of the CPD curriculum are outlined in the three tables below. The implementation of the learning programme needs to begin with orientation and/ or initiation into a new or expanded nursing role within the organisation. See as well the appendices for additional information to support the learning programme implementation process.

13. SUMMARY

All nurses, regardless of their domain, level or workplace setting, have a responsibility to maintain and enhance their practice. To stay competent in a particular practice domain a nurse needs to work within the specialty and continually develop professionally. Nurses also demonstrate self-regulation for practice when they continue to develop competencies (knowledge, skills, attitudes, values and judgment) and apply new insights and learning to practice. CPD is essential for rendering quality practice. Patient/client outcomes are positively impacted by the rendering of quality practice (CNA, 2003; Muller, 2003).

Nurses and other health professionals, however, require a supportive environment to provide quality care. An initial step in creating a supportive learning environment is to implement a comprehensive orientation programme, adhering to evidence-based practice standards. Opportunities for and commitment to CPD are also critical ingredients. A structured CPD learning programme for nurses is recommended.

OUTCOME: The professional nurse, either as a new employee or working in a new role integrates and internalises country practice standards as well as specific standards and concepts within this learning programme into her or his nursing practice.

PRACTICE STANDARDS[1]	SPECIFIC OUTCOME	STANDARD CRITERIA	STANDARD RANGE	EMBEDDED KNOWLEDGE	PRACTICE ASSESSMENT
1. PROFESSIONAL, ETHICAL AND LEGAL -the nurse approaches her/his practice (doing the right thing)					

Standard one:
 	
Responsibility and accountability
 	
Standard two:
 	
Code of ethics
 	
Standard three:
 	
Self-regulation
	▪ Maintains standards of nursing practice and professional conduct as determined by country of origin's regulatory boards/ councils and current practice setting
	
	▪ Adheres to nursing professional, ethical and legal standards (including policies and procedures of the organisation)
	
	▪ Assumes primary responsibility for maintaining competence and fitness to practice
		Critically analyse:
		
		▪ Professional regulation and credentialing
		
		▪ ICN and different countries of origin nursing codes of ethics and scopes of practice
		
		▪ Responsibility and accountability in relation to nursing practice
			▪ Definitions (Appendix 1)
			▪ Practice context – Saudisation (Appendix 8)
			▪ Regulation & credentialing (Appendix 3)
			  ▪ ICN regulation principles
			  ▪ Regulation dimensions
			  ▪ Regulation mechanisms
			  ▪ Authorities and agents
			  ▪ Credentialing process
			  ▪ Maintenance of credentials
			  ▪ Proof of licensure
			  ▸ Saudi Arabia
			  ▸ Country of origin
			▪ ICN Code of Ethics
			▪ Gulf Cooperation Council (GCC) Code of Conduct
			▪ Country of origin code of ethics and practice scope
			▪ Scope of practice (Appendix 4)
			▪ Accountability/ responsibility (Appendix 5)
			  ▪ Levels of accountability
			  ▪ Pre-conditions of accountability
			▪ Professional development (Appendix 6)
			  ▪ Philosophy of nursing practice
			  ▪ Continuing education
			  ▪ Professional enhancement
			  ▪ Quality improvement
			▪ Registration responsibilities
			▪ Job description
				Implement and maintain regulation and credentialing in nursing practice
				
				Implement and maintain professional responsibility and accountability
					Continuously during orientation and probationary period, at end of each year thereafter
					
					Compare and contrast::
					▪ Respective regulatory boards/ councils
					▪ Different codes of ethics/ conduct
					▪ Different scopes of practice
					
					Maintain registration and licensing for Saudi Arabia and own country
					
					Demonstrate competence:
					▪ Nursing practice philosophy
					▪ Code of ethics (conduct)
					▪ Scope of nursing practice
					▪ Accountability regarding:
					  ▪ Role and responsibilities
					  ▪ Continuing professional development (CPD)

[1] Based on: International Council of Nurses (2003), Registered Nurses Association of British Columbia (2003), College of Nurses of Ontario (2002) and College of Registered Nurses of Nova Scotia (2004)

PRACTICE STANDARDS[1]	SPECIFIC OUTCOME	STANDARD CRITERIA	STANDARD RANGE	EMBEDDED KNOWLEDGE	PRACTICE ASSESSMENT
2. QUALITY NURSING PRACTICE - PROVISION & MANAGEMENT – what the nurse is able to do (doing the thing right)					

Standard Four:
 	
Competent application of knowledge, skills and judgment
	▪ Makes decisions about actual or potential problems and strengths, plans and performs interventions and evaluates outcomes
	
	▪ Renders quality nursing and collaborates with other members of the health care team in providing quality nursing practice
		Critically analyse:
		▪ ICN Competencies for the Generalist Nurse Framework
		
		▪ Comprehensive approach to competency-based practice
			▪ Definitions (Appendix 1)
			▪ Competence based practice (Appendix 7)
			▪ Scientific process
			  ▪ Assessment
			  ▪ Planning
			  ▪ Implementation
			  ▪ Evaluation
			  ▪ Documentation
			▪ Situational analysis
			▪ Profile of nurse's role and responsibilities
			▪ Domains of practice
			  ▪ Clinical
			  ▪ Management
			  ▪ Education
			  ▪ Research
			▪ Transition into workplace
			▪ Computer/ technology literacy
			▪ Self-assessment
			▪ Competencies assessment and maintenance
			▪ Characteristics of effective leadership
			  ▪ Self-knowledge
			  ▪ Acts and omissions
			  ▪ Communication skills
			  ▪ Cultural competency and staff diversity
			  ▪ Team building
			  ▪ Conflict management
			  ▪ Violence prevention
			  ▪ Role modelling
			  ▪ Preceptoring and mentoring
				Assess, implement and evaluate competence based practice as part of self-regulation in nursing practice and rendering of quality nursing practice	Complete a self-assessment of competencies required for domain of practice provided
					
					Identify own learning needs from self-assessment
					
					Demonstrate competence (minimum) by:
					▪ Achieving specific competencies based on domain of nursing practice
					▪ Integrating into new team
					▪ Protecting & promoting patients' right to autonomy, respect, privacy, dignity and access to information (e.g., documentation, patient education, advocacy)
					▪ Attending courses (in-services, precepting, etc)
					▪ Managing personal stress
					▪ Promoting health of self and others
					▪ Fulfilling performance criteria for competencies
					▪ Creating an environment in which opportunities for professional growth can flourish

Standard Five: Professional relationships and advocacy	▪ Establishes and maintains respectful, collaborative, therapeutic professional relationships	▪ Specific competencies required for role/ responsibilities and domain of practice ▪ Acts and omissions			
Standard Six: Professional leadership	▪ Demonstrates his/her leadership by providing, facilitating and promoting the best possible care/ service to patients/clients	▪ Communication skills			

PRACTICE STANDARDS[1]	SPECIFIC OUTCOME	STANDARD CRITERIA	STANDARD RANGE	EMBEDDED KNOWLEDGE	PRACTICE ASSESSMENT
3. PROFESSIONAL DEVELOPMENT – the nurse as a professional (the right person doing it)					

Standard seven:
 	
Continuing professional development (CPD)
	▪ Maintains and continuously improves his/her competence by participating in CPD, self -regulating practice and career management
	
	▪ Gathers evidence of CPD and performs a yearly practice review
		▪ Implement quality nursing practice through standards and competencies maintenance and enhancement
		
		▪ Implement scientific process in career management
			▪ Definitions
			▪ Novice to expert theory
			▪ Criteria for nurse expert
			▪ Practice domain specific competencies
			▪ Career management strategies
			▪ Phases of the scientific process
			▪ Characteristics of curriculum vitae (CV)
			▪ Self-assessment strategies
			▪ Performance appraisal
			▪ Evidence- based practice (Appendix 10)
			▪ Quality work environment
			▪ Reflective practice (Appendix 11)
			▪ Management of practice
			  ▪ WHO "Health for All in 21st Century"
			  ▪ Eastern Mediterranean Regional Office (EMRO) and GCC nursing reports
			  ▪ Quality improvement (QI) ans quality assurance (QA)
			  ▪ Risk management
			  ▪ Health education
			  ▪ Informed consent
			  ▪ Patient/ public safety
			  ▪ Work place safety
			  ▪ Infection control
			  ▪ Medication administration system
			  ▪ Pain management
			  ▪ Basic life support
			  ▪ Clinical pathways
			  ▪ Portfolio purpose, uses, components
			  ▪ Delegation and supervision
			▪ Accreditation of health organisation
				Utilise a plan to further career
				
				Implement: a professional portfolio as an aspect of:
				
				▪ Self-regulation
				
				▪ Evidence for performance assessment
				
				▪ Professional requirements of regulatory board/ council
				
				▪ Career management
					Compile a career management plan (Appendix 9):
					▪ Utilise self assessment
					▪ Create vision and mission
					▪ Develop, implement and evaluate plan
					
					Assess workplace and make recommendations based on:
					▪ QI strategies
					▪ Quality work environment indicators
					
					Invest time and effort in maintaining and enhancing EBP
					
					Participate in QI initiative at unit and/ or program level
					
					Participate in reflective practice
					
					Develop and maintain a professional nursing portfolio

Standard eight: Quality improvement (QI) and evidence - based practice (EBP)	▪ Participates in quality improvement strategies ▪ Bases practice on the best evidence from nursing practice and other sciences and humanities	▪ Analyse low volume, high risk and problem prone aspects of nursing practice ▪ Develop professional portfolio (Appendix 12) – include evidence of participating in QI and EBP			

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15. APPENDICES

15.1 Appendix 1: Definitions

Term	Definition
Adult learners	▪ Self directed individuals who derive positive benefits from experiences, possess readiness to learn ▪ Voluntarily enter educational activity with a life centred, task centred, or problem centred orientation to learning and internally motivated (Knowles, Holton & Swanson, 1998)

Assessment criteria	▪ Are broad evidence statements to determine whether specific outcomes have been achieved
	▪ Observable processes
	▪ Learning products
	▪ Can be used to
	  ▪ Generate options for appropriate action
	  ▪ Determine appropriate course of action in relation to particular context, topic, learner group, learning level and resources available
	  ▪ Evaluate performance and identify areas for improvement
	  ▪ Develop plan or strategy for future action (Geyser, 1999)

Attitudes	▪ Feelings, beliefs, opinions and values predisposing an individual to behave in a certain way (RNABC, 2000)
Code of conduct	▪ A guide for action based on social values and needs of the population ▪ Acquires meaning when it is used in practice, to the realities of nursing and nursing care ▪ Ethical foundation of nursing reflecting the nurse's service directive (ICN, 2000)
Competencies	▪ Integrated knowledge, skills, attitudes and judgment required to perform safely within the scope of an individual nurse's practice (RNABC, 2000) ▪ Incorporates abilities of a nurse to effectively integrate and apply knowledge, skills, attitudes to his/her practice (ICN, 2003)
Competencies – shared	▪ Health related interventions within scope of practice of more than one health care profession ▪ Medication administration and infection control are examples of shared competence
Continuing professional development (CPD)	▪ Lifelong process of active participation in learning activities to enhance professional practice (American Nurses Association, 1994) ▪ Consists of the learning experiences organised by the nurse, a facility, agency or an educational institution and undertaken by the nurse to enhance his or her nursing competencies
Cultural competence	▪ Process as opposed to an end point ▪ Nurses continuously strives to effectively work within cultural context of an individual, family or community from a diverse or different cultural background (Leininger, 1988)
Domains of nursing practice	▪ Includes four domains: clinical, education, management and research
Evidence-based practice	▪ Conscientious, explicit, and judicious use of best evidence in making health care decisions (Sackett, Rosenburg, Gray, Haynes & Richardson, 1996)

Term	Definition
Exit outcomes	▪ Refer to applied competencies nurses should demonstrate ▪ Are the highest level and most challenging to meet ▪ Formulated using high powered performance verbs ▪ Can impact learners, organisations and instructional processes (Geyser, 1999)
Integrated assessment	▪ Process which determines learner's ability to apply competencies, includes a range of practice competencies, over a length of time and in diverse contexts (Geyser, 1999)
Judgment	▪ An intellectual process exercised in forming a conclusion, decision and plan of action based upon a critical analysis of relevant evidence (RNABC, 2000)
Knowledge	▪ Broadly interpreted to extend beyond information, facts and "knowing about" to include cognitive, experiential and intuitive sources of knowledge applied in nursing practice (RNABC, 2000)
Learning outcomes	▪ What learners can actually do with what they know and have learned (Spady 1994)
Mission	▪ Clear, concise statement identifying: ▪ What organisation is – name ▪ What type of organisation it is ▪ What it does, for whom and where
Nurses' (practice) act	▪ Contains laws and administration regulations defining nursing practice and establishing legal standards ▪ Regulates the practice of nursing, and safeguards the public by setting standards for education and practice and investigation of standards violations (ICN, 1998) ▪ Most countries have a legislated "nurses' act"
Outcomes-based education (OBE)	▪ Comprehensive approach to organising and operating education system focused in and defined by successful demonstrations of learning sought from each student (Spady 1994) ▪ Educational structures and processes regarded as means not ends. If they do not support learning, they are rethought (Willis & Kissane, 1995)
Outcome standards	▪ Expected measurable results e.g., delivery of quality health services, patient satisfaction, nurses perception of care rendered (Muller, 2003)
Paradigm shift	▪ Occurs when new knowledge is so contradictory it requires major (as opposed to incremental) changes in the approach one takes to that system (Porter-O'Grady & Krueger-Wilson, 1995)
Philosophy	▪ Guides one's understanding of human relationships and sensitising needs of others ▪ Provides a framework for distinguishing and understanding personal values and promoting flexibility and consistency in working with adult learners (Hiemstra, 1988) ▪ Can inform/ guide practitioners in daily practice
Preceptor	▪ Experienced nurse serves as role model and resource for nurses new to organisation and/or role, orients nurse to roles and responsibilities. Role is complete at end of designated period (Myrick & Yonge, 2004)
Process standards	▪ Step by step action how action or nursing act is to be performed – scientific nursing process – e.g., competency-based practice orientation, effective leadership, management of services and environment delivered within, interaction and sequencing of care rendered (Muller, 2003) ▪ Starts with action verb e.g., demonstrate
Performance appraisal	▪ Systematic assessment of the nursing practitioner's knowledge, skills and conduct related to the job description and scope of practice (Muller, 2003) ▪ Maintained through continuing professional development
Praxis	▪ Action with reflection or learning by doing is the way adult learn concepts, skills and attitudes. Learners can reflect or act on particular instances by using new content or considering new content, recreating it and applying it to new situations. When

Term	Definition
	learners implement a skill then reflect on and analyse the quality of their practice, this is also praxis (Vella, 2002)
Programme outcome	▪ Reflects all exit outcomes
Proof of registration/ licensure	▪ Permission to practice as professional nurse ▪ Comes from a nursing council or board ▪ Requirement for practice – differs from one country to another ▪ Completed yearly or as stipulated ▪ Responsibility of nurse to maintain
Quality	▪ Refers to the attributes/ characteristics of excellence (Muller, 2003)
Quality of excellence – characteristics	▪ Applicability – make the right decision at the right time ▪ Acceptability – be legally and culturally acceptable ▪ Safety – maintain a therapeutic environment (physical, mental and spiritual) with appropriate risk management ▪ Equality – money, race, sex and social status does not play a role ▪ Accessibility – provide health care services, facilities, equipment and expertise of personnel ▪ Effectiveness – be assessed in the clinical results and resource utilisation ▪ Professional knowledge and competence – should be based according to the needs and demands of the public ▪ Satisfaction – demonstrated by patient, family, doctor, nurses, management, nurse and other team members (Muller, 2003)
Quality improvement	▪ Standard formulation first step in process followed by performance monitoring and evaluation of compliance against formalised standards (Van Belkum, 2001) ▪ Systematic, formal, cyclic process

Quality practice environment	▪ Quality work environments enable quality care (CNA, 2002b; RNABC, 2002)
	▪ Developing and supporting shared responsibility between nurses, other health professionals, employers, governments, regulatory bodies, professional associations, educational institution and public (CNA, 2001b)
	▪ Canadian Policy Research Networks (CPRN, 2002) proposes a multi-disciplinary and holistic approach which is based on the following factors:
	  ▪ Broad work environment and human practices that shape it
	  ▪ Job design and organisational structures including technology
	  ▪ Employment relationships covering issues from trust to commitment to communication, and
	  ▪ Industrial relations

Range statements	▪ Exact details of what and how much should be learned ▪ Mark an acceptable level ▪ Increase progressively in complexity and sophistication ▪ Not required for all assessment criteria (Geyser, 1999)
Reflection	▪ Thinking and feeling activities in which individual(s) explores experiences leading to new understandings and appreciations ▪ Central dynamic in intentional learning, problem solving, problem posing and validity testing occurring through rational dialogue (Mezirow, 1991)
Scope of practice	▪ Communicates to others areas of competencies and professional accountability of nurse (ICN, 1998) ▪ Includes activities educated and authorised to perform ▪ Based on code of conduct ▪ Scopes of practice may vary from country to another
Self-assessment	▪ Ability to appraise one's knowledge, performance and practice ▪ Fundamental to any profession and professional practitioner (RNABC 2000)
Self-regulation	▪ Involves nurses regulating nurses in the interest of the public (CNA 2001c)

Term	Definition
	▪ Built on premise nursing profession has knowledge and skills to set standards for practice and conduct of members (Muller, 2003) ▪ Implement through control of professional, ethical and legal decisions of individual nurse (ICN, 1998) ▪ Encompasses fitness to practice and maintenance of competence (ICN, 1998) ▪ Privilege that can be taken away, maintain privilege by retaining public trust (CNA, 2001c)
Skills	▪ Action or behaviour, in the performance of tasks, carried out with a reasonably adequate degree of proficiency or dexterity ▪ Can be psychomotor (involving body movement and dexterity), cognitive (involving critical interpretation and decision-making), or relational (involving communication and being with clients) (RNABC, 2000)
Situational analysis	▪ Determining the components of a complex situation, place or surroundings, utilizing a SWOT – strengths and weaknesses (internal); opportunities and threats (external) analysis
Specific outcomes	▪ Serve as basis to establish what competencies to be mastered ▪ Formulate for each exit outcomes ▪ Use to derive assessment criteria (Geyser, 1999)
Standards	▪ Desirable and achievable level of performance against which actual practice is compared (ICN, 1997)
Structure standards	▪ What is required for performance of action or nursing act – support system e.g., philosophy, vision and mission, policy and procedures, scope of nursing practice, system for measuring performance (Muller, 2003)
Trans-cultural nursing	▪ Formal area of study and practice in which different cultures and subcultures are compared with respect to cultural care, health/ illness beliefs, values/practices with the goal of using derived knowledge to provide cultural appropriate nursing care (Leininger & McFarland, 2003)
Values	▪ Judgments about the importance or unimportance of objects, ideas, attitudes and attributes ▪ Quality of the thing that makes it more or less desirable or useful ▪ Part of the person's conscience and world view ▪ Provide a frame of reference and act as pilots to guide behaviours and assist in making choices (Tappen, Weiss & Whitehead, 2001)
Vision	▪ Ideal image of a unique future toward which the leader directs the group or organisation (Gregory, 1995) ▪ Compelling, inspiring statement of a preferred future person or organisation committed to creating (ICN, 1999) ▪ Ability see beyond present reality, create or invent what does not exist, become what not yet are - gives capacity to live out imagination instead of memory (Cove, 1994) ▪ Shared vision touches people's hearts - one of most powerful tools for change (ICN, 1999)

15.2 Appendix 2: Empirical indicators from continuing professional development literature

Table: Empirical indicators for continuing professional development learning programme – professional, ethical and legal practice

Regulation and credentialing	Ethical and legal foundations	National nursing associations

Primary purpose –inherent in self-regulation public protection
Goals
- serve public's interest
- define profession and members – use of title
- determine practice scope
- set education standards
- establish accountability
- establish credentialing
- facilitate effective working relationships with other providers
- provide for mobility of competent nurses
Code of ethics
Practice standards
Key regulation components:
- nursing schools and education programmes
- nurses
- nursing practice
- health care system/ agencies/ organisations
- government/ governance/ regulation system
Regulation dimensions:
- purpose
- target group
- mechanism
- authorities and agencies
- standards
- work methods
ICN principles (12)
Continuing competence requirements for nurses
	Laws – nurses' act
	Code of ethics
	ICN goals
	- advance nurses/ nursing worldwide
	- health policy
	Practice standards
	Scope of practice
	- competencies
	- responsibility
	- authority
	- accountability
	- acts and omissions
	Self-regulation
	- nursing profession
	- nurses
	- lifelong learning
	Personal and professional experiences
		Protect public
		Goals
		Code of ethics
		Scope of practice
		Practice standards
		Qualifications/ credentials
		- basic
		- advanced or specialised
		Discipline
		Approval
		Professional accountability
		- levels
		  - public
		  - employer
		  - government
		  - other professionals
		  - professional board
		  - practitioner
		- continuing competencies
		- ongoing professional development
		- self-regulation
		Health policy

Table: Empirical indicators for continuing professional development learning programme – nursing education practice

Nursing education	Curriculum development	Outcomes-based education (OBE)

• Nurse educator roles:
  ▪ educator
  ▪ facilitator
  ▪ designer
  ▪ change agent
  ▪ consultant
  ▪ researcher
  ▪ leader
  ▪ lifelong learner
• Competence based practice
  ▪ novice to expert
• Teaching what was promised
• Evaluation
• Continuing professional development
• Quality practice environment
  ▪ supportive factors
  ▪ enhance critical outcomes
  ▪ quality continuous process with
  ▪ quality work indicators
  ▪ resources adequate
  ▪ strategies to support practice excellence
  ▸ Magnet hospitals
  ▸ preceptorship
  ▸ mentoring
	• Design
	• Educational philosophy
	  ▪ learning
	  ▪ education
	• Target group (who)
	• Situational analysis (how)
	• Outcomes (why)
	• Learning content (what)
	• Educational principles and strategies (how)
	• Implementation strategies (when and where)
	• Assessment/ evaluation strategies (so what, now what, then what)
		• Outcomes
		  ▪ Clear learning results
		  ▪ Learning experiences
		  ▪ Demonstrations
		  ▪ Integrated into practice
		  ▪ Accountability in teaching
		• Comprehensive
		• Successful learners
		• Process, structures
		• Quality improvement
		• Supported internationally
		• Roots
		  ▪ Tyler's objectives
		  ▪ Bloom's taxonomies and mastery learning theory
		  ▪ Competency-based education
		  ▪ Glaser's criterion referenced
		  ▪ Mager's guidelines, expected performance
		  ▪ Spady's OBE approach
		• Principles
		• Purpose
		• System's characteristics

Table: Empirical indicators for continuing professional development learning programme – continuing professional development (CPD)

Personal and professional development	Career management	Transformative learning

▪ Lifelong (formal/ informal)
▪ Different groups accountable and responsible
  ▪ individual nurses
  ▪ regulatory body
  ▪ nurse educators
  ▪ employers
  ▪ governments
▪ CPD intertwine with
  ▪ self-regulation; and
  ▪ motivation
▪ CPD based on continuous improvement process
	▪ Scientific process
	▪ Vision/ mission
	▪ Structured
	▪ Professional portfolio
	  ▪ Encourage reflection
	  ▪ Collect documents of talents and accomplishments
	  ▪ Dynamic process
	  ▪ Evidence of CPD
		▪ Worldwide more complex
		▪ Profound impact on learner
		▪ Different person – can be sudden or gradual
		▪ Cognitive process
		▪ Mezirow's meaning schemes
		  ▪ Complex, dynamic and holistic
		▪ Premise changes
		▪ Learning and critical reflection linked
		▪ Educator's role to challenge learner and facilitate change
		▪ Fundamental democratic vision
		▪ Self-directed learning

Competency-based practice	**Adult learners**	**Reflective practice**

▪ Based in sciences, liberal arts, research and ethics
▪ Demonstrate and internalise
  ▪ knowledge
  ▪ skills
  ▪ values
  ▪ attitudes
  ▪ judgment
▪ Competence
  ▪ initial licensure; and
  ▪ throughout nursing career
  ▪ assessed best in practice
  ▪ can erode if not used
  ▪ greater emphasis on employer to ensure nurses competent
	▪ Adults learning needs are different from children
	▪ Pedagogical approach used when had no prior self-directed learning
	▪ Adults caught in history
	  ▪ Formulate learning habits in childhood
	  ▪ Culture approves and rewards
	  ▪ Seeing and knowing shaped by language, culture, experiences
		▪ Learning process
		▪ Examination of practice
		▪ Skills required
		▪ Time to develop
		▪ Enhance theory integration
		▪ Arise during situation of doubt
		▪ Prompt search new ways
		▪ Reflection in/ on action
		▪ Critical thinking/ reflection
		▪ Critical reflective assumptions
		▪ Uncover power dynamics

15.3 Appendix 3: Regulation and credentialing

"Every day nurses walk or drive to their workplaces. Think for a moment what it would be like if there were no rules governing traffic. How would we be confident that drivers have the knowledge and skills needed to perform safely? How would we determine who has the right-of-way at intersections? What options would we have if someone ran into us, causing damage? It's hard to imagine what our society would be like without traffic regulation" (CNA, 2001a:1). Regulation is one of nursing highest priorities, something to which it is continually working toward and actively developing and updating. While its priority remains constant, the language and activities required continue to evolve (Styles & Affara, 1997).

The primary purpose of regulation is to protect the public from potential harm that can occur when nursing is provided by an unqualified worker. An unqualified worker is defined firstly as an individual who is not a member of a regulatory board/council and secondly as registered nurse without relevant and current knowledge in the field of practice (CNA, 2001a). The professional nursing council or board must act in the interests of the public controlling by regulating its members' practice, identifying those who are qualified registered nurses and ensuring they are competent to practice. The nursing board must also identify what should be done when there is unsafe nursing (CNA, 2001a; ICN, 1996). Thus regulation of nurses is fundamentally essential to protect the public. Implementation of a regulatory framework to strengthen nursing practice also enhances the social agreement of nurses to protect the public (Styles & Affara, 1997; CNA, 2001a; Van der Merwe, 2002).

The International Council of Nurses (ICN) defines regulation as all of those legitimate and appropriate means – governmental, professional and private – whereby the following are reached:

- Define the profession and its members.
- Determine scope of practice.
- Set standards of education.
- Set standards of ethical and competent practice.
- Establish systems of accountability.
- Establish credentialing processes (Styles & Affara, 1997).

Finocchio and colleagues, with the Taskforce on Health Care Worker Regulation (1995, quoted cited in Brunke, 2003:144) take a broader perspective on regulation. From their viewpoint, regulation of health care workers better serves the public's interest when it "promotes effective health outcomes and protects the public from harm; ensures accountability to the public; respects consumers' rights to choose their health care providers from a range of safe options; facilitates effective working relationships among health care providers; and provides for professional and geography mobility of competent providers".

Regulation also encompasses credentialing processes, including registration, licensure, qualification, accreditation, certification, and endorsement. Credentials are defined as a "predetermined set of standards, such as licensure or certification, establishing that a person has achieved professional recognition in a specific field of health care" (Glanze, Anderson & Anderson, 1990). "Credentialed individuals, institutions, programmes, services and products are designated by 'credentialing agents' (governmental and non-governmental) as having met specified standards"

(Styles & Affara, 1997). Under the leadership of the ICN, nurses throughout the world assemble periodically to examine and provide policy support for regulation and credentialing.

Authority to regulate the nursing profession comes from legislation enacted from either the provincial/state or national level. The exact nature of legislation varies within countries and between countries. The first "nurses' act" to be proclaimed was under the direction of medical practitioners in South Africa in 1892, while the most recent one is Saudi Arabia in 2004. In most countries, nursing legislation has undergone revision. Styles and Affara (1997) note between the years 1988 and 1993, seventy-five countries enacted legislation directly related to regulatory policies and practices or to the policy environment that touches on nursing practice. Regardless of the form of legislation, nursing regulatory bodies have authority for:

- standards of education and qualification of its members;
- standards of practice and professional ethics;
- use of title;
- scope of practice;
- professional discipline;
- approval of education programmes for entry to the profession;
- continuing competence requirements for its members.

As mentioned the nursing professional has a social agreement with the public that is fulfilled through responsive and responsible self-regulation (Van der Merwe, 2002). Self-regulation of nursing practice by the nurse and the profession is critical to provide quality care and thus protect the public from harm (ICN, 2003; CNA, 2001).

Self-regulation

Donabedian (1976 quoted in Affara & Styles, 1992:ii) describes self-regulation as follows: "There is a social contract between the society and profession. Under its terms, society grants the profession authority over functions vital to itself and permits (nursing) considerable autonomy in the conduct of its affairs. In return the professions are expected to act responsibly, always mindful of the public thrust. Self-regulation to assure quality is at the heart of this relationship. It is the authentic hallmark of a mature profession".

ICN (Styles & Affara, 1997) refers to self-regulation as self-governance or governance of nurses and nursing by nurses, in the public's interest. The ICN developed a conceptual framework through which to study occupational regulation and suggests its framework could be used to ask a series of fundamental questions when examining internal and external relationships of any system of professional governance (Styles, 1986). With regards to the internal aspects, what are the features of the system that regulated education and practice? Are these features in accord with one another and consistent with their purpose? From an external perspective, ICN (Affara & Styles, 1992) recommends the profession look at the effects of the regulatory systems on the:

- quality and goal of health services;
- accessibility and cost of health services;
- public policies (health, education, labour, social welfare, economic);
- other health workers;
- goals of the nursing profession; and
- status and welfare of nurses.

And conversely how do these elements impact on the nursing regulatory systems? Figure 2 illustrates the ICN conceptual framework for studying occupational regulation (Styles, 1986).

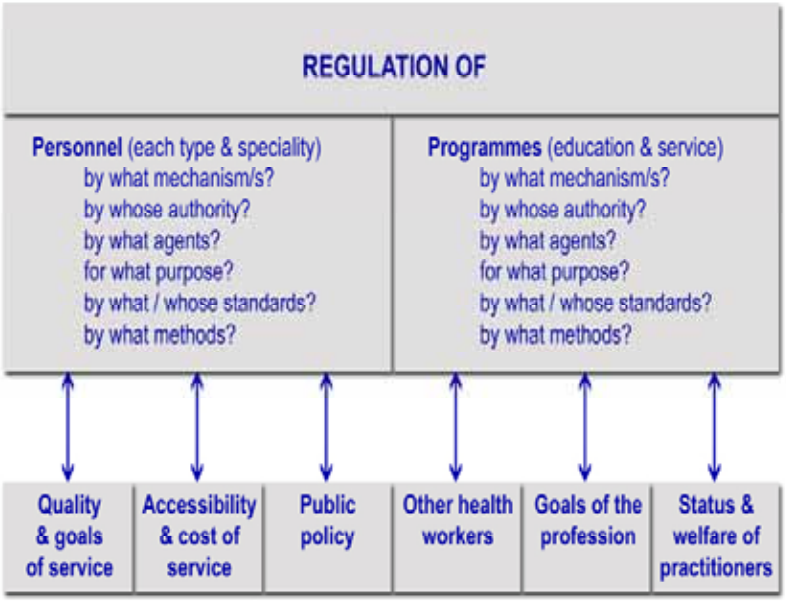

Figure: A conceptual framework for studying occupational regulation
(Source: Styles, 1986)

Muller (2003) adds that self-regulation is based on the premise that the nursing profession has acquired the knowledge and skills to set their own standards for the practice and conduct of its members. Historically professional self-regulation has referred to the nursing regulatory body's work, however today it also includes individual nurse's practice. For nurses, self-regulation encompasses fitness to practice and maintenance of competence (CNA, 2001a). For the regulatory board it entails standards (credentials) for professional practice and conduct (Van der Merwe, 2002).

Through continuously learning from practice, nurses acquire and enhance competencies required to fulfil their roles. ICN (2003) has recently published its "Competency Framework for the Generalist Nurse" and called for standardisation and credentialing of nursing practice. For nurses to maintain competence and professional commitment, a proactive and comprehensive nursing regulatory system should be in place.

Nursing professional regulatory system

Nursing practice, the nursing profession and nurses are regulated by certain mechanisms that can be encompassed under a regulatory system. The obligation of the nursing profession is to put a regulatory system in place, and maintain it, all the time striving for the ideal. Under the regulatory system standards can be identified, implemented, maintained and evaluated. Standards are defined as the desirable and achievable level of performance against which actual practice is compared (ICN, 2003). In Canada, for example, standards represent criteria against which the registered nurses' practice can be measured by the public, patients/clients, employers, colleagues and nurses themselves. Taken in their entirety, such standards reflect the value of the profession and clarify what is expected in a particular province or jurisdiction. The establishment, adherence and regular updating of standards and other forms of statements from regulatory bodies to elucidate nursing practice are important from a legal and ethical perspective (CNA, 1993).

The Registered Nurses Association of British Columbia (RNABC, 2002) emphasises that governments, employers, and nursing organisations and schools of nursing are jointly responsible for creating and maintaining a quality nursing practice environment necessary for safe and appropriate care. Key aspects of nursing regulation are identified by the ICN and featured in the table below.

Table 2.2: Key aspects of nursing regulation (Source: Styles & Affara, 1997)

Key aspects	Description
Nursing schools	▪ Students - pre-defined qualifications ▪ Prescribed basic and ongoing education programme based on practice standards, code of conduct ▪ Accreditation from external authority (e.g. nursing board/ council)
Nurses	▪ Qualified to provide services to public ▪ Given compensation and title ▪ Certified specialists - advanced education / experience - additional responsibilities / authority ▪ Bound by a code of ethical conduct ▪ If a nurse violates code, laws or regulations, it may lead to disciplinary action – by professional regulatory body and / or through legal system
Nursing practice	▪ Set boundaries defined in scope of practice ▪ Directed by governmental rules and regulations ▪ Educational programmes and roles / responsibilities reflect practice scope and standards
Health care agencies/ Organisations	▪ Responsible to protect the public ▪ Health care agencies accredited ▪ Standards set by specific external authority ▪ Standards include qualifications and health care personnel ▪ Designated roles / responsibilities ▪ Supervision of lesser prepared auxiliaries by qualified nurses
Government	▪ Set health care and civil services policies (e.g. health care priorities, financing, health care systems, qualifications, rights / responsibilities, working conditions and compensation) ▪ Shape overall professional practice framework

According to the ICN (1992) the various dimensions of professional regulation include: the fundamental objectives, the target group, the mechanism of the regulation, the authorities involved, the standards and work methods (instruments). Each is explained in the table below. The role of the professional board/council is also to act in the interest of the public by regulating nursing education and the practice of the nurse. The quality of nursing education and practice, protection of the public as well as the mobility of nurses can be greatly enhanced when countries and nursing regulatory bodies adhere to the ICN regulatory principles and guidelines. Global trend toward reciprocal licensing of professionals and ease of movement at the borders necessitate similar regulatory practices (CNA, 1993). In the next section the ICN principles of regulation are highlighted.

Table: Dimensions of professional regulation (Source: Affara & Styles, 1992)

Dimensions	Explanation
Fundamental objectives: Why the regulatory system was established. For what purpose?	Regulatory board/council's objectives include: - Protect public from unsafe practices - Set professional-ethical standards - Confer accountability - Identify and confer professional status - Utilise country's policy statement - Ensure nursing services acceptable and accessible
Target group: Who is being regulated?	- Practitioner – provides services - Education system - establish educational programme - practitioner education/preparation - Health care services system hires qualified educators
Professional regulation mechanism: What forms does regulation take?	Credentials assessed, standards met and practice approved - - Require formal regulatory system with routine assessment: - reliable record keeping system of each member - monitor standards - remedial action when standards not maintained - Credentialing mechanisms include: - education agency standards e.g. building and classrooms - approval and assessment credentials - basic and graduate levels - situational analysis of learning opportunities available - teaching staff credentials - educational programme standards - examination of students - meet education objectives licensed/ registered - professional-ethical guidelines conduct of practice - formal practice authorisation (registration and credentials)
Authorities and Agencies: Inside and outside of profession	- External regulation - government authority - Internal profession itself – autonomous / independent regulation - Autonomous regulation - public trusts profession - Agent - organisation performs / administers regulation - Authorised by government - national or provincial / state level - Authorisation in legislation – e.g. proclaimed as a nurses' act
Standards	- Acceptable to all role players - Provide minimum achievable level to ensure quality - Reflect practice scope and demands - Evidence knowledge and performance described - Relate to education, health care services and resources
Work methods	- Compile curricula / education programmes - Develop valid and reliable competence instruments - Visits to nursing schools, educational institutions and health care organisations for the purpose of evaluation - System for examination and certification - System for continuing professional development and accountability - System for disciplining when required

ICN Principles of nursing regulation

As the global voice for nurses, the ICN has cultivated an international network of nursing experts and has developed and improved techniques and principles to guide regulation policies and practices. The wide disparity among nations regarding the purposes, standards and procedures of regulation necessitated fundamental agreement on these issues and hence, the ICN adopted the following rationale and resolution to under-scribe nursing regulation: "Health is a vital social asset. Health For All is a global objective. The nursing profession offers its utmost to this world-wide social purpose. Fulfilling this promise calls for influencing and responding to changing health needs and priorities; and developing and mobilising the fullest potential of the profession" (Styles & Affara, 1997). ICN (1986) also believes the system of governance for nursing must provide for the following:

- high standards for the personal and professional growth and performance of nurses
- public sanction for nurses to perform to the extent of their capabilities
- participation of the profession in the development of public policy
- accountability of the profession to the public for the conduct of its affairs on their behalf
- proper recognition and remuneration for the contribution of the profession and opportunity for self-actualisation of its members

The ICN has identified twelve principles to guide the formulation and review of professional regulation. The principles attempt to distinguish between governmental and professional responsibility as well as the common ground between. ICN (1986) leaders argue that this "common ground thus shapes joint effort and that distinction needs to be made between the right to practice which is a provision of the law and the standards to practice which are determined by the profession". The ICN principles underscore the responsibility of the profession to prepare its own code of ethics and to establish standards of practice (Percival, 2001).

The principles are related to: purposefulness, relevance, definition, professional ultimacy, multiple interest and responsibility, representative balance, professional optimacy, flexibility, efficiency and congruence, universality, fairness and interprofessional equality and compatibility. Each is briefly described within the table below.

In conclusion, professional regulatory system exists to serve and protect the public. The ICN has set out guidelines and principles for professional regulation. These standards are directed at protecting the public, as well as maximising the advancement of the profession to fulfill its responsibility to the public. The ICN calls for representation of all participants in the process of professional regulation and the maintenance of certain standards. The role of the professional board/council is also to act in the interest of the public by regulating nursing education and the practice of the nurse in a particular country. The quality of nursing education and practice, protection of the public, as well as the mobility of nurses, can be greatly enhanced when countries and nursing regulatory bodies adhere to the ICN regulatory principles and guidelines. A global trend toward reciprocal licensing of professionals and ease of movement at the borders necessitates similar regulatory practices, including scopes of practice (CNA, 1993).

Table: The International Council of Nurses' regulation principles (Source: Styles, 1985)

Principles	Description
Purposefulness	Regulation be directed toward an explicit purpose
Relevance	Regulation be designed to achieve the stated purpose
Definition	Regulatory standards be based upon clear definitions of professional scope of practice and accountability
Professional ultimacy	Regulatory definition and standards promote fullest professional development commensurate with potential social contribution
Multiple interests and responsibilities	Effective regulatory system incorporate legitimate roles and responsibilities of interested parties – public, profession, government, employers, other professions – aspects of standard-setting and administration
Representational balance	Regulatory system's design acknowledge and appropriately balance interdependent interests
Optimacy	Regulatory system provide limited controls and restrictions necessary to achieve objectives
Flexibility	Regulation practice standards are sufficiently broad and flexible to achieve objectives and permit freedom for innovation, growth and change
Efficiency and congruence	Regulatory system operate in most efficient manner, ensuring coherence and co-ordination among parts
Universality	Regulatory system promote universal performance standards and foster professional identity and mobility compatible with local needs and circumstances
Fairness	Regulatory processes provide honest and just treatment for parties regulated
Inter-professional equality and compatibility	Regulatory system practise standards incorporate equality and interdependence of various professions

15.4 Appendix 4: Scope of practice

A scope of practice defines the range of roles, functions, responsibilities and activities professionals are educated, competent and authorised to perform and within what context of practice boundaries. A scope of practice communicates to others the competencies and professional accountability of the health care provider (ICN, 1998).

Scopes of practice are generally defined by legislation, public policy, national and local guidelines, education and individual levels of competence. Legislation specific to nursing practice is found within the respective nurses' Act. Other acts within a particular country will also define practice parameters or may have specific implications for nursing practice. As well, government policy (such as Saudisation) has implications for nursing practice, and may define the boundary of a scope of practice (CNA, 1993).

Some professional scopes of practice overlap while others may be shared between disciplines. As Styles and Affara (1997) note, while restrictive scopes of practice can protect the public from unsafe practitioners, they can also exert control over professionals not enabling them to practice to the extent of their competence, changing consumer needs or respond to the increased demands of the health care system. The Canadian Nurses Association, Canadian Medical Association and Canadian Pharmacists Association have developed joint principles for their respective scopes of practice (CNA, 2003a). This collaboration is important because it decreases rigid boundaries between the different health professionals that can run counter to the needs of the public. The following five principles have been identified.

Table: Joint principles and explanation [Source: Canadian Nurses Association, Canadian Medical Association and Canadian Pharmacists Association (CNA, CMA & CPA, 2003a)]

Principle	Explanation
Focus	▪ Scopes of practice statements should promote quality care that responds to the needs of patients and the public in a timely manner, be affordable, and provided by competent health care providers
Flexibility	▪ A flexible approach is required that enables providers to practice to the extent of their education, training, skills, knowledge, experience, competence and judgment while being responsive to the needs of patients and the public
Collaboration & cooperation	▪ Health professionals engage in collaborative and cooperative trained and who use, where possible, an evidence-based approach to support interdisciplinary approaches to patient care and good health outcomes. Good communication is also essential
Coordination	▪ A qualified health care provide should coordinate individual patient care
Patient's choice	▪ Scopes of practices should take into account patients' choice of health care providers

These three professional associations also identified the following scope of practice criteria, including an explanation for each.

Table: Scope of practice criteria & explanation
[Source: Canadian Nurses Association, Canadian Medical Association and Canadian Pharmacists Association (CNA, CMA & CPA, 2003a)]

Criteria	Explanation: Scopes of practice should
Accountability	Reflect the degree of accountability and responsibility and authority that the health care provider assumes for the outcomes of his or her practice
Education	Reflect the breadth, depth and relevance of the training and education of the health care provider. This includes consideration of the extent of the accredited or approved educational program(s), certification of the provider and maintenance of competency
Competencies and practice standards	Reflect the degree of knowledge, skills, values and attitudes (i.e., clinical expertise and judgment, critical thinking, analysis, problem solving, decision making, leadership) of the group
Quality assurance and improvement	Reflect measures of quality assurance and improvement that have been implemented for the protection of the patients and public
Risk assessment	Take into consideration the risk of patients
Evidence- based practice	Reflect the degree to which the provider group practices are based on valid scientific evidence where possible
Setting & culture	Be sensitive to the place, context, and culture in which the practice occurs
Legal liability and insurance	Reflect case law and the legal liability assumed by the health care provider including mutual professional malpractice protection or liability insurance coverage
Regulation	Reflect the legislative and regulatory authority where applicable, of the health care provider

In Canada, nursing regulatory bodies have established broad range goals/principles recognising a continuum of educational preparation, from basic to advance. National regulatory bodies in other countries such as the United Kingdom and the United States have also taken a similar approach. As nursing scopes of practice are broader than that of individual nurses' ability to practice, individual nurses must practice within the limits of their preparation, education and competence. The actual scope of practice of individual nurses is "influenced by the settings in which they practice, the requirements of the employer, and the needs of their patients or clients" (CNA, 1993). Nurses also need to practice within their scope and accept professional responsibility and accountability for practice rendered.

15.5 Appendix 5: Accountability and responsibility

The word accountable comes from the French word “compter” or “conter” meaning to count or to enumerate (Matek, 1977). An individual is accountable when she/he is responsible and bound to give account, thus it is a state of being answerable for one’s actions and decisions. Professional accountability is defined as the responsibility of the nurse for acts and omissions during action performed. Accountability also implies conditional liability for the nurse’s own acts and omissions and willingness for him or her to be judged against professional rules/ norms/ expectations that have been set and thus bear the consequences for such judgment. Nurses are held responsible and accountable for their actions and are expected to be willing to accept the consequences of their respective behaviour. However when full authority is granted to a nurse, it signifies official permission to take over the role and includes the responsibility to inform the immediate supervisor whenever the nurse is uncertain about his or her ability to perform a particular activity or competence (knowledge, skills, values and attitudes [KSVA]) required to do the work. Until such time, accountability for work rests in the hands of others. When a nurse has demonstrated the relevant competencies (KSVA) and related judgment, she or he has satisfied the conditions necessary for professional accountability (Muller, 2003).

Conditions for accountability

Accountability comes with experience as it is based on demonstration of KVSA and related judgment. Bergman (1982, cited in Muller, 2003) illustrated three conditions for accountability in a pyramid. See the figure below. Bergman’s conditions for accountability lay the ground for determining the consequences derived from a nurse’s acts or omissions and are: ability, responsibility, and authority. Each is described briefly.

Figure: Conditions for professional accountability
(Source: Bergman, 1982, cited in Muller, 2003)

i) Ability

A nurse must demonstrate the abilities or competencies (KSVA and judgment) to perform a given action. The knowledge required for nursing practice is implicitly identified in legislation of a particular country (Muller, 2003; ICN, 2003). Competencies required include:

- Advanced scientific principles specific to selected areas and applied to nursing practice.
- Relevant knowledge of human anatomy, physiology, biochemistry, and physics.
- Principles of human behaviour (psychology), social behaviour of humankind, family and community, child and adult education, as well as spiritual and cultural practices.
- Professional and personal values and norms.
- Self-directed learning.
- Communication skills.
- Self responsibility skills in group work and multi-disciplinary team work.
- Decision making and critical analytical skills in the application of the scientific principles of assessment, planning, implementation, evaluation and documentation.
- Research skills.
- Current technology and advanced literacy.

The most obvious knowledge and skills that the nurse practitioner needs are identified in the educational programme of a specific course, whether it is basic, post-basic, specialized, or advanced practice. Curriculum for nursing education is approved by the respective country's regulatory board (e.g., South African Nursing Council, Provincial Nursing Regulatory Bodies in Canada,). A country's nursing regulatory board/council certifies the practitioner as having achieved the prescribed competence, including values. The nurse's personal value system is based on her or his world view/belief system (Nadan & Eriksson, 2004). The values of the nursing profession and workplace are illustrated in the respective policy statements and philosophical convictions. Society also has a great influence on the nurse's perspective of what is right or wrong, as does the social values of a specific community or group of people served by the health organisation and thus also directly on the nurse's acts (Muller, 2003). The second condition of accountability is responsibility.

ii) Responsibility

The allocation of responsibility must be in place before liability for a nursing act can be accepted. The professional-ethical responsibilities are identified in a country's nursing scope of practice regulation (Muller, 2003). The nurse carries out these responsibilities throughout the course of her/his nursing practice. If the nurse neglects to carry out prescribed professional responsibilities and her/his acts or omissions result in harm to the patient, he/she can be disciplined professionally-ethically by the respective regulatory board or the judicial system. A nurse is accountable for his/her job responsibilities in terms of the "job description/contract" allocated by an employer. The third condition that must be granted is authority.

iii) Authority

Authority is the right to do a task or make a decision. The authority granted a nurse comes initially from legislation as an "Act" which authorizes certain work to done by a "registered" nurse. Hence the boundaries of nursing practice are set by legislation (Muller, 2003). The nurse must also abide by the principles underlying other laws such as informed consent, or a narcotic act. The last condition in the pyramid is accountability

iv) Accountability

Only after the other three conditions are met can a nurse be held personally and solely accountable for her practice. Before being delegated responsibilities she/he must demonstrate the necessary abilities (KSVA). A nurse learner who is not yet competent to perform a certain task (i.e., medication administration) cannot be held solely accountable. This means that the supervisor is also professionally accountable for the task performed by the learner. If the learner is not competent to perform the task, he or she is personally accountable for seeking expert help from the supervisor whenever performing the task (Muller, 2003). Muller identifies six levels of accountability. See the table below.

Table: Levels of accountability (Source: Muller, 2003)

Levels of Accountability	Explanation
Public	Require acceptable & adequate services Trust professional nurses to implement correct nursing actions
Employer	Liable for quality health care services to patient/client Responsible for health care facility (e.g., hospital or community unit) Partner in continuing professional development
Government	Responsible for health care & legal systems Laws of the country established to "protect the public" Nurses who violate laws are answerable & must accept consequences Nurses cannot take over job of other health professionals (e.g., giving or changing medication without valid a physician's prescription)
Other Professionals	Provide similar/ auxiliary services (i.e., physicians, pharmacists, nutritionists)
Professional Council/ Board	Responsible social mandate & acceptable quality of public services
Practitioner	Demand high quality education within professional framework Depend on profession for social status & credibility Responsible for continuing professional development maintain/ enhance competencies

Quality care is essential to protection of the public from harm (ICN, 2003; CNA, 2001). Self-regulation of nursing practice by the nurse and the profession and demonstration of competencies are critical ingredients of quality care. Competent practice does not simply entail knowledge and skills. Nurses are competent when they have demonstrated the necessary KSVA and judgment (ICN, 2003). Ensuring judgment in nursing practice takes time and thus until a nurse demonstrates competence required for the role she or he should not be granted full authority. The need to maintain and enhance competence to ensure best care for patients/clients [the public] is the key rationale behind legislation of continuing professional development (CPD) in many countries. CPD is one means by which nurses fulfill the obligation of public trust and is an integral part of quality nursing and quality work environments (Lowe, 2002; RNABC, 2002).

15.6 Appendix 6: Continuing professional development

The American Nurses Association (1994) defines continuing professional development (CPD) as "…the lifelong process of active participation in learning activities to enhance professional practice". This definition reflects a similar path now being taken by other countries such as the United Kingdom (Furze & Pearcey, 1999), Canada (CNA & CASN, 2004a) and South Africa (Muller, 2003). CPD consists of the learning experiences organised by the nurse, a facility, agency or an educational institution and undertaken by the nurse to enhance his or her nursing practice.

In today's fast paced world, lifelong learning is necessary for individual success as well as economic development and social cohesion. CPD need not be "merely for the acquisition of skills or an increase in one's fund of knowledge, but education for development, education for transformation" (Kegan, 2000). Nearly all western (i.e., United Kingdom, South Africa, Canada, Australia, New Zealand, Ireland and United States) and several non-western (e.g., Philippines, Malaysia) countries expect their health professionals including nurses to continue developing professionally once they have completed their basic education and begun to practice competently within the workforce. Various players, including nurses, share responsibilities with regards to CPD. See the table below.

Table: Continuing professional development group responsibilities
(Source: CNA, & CASN, 2004b)

Groups	Responsibilities
Individual Nurses	▪ Demonstrate commitment to life long learning, reflective practice & integrating learning ▪ Ensure competencies are relevant & up to date ▪ Seek quality-relevant educational experiences ▪ Support development of others ▪ Work with employers to support quality practice workplaces ▪ Meet regulatory requirements of continuing competence
Regulatory Body	▪ Promote competent practice throughout career of nurses ▪ Promote, develop, maintain & monitor/evaluate high quality CPD programmes ▪ Establish effective, flexible CPD programmes
Nurse Educators	▪ Provide multiple opportunities for CPD ▪ Work with others to promote and sustain high quality CPD
Employers	▪ Put mechanisms in place to promote identification of practice competencies ▪ Maintain quality practice workplaces to support/foster CPD
Governments	▪ Facilitate collaboration among nursing profession, educational institutions & respective ministries (health, education, etc) to support CPD of nurses

15.7 Appendix 7: Competence-based practice

The International Council of Nurses (ICN, 2003) define competence as "…a level of performance demonstrating the effective application of knowledge, skill and judgment". In addition, nursing competence should evaluate the nurse's own belief, ethical values, attitudes, accountability and knowledge, matching the expected outcomes (Whittaker, Carson & Smolenski, 2000). The challenge for licensing boards and employers is to ensure nurses are competent throughout their careers, not just with their initial licensure. Once competence has been determined the regulatory board and the employer have an obligation to assess and hold nurses accountable for their practice. To achieve this outcome all concerned need to take an active role in assessing, maintaining and enhancing nurse practice competence (CNA & CASN, 2004b). Continuing competence process must also be linked to the code of ethics, standards of practice and life-long learning process and be maintained and sustained throughout the nurse's career. See the figure below.

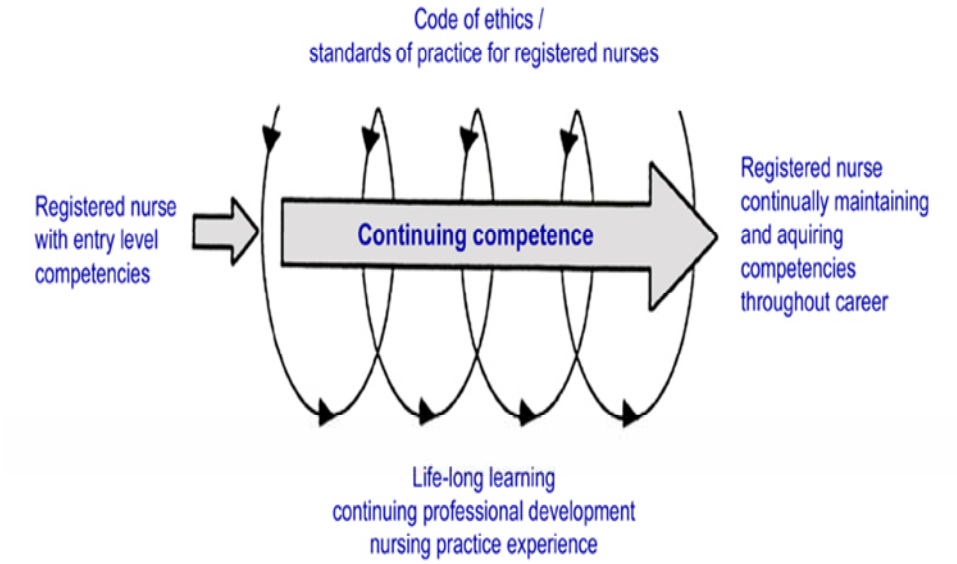

Figure: Continual linkage process to continuing competence
(Source: Canadian Nurses Association, 2000b)

Nursing competencies have as their basis, a strong foundation of nursing sciences, biological, psychological and sociological sciences, humanities, liberal arts, research and ethics (RNABC, 2000b). Such competencies form the basis of nursing practice, preparing nurses to care for patients of all ages across the whole continuum of care in multiple settings both within and outside of tertiary hospitals. When met these competencies ensure that nurses have the foundational knowledge in health promotion and illness prevention, as well as acute and chronic disease management. Further they support nursing practice in education, management, research and evolving areas (i.e., informatics, infectious diseases, genetics, environmental health and

immunology). Continuing professional development (CPD) is crucial to nursing careers and to being a member of a profession, especially to ensure that nursing practice is congruent with the health needs of the society.

Each profession, including nursing, has unique characteristics and traditions which are determined by its practitioners. Muller (2003) who likens a profession to a specific career where work of an intellectual nature is performed has identified 18 characteristics. These are defined in the table below.

Table: Professional Criteria with explanation (Source: Muller, 2003)

Criteria	Explanation
Criterion One	Extensive, specialised theory-content with well developed technical skills based on such a theory
Criterion Two	Utilisation of the theory of physical science, as well as other disciplines related to the practice thereof
Criterion Three	Specialised preparation over a long period at a recognised educational institution
Criterion Four	Testing of professional competence prior to admission to the ranks of the profession
Criterion Five	Some form of registration and licensure to practice
Criterion Six	Self-organisation which leads to the establishment of a professional association and a self-governing body to exercise control over professional standards
Criterion Seven	Ethical control of professional conduct by the members of such a profession
Criterion Eight	A service motive based on the needs of the client who requires professional assistance, regardless of his or her ability to pay for services, because the well-being of the client is the primary consideration
Criterion Nine	A high degree of accountability for professional acts towards the public, the client, the employer, and other members of the profession
Criterion Ten	A feeling of exclusiveness
Criterion Eleven	An acknowledged status in terms of legislation
Criterion Twelve	A high social status and considerable power in society
Criterion Thirteen	The performance of activities that are base on an understanding of what these activities involve, so that the consequences can be predicted
Criterion Fourteen	Sustained critical analysis of activities which leads to a change in practice on the basis of such analysis – thus a profession is always subjected to change and development is never static
Criterion Fifteen	The ability of its members to select, in a responsible manner, the activities that are of importance to the practice and the mastering thereof falls within the realistic reach of members of the profession
Criterion Sixteen	The individual members being allowed the maximum discretion and initiative in the practice, while independent functions and accountability for the performance are inherent
Criterion Seventeen	The obligation of its members to use their best endeavors in meeting the needs of the patient
Criterion Eighteen	A sustained striving towards excellence because competence alone is not enough

Rendering quality nursing practice requires a high degree of competence and professionalism. A nurse's professionalism refers to his or her professional attributes, norms and fulfilment of practice expectations. Nurses acquire competence and professionalism over time and with experience

through their basic education, continuing professional development (CPD) and practice as well as from other forms of life experiences (Benner, 1984; Muller, 2003).

A novice nurse requires additional education and professional/personal experiences to move to advance beginner and then on to demonstrate competence. Competence implies the nurse has the ability to apply knowledge, skills, attitudes and values to yield desirable outcomes both in familiar and new situations. Although an important stage in professional development, competence is not the final point. The last stages of proficiency and expert require many years of continuing professional development and practice experience before they are reached (Benner, 1984).

Assessing competence is critical in determining whether a nurse is able to render quality patient care, perform assigned duties and responsibilities, and meet standards of practice within a given practice context. Nurses' competence can be assessed at specific points in time as well periodically, for areas considered low volume, high risk or problem prone. The relationship between competence (can do) and performance (does do), however, is very complex. While the former does not necessary predict the latter, competence is a necessary step to higher level of performance. Individual factors (e.g., abilities, traits, values, motivation) and/or external factors (e.g., availability of equipment, medications, organisational and educational support) can play a part in the level of performance. A nurse may have the knowledge and skills but not use them properly due to an inter-play of internal and external factors. Thus it is critical to treat nurses holistically being mindful the quality of the environment has a significant influence on quality of nursing practice (Lowe, 2003).

Competence to practice is dependent on the continuous updating of knowledge and skills and the personal and professional growth of the individual nurse. Continuing professional development is therefore a career long process. Today nurses are encouraged not only to maintain and enhance their competence but also to manage and plan their career (Donner & Wheeler, 2004).

15.8 Appendix 8: Culturally sensitive care for Saudi patients

Introduction

The Saudi Arabian health system is mainly staffed by a multi-national group of health professionals many of whom are also not Muslim. To render quality care there is a need for non-Saudi, non-Muslim health professional to improve their cultural awareness and sensitivity. Saudi culture education should therefore be a part on health professionals' continuing professional development.

The purpose of this handout is to describe some of the pertinent cultural aspects that may help non-Saudi health professionals improve their practice. Information contained is based on the work of Al-Shahri (2002) and was originally designed in collaboration with Renee Pyburn and later vetted by several Saudi nurses. As Al-Shahri notes, the religion of Islam is the main, though not the only, factor that shapes the Saudi culture.

As a fundamental Islamic doctrine, people attribute the occurrence of diseases to the will of Allah. This does not, however, mean they do not seek medical treatment or utilise available preventable services. Key aspects of Islamic religion are the five pillars of Islam, prayer times, preparing for prayers and use of one's hand; each is described in the next section.

Five pillars of Islam

The five pillars of Islam are to:

- testify that there is no God but Allah, and that Mohammed is his messenger;
- pray five times a day at designated times;
- give 2.5% of one's wealth for the needy Muslim community;
- abstain from eating, drinking, smoking and sexual intercourse in the daytime during the Holy month of Ramadan; and
- undertake a pilgrimage to Mecca once in a lifetime for those who are physically and financially able.

Prayer times

During prayer, patients must face Mecca and hence nurses should assist them in doing wherever necessary. Patients appreciate it if medical and nursing interventions are planned so as to not to coincide with prayer times. During prayer, it is important for the patient to have a quiet environment without any interruptions. Therefore it is not the time to provide nursing care or interrupt (e.g., ask questions).

Preparing for prayers

Before prayer, patients are required to perform a ritual cleansing. This involves washing certain parts of their bodies. Clothes or body parts should not be soiled with urine, stool or blood. Some patients may need assistance with this ritual washing before prayer. If washing is not an option for the patient, offer a clean tray of sand found on the unit.

Check with the patient, family member or sitter before discarding any water in the patient's room. It may be Holy water (Zam Zam) and therefore should not be carelessly touch or thrown away.

Use of one's hands

The left hand is used for cleaning the genitals and the right for eating, handshaking, and other hygienic activities. Using the left hand while eating or other hygienic activities is considered extremely rude.

Fasting during the Holy month of Ramadan

Fasting during the daylight hours during the Holy month of Ramadan is also a pillar of Islam. Although the sick are generally exempted from this practice, some patients prefer to do so. This choice should be left up to the patient after fully informing them of the medical ramifications. Women who are either pregnant or menstruating do not fast during this time. In the following section norms and values in relation to Saudi men, women and the elderly are described.

Other cultural practices and social norms

Saudi men

The religion and customs of Saudi Arabia dictate conservative dress for both men and women. A man's headdress consists of three things: the tagia, a small white cap that keeps the gutra from slipping off the head; the gutra itself, which is a large square of cloth; and the igal, a doubled black cord that holds the gutra in place. Some men do not wear the igal. The gutra is usually made of cotton and traditionally Saudis wear either a white one or a red and white checked one. The gutra is worn folded into a triangle and centred on the head. Normally men wear a white thobe but during the winter months some may wear colour ones made of heavier cloth.

A Saudi man's beard is important from a religious and cultural standpoint. Nurses should ask permission before touching the beard, and if shaving is medically necessary the patient should be asked to sign a consent form.

Female health professionals should wait for the male to extend his hand before doing likewise whenever greeting (handshake) a Saudi man. He may not consider handshaking (or touching) appropriate with females.

In ordinary situations, a male member leads the Saudi family. Thus the male family member may answer questions addressed to a female. As well, the male family head (father, husband, uncle or brother) usually signs the medical consent for female patients and under aged children. In the next section customs and norms in relation to Saudi women are highlighted.

Saudi women

One of the most important community values in Saudi Arabia is the modesty and chastity of women. When Saudi women appear in public, they normally wear a voluminous black cloak called an abayah, a scarf covering her hair and many have a full face veil. Saudi women cover themselves in public and in the presence of men who are not close relatives.

Male health professionals should never interview or examine a female patient without a relative present. When speaking to male health professionals, a Saudi female patient may avoid eye contact. Islam also forbids unnecessary touching between unrelated adults of opposite sexes. It is not acceptable to have opposite gender patients and sitters in the same room.

Likewise when an interpreter is needed, it is preferable to have one of the same gender to put the patient more at ease and help facilitate more effective communication. Practice caution whenever asking about smoking, questioning about drugs or alcohol, or extramarital sexual activities as such questions are insulting to the majority of Saudi patients and to the female in particular. Never shave or cut hair without acquiring prior permission. Pelvic examinations are to be avoided on young girls and unmarried women. In all cases, prior to undergoing this form of examination an appropriate consent is to be signed.

Respect for the elderly

In Saudi culture the elderly are held in high respect. It is important to be soft-spoken, humble, gentle and patience with the elderly.

Permission to enter the patient's room

Always ask permission before entering a patient's room as Islamic teaching requires gaining permission from inhabitants before entering.

Visiting patients

As visiting the sick is encouraged in Islam, patients may have a large number of visitors. It is considered culturally unacceptable for the patient to dismiss them and dismissal of the visitors by the nurse could also be embarrassing for the patient. Nurses are encouraged to allow visitors to stay if possible.

Traditional medical practices

Traditional medical practices are still common in some parts of Saudi Arabia. These practices may include cauterising, herbal medical, dietary treatments, chiropractic, fracture reduction, and cupping. Detailed explanation of the expected course of the patients' illness and the effects of the medical management plan might help to keep some patients and their families from seeking traditional healers' advice. However expression of respect toward spiritual healing practice by the health professional is more likely to foster a good relationship with patients and families. Spiritual

healing practices may include the need to get rid of bad spirits (Jinn) through the act of prayer, reciting verses from the Qur'an, using holy water, honey, black cumin and/or spitting.

Death and dying

Belief in predestination and life after death, helps Saudi patients cope with the diagnosis of terminal illness. As a belief is no one but Allah (God) knows the future, a reference to this when discussing life expectancy might be appreciated by the patient. In Saudi culture, the authority of the family overrules the individual's autonomy. The family, not the patient, may be told the bad news first who may choose to withhold bad news from the patient. The concept of hastening death is not one that is accepted thus issues may arise in relation to using opiates or feeding. The environment of the dying person should be as righteous and as peaceful as possible.

When patients are dying their families may request that they be turn to face the Holy Mosque in Mecca. Immediately after death, the eyes of the deceased person should be closed, all needles and connecting tubes removed, and the body completely covered. A female handles the dead woman's body. Where possible the nurse should speed up the process of documentation so that family members can be allowed to start the Islamic rites of washing, shrouding and burying the body. The religious person (Imam) may be asked to attend and read from the Holy Qur'an aloud.

15.9 Appendix 9: Career management

Career management is a stage of the journey through professional life that is guided by a vision/mission of how the nurse chooses and expects to use his/her time in employment (Donner & Wheeler, 2001). Moves may be planned or may come about as opportunities arise while learning is ongoing. New learning will mean new qualifications, thus meaning validation of the learning process and practical skills (Alsop, 2000). To optimise career opportunities it is essential for nurses to identify their strengths, weaknesses, opportunities and threats and to seek future promotion or employment.

Donner and Wheeler (2004) stress that career development is a continuous process which is iterative as oppose to linear. They also note that career development requires nurses to understand the environment in which they live and work, assess their own strengths and limitations, and as well ask others to validate their self-assessment. It is essential for nurses to include their beliefs and values, knowledge and skills, interests and accomplishments in their self-assessment.

Once an assessment is completed the authors recommend creating a career vision, developing a plan of action to focus professional development strategies to help nurses take greater responsibility for their practice and their career. Donner and Wheeler believe career planning is something a nurse does as part of everyday professional activity. These authors have designed a five phase model for career development and planning:

- Phase One: Scanning Your environment – What are the current realities/future trends?
- Phase Two: Completing Your Self-Assessment and Reality Check –Who am I? How do others see me?
- Phase Three: Creating Your Career Vision – What do I really want to be doing?
- Phase Four: Developing Your Strategic Career Plan – How can I achieve my career goals?
- Phase Five: Marketing Yourself – How can I best market myself?

It is important for nurses to understand that a career management plan is only a structured method to goal achievement and does not signify definite success (Van der Merwe, 2004). While it is still up to the individual and the availabilities of opportunities to be successful, due to the great diversity of needs and availability of choices, career pathways are also recommended (Heath, 2002).

Nursing career pathways need to be structured to demonstrate the diversity within nursing, including clinical, education, management and research. Career pathways should be based on the individual's choice, outcomes to be achieved and strategies by which to reach them. They also need to be flexible to accommodate individual differences and experiences, emergent changes within the health care system and the health needs of the community and population (Price, Heartfield & Gibson, 2001). Heath (2002) suggests the following strategies when developing career pathways:

- Select a primary practice domain – clinical, education, management or research.
- Scan the environment for employment opportunities.
- Complete qualifications requirements, including based practice.
- Identify ongoing learning options.

- Maintain professional registration requirements.
- Integrate nursing practice with other healthcare professional practice.
- Utilise diverse educational practice placements.

While the career planning process explained in the Donner and Wheeler's (2004) book can be time consuming, it can help nurses to develop life skills applicable to a workplace as well as personal life. The process can also help nurses to become career resilient, stay in charge of their respective practice and to continue their professional development. This planning process requires the nurse to understand and utilise evidence-based practice.

15.10 Appendix 10: Evidence-based practice

"But facts do not make history; facts do not even make events. Without meaning attached and without understanding of causes and connections, a fact is an isolated particle of experience, is reflected light without a source, planet without a sun, star without constellation beyond galaxy, galaxy outside a universe – fact is nothing". Russell Banks 1997

Nurses are accountable for delivering patient/client-centred care based on the best available evidence. Evidence is defined as something that furnishes proof or testimony (Merriam-Webster Collegiate Dictionary, 2003). The meaning of the word is rooted in the concept of experience, relating to what is manifested and obvious. Within the health system, the concept of evidence has been interpreted in relation to proof and rationality and generally conceived within a scientific context. As evidence is construed it needs independent observation and verification to ensure when used to inform practice or policy, it has been subjected to scrutiny (Rycroft-Malone, Seers, Titchen, Harvey, Kitson & McCormack, 2004).

Evidence-based practice is defined as "…the conscientious, explicit, and judicious use of best evidence in making health care decisions" (Sackett, Rosenburg, Gray, Haynes & Richardson, 1996). Evidence from systematic reviews and meta-analysis has been placed at the top of the hierarchy as it is less likely to provide 'misleading information about the effect (both therapeutic and financial) of an intervention (Sackett et al 1996; Rycroft-Malone et al, 2004). Hence quantitative research tends to be more highly valued than other sources of evidence in the delivery of health care services. Interaction of research evidence with contextual, individual practitioner and patient variables has received less attention (Rycroft-Malone et al, 2004; Upshur, 2001). There are competing views about evidence, some are contrary to others but there is also considerable overlap (Upsur, 2001).

Higgs and Jones (2000) propose that evidence in evidence-based practice should be considered to be knowledge synthesised from a variety of sources, tested and found to be credible. What then is knowledge? Knowledge is described as fundamental to reasoning and decision-making and thus central to professional practice (Higgs & Titchen 2000). Eraut (2000, as cited in Rycroft-Malone et al, 2004) classifies knowledge into two categories:

- Propositional or codified – formal, explicit, derived from research and scholarship and concerned with generalisability.
- Non-propositional or personal – informal, implicit and derived primarily through practice forming part of the tactic knowledge of health professionals.

The relationship between the two is dynamic but unlike propositional, tactic knowledge generally doesn't extend beyond the case or particular setting. Personal professional craft knowledge may become propositional knowledge once it has been articulated, debated, contested and validated through communities of practice in the critical social science tradition of theory generation. Four primary sources of practice based knowledge have been identified (Rycroft-Malone et al, 2004):

- Research evidence tends to provide specific answers to questions posed but may change as new evidence emerges. Upshur (2001) argues that this form of evidence needs to be viewed

as propositional, however, it is rarely constant but rather evolving because it is socially and historically constructed, not certain and static but dynamic and eclectic. This type of evidence needs to be translated for it to make sense in the context of individual patients or different communities. While essential to improving patient care, research evidence is not the only source in nursing practice. Indeed, Upsur (2001) argues that research evidence is more powerful when matched with clinical experience and conversely when it doesn't match its use may be variable.

- Clinical experience and knowledge expressed and embedded in practice is sometimes referred to as intuitive or tactic (Rycroft-Malone et al, 2004). Research verifies that nurses act on their own practical knowledge, as well call upon others' expertise to inform their practice (Thompson, McCaughan, Cullum, Sheldon, Mullhall & Thompson, 2001). Rycroft-Malone et al. (2004) propose that the individualised evidence-based care requires professional practical knowledge and reasoning to integrate the four different types of evidence within the contextual boundaries of the practice experience. On the other hand, professional knowledge has to be made explicit in order for it to be disseminated, discussed, analysed and further developed. Therefore improving practice requires more than accessing new knowledge. Integrating new knowledge into current practice and sharing with patients/clients, also requires reasoning, analytical and communicative skills.
- Patients, clients and carers personal knowledge and experience is the third source of evidence. Good practice cannot be separated from the unpredictable ways in which individuals and their families respond to concepts of health and illnesses (Barker, 2000). There has been however, very little research conducted on the role that individuals play or the contribution their experience makes (Rycroft-Malone et al, 2004). Even when scientific advance in health care delivery is substantial and extremely important, it needs to be placed within the context of the individual person and her or his experience to make sense and for meaning to be attached (Barker, 2000). The mixing of science with human behaviours presents a number of challenges. It is essential "…to acknowledge individuals' values and personal experience as source of knowledge that informs the evidence-base of practice and subsequently to incorporate this into caring, therapeutic actions" (Rycroft-Malone et al, 2004).
- The context of the local community and the organisation is the last source of evidence. Rycroft-Malone et al. (2004) identified local sources of data as follows:
- Audit and performance data.
- Patient stories and narratives.
- Knowledge about the culture of the organisation and individuals within it.
- Social and professional networks.
- Information from the fullest possible constituency of stakeholders.
- Local and national policy.

The potential contribution of local knowledge sources generally is not included as part of evidence-base practice. Rycroft-Malone et al. (2004) suggest more research is needed before this last source can be systematically collected, appraised, and integrated with other kinds of evidence to inform clinical decision making and patients' preferences. From a nurse's perspective of working within a Saudi Arabian context, this source can be extremely challenging due to such factors as an emerging regulatory nursing board, multi-national mix of nurses and other health professionals, ability to communicate in Arabic or English and understand and integrate the local culture into one's nursing practice appropriately.

”Where available research studies characterised by good methodologic quality and rigorous scientific design such as systematic reviews, meta-analysis and randomised controlled trials…” (Registered Nurses Association of Ontario, 2005) provide the highest level of evidence. Levels of evidence are explained in the following table.

Table: Levels of evidence (Source: Registered Nurses Association of Ontario, 2005:11)

Levels	Explanation of Evidence Classification
Ia	Evidence obtained from meta-analysis or systematic review of randomisedrandomized controlled trials (RCT)
Ib	Evidence obtained from at least one RCT
IIa	Evidence obtained from at least one well-designed control study without randomisation
IIb	Evidence obtained from at least one other type of well-designed quasi-experimental study
III	Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case studies
IV	Evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities

Recommendations generated as a result of the literature review can be assigned a grade. The Canadian Task Force on Preventive Health Care (CTFPHC, 1997) has developed grades of recommendation which are identified in the following table.

Table: Grades and explanation of recommended grades
(Source: Canadian Task Force on Preventive Health Care, 1997)

Grades	Explanation of recommended grades
A	There is good evidence to recommend the clinical prevention action
B	There is fair evidence to recommend the clinical prevention action
C	The existing evidence is conflicting and does not allow making a recommendation for or against use of the clinical prevention action: however other factors may influence decision-making
D	There is fair evidence to recommend against the clinical prevention action
E	There is good evidence to recommend against the clinical prevention action
I	There is insufficient evidence (in quantity and/or quality) to make a recommendation, however other factors may influence decision-making

In summary, nurses are encouraged and required to use evidence in their practice. They do so by drawing on multiple sources of knowledge including science, practical and through interaction with their patients and others within the practice context. Facilitated reflective practice sessions and pilot research studies are methods by which nurses can develop and internalise the process of evidence-based nursing practice.

15.11 Appendix 11: Reflective practice

Reflection is a specific thinking process that can take place on four levels: empirical, personal, ethical and aesthetic. Empirical means the situation is guided according to some rule or regulation. A nurse's own engagement in the practice setting is the personal level. Ethical is concerned with managing value conflicts that require value judgment. The aesthetic is when the desired outcomes are envisioned and the achieved outcomes are reflected. These four levels are based on the implementation of the scientific (nursing) process (Johns, 2000; Kemper, 2001). Documentation is an integral part of the nursing process as it is to reflective practice. Reflective thinking can arise out of situations of doubt, hesitation, perplexity and/or mental difficulty prompting the individual to search for ways to resolve or clear the situation oftentimes using past experiences (Teehman, 2000).

Reflective thinking for evaluation differs from the type of thinking required for taking action as it is critical to understand the whole situation. Reflective thinking includes analysing and clarifying experiences, meanings and assumptions to evaluate one's actions and beliefs as well as the "vulnerable part" in the person of not having all the answers, how she/he responded or behaved. Evaluative reflective thinking occurs at a deeper level and generally is not limited to the situation at hand. It can assist in monitoring personal and professional performance. However, reflection is not by definition, critical. It is quite possible for adults to work reflectively while focusing solely on technical/routine decisions (Brookfield, 1995).

Critical inquiry generally starts with examining one's assumptions, values, and beliefs and has the potential of effecting a change in one's established frame of reference. Brookfield (1995) identifies three interrelated processes that support critical reflection:

- Questioning and replacing or reframing previously held assumptions - some representing "commonsense wisdom".
- Taking an alternative perspective on previously taken for granted ideas, action, forms of reasoning and ideologies.
- Recognising "hegemonic" aspect of dominant cultural values and understanding power and self-interest of unrepresentative minorities.

Reflecting on one's nursing practice is a subjective process of self-questioning and review of one's nursing experiences and subsequently changing actions in light of that thought and review (Cooper & Emben, 2001). The key is critical and reflecting thinking as it enables the nurse to think ahead, clarify issues, make meaning and evaluate practice situations. It also supports critical inquiry, however, when centred on the "here and now", reflecting mostly focuses on "filing practice gaps".

Self-questioning does not work in situations where the individual is unable to recognise patterns or where there is knowledge deficit. While dialogue with and posing questions to self can help some make sense out of situations, it does not compensate for gaps resulting in lack of information, inexperience, or dealing with information overload.

The figure below demonstrates the different levels of reflective thinking.

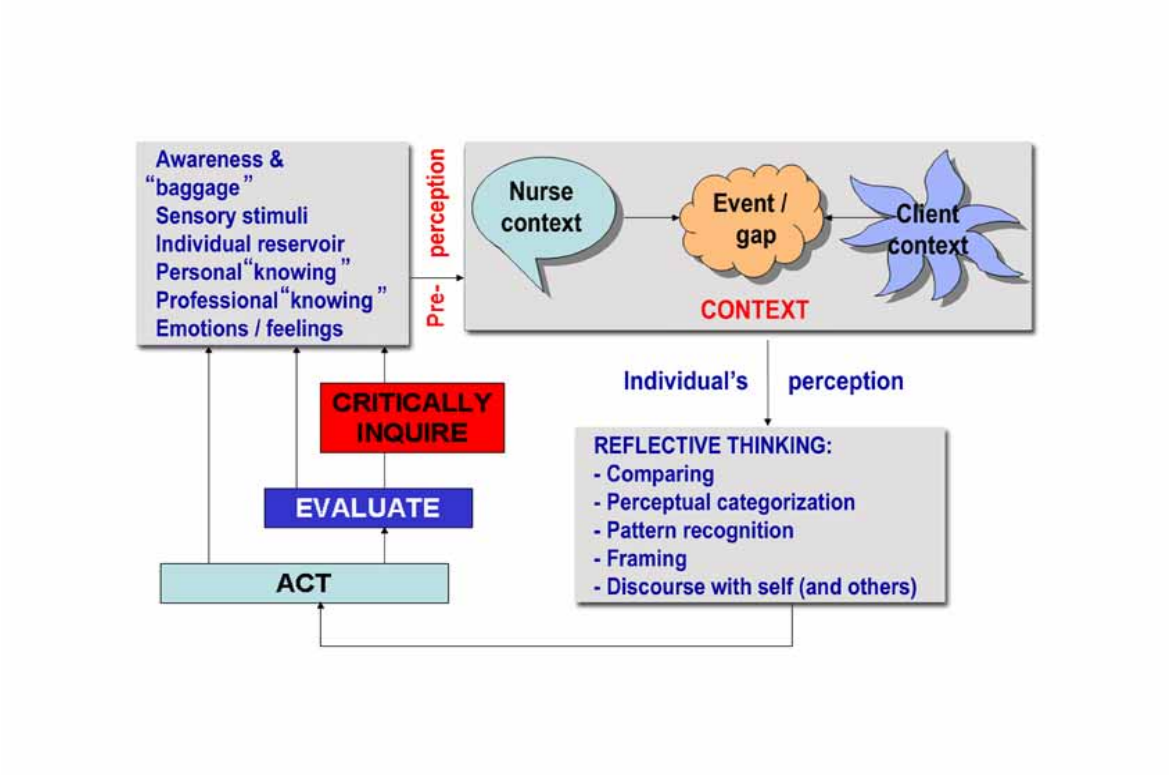

Figure: Reflective thinking as a dynamic process
(Source: Teekman, 2000)

Reflective Cycle

The following questions may help when reflecting on a particular situation or event from nursing practice:

- Describe what happened.
- What specifically do you recall about the situation?
- Who was involved? How were you involved?
- Where, when did the situation happen?
- What were your feelings at the time?
- What was good and bad about the situation?
- What sense can you make of the situation?
- Were the results what you expected?
- What did you learn from the situation?
- What else could you have done?
- How can you use what you learned in the future?
- If the situation arose again, what would you do?

See as well the reflective cycle figure below.

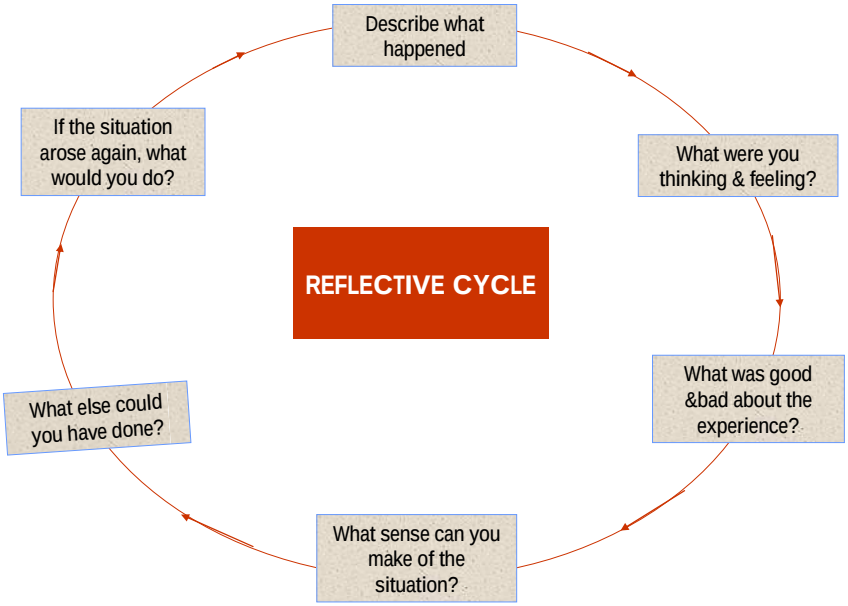

Figure: Reflective Cycle
(Source: Adapted from Bulman, & Schutz, 2004)

Reflective practice is a process of learning and development through examination of one's own practice including experiences, feelings, action and knowledge (Atkins, 2004). This process assists individuals to stand outside of themselves and come to a clearer understanding of what to do and who they are by freeing distorted ways of reasoning and acting (Brookfield, 1995). While problem solving is utilised extensively in nursing, it use tends to be reactionary. Problem posing, on the other hand, does not require an active problem per se as it encourages self-questioning even in routine situations. Reflective practice can help nurses shift from problem solving to problem posing. This change is important as knowledge developed from problem posing is likely to be transferred to other situations and settings (Teehman, 2000).

Skills necessary for reflective practice include self-awareness and assessment, description, critical analysis, synthesis, judgment and evaluation (Atkins & Murphy, 1993). When engaging in reflective practice with others, additional skills include: active listening, empathy, assertiveness, supporting and challenging and the planning and management of change (Atkins, 2004). Higher levels of skills necessary for critical thinking are harder to develop and take longer (Duke& Appleton, 2000). Evidence of self-assessment and reflective practice as well as continuing professional development and career management can be kept in a nurse's professional portfolio.

15.12 Appendix 12: Professional portfolio

A portfolio is a collection of professional and personal documents purposefully assembled to illustrate an individual's talents and accomplishments. Calman (1998) defines a portfolio as a personal professional development tool aimed at encouraging reflection and self-direction in identifying training needs.

Maintaining a portfolio provides an opportunity to reflect on one's practice, identify learning needs and stay in charge of one's career. Hence it is a dynamic process needing to be updated to reflect ongoing learning needs and opportunities. It can include the following:

- "Picture" and personal story of the individual.
- Career management plan.
- Current practice assessment.
- Current professional development plan.
- Evidence from professional activities.
- Assessment of learning.

A portfolio can also be a place to bring together evidence of how a nurse:

- Evaluates and self-regulates his/her practice.
- Identifies ongoing learning needs and professional achievements.
- Contributes to quality patient care and goals of the organisation.

Portfolios are presented differently in ways, reflecting the interests, priorities and intentions of those individuals who compiled them (Alsop, 2000). It is a vehicle for individual nurses to record learning, and plan how to integrate what has been learned into practice; it can be either generic, or specific to competencies in an area of practice. Compiling a portfolio requires skills of recording, analysing and reflecting on experience to inform continuing professional development (Hyde, 2003). In essence, portfolios demonstrate the achievements and capabilities of the respective owner.