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Pediatric Nurses' Perceptions of Continuing Professional Development Opportunities

Suzanne Taylor
Walden University

Walden University

COLLEGE OF EDUCATION

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Suzanne L. Taylor

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Dr. Janet Reid-Hector, Committee Chairperson, Education Faculty
Dr. Ramo Lord, Committee Member, Education Faculty
Dr. Paul Englesberg, University Reviewer, Education Faculty

Chief Academic Officer

Eric Riedel, Ph.D.

Walden University
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Abstract

With the growth in healthcare research and rapid changes in technology, nurses' participation in lifelong learning is a critical factor in providing excellent patient care. However, many nurses encounter difficulties engaging in continuing professional development (CPD) activities. The purpose of this case study was to understand pediatric nurses' perceptions of CPD opportunities at a tertiary, freestanding, children's hospital in Southern California. Social cognitive theory was the framework for the study. Interviews and focus groups were conducted with a purposeful sample of 39 nurses comprised of day- and night-shift nurses plus nurse managers. The data were coded into categories and themes to explain the findings; the resulting 7 themes illustrated how these nurses perceived CPD. The nurses identified motivators and barriers that influenced their involvement in CPD activities. Most nurses reported that they were able to incorporate new knowledge into their practice and produce excellent patient outcomes but some nurses expressed instances of resistance and practice not supported with evidence-based approaches to care. Although the nurses found the programs adequate, they recommended ideas for improvement, including a need for leadership and management development. A project aimed at providing nurse managers with professional development in leadership was created to improve CPD. The project could improve the nursing profession by helping educators enhance CPD to support nurses in delivering high-quality patient care, thus supporting the healing and well-being of children under their care.

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Section 1: The Problem

Introduction

Nurses have a professional responsibility to partake in continuing professional development (CPD) and this education is key to organizational and professional achievement (O'Sullivan, 2004). It is deemed as having a crucial role in uniting service delivery needs and the educational requirements of healthcare professionals (Yfantis, Tiniakou, & Yfanti, 2010). CPD is regarded as a lifelong learning process for all individuals and teams, and is targeted to meet the needs of patients and to deliver quality healthcare outcomes (Banning & Stafford, 2008). Nurses must continue to learn to keep up with the rate of change in today's fast-paced healthcare environment; professionals must learn and train to maintain competence and increase their skill set (Murphy, Cross, & McGuire, 2006). CPD provides a range of endeavors, from informal work-based learning to formal education in academic environments (Tame, 2012).

Participation in CPD is vital to improve patient care outcomes by enhancing nursing practice with educational endeavors that include reflection, evaluation, and using evidence-based knowledge so that patients are recipients of care founded on best practices (O'Sullivan, 2004). In addition, professional development opportunities engage the nurse in a process of growth because the education provides different perspectives that can impact the nurses' practice environment (Dickerson, 2010).

CPD learning activities can be formal, informal, and nonformal (Tissot, 2004). Formal activities are those associated with learning that is structured, such as enrollment

at a university in pursuit of a baccalaureate or advanced degree (Tissot, 2004). Informal learning means learning from daily work and is referred to as *experiential learning* or *on-the-job training* (Tissot, 2004). Nonformal activities are planned activities and include (a) in-house training and class opportunities such as self-directed and experiential learning, (b) reflective practice, clinical supervision, online learning, simulation events, technology/equipment in-services, and practice development projects and performance improvement projects (Banning & Stafford, 2008). Nonformal activities can also include reading journals, journal clubs, researching evidence-based information on the Internet and electronic research databases, and attending conferences.

In addition to this professional obligation, national and state regulatory authorities mandate CPD for accreditation purposes and ongoing license registration. The Joint Commission is a certifying body that accredits health care facilities throughout the country; it signifies quality reflecting a hospital's ability in complying with a plethora of strict criteria and principles (The Joint Commission, 2014). One of its education standards mandates that staff participate in training to maintain or increase their competency and must be documented annually (The Joint Commission, 2014).

The State of California requires registered nurses to complete 30 hours of continuing education every 2 years to qualify for license renewal. The educational content is required to increase the competency of the registered nurse at a higher standard than what is mandated for license renewal and must be associated with scientific knowledge and competencies necessary for the nursing practice (California Board of

Registered Nursing, 2014). Patient safety in clinical environments is a focus of regulatory boards and nursing competence is the key component (Dickerson, 2010).

Definition of the Problem

[redacted], a freestanding children's hospital in Southern California, is the largest pediatric hospital in the area and is the only hospital in California to be ranked in all 10 pediatric specialties by U.S. News & World Report. The hospital has 365 active licensed beds and is a nonprofit, academic, pediatric medical center (CHLA, 2014a). CPD had never been examined at [redacted]. Consequently there was a lack of understanding about the perceptions of pediatric nurses regarding continuing professional development opportunities offered by the hospital (M. Hacker, personal communication, January 14, 2013). The hospital's chief nursing officer (CNO) voiced concerns about the lack of a sustainable education platform. She remarked that the hospital had a rigorous onboarding process but not much after that, and pondered whether there was another way to disseminate knowledge more efficiently (M. Hacker, personal communication, January 14, 2013). The CNO recommended to me, the Director of Clinical Education and Professional Development, to investigate how to build a culture of commitment to CPD and to find ways to provide continuous education to our nursing workforce (M. Hacker, personal communication, January 14, 2013). I have observed that numerous registered nurses take great pride in continuing their lifelong learning while many others do not engage in CPD activities (D. Reid, personal communication, July 3, 2014). I witness every day that nurses are busier now than in previous years due to high

patient acuity. They cannot leave the bedside during a shift to participate in CPD. To compound this, when the nurses have a day off, they will not drive in to attend a 1-hour class (D. Reid, personal communication, July 3, 2014). Courses are offered but many times they are poorly attended even when start and end times are adjusted in order to accommodate various schedules (D. Reid, personal communication, July 3, 2014). Night shift nurses frequently complain to me that they are forgotten and feel that most CPD activities cater to day shift nurses. Other reasons for nonparticipation include insufficient resources or support on night shift and nurses' preference to use a computer for learning (see Appendix B). Therefore, it is necessary to examine the nurses' perceptions of CPD opportunities. This information will allow educators to create CPD offerings that will better meet the needs of staff and increase opportunities and involvement (Schweitzer & Krassa, 2010).

Rationale

Evidence of the Problem at the Local Level

The CNO at [redacted] requested a nursing department academic review; several gaps in practice were identified. The CNO assembled three nurse executives and a health care economist to conduct a full academic review. The review team offered four suggestions for opportunities to strengthen the education department in the hospital (Valentine, Gorman, Needleman, & Nelson, 2012).

First the review team recommended using the significant support for formal education and lifelong learning to re-engineer the infrastructure, processes, and protocols.

The team also suggested using the support to identify, deliver and evaluate professional development programs in order to implement programming aligned with the hospital's strategic plan (Valentine et al., 2012).

Second, the team proposed a needs assessment due to the wide spectrum of ages, learning styles, and needs in the nursing workforce (Valentine et al., 2012). In order to assure effective learning and gain full benefit of the financial outlay for education, accurate learning assessment and implementation of appropriate learning modalities is essential.

Third, the team advised the CNO to ensure that the programming is evidence-based and comprehensive, and that it is delivered in an efficient and timely manner using teaching/learning techniques that are appropriate and effective (Valentine et al., 2012). They emphasized that the programming should be measured for effectiveness.

Lastly, the review team pointed out that the educational skill levels of nurse educators are, for the most part, below graduate level, and are focused on content expertise rather than teaching/learning expertise (Valentine et al., 2012). Evaluation is needed of the assessment and teaching skills of nurse educators. The CNO and directors should raise the expected level of academic preparation to the master's degree for education managers. Graduate preparation in teaching nursing would shift the current paradigm of clinical nurse education from the nurse educator as content expert to the nurse educator as teaching expert who leverages the clinical expertise of clinical nurse specialists, physicians, and other members of the interdisciplinary team. In addition to

assuring more effective learning, this approach would encourage interdisciplinary relationships that are beneficial beyond the teaching encounter. Pursuing advanced degrees needs to be supported by management for those education managers desiring to obtain a higher degree.

In addition to the academic review, during a monthly meeting of the nurse educators at [redacted], a discussion focused on criticisms found within the hospital's education department (Professional Development Advisory Board [PDAB], 2013). Topics talked about at the meeting centered on many aspects of the department that the educators found lacking including the need for an expanded and detailed education calendar listing all of the hospital courses offered and posted online in a central location (PDAB, 2013). Additional remarks were made that the calendar should be based on needs of the staff, new classes are difficult to create, and some staff attends classes outside of [redacted] because of intimidation and registration difficulty (PDAB, 2013). Other statements were made about the low rate of school tuition reimbursement and that staff would like to see more variety in the class offerings that are open to more people (PDAB, 2013). One comment in particular was disconcerting when an educator stated that many staff do not really see that there is an education department (PDAB, 2013).

Nursing staff that are members of the hospital's collaborative governance structure voiced similar concerns during a bi-monthly council meeting (Education and Professional Development Council [EPDC], 2013). They stated that less experienced nurses have more CPD opportunities than experienced nurses and that nurses not hired

through the RN Residency program do not receive as much dedicated training and education (EPDC, 2013). They expressed frustration with a lack of an education website with all information about CPD available to all employees; there is no central source for all education updates and just in time training (EPDC, 2013).

The diversity of the nursing staff generates numerous difficulties in offering CPD courses that will meet the needs of everyone. From learning styles to working different shifts, the nursing staff have different educational needs. The members of EPDC conducted a needs assessment survey (EPDC, 2014), which demonstrated the varied ways the staff prefer to learn. For example, when staff were asked which learning method best matches their learning style, the three top-ranked formats included the hospital's web-based learning management systems at 56%, clinical skills lab at 46.7%, and 4-hour classes at 45% (EPDC, 2014). Poster presentations and Grand Rounds (live speaker presentations) were ranked the lowest (EPDC, 2014). When asked the best time to attend new education, the preferred time was rank ordered by the staff respondents showing that day shift employees prefer to learn between 8am-3pm while night shift selected 8-10 am and various other times as their preferred learning times (EPDC, 2014). The data demonstrate the complexity of trying to meet such diverse and different learning needs and preferences and provides insight as to why many staff have difficulty attending CPD activities. Laal (2011) acknowledged the diverse needs of learners stating a flexible learning framework is necessary in order to support staff to learn at all times and in all

places. Because of the difference between individuals, there must be an adjustable pace and way of study suitable to the staffs' needs (Laal, Laal, & Aliramaei, 2014).

Evidence of the Problem from the Professional Literature

This local problem was amplified by the current state of nursing education throughout the United States. Billings and Halstead (2011) discussed how technological advancements and a knowledge explosion have changed the face of healthcare where the critical thinking skills of the nurse become more important than the ability to perform psychomotor and task skills. Continuing professional development opportunities must be developed to respond to improvements in science and technology. For that reason, there has never been a more crucial time to make certain that healthcare providers have sufficient access and opportunities for lifelong learning. This overarching current state has a direct impact on the nursing leaders dealing with educational issues at a national level.

The initiatives currently being addressed by thought leaders around the country center on education and preparing the nursing workforce. These initiatives include three concerns that will require a steadfast commitment to continuing professional development offerings. First, the Institute of Medicine (IOM, 2010) published a report, *The Future of Nursing: Focus on Education,* making recommendations for the future of nursing. As part of this report, it was determined that nurses should achieve higher levels of education and training through an improved education system. Voge, Hirvela, and Jarzemsky (2012), strongly encouraged nurse educators to help students make

connections between knowledge, clinical reasoning, and practice. Moreover, Voge et al. (2012) recommended that teaching strategies should emphasize teamwork and active learning, in which students are emboldened to use knowledge instead of memorizing facts.

The future of nursing - focus on education. The IOM's (2010) *The Future of Nursing: Focus on Education* report was prompted by the overhaul of health care resulting in the 2010 Affordable Care Act. Transforming to a new health care system will require a comprehensive redefining of many health care roles including nurses. In response to a need to evaluate the nursing profession, a report was produced which delineated numerous issues that confront the educational system for nurses (IOM, 2010). The report contained five sections that are key in recommending solutions to the challenges and are described in the following paragraphs.

The need for highly educated nurses. Most health care today involves the treatment of chronic conditions (e.g., diabetes, hypertension, arthritis, cardiovascular disease, mental health conditions) and fewer acute illnesses as in previous decades. The ways in which nurses were previously educated are no longer adequate for today's healthcare environment (IOM, 2010). Because of this shift in the type of illness conditions, nurses need to be instructed in preparation to support the needs of this changing patient populace. Because patient care needs and health environments are now more complicated than ever before, nurses need to acquire new skills to deliver high-quality patient care reflecting the expertise required in healthcare today (IOM, 2010). In

response to these new demands, the IOM report called for nurses to achieve higher levels of education with academic preparation at a baccalaureate level or higher.

The need for an improved education system. With the change in health care delivery, academia curricula also need to change to reflect the research and knowledge of medicine and care delivery. IOM (2010) specified that competencies must move from task-based competencies (basic nursing care) to high-level ones such as leadership, research and evidence-based practice, and quality improvement that provide a basis for care coordination and problem-solving skills that need to be included in every nurse's professional competency skill set.

***Entering the profession*.** Education requirements for beginning level into nursing practice have been argued for years. The IOM (2010) report acknowledged that a Bachelor of Science in Nursing (BSN) degree introduces students to a wider range of competencies and stated that this degree should be mandatory as entry into practice. Aiken, Clarke, Cheung, Sloane, and Silber (2003), in their landmark study, found that a 10% increase in the number of nurses with a bachelor's degree was related to a 5% decrease in the probability of patients dying within 30 days of admission. These findings support the recommendation from the IOM that the proportion of nurses with baccalaureate degrees be increased to 80% by 2020 (IOM, 2010). The report also recommended doubling the number of nurses with doctorate degrees within the same timeframe.

The National Sample Survey of Registered Nurses revealed that in 2008 only 45% of nurses in the United States had earned a baccalaureate degree (Health Resources and Services Administration, 2010). Similar numbers were found in California nurses showing 42.3% holding a BSN degree (California Board of Registered Nursing, 2013).

Lifelong learning. The changes in healthcare require profound changes in nurses' knowledge after they receive their initial license to ensure they acquire advanced practice education to become a more highly educated workforce. Nursing education should be an exemplar for lifelong learning and must encompass opportunities for unified shifts to include advance degree programs (IOM, 2010).

Enough nurses with the right skills. Healthcare providers need to ensure there are enough nurses with the skills needed to contribute to the overall quality of patient care. The report endorsed the completion of a nurse residency program as these programs can transition the new graduate nurse from academia into clinical practice with reducing turnover rates thereby increasing the stability in staffing levels (IOM, 2010).

Preparing the nursing workforce for the future is a daunting challenge but one that may be achieved through research and systematic identification prioritization of continuing professional development educational opportunities that meet the needs of the nurse within the context of their practice setting and patient population. At the same time, exceptional resource management is needed to develop infrastructure, mechanisms and tools, to not only provide needed CPD education, but to do so in an efficient and effective manner (Valentine et al., 2012). The data obtained from this research study will provide

information for educators to enhance CPD offerings and opportunities for lifelong learning by targeting the specific identified CPD needs voiced by the pediatric nurses.

Nursing education. Secondly, Benner, Sutphen, Leonard, and Day (2010) examined the strength and weaknesses in nursing education and concluded that nurses are undereducated for the requirements of the profession. The authors appealed for a major new comprehension of the curriculum and emphasized the need to move beyond knowledge acquisition to knowledge application. Benner et al. (2010) asserted clinical inquiry needed to be encouraged in a continuing professional development environment.

Learning design. Third, the American Society for Training and Development (2013) emphasized the need for educators to design learning for a 21st Century workforce. "Globalization, increased competition, complexity, uncertainty, emerging technologies, different generations in the workforce, and a shorter shelf life of knowledge all converge to fuel the need for the constant re-skilling and up-skilling of the workforce" (van Dam, 2012, p. 1). Due to this complexity, a blended learning design is needed that is a mixture of learning strategies, methods, media, and delivery modalities that maximize effective experiential learning of continuing professional development education.

Definitions

Continuing professional development (CPD): The knowledge and skills transfer assumed by registered nurses with the intention of maintaining and increasing proficiency in practice (Hegney, Tuckett, Parker, & Robert, 2010).

Lifelong learning: The progression of knowledge that endures throughout one's lifetime centered on specific requirements, circumstances, and interests (Merriam & Cunningham, 1989).

Evidence-based practice: A problem-solving method to health care delivery that combines the best outcomes from research and patient care outcomes with nursing proficiency (Melnyk, Fineout-Overholt, Stillwell, & Williamson, 2009).

Significance

CPD opportunities should be available to all nursing professionals as part of their expected commitment to lifelong learning. Yet many nurses struggle to gain access to continuing professional development (Yfantis et al., 2010). One author hypothesized that failure of nurses to participate in CPD could be attributed to resistance to change but acknowledged that little is known about what nurses expect to get from CPD opportunities (Perry, 1995). Decline in attendance was found by many educators as they voiced frustration with CPD classes when large number of attendees were anticipated only to find conference rooms were nearly empty; other activities were cancelled at the last minute due to low attendance (Kubsch, Henniges, Lorenzoni, Eckardt, & Oleniczak, 2003). Scott (2011) stated that it would be easy to gain the impression that no one is taking nurses' CPD seriously anymore as employers are reluctant to provide funding and backfill, leaving nurses paying for their own courses and conferences, and taking them on their own time. Scott emphasized that continuing education must be a priority. Because healthcare organizations are primary sources of continuing education for their staff,

nurses need additional support in their CPD efforts in order to remove organizational barriers to participation (Nalle, Wyatt, & Myers, 2010). In addition, with an expansive surge in healthcare research and technology, providing excellence in patient care is dependent on nurses' participation in lifelong education (Santos, 2012).

Health providers are directed to increase the level of health professionals' education to meet patient standards for excellent health care services. What is more, policy changes, complex patient acuity, evidence based practice, and required continuing education are key reminders that healthcare providers need to be in a constant state of lifelong learning (Cleary, Horsfall, O'Hara-Aarons, Jackson, & Hunt, 2011). Supporting CPD is costly to health service. Cleary et al. (2011) acknowledged that a key question is how to move the staff development of nurses from the fringes of nursing practice to becoming an obligation and goal of the hospital and included in central clinical activities. To be sure, this will require additional fiscal dollars and resources. The increasing need of congruence between staff needs and employer requirements points to the importance of career planning. Feedback from nurses is necessary to address future nursing and employer needs.

In addition, research has shown that nurses practicing in different nursing domains have different education needs, such as nurse educators, perioperative nurses, and critical care nurses (Doyle, 2006). A nurse researcher expanded on this further and believed that professional development applies to nurses in all practice settings (e.g., educator, administrator, researcher) and that professional development and ongoing

competence is not just for the nurse at the bedside (Dickerson, 2010). Pediatric nurses, in particular, have specialized learning needs in order to take care of critically ill children. In London in 1888, Catherine Wood, a superintendent at the Great Ormond Street Hospital for Children, proclaimed, "I commence by saying two propositions: first that sick children require special nursing; and second that sick children's nurses require special training" (as cited in Whiting, Gibson, & Buckingham, 2002, p. 26). It is understood that children's rights include the right to obtain care from a highly skilled nurse making CPD central to the education of pediatric nurses for providing excellence in patient care (Doyle, 2006).

Magnet® Recognition Program

Another factor that carries great significance for nurses' CPD is the requirement by Magnet hospitals to provide an educational environment for their nurses in which they can grow professionally. The Magnet® Recognition Program acknowledges health care facilities for excellence in patient care, nursing merit, and improvements in professional nursing practice (American Nurses Credentialing Center [ANCC], 2014). Patients and families trust Magnet designation as the symbol for high quality nursing and excellent patient outcomes. Magnet hospitals demonstrate high nurse satisfaction scores, low nurse turnover and vacancy rates, improved clinical outcomes, and above benchmark patient satisfaction scores (ANCC, 2014). Only 7% of all hospitals in the United States have been granted Magnet recognition status (ANCC, 2014).

The hospital site of this research study is a Magnet hospital and therefore held to the many rigorous standards mandated by the ANCC, the Magnet credentialing body. The hospital must be reaccredited every 4 years by providing evidence of best practices that meet certain standards with strict requirements. ANCC has two standards that specifically target nursing CPD: the Structural Empowerment Standard No. 3 - the organization supports nurses' continuous professional development, and Structural Empowerment Standard No. 4 - nurses participate in professional development activities to increase their knowledge, skills, and/or practices in the healthcare environment; professional development activities are intended to improve the professional practice of nursing or patient outcomes (ANCC, 2014). Thus, in order for the hospital to maintain Magnet status, it is critical to have CPD programs and protocols in place with numerous opportunities available for all nursing staff to enhance their professional development.

The purpose of this case study was to develop research based descriptions of the perceptions of pediatric nurses regarding continuing professional development opportunities at a tertiary freestanding children's hospital in order to develop evidence based CPD programs and course offerings.

Guiding/Research Question

Research has shown that nurses throughout the United States and in nations around the world are facing many of the same issues of lifelong learning and partaking of CPD offerings. Nurses in multiple practice settings (e.g., urban, rural, mental health) experience various perceptions of CPD with many finding multiple barriers and

difficulties in participating in continuing education. A similar problem existed in a local Southern California hospital but no research had been conducted to ascertain research-based perceptions of the nurses in order to find out as much as possible about how they experience CPD opportunities within the hospital. To address the local problem, evidence based data produced from an in-depth study into the nurses' perceptions of CPD provided credible information for educators to strengthen CPD opportunities.

In alignment with the research problem and purpose, the following guiding research question was posed for this study: What are the perceptions of nurses at a pediatric hospital regarding continuing professional development opportunities? Questions used to guide the data collection were:

- What kind of CPD activities do nurses participate in?
- What factors influence and contribute to nurses' participation in CPD?
- What are reasons/barriers for nonparticipation?
- How do nurses perceive the adequacy and quality of CPD courses/programs offered by the hospital?
- How do nurses perceive the knowledge obtained from CPD being incorporated into their practice?
- How do nurses perceive that CPD improves the professional practice of nursing and patient outcomes?

Review of the Literature

Because it is vital to review the literature through multiple perspectives, the review includes the following sections: continuing professional development, social cognitive theory, historical research context of CPD, CPD for adult learners/teachers, other healthcare disciplines, nursing CPD in countries outside of United States, nursing CPD within the United States, and systematic/integrative reviews. Following an overview of social cognitive theory, the CPD topics begin with a general historical overview of CPD research and gradually move toward the specifics of CPD in the field of nursing. Many of the studies reviewed are from research conducted outside the United States therefore the generalizability of the results to populations in the United States is unknown. By examining these studies, a picture of the past and current status of the perceptions and practices of continuing professional development will emerge by those most closely involved.

The following electronic databases were used: Academic Search Complete, Education Research Complete, SAGE Premier, Educational Resource Information Center (ERIC), Cumulative Index to Nursing and Allied Health Literature (CINAHL), MEDLINE, Health and Medical Complete, Ovid Nursing Journals, PsycINFO, PsycARTICLES, Google Scholar, and SAGE Premier. The following keywords were used: *continuing professional development, nursing, continuing education, continuing professional education, lifelong learning, professional practice*, and *competence*.

Continuing Professional Development

CPD is a multifaceted concept with many perspectives and ideals. CPD is viewed as a principal strategic instrument for improving healthcare delivery and is concerned with quality, health professionals' accountability, and their ability to examine skills and knowledge to keep current with changes in practice (Maharaj, 2013). Hughes (2005) added the focus of CPD is to make sure that nurses are able to critically reflect on their practice and recognize their own educational needs. Grant (1992) outlined the half-life concept for educational competency as the amount of time 50% of the contents of a course become obsolete. The author stated that what nurses learn is only useable for a few years and projected the half-life of nursing courses to be less than 5 years (Grant, 1992). As well, technological advances lead to outdated knowledge and professional skills in a short period of time (Peña & Castillo, 2006). Thus, because technology and nursing practice continually change, nurses must attend CPD activities to remain competent (Schweitzer & Krassa, 2010). Lastly, Megginson and Whitaker (2003) believed that CPD is an aspirational and potentially life-changing process because professionals control it themselves through critical reflection and action.

Definitions. Several definitions of CPD are relevant to fully understand the scope and necessity of continuing education and lifelong learning. CPD means maintaining, improving, and broadening knowledge and skills required for the implementation of professional and procedural duties across the lifespan of a nurse's professional career (Yfantis et al., 2010). In addition, the scope and standards for nursing professional

development practice defined continuing education as the professional learning experiences developed to increase the knowledge, skills, and attitudes of nurses, deepening the impact that nurses have on delivering excellent patient care nurses' and their attainment of career goals (American Nurses Association [ANA], 2010). Nurses apply knowledge obtained from this education to their practice, regardless of employer.

Nursing professional development, as defined by the American Nurses Association (ANA, 2014) is active participation in learning activities that increase the nurses' continuing proficiency, enhances their nursing practice, and helps achieve their career goals. In addition, ANA's members assert that consumers have an expectation that registered nurses with active licenses continue to increase their skills and proficiency. The ANA members further stipulate that it is the nurse's obligation to direct the processes for guaranteeing nurse competence.

The participants of the Australian Nursing and Midwifery Council (2010) defined CPD as the means nurses take to maintain and improve their knowledge and competence to develop the professional qualities needed during their careers. Nurses view CPD as a progression that includes appraising their practice, identifying learning needs, participating in and reflecting on relevant learning activities, and incorporating new knowledge into practice. Finally, Bignell and Crotty (1988) had a more global perspective of CPD in that they believed CPD consists of planned activities targeted to increase the experiential foundation of the nurse for improving the health of the community.

Benefits. Several authors have discovered numerous benefits to nurses who participate in CPD. With CPD attendance, burnout is decreased, nurses have greater job satisfaction and organizational commitment, and lower stress (Berings, 2006; Chien, Chou, & Hung, 2008; Espeland, 2006; Kubsch et al., 2003; Wood, 2006). Conversely, the lack of CPD appears to guide nurses' decisions to retire early or leave the profession altogether (Andrews, Manthorpe, & Watson, 2005; Armstrong-Stassen & Schlosser, 2008; Hallin & Danielson, 2008). Consequently, CPD is used in recruitment and retention strategies to attract and retain competent nurses (Cleary et al., 2011; Covell, 2009) and Ulrich, Buerhaus, Donelan, Norman, and Dittus (2005) found 64% of the study's nurses said that more opportunities for professional development would keep them at their current place of employment. Levett-Jones (2005) cautioned that although recruitment strategies should not be overlooked, it is more cost-effective to concentrate on retaining existing staff. In conclusion, Kramer and Schmalenberg (2004) stated that in the 20 years they have been studying the defining features of Magnet hospitals, support for educational opportunities is cited as the most significant reason nurses decide to stay at a certain hospital.

Theoretical/Conceptual Framework

Bandura (1986) is the originator of the social cognitive theory that is a comprehensive theory of human motivation and action from a social cognitive perspective. Social cognitive theory has become one of the most influential theories of learning and development (Cherry, 2011) and was selected for the framework of this

research study because it addresses both the psychosocial dynamics influencing behavior and the methods of promoting behavioral change. Because the outcomes of this research study are expected to encourage educators to develop CPD offerings to better meet nursing staff needs and increase participation, it is critical that programs of continuing education be systematically planned and developed applying effective educational techniques and methodologies specifically designed for adults (Jarvis, 2005). CPD courses should be created so that all nurses have the opportunity to develop their own interests and to keep current with the most recent changes in nursing necessitating that all teaching and learning should be conducted according to the best researched principles and concepts of the education of adults (Jarvis, 2005).

Social cognitive theory deals with three interacting determinates that influence each other bi-directionally: the theory highlights reciprocal causation through the relationship of personal, behavioral, and environmental factors (Wood & Bandura, 1989). In this transactional view of self and society, these three factors function as interacting causes that affect each other bi-directionally and is pictured as a triangle in which learning is positioned within a social context (Bandura, 1986). See Appendix C for a deeper look into the triadic reciprocal causation relationship with an explanation of the components (Bandura, 1997). In addition, Stuart (1989) defined social learning theory as a method of describing, analyzing, and potentially influencing behavior. It is an education in human relations that attempts to provide an environment in which effective learning may occur. In as much as Bandura believed that direct reinforcement did not take into

account all forms of learning, he included a social element into the theory, asserting that people can learn new information and behaviors by watching other people; this concept is categorized as observational learning or mastery modeling (Cherry, 2011). Bandura (1986) maintained that people could increase their knowledge vicariously through observing people's behaviors and the consequences from it.

Critique of social cognitive theory. Bandura is not without critics regarding social cognitive theory. Around the same time that Bandura changed the theory from social *learning* theory to social *cognitive* theory, three psychologists critiqued the new direction and openly expressed their concerns. Powers (1991) declared disagreement with Bandura regarding his explanation of principles of control theory and human agency. Powers stated the attempt suffered because of the author's unfamiliarity with control theory and claimed that Bandura was recreating a theory that many others have helped to develop. Powers continued with his dispute of Bandura's thinking maintaining that very little of what Bandura said about the properties of control systems was right and appealed to Bandura that he should at least demonstrate knowledge of the theory and show how his version is an improvement on it. Powers concluded with one final comment aimed at Bandura's perceived lack of understanding new principles of control theory: "It behooves everyone who wants to use this new tool, however, to learn what it is about: As any wide receiver would advise, don't run with the ball before it is securely in your hands" (Powers, 1991, p. 153).

The critique continued with Corcoran (1991) saying that Bandura's presentation of the revised theory warranted closer examination and evaluation. Corcoran expressed criticism with Bandura for not offering operational definitions to new terms in the theory and felt the modification in language caused a subtle change in conceptualization, focusing on the cognitive aspects of the theory and had muddled the distinction between terms. Corcoran further indicated that Bandura missed connections and crucial linkages. Corcoran (1991) concluded saying Bandura has contributed little to understanding human behavior.

Finally, Rottschaefer (1991) desired an explanation regarding issues surrounding the reductionism doctrine concept and disagreed with Bandura's view on the interactive account of human agency. Rottschaefer did, however, give Bandura credit with providing a strong support in the ongoing cognitive transformation to clarifying human agency. As a point of interest, Bandura (1991) wrote a six-page rebuttal addressing all three psychologists' concerns.

In summary, the triadic reciprocal causation concept can produce lifelong behavior changes and nurses would be in an advantageous position to learn through vicarious and observational experiences, modeling, verbal and social persuasion, and instruction and performance mastery. It serves as an impetus for educators to create and develop CPD programs that include this powerful triad of social cognitive theory concepts.

Historical Research Context of CPD

The study of CPD can be traced back almost 40 years with the first research found in this review of literature conducted in 1976. Because the subsequent sections of the literature review contain current research within the past 5 years (2009-2014), it is vital to include an overview of the previous inquiries carried out pertaining to nurses and CPD. In order to have a full and complete picture of CPD, it is key to know the answers to such questions as, "Has CPD changed over the years?" and "Are nurses' perceptions of CPD the same today as in years past or have they shifted to a different paradigm?" Only by reviewing past history will these answers be found. Altogether 250 journal articles were discovered during the literature review for this research proposal. See Table 1 for a compilation of all the articles found regarding CPD.

In order to select only research studies that were pertinent to this research proposal, each one was filtered in order to meet the following criteria: the research must pertain to CPD with a focus on nurses' perceptions and practices of various CPD opportunities. This standard was set as it directly relates to the research question proposed for this study. The following subsections are a synthesis of what was historically studied: 1970-1979, 1980-1989, 1990-1999, and 2000-2008.

Table 1

Overview of All Articles Found Regarding Continuing Professional Development

Year	Category	Number of Articles
1970 - 1979	Research	4
1980 - 1989	Research	3
1990 - 1999	Research	19
2000 - 2008	Research	42
2009 - 2015	Research - Adult Learners/Teachers	8
	Research - Other Healthcare	13
	Research - Outside US	38
	Research - Inside US	9
	Research - Systematic & Integrative Reviews	9
Various	Non-Research Articles	105
	Total	250

Note. Search conducted from February 2013 through January 2015; includes 1 pediatric.

1970-1979. In the first research study found on CPD of nurses, Clark and Dickinson (1976) examined 220 Canadian nurses' extent of CPD participation and their reasons for and attitudes with participation. The findings indicated that all nurses participated to some extent in CPD but attended more self-directed than other-directed learning activities to improve job competency. Most nurses had a positive attitude, which correlated positively with their level of participation. Baccalaureate graduates and those with some university experience appeared to be more active participants. Curran (1977) followed this study as a response to new mandatory CPD requirements and surveyed 600 nurses in Illinois to obtain information about nurses' CPD needs and participation in CPD

programs. Curran's findings agreed with those of Clark and Dickinson and reported that graduates of diploma nursing programs were less active CPD participants than those baccalaureate prepared. In addition, Curran found older nurses read more frequently than younger nurses, and lower income nurses spent more money on educational materials and enrolled in courses for college credit more often than nurses in the higher income groups. The learning needs expressed by nurses closely correlated with the job activities of their specific role. In another study, O'Connor (1979) identified motivational intentions of 843 nurses and the findings suggested that the existence of mandatory CPD had little influence in motivating participation. Instead, the nurses from this study participated in CPD programs to maintain professional expertise.

The final study found during the 1970s was closely aligned with the previous two studies. Matthews and Schumacher (1979) surveyed 150 Virginia nurses and found that nurses valued CPD but disagreed on the necessary content/course material. Benefits of CPD were increased knowledge and skills, increased awareness of current nursing trends, better patient care, and maintenance of professional competence. Barriers to participation were the length of the program, dollar cost, and if no credits were given for the activity. The four studies included in this section begin to lay the foundation for what future studies would continue to examine and were groundbreaking research as there were no studies, up until this time, in which to compare nurses' perceptions and practices of CPD opportunities.

1980-1989. Millonig (1985) disagreed with several of the studies from the 1970s regarding education level and CPD participation. Millonig found nurses with master's degrees participated most frequently in CPD and although this agrees with the precedent set that the more education people have, the more they will pursue learning, the agreement ended there. What is more, Millonig reported that hospital diploma nurses participated at rates higher than nurses with baccalaureate and associate degrees. The most frequent participants were nurses at the administrative level with staff nurses participating the least. Urbano, Jahns, and Urbano's (1988) research supported O'Connor's (1979) study and found that nurses are motivated to participate in CPD activities by the desire to learn more, increase knowledge and skills, and for community service to mankind. Similarly, Dolphin (1983) used the same survey tool as O'Connor and Urbano et al. and found comparable results. Dolphin ranked ordered (in descending order) the factors central in participating in CPD: increased job competence, growth, peer learning, learning, employer requirements, community improvement, community service/interactions, employer benefits, sociability, and peer pressure. This decade revealed similarities and differences in nurses' CPD.

1990-1999. Out of the 19 research articles found for this decade, 10 of them added depth to this literature review. For instance, Stefanik et al. (1994) found nurses' opportunities for growth and development as a significant factor in job satisfaction and organizational commitment. The authors also showed that full time nurses held a higher value of CPD than part time staff. Barriball's (1996) outcomes supported these findings

with evidence that part time and night shift nurses attended less CPD activities than full time and day shift peers. In another case, Cullen (1998) determined reasons for not participating in CPD and rank ordered 12 explanations. In contrast, Turner (1991) categorized 33 benefits of CPD and DeSilets (1995) provided 30 reasons for participating in CPD with *knowledge and skills* and *quality of performance* as the highest motives. DeSilets also found, as per previous studies, baccalaureate nurses placed significantly greater importance on CPD that did diploma nurses. In the same way, Nolan, Owens, and Nolan (1995) reported 10 benefits of CPD stating that *update of knowledge* and *better patient care* were the top two reasons. Additionally, the researchers found difficulty in accessing CPD as the number one rated cause of frustration. Nolan et al. cautioned that CPD is only effective to the extent that changes in practice occur and suggested future research needs to focus on the practice environment. Finally, Staring (1995) confirmed previous research as she found the longer the intensive care (ICU) nurses were in their role the less motivated they were to attend CPD and the older the ICU nurse, the less likely they were to participate.

Three studies deserve special consideration as the researchers looked at new perspectives of CPD not previously reported in the literature review. White et al. (1998) gained insight into the attitudes of the staff nurse toward on-the-job training. The authors encountered very negative feelings due to a dynamic push-pull between the need and desire to learn with the feelings of responsibility to attend to patient care duties and heavy workload. The outcome was that on-the-job training was an impediment to learning. A

year earlier, Ofosu (1997) looked at conferences and workshops and found the following: the increased number of years of nursing experience produced increases in conference attendance, decreased attendance of nurses who graduated from college, married and single nurses participated at the same rate, and there was no significance between the nurses' age and attendance. In closing, Scheller (1993) wanted to know what factors influence nurses' use of knowledge gained from CPD and found the inability to apply knowledge to the practice environment and resistance to change were the top two factors inhibiting application to practice.

Many researchers in the 1990s reported and supported findings from earlier research but many focused on new and different aspects of CPD. When put all together, they provided an increased knowledge base of CPD and the nurses' perceptions and practices.

2000-2008. The first decade of the millennium produced a plethora of CPD research much of which looked at different samples and different practice locations and environments but returned evidence previously found in other studies. Only research with newfound outcomes that have not been discussed in this literature review will be presented for the years of 2000-2008.

It is noteworthy to mention that only one study of all the 250 articles found relating to nurses' CPD focused specifically on pediatric nurses. This was unexpected and provided credible evidence for the need to conduct further studies concentrating on the specialty of this nursing practice. Doyle (2006) studied 250 pediatric nurses in Ireland

firmly believing that the CPD of children's nurses was a key factor to the development of the nurses and the ability to proved excellent care. The study established that the pediatric nurses favored reading journals for keeping current. However, it was disclosed that the journals very often did not have a pediatric focus and did not contain relevant articles of interest in pediatrics. The nurses also chose study days and conferences as alternative CPD activities but the travel distance to the conferences had often proved difficult. The author surprisingly reported that the nurses did not like the Internet or electronic journal databases as a method to keep current with CPD due to lacking computer skills.

Investigators from five other studies examined new aspects of CPD not previously reported. Ellis (2003; Ellis & Nolan, 2005) desired to know the factors that appear to influence CPD outcomes over time. In a case study (Ellis, 2003; Ellis & Nolan, 2005), the researchers found four factors: the nature of the selection process, the nurses' disposition towards the program, the quality of the CPD experience, and the nature of the practice environment. This has vast implications for practice as these factors were found to significantly influence the likelihood of making changes to the practice environment after participating in a CPD event. In another study, Upenieks (2002) conducted the first research found on the differences of CPD in Magnet hospitals versus non-Magnet facilities. Non-Magnet leaders stressed the importance of adequate staffing, whereas Magnet leaders focused on additional education services as a retention strategy. The Magnet leaders emphasized the importance of providing clinical nurses with CPD opportunities to increase job satisfaction. In a study to determine nurses' views of the

workplace environment, Ulrich et al. (2005) found more opportunities for CPD than opportunities for advancement. Furthermore, 64% of the nurses said that more opportunities for CPD would cause them to reconsider leaving; only 25% of the nurses indicated that their organization had offered career development CPD programs in a deliberate effort to retain them (Ulrich et al., 2005). Even though many researchers previously looked at motivation to participate in CPD, Bahn (2007) reported a finding not previously discovered. In addition to other motivators, Bahn (2007) reported the initial motive for taking part in CPD was the perception that the nurses were being left behind by the higher educational level of nurses entering the profession.

The look at 40 years of previous CPD research provided a wide overview on what researchers wanted to know about nursing CPD during this era. It provides a solid base to move forward with as the literature review turns to look at current research.

CPD for Adult Learners/Teachers

Even though the focus of this research study was on nurses, it is helpful to understand how professionals outside of nursing and healthcare view professional development. Many researchers have concentrated on adult learners and teachers and their studies are worthy to be discussed in order to obtain a wider view of CPD.

Three research studies were conducted in England offering CPD perspectives from adult learners and teachers. White (2012) surveyed 47,000 adult learners to discern their patterns of participation in adult education and found that patterns of participation appear to be replicated generationally with parents' educational experiences and

qualifications being the two strongest predictors of their offspring's participation. An individual's own educational experience was also reported to be key in determining the likelihood ongoing continued education. White also found occupational class a chief predictor with individuals in professional and higher managerial occupations reporting the highest levels of participation. White was able to obtain documentation that measured participation over an eight year span that previously had not been studied and interestingly found that no significant increase had taken place over time. In interpreting his findings, White suggested that whatever changes that have happened over the past 8 years in terms of policies, funding, technological advances and societal change, they had very little impact on individuals engaging in adult learning.

Moving from adult learner study participants to teachers, Opfer and Pedder (2010a; 2010b) conducted two research studies that specifically focused on teachers' practices of CPD. In one study, the authors found that teachers spend the majority of their professional time in workshops and seminars that did not have a positive impact and reported little change at the learner and school levels (Opfer & Pedder, 2010a). Overall, the authors reported that CPD in England tends to occur passively and rarely occurs in conjunction with colleagues. In the second study, Opfer and Pedder, (2010b) found three types of barriers to CPD reported by the teachers that pinpointed older teachers having less interest in CPD. In addition, teachers reported budget constraints to participation but also felt the CPD offerings lacked quality and therefore held negative views about any potential benefits that CPD could offer (Opfer & Pedder, 2010b).

Similarly, teachers in Lebanon also had dissatisfied views of CPD. Nabhani and Bahous (2010) discovered in surveying 739 teachers that even though the teachers were able to attend workshops, there was no follow-up for application of what was learned. The teachers stated their measure of CPD worthiness is the applicability to the workplace. Teachers in Australia voiced disgruntled opinions of CPD and complained that CPD used to be for professional development but it has turned into a logging of hours and credits for certifying professional organizations (Boud & Hager, 2012). They wanted the focus of CPD returned to the professional practice of learning located in what professionals do and how they do it. With this overview of teachers' perceptions and practices of CPD in mind, it is necessary to review CPD practices in other healthcare disciplines in order to progress from the general to specifics in the literature review.

CPD in Other Healthcare Disciplines

It is equally as helpful to study CPD research conducted in healthcare disciplines outside of nursing to determine and understand the similarities and differences to nursing. CPD has been studied within various disciplines including pharmacists, psychologists, radiographers, physiotherapists, doctors, physical therapists, and physician assistants. The following is a composite look at how these different healthcare professions perceive CPD.

Pharmacists. Pharmacists, just like all other healthcare professionals, must maintain their competence and are required to participate in continuing education events (Tofade, Hedrick, Dedrick, & Caiola, 2012). A group of pharmacists in North Carolina

participated in a random CPD portfolio audit to evaluate the portfolio as a means to meet the CPD requirements when applying for re-licensure. Tofade et al. (2012) found that 60% of the portfolios were deemed adequate and the Board of Pharmacy accepted portfolio demonstrated CPD as a feasible alternative to traditional methods. Unfortunately, the small sample size (2% of North Carolina pharmacists) does not allow for generalizability of these findings. Likewise, a group of pharmacists covering five states (Indiana, Iowa, North Carolina, Washington, and Wisconsin) also looked at participating in non-traditional CPD methods to increase their knowledge and skills. Dopp, Moulton, Rouse, and Trewet (2010) examined whether pharmacists who participated in a certificate program would be more successful at learning than through a traditional method. Not only did Dopp et al. find a positive impact to learning, the results also included the use of portfolios as previously discussed. In addition, the pharmacists were very pleased that this new structure allowed multiple educational opportunities that permitted them to pursue their own interests (Dopp et al., 2010). What is more, other pharmacist researchers confirmed the findings in the previous two studies (McConnell, Delate, & Newton, 2012). A group of pharmacists from Colorado participated in a randomized controlled trial and found that pharmacists who espoused a new CPD tactic to learning (including workshops and targeted information designed specific for their learning needs) were more likely to report improved learning behaviors as compared with those who participated in the more traditional CPD (McConnell et al., 2012).

Psychologists. Neimeyer, Taylor, Zemansky, and Rothke (2013) conducted an experimental study to see if there were differences in CPD between psychologists who were aware of a new mandate requiring CPD versus those who were not yet aware. They found that the awareness of the upcoming mandates was associated with higher levels of participation in formal CPD but not in informal means. Two of these researchers also looked at what kinds of CPD activities psychologists participate in and to what extent did they contribute to ongoing proficiency (Neimeyer, Taylor, & Cox, 2012). The researchers found that CPD activities including self-directed learning, peer consultation, and formal CPD were perceived as highly causative to proficiency, whereas serving on professional boards, performing client assessments, and enrolling in graduate courses contributed very little (Neimeyer et al., 2012).

Other disciplines. Numerous other researchers also studied CPD and examined professionals' perceptions regarding CPD in other disciplines in relation to attitudes, motivators, barriers, preferences, support, learning strategies, employee interests and goals. For example, Radiographers expressed dissatisfaction with the requirement to evidence CPD both in the time it took to attend the activity and the time it took to document it (Henwood & Flinton, 2012). Physiotherapists found their clinical competence improved and changed positively after participating in an annual in-service education program designed specifically around their clinical practice needs (Banks, Meaburn, & Phelan, 2012). Doctors in the United Kingdom, when asked what promotes or inhibits CPD, reported widespread consensus as to the value of learning in professional

settings (Schostak et al., 2010). However, they agreed there ought to be a move away from the tick box evaluation method to an in-depth identification of learning needs and how they can be met. Physician assistants studied which methods of CPD are deemed most affective to their learning and found that those utilizing real patient problems were most helpful (Polansky, 2011). This is consistent with principles of adult learning in that active forms of learning are most valuable. Continuing on, Physical therapists in New York found CPD to be inadequate with significant gaps reported between current and desired availability (Recker-Hughes, Brooks, Mowder-Tinney, & Pivko, 2010). They also stated they received little or no support from their academic programs to attend and participate in CPD. Likewise, rehabilitation therapists (speech/language, occupational and physical) in South Africa found similar concerns (Maharaj, 2013). The therapists reported that 1 to 3 day courses, mini-congresses and journal clubs were the most frequently attended events but found several barriers. These barriers included time, cost of the courses, cost of travel due to geographical distance, staff shortages, lack of employee support, and inappropriate courses. The authors did, however, make suggestions for improvement: introduce state subsidized and corporate sponsorships, and increase in-service journal club activities, video conferences, on-line presentation, and profession-specific courses (Maharaj, 2013). Finally, a variety of healthcare professionals (physicians, nurses, physician assistants, speech pathologists, and surgical technologists) explored vocational interests and goal orientation for their potential influences on their decision to engage in CPD (Johnson & Beehr, 2014). The results contribute to the support

and relevance of vocational interests in predicting employees' voluntary participation in CPD suggesting that interests may influence behavior by motivating staff to pursue CPD opportunities. Goal orientation was found not only to predict the extent that people will voluntarily participate in CPD but also the extent they will apply the new acquired knowledge and skills to their work (Johnson & Beehr, 2014).

Some of the studies (Dopp et al., 2010; McConnell et al., 2012; Polansky, 2011; Tofade et al., 2012) reviewed in this section included a pro-active approach to CPD showing a desire to improve the CPD learning process to becoming more beneficial to the profession. However, some researchers (Recker-Hughes et al., 2010; Maharaj, 2013) found a discontentment with CPD and barriers to participation. These studies add to the body of knowledge regarding the perceptions of CPD in other healthcare disciplines outside of nursing. The review of the literature continues with a more specific look at CPD in the nursing profession.

Nursing CPD in Countries Outside of United States

By far, most of the nursing studies found in the literature originated from countries other than the United States. During the review of literature, many themes developed including motivators and barriers to CPD, rural nursing, resource allocation, quality of care, job satisfaction, commitment and retention, horizontal violence, age of nurses, and content and teaching methodology. Knowing nurses' perceptions of CPD from around the world and from a variety of cultures will provide a broader perspective

and further inform this study's research question desiring to know the perceptions of nurses regarding continuing professional development opportunities.

Motivators and barriers to CPD. Researchers found that Australian nurses appeared to be consistent across the literature in their perceptions of CPD regardless of the practice setting. Three Australian studies are described here and are typical of other studies found (Brideson, Glover, & Button, 2012; Ross, Barr, & Stevens, 2013). In response to a questionnaire, 289 public and private hospital nurses and midwives in Queensland, Australia were surveyed to find out their current understanding, practice and future CPD needs (Katsikitis et al., 2013). The researchers showed that participants valued ongoing learning, preferred education to occur within work hours, and organizational support positively influenced attitudes to CPD. Barriers to participation in CPD included understaffing and the concern that CPD would interfere with time outside work. The authors discovered the importance of the role of supportive management in encouraging their staff to participate in ongoing learning.

In another study, Hegney et al. (2010) reported comparable findings in an exploratory study related to nurses' self-reports of CPD access and support. Two surveys were taken in 2004 and 2007 each, which sampled 3,000 nurses who were members of the Queensland Nurses' Union. Over 85% of the nurses reported they had access to CPD activities. However, between 2004 and 2007, the amount of financial support provided by employers had decreased significantly. The major barriers to attend CPD programs were financial (could not afford the fee, could not take unpaid leave to attend). In addition, not

having the time to participate in the activity surfaced as an additional barrier as well as geographical distance for nurses in rural and remote areas. Generalizability of union nurses to non-union populations is unknown and should be used with caution. Consistent with this study, in another investigation the researchers explored clinical ward-based nurses' values and perceptions towards CPD and what factors impact continuing education in the ward (Govranos & Newton, 2014). Twenty-three nurses from a major teaching hospital in Melbourne participated in four focus groups and six semi-structured interviews. The nurses valued CPD as important and topics ranged from keeping up to date with careers, improving standards, providing excellent quality care to time management (Govranos & Newton, 2014). Others felt that nurses should be responsible for their own learning and they did not feel motivated when having to use personal time to learn. Inhibiting factors included comments that there needed to be a closer link between management and education, and that the education offered failed to capture the workplace content. The authors suggested that increased organizational support is necessary so that managers can promote and sustain lifelong learning and a culture conducive to learning.

In England, Lee (2011) found very little systematic follow up and support following CPD activities. As in previous studies, Kelly, Berridge, and Gould (2009) found time constraints and access as barriers to CPD in England. Five senior neonatal nurses in England participated in focus groups to discuss how they perceived their experience of a CPD module on their practice (Stanley & Simmons, 2011). Several

barriers were found to CPD during work including the lack of time for learning and reflection in their working day. An additional difficulty found was a contradiction between the manager who wanted nurses to take part in the learning and yet not allowing them to implement new innovations discovered.

Only one study was found from China exploring Chinese nurses perceptions of the motivators and barriers to CPD. Similar to the data results of previous studies, nurses in China were motivated to participate in CPD to update knowledge of the latest nursing developments and procedures, to improve their practical skills and comprehensive qualities, to maintain professional status, and to receive an academic degree (Ni et al., 2014). Hindrances included time constraints, work commitments, lack of opportunity, cost of the courses, and previous negative experiences with CPD programs.

Yfantis et al. (2010) surveyed 23 nurses in Greece to evaluate the concept of CPD and analyze whether it can offer opportunities for advanced professional development among nursing staff. Most respondents understood CPD to be part of lifelong learning but not as an ongoing process of the higher level concepts of reflection and action. The authors indicated that nurses need a stimulating work environment, including mentoring and support, to enable CPD to be effective in healthcare. Barriers included busy clinics and already fully booked programs with no seats available to all that wanted to attend.

Two studies were identified from Iran. In one Iranian hospital, the researchers conducted a cross-sectional survey study of 361 Iranian nurses who answered questions on topics covering their attitudes of facilitators and barriers of their participation in

continuing education (Hamzehgardeshi & Shahhosseini, 2014). The highest mean scores of nurses' participation in CPD were related to updating knowledge, giving qualified care to patients, improving clinical practice skills, and obtaining knowledge to achieve personal status. The highest mean scores for barriers to participation were work commitments, cost of courses, time constraints, geographic distance, poor scheduling of programs, and lack of organizational support, information and accessibility to programs. These findings are supported by other research reported in the literature review. In a qualitative study with 21 Iranian nurses, researchers examined the outcomes of CPD with the nurses describing how they had grown and developed professionally due to CPD (Rahimaghaee, Nayeri, & Mohammadi, 2010). They described their development in two broad areas: skill development (judgment, communication, confidence) and psychosocial development (seeing the whole patient, increasing commitment). Unlike any of the previous studies, this research addressed some of the personal and spiritual aspects of the clinical nurses' professional role.

Nurses from four states in Malaysia sought to identify factors that influenced nurses' participation in CPD (Chong, Sellick, Francis, & Abdullah, 2011). The authors revealed five essential motivating factors: to update knowledge, provide quality care, to improve skills, improve communication skills, and to obtain knowledge. The five top deterrents were work commitments, domestic responsibilities, time constraints, scheduling of activities, and cost of courses. These findings once more confirm previous studies' outcomes. Interestingly, all demographic data were significantly associated with

CPD participation, except marital status. Those demographic areas included nurses' age, number of children, professional education, household income, working institution, and number of years of service (Chong et al., 2011).

Researchers in Nepal explored nurses' views on the need for CPD and Shrestha, Bhandari, and Singh (2010) found major barriers for lack of participation in CPD education. Eleven nurses participated in the study including two staff nurses, four charge nurses, three nurse administrators, and two nurse teachers. Themes emerged from the qualitative data: continuing professional development, supportive management, nursing leadership, recognition and respect, and professional networking were considered as essential factors for CPD. Lack of commitment by the nurses, female gender professional bias, and lack of autonomy were found as barriers for CPD. This supported previous research discussed thus far.

Rural nursing. Anderson (2012) studied 38 rural nursing students through a photovoice qualitative research method. The photovoice research design provided study participants the opportunity to use cameras to document and reflect upon information relevant to the study. Through the pictures and interviews, the nurses identified several challenges to rural CPD: inadequate rural education, professional isolation, and lack of autonomy. Professional isolation caused nurses to have few opportunities for professional development due to distance, weather, and staffing issues.

Resource allocation. Researchers from four hospitals in Norway participated in a study that included interviews of 19 nursing leaders at the unit level and 24 executive

nurse leaders who had systematic and organizational responsibility for nursing service (Bjork, Torstad, Hansen, & Samdal, 2009). Thoughts and actions related to promoting CPD through clinical ladder participation, securing support and recognition, and competence were the issues under study. The nurse leaders revealed that although the organization endorsed clinical ladder programs, resource allocation was limited in relation to what they judged necessary and desirable. This outcome prompted the leaders to develop a cost expenditure model that captured the cost of providing CPD activities that convincingly and precisely demonstrated the need when arguing for allocation of more money.

Quality of care. Nurses in Thailand ranked active staff development and CPD for nurses as the central factor in nursing foundations for quality of care (Marzuki, Hassan, Wichaikhum, & Nantsupawat, 2012). Marzuki et al. (2012) correlated CPD with patient falls and found a weak level of statistical significance. The authors interpreted this to mean the highest knowledgeable nurses (the most actively participating nurses in CPD programs) could decrease patient falls. This focus had not been reported in previous studies.

Job satisfaction, commitment and retention. Drey, Gould, and Allan (2009) believed that United Kingdom nurses have a responsibility to partake in CPD to keep up with changes in healthcare and that these opportunities increase retention. They conducted a quantitative study with questionnaires filled out by 451 nurses. The purpose of this study was to explore the relationship between CPD participation and commitment

to the profession. Organizational commitment was highest in younger, less experienced nurses and those who worked part-time. The authors suggested that commitment declines as the realities of nursing work become increasingly apparent to those who have been in the workforce for a longer period of time. No relationship was found between commitment and participation in CPD education. The age of the nurse and its relation to CPD was not always supported in previous research reviewed. Agreeing with previous Australian research findings, Cleary et al. (2011) looked at mental health nurses' views and preferences about CPD and its relevance to career intentions. Through semi-structured face-to-face interviews with 50 mental health nurses, the authors found that the majority of the participants valued CPD and sought more opportunities to participate. The researchers highlighted the value clinical nurses place on having access to work-based and clinically focused education and development. The authors concluded that relevant on-the-job professional education has the potential to improve job satisfaction and retention of clinical nurses (Cleary et al., 2011). From a different perspective, Walker, Fitzgerald, and Duff (2014) studied the nursing practice environment of 492 nurses in a Magnet hospital in Australia. Walker et al. conceded that sustaining a culture of success and high levels of staff engagement and empowerment are challenging after receiving initial Magnet designation but they found the nurses exceeded four of the six benchmarks on the practice environment scale 3 years after Magnet designation proving that a healthy work environment can be maintained.

Horizontal violence. With interviews of 23 perioperative nurses in England, Tame (2012b) investigated workplace culture and intra-professional conflict associated with horizontal violence as a direct result of nurses participating in a formal study program. This had not been previously discussed in any of the studies found for this literature review. During the interviews, the participants were encouraged to illustrate their experiences using examples and the author found a relationship between CPD and horizontal violence in the perioperative practice. Through the interviews, the authors showed that not all colleagues were supportive, not everyone liked that some nurses were studying, some colleagues seemed jealous and irritated, and some managers prevented the nurses from progressing. Tame commented that as participants discussed their negative experiences, they became visibly agitated and anger could be heard in their voices; the depth of emotion was so strong for one participant that she began to cry. These outcomes support findings found in previous research conducted by Tame (2009, 2011, 2012a). Tame (2009) coined the word 'secret study' when she discovered that some nurses did not disclose to colleagues that they were participating in CPD. Reasons varied related to cultural discourse of the workplace, participants' academic confidence, and potential ramifications of failure.

Age of nurses. Lammintakanen and Kivinen (2012) studied differences of CPD practices and attitudes between nurses of different ages. 653 Finnish nurses responded and the data showed that the younger nurses participated the least in CPD practices; attitudes were similar between age groups and did not explain participation in CPD. They

also reported more experiences of injustice (e.g., younger nurses felt more emphasis was given to older staff) than the older nurses (Lammintakanen & Kivinen, 2012).

Pool, Poell, and ten Cate (2013) studied age-related differences in CPD among nurses and their managers in the Netherlands. Focus groups were conducted interviewing 22 nurses in three age groups. Pool et al. found that participants do perceive differences in CPD between younger and older nurses with older nurses participating less possibly because they perceive a ceiling in relevant courses. However, the authors did find evidence that some of the differences may be related more to nurses' attitudes towards work than to their age (Pool et al., 2013). These findings are in direct opposition with those found by Lammintakanen and Kivinen (2012) in Finland.

A Delphi study was conducted with 38 Dutch expert nurses and demonstrated a clear consensus of the need for nurses to participate in CPD (Brekelmans, Poell, & van Wijk, 2013). The expert nurses advocated for a change in mentality among nurses, from apathy to taking responsibility for their own CPD. Also identified was the need for managers to support nurses and to help them understand the importance of CPD as well as make education more attractive and accessible. Brekelmans et al. (2013) found ageing was considered a key obstacle to CPD, which supports other research reported in this literature review. As with many researchers, similarities exist in previous study findings. Wray, Aspland, Gibson, Stimpson, and Watson (2009) found that older nurses in England attended fewer CPD opportunities than younger nurses with 20% of their respondents reported experiencing some form of discrimination.

Content and teaching methodology. Not previously reported, Haywood, Pain, Ryan, and Adams (2012) indicated face-to-face delivery methods may improve CPD effectiveness and teaching based on evidence, rather than experience, is preferred by UK participants. Likewise, Pawlyn (2012) determined that E-learning is a potentially valuable way for UK healthcare professionals to undertake CPD activities. Two hospitals in Nigeria were the target to determine nurses' perceptions on various aspects of CPD (Nsemo, John, Etifit, Mgbekem, & Oyira, 2013) revealing some new motivators and barriers for participation. The nurses generally perceived CPD to be valuable and worthwhile but participated in it only because it was mandatory and helped them to retain their job. Nevertheless, the data did find several criticisms. The researchers found the content to be more relevant for clinicians than for educators, with evidence-based practice, attitudinal issues, nursing theories, and patient safety being inadequately covered. CPD was perceived as fragmented without follow-up monitoring or evaluation. A researcher in Canada looked at another aspect of CPD to see if journal clubs had an affect on practice (Nesbitt, 2013). A case study design was used in two Canadian intensive care units and Nesbitt (2013) found that journal clubs did provide nurses with an incentive to participate and they did report changes in practice. However, the author stated any gains in competence were probably modest indicating that journal clubs would have a bigger impact when combined with other knowledge transfer strategies.

In summary, much research has been conducted regarding nursing CPD in countries outside the United States. Many of the findings complement and support one

another yet others were found to be contradictory. In either case, this section of the literature review offered an in-depth look at nurses' perceptions of CPD and provided a vast array of new knowledge.

Nursing CPD Within the United States

There is a dearth of research studies centering on nurses and CPD within the United States. Only nine studies were found, and they all targeted different populations of nurses and aspects of CPD. Themes emerged from the research comprising motivators and barriers to CPD, origin of nursing education, learning styles, and rural nursing.

Motivators and barriers to CPD. In a survey of 672 nurses in Tennessee, Nalle et al. (2010) discovered motivating factors for CPD participation varied. Participants showed that increased knowledge, career advancement, and professional competence were more important motivators for CPD than compliance with certification or licensure requirements. Program costs, travel, and time away from work were key barriers to participation. Fahnestock (2012), in a PhD dissertation, examined the deterrents to Oklahoma nurses' participation in CPD. She found the most influential deterrents to participation to be inconvenient times of the program offerings, lack of fit of available programs with the nurses' schedules, poor reputation of program sponsors, indirect cost of attending program offerings, and inconvenient locations. These findings mirror those previously identified through the review of literature. An exhaustive list of specific deterrents are compiled in Appendix D for a detailed look at all 41 reasons given for not attending CPD offerings (Fahnestock, 2012).

Origin of nursing education. Through a completely different CPD research focus, Adeniran, Smith-Glasgow, and Bhattacharya (2013) studied the differences in levels of participation in CPD and career advancement between internationally educated nurses (IENs) and nurses educated in the United States (UENs). 483 nurses participated in a web-based survey in a Philadelphia area hospital and the evidence suggested that IENs progress relatively slowly through the career ladder and participate less in professional development compared with UENs. Interestingly, twice as many UENs received another degree since receiving their licensure compared with IENs. IENs were also half as likely to pursue another degree compared with UENs.

Learning styles. In yet another research application of CPD, Robinson, Scollan-Koliopoulos, Kamienski, and Burke (2012) conducted a descriptive study to explore whether a relationship existed between nurses' generation and learning styles. A learning style inventory tool was administered to 122 nurses at a medical center in northern New Jersey. The most preferred learning style found in the sample was diverger (37.7%) indicating a combination style of concreteness and imaginative ability to view different perspectives. This surprised the researchers as nurses are believed to be concrete learners. Younger generations were more likely to be assimilative or converger learners. The older generation used more concrete learning styles. The outcomes from this study underscore the importance that educators need to consider generational learning styles when developing CPD programs.

Rural nursing. Rural nursing was a focus of several research studies. McCoy (2009) found nurses working in rural settings faced challenges not found in urban and suburban areas such as amount and type of educational preparation and the availability of CPD. Similarly, Fairchild et al. (2013) studied the perceptions of CPD in 40 rural healthcare facilities and found that the unique needs of rural nurses to promote personal and professional empowerment should be encouraged to support a healthy work environment. Additionally, Belden, Leafman, Nehrenz, and Miller (2012) strengthened these findings by determining that nurses' educational background was a variable in workplace empowerment. Moreover, rural nurses in Idaho rated their education as ineffective for practicing in rural areas and New York rural nurses found rural nursing fragmented and lacking in a solid theoretical foundation to guide research and practice (Molanari, Jaiswal, & Hollinger-Forrest, 2011; Williams, Andrews, Zanni & Fahs, 2012). As established through this research, rural nursing was lacking in CPD opportunities for knowledge and growth.

Systematic and Integrative Reviews

A wealth of information can be garnered from systematic and integrative reviews and they are included in this review of the literature because of the breadth and depth they add to the knowledge of CPD in nurses. A systematic review is a high-level overview on a specific research question that identifies, selects, synthesizes, and appraises all evidence pertinent to that question in order to answer it (The Cochrane Collaboration, 2014). Systematic reviews most often pool and analyze evidence and use

summary statistics to answer the question (Melnyk & Fineout-Overholt, 2005). In comparison, integrative reviews use a search strategy to find applicable substantiation to answer a question. Unlike systematic reviews, integrative reviews do not pool samples and statistics but rather focus on the problem researched and the evaluation of all the data found in order to present an overall evaluation of the evidence from varied perspectives (Melnyk & Fineout-Overholt, 2005).

Systematic reviews. Two systematic reviews were found in the literature about clinical decision-making and judgment, and continuing education meetings and workshops regarding their effect on CPD and professional practice. First, Thompson and Stapley (2011) synthesized and summarized 24 studies comparing evidence for educational interventions to improve nursing judgments and clinical decisions. Despite the fact that the reviewers found the study quality and content reporting generally poor in all the studies reviewed, Thompson and Stapley did find that pedagogical theories were widely used. However, the use of decision theory was rare resulting in the effectiveness and efficacy of interventions being mixed. The authors cautioned educators to pay attention to decision as well as theory in the design of CPD interventions.

In the second systematic review, Forsetlund et al. (2012) assessed the effects of educational meetings on professional practice and healthcare outcomes by reviewing 81 randomized controlled trials. Educational meetings are commonly used for CPD education with the aim of improving professional practice and ultimately, patient outcomes. Examples of these meetings include conferences, courses, lectures, workshops,

and seminars. The reviewers found that educational meetings alone are not likely to be effective for changing complex behaviors but used in combination with other interventions, professional practice could be improved. It was found that the higher attendance at meetings was associated with greater effects and that mixed interactive and didactic education was more effective than either one alone (Forsetlund et al., 2012).

Integrative reviews. Santos (2012) reviewed ten research studies and extrapolated, compared, and contrasted primary sources resulting in five themes describing nurses' barriers to learning. Nurses reported time constraints as a barrier to participating in CPD activities due to no time off work, inflexible work hours, and time needing to be spent with personal and family time. Financial constraint barriers included lack of reimbursement by employer, no paid leave for education, and lack of an educational budget. Nurses also found the workplace culture as a hindrance stating managers have control over access to CPD with some managers playing favorites and selecting certain staff to attend. Lack of peer support was found to be a major role in nurses' learning as well as the lack of empowerment to implement practice changes based on new knowledge. Access barriers were identified by some nurses with lengthy travel times to participate in CPD plus some commented on the relevance of the content to their job. Finally, 25% of the nurses reported lack of confidence in accessing electronic evidence-based practice literature (Santos, 2012). In another integrative review, Schweitzer and Krassa's (2010) compilation of evidence supported these findings and discovered additional ones. The authors found the most frequent deterrents in

participating in CPD were the cost of attending CPD events, inability to get time off of work, and child-care and home responsibilities. They also reported numerous other barriers that included lack of information about programs, work responsibilities, peer opinions and attitudes, and distances to travel. Additional barriers were lack of available courses on personal interests, limited time, difficulty in requesting time off of work, non-supportive supervisors and spouses, and inflexible work schedules. These findings have valuable implications in reducing the barriers for nurses' participation in CPD activities, in order to ultimately provide quality patient care (Santos, 2012).

Other reviewers looked at professional development for night shift nurses (Mayes & Schott-Baer, 2010). Mayes et al. (2010) indicated that nurses who work at night are motivated to learn but have fewer opportunities and less access to CPD programs than nurses who work during the day. Covell (2009) believed that in today's healthcare environment that the nurses learning needs have outpaced their ability to independently update their knowledge and required financial assistance from employers in order to remain clinically competent. To that end, Covell conducted an integrative review to look at outcomes achieved from organizations that invest in their nurses' CPD. Interestingly, her findings suggested that organizations that invest in nurse CPD should anticipate reductions in human resource costs associated with the hiring and training of new nurses. Covell's review of the literature supported organizations to sponsor internal CPD activities and provide funding to support external events as this may attract and retain experienced nurses. In addition, the reviewer stated the literature supported that the

retention of experienced nurses is critical to organizations as units with the greater nurse experience have better patient safety outcomes (Covell, 2009).

The lack of empowerment to implement changes based on new knowledge has been identified as a problem for many nurses (Santos, 2012). In the integrative review lead by Williams (2010), a deeper look was obtained on how work-based learning has the potential to change practice. Williams reported that for work-based learning (applying knowledge to practice) to be effective, nurses should take control of their own learning, receive support to critically reflect on their practice, and be empowered to make changes to that practice. The researcher advised nurse managers to develop learning cultures in their workplace that support staff to effect changes in their practice (Williams, 2010). Finally, in studying CPD for rural nurses, Phillips, Piza, and Ingham (2012) found evidence that CPD positively impacted patient and family outcomes supporting ongoing investment in learning activities. Phillips et al. also verified that it is imperative for rural nurses to develop and maintain their computer competencies due to the always-changing web-based technology.

In summary, this review of the literature has provided a detailed and comprehensive look of many perspectives of CPD. From adult learners, to teachers, to healthcare professionals and nurses, CPD has been examined exposing the benefits, barriers and new ideas to offer insights in how to help staff increase their knowledge and competence in various ways. By reviewing research on how others perceive and practice CPD, this knowledge will only help in providing quality CPD programs and activities to

support staff in their professional development endeavors. The literature reviewed demonstrated that nurses face many of the same CPD issues throughout the world yet it also provides evidence that specific issues surface depending on location and population. Even though the review of the literature produced a plethora of research regarding nurses' perceptions of CPD, the dearth of research found pertaining to pediatric nurses demonstrates a critical need for future research in this specialty nursing population.

Implications

It is important to understand pediatric nurses' perceptions of CPD opportunities in order to provide effective lifelong learning. Time constraints and higher priorities with patient care make learning during a shift less than desirable plus learning during a busy day makes it less likely that nurses will remember information accurately (White et al., 1998). To make CPD programs more effective, a concentrated effort should be made to make continuing education attainable and realistic (Griscti & Jacono, 2006). If nurse educators fully understood the barriers and motivators to participating in CPD, they would be able to design learning experiences for maximum learning and make them easily accessible for staff participation.

It is beneficial to create CPD programs based on best practices that address factors that motivate nurses to attend CPD activities and those that are found as barriers to participation. One such model is outlined by Ellis and Nolan (2005) and is based on the premise that programs should be responsive, accessible and based on a partnership between those providing and those receiving education.

To promote change in CPD education, a project was created centered on curriculum development to provide training that would shift the current paradigm from the nurse manager as content and clinical expert to a nurse manager as a leader with teaching expertise who leverages the principles of adult education (Knowles, 1980) and experiential learning (Dewey, 1938). In addition, the educational level of nurse managers, for the most part, is below graduate level. This underscores a statement made by Staykova (2012) that historically, the educational backgrounds of nurses have not prepared them for leadership or teaching roles. Nurses prepared at the baccalaureate level have very little exposure in learning how to develop courses and programs that provide pertinent and valued topics that engage staff in participating in CPD. As a result of this project, a curriculum for nurse managers would provide leadership and management training offering an area of expertise that most nurse managers find missing from their skill set. By including topics such as facilitating discussions, communication, budget development, and curriculum design, nurse managers would be able to enhance their ability to lead and train staff resulting in nursing excellence in patient care.

Summary

CPD is part of nurses' professional responsibility and can take the form of formal to informal activities. Whether a nurse pursues an advanced degree through formal education or participates in continuing education courses and activities provided by their employer, nurses must maintain or increase their competency as required by regulatory agencies. Engaging in opportunities for CPD allows the nurse to learn new information

but to also apply that knowledge to practice (Dickerson, 2010). This concern with CPD involvement was the impetus for this research study in order to fully understand the perceptions that pediatric nurses have regarding CPD opportunities, how they view it, how they use it, and how it impacts their practice. Guiding research questions were provided as well as a literature review examining other research studies from around the world providing a picture of the current status of perceptions and practices of CPD. Bandura's social cognitive theory provided the conceptual framework for the study presenting a clear foundation designed to improve learning.

In closing, the nursing profession demands its practitioners to possess specialized knowledge and skills, but the meager attainment of knowledge and skills is not enough. Lifelong learning is needed to develop within the profession. Florence Nightingale once said, "Nursing is a progressive art in which to stand still is to have gone back" (Dolan, 1968, p. 219). Creating a culture where nurses are encouraged to grow professionally should be emphasized in all health care settings (Cooper, 2009).

In Section 2, I describe the qualitative methodology of the research study. I outline the research design and approach in detail and define the study's participants. In addition, I review data collection techniques along with the data analysis process in coding and interpreting the outcomes. Section 2 concludes with a compilation of the data analysis results. Section 3 includes the project selected from the data results. Section 4 provides a reflective conclusion to the doctoral project study.

Section 2: The Methodology

Introduction

The purpose of this study was to develop research-based descriptions of the perceptions of pediatric nurses regarding CPD opportunities at a tertiary freestanding children's hospital in order to develop evidence-based CPD programs and course offerings. This study used a qualitative design with a case study approach. Section 2 includes a detailed overview of this design as well as a description of the participants, data collection methods, analysis techniques, and findings.

Research Design and Approach

According to Yin (2014), all empirical research has a design. The design is the ordered sequence that connects the data to the study's research question—all the way through to its conclusion.

Research is usually divided into two categories: *basic* and *applied* (Merriam, 2009). Basic research is focused on an intellectual interest in a phenomenon and used to extend knowledge while applied research is used to improve the quality of a particular discipline and is the most common form of qualitative research found in education (Merriam, 2009). Researching nurses' perceptions of CPD is an example of applied research, whereby I sought to improve the participation of the hospital's nursing population in lifelong learning. In order to undercover the meaning of CPD among pediatric nurses, a qualitative research design was used to understand their experiences. Denzin and Lincoln (2011) stated that qualitative researchers examine problems in their

own environments and attempt to find the meaning held by those involved. Merriam (2009) concurred and believed that qualitative researchers are drawn to comprehend how people have created and defined the experiences they have in the world. I conducted a qualitative study because I was interested in how pediatric nurses perceive their CPD experiences and what significance they give to their experiences (Merriam, 2009). The purpose was to know how nurses make sense of their CPD practices in order to develop evidence-based CPD programs and course offerings to increase participation in continuing professional education and training.

Five types of qualitative research designs are found in the social sciences and applied fields of practice: phenomenology, ethnography, grounded theory, narrative analysis, and case study (Merriam, 2009). Phenomenology researchers inquire about a phenomenon from the real experiences of the study's participants, whereas ethnography is a strategy to look closely at a cultural group in their actual environment over an extended length of time (Creswell, 2009). Narrative researchers analyze human experience through stories about their lives and grounded theory is used when researchers derive a theory based on the views of participants (Creswell, 2009). Although these are all viable ways to conduct studies, the case study strategy fit best to understand nurses' perceptions. In this study, I was not seeking to examine a phenomenon or study a cultural group nor was I inquiring about individual stories or to develop a theory with categories of information. The case study approach was an applicable design to study the research question in that I

planned to explore in depth perceptions of CPD opportunities within a bounded case of pediatric nurses.

A qualitative case study research design was appropriate to answer the overarching research question asking about the perceptions of pediatric nurses regarding CPD opportunities because it used a case study approach to obtain a thorough description and close examination of a bounded system (Merriam, 2009). This bounded system sets case studies apart from other qualitative designs (Lodico, Spaulding, & Voegtle, 2010). The bounded system for this research was the pediatric nurses at [redacted] and this case was separated out as the unit of analysis for research and used to develop an evidence based understanding of CPD opportunities for pediatric nurses (Creswell, 2012). I focused on a comprehensive examination of the central focus of the study, which was nurses' perception of CPD. According to Stake (1995), the real concern of case study is particularization, not generalization. Researchers select a specific case and come to know it well; not how it is different from other cases but what it is and what it does.

A case study design was the best choice for this study because the data produced was anchored in real-life situations resulting in rich and holistic accounts about CPD thereby producing the data needed to answer the study's research questions (Merriam, 2009). This research on CPD met the four characteristics identified by Merriam (2009) as key to understanding the nature of qualitative research. First, the overall purpose of the research study was to achieve an understanding of how nurses perceive CPD and described how they interpreted what they experienced. In addition, I was the primary

instrument for data analysis. Third, this research was an inductive process and I gathered data to build concepts, working from the particular to the general. Finally, this research was reported using rich, thick descriptions to convey what was learned and the narrative included quotes from the study's participants that supported the findings. Consequently, case study was a good design to use in order to discover nurses' perceptions about CPD that can affect and improve practice (Merriam, 2009). Stake (1995) sums up a good case study researcher as patient, reflective, willing to see another view of the case, and trying hard to understand how the participants perceive their world.

Stake (1995) described three types of case studies: intrinsic, instrumental, and collective. An intrinsic case study is selected when there is a need to know about a specific and particular case while an instrumental case uses the case to understand something else and the researcher gets insight into a question by studying a particular case (Stake, 1995). A collective case study uses multiple cases to study rather than just one with each case being instrumental to learning (Stake, 1995). Through a case study design used in this research study, I focused on highlighting a particular issue - CPD - and therefore was an instrumental case (Creswell, 2012).

Yin (2014) outlined four types of case study designs: single-case (holistic), single-case (embedded), multiple-case (holistic), and multiple-case (embedded). In addition, Yin discussed five rationales for using single-case designs: critical, unusual, common, revelatory, or longitudinal. The design for the proposed research study was a single-case (embedded) design because the objective was to obtain the circumstances and conditions

of an everyday common situation—CPD. An embedded design was used as the single-case of pediatric nurses involved different units of analysis at more than one level (Yin, 2014). Attention was given to three subunits of nurses within a single case: night shift nurses, day shift nurses, and nurse managers. Yin (2014) acknowledged the subunits could often add significant chances for extensive analysis, enriching the insights into the single case.

Participants

Sample and Sampling Techniques

The participants consisted of registered nurses and the sampling was taken from the approximately 1,600 nurses employed by the hospital. I used a nonprobability and purposeful sampling to selectively gain insight and understanding from the nurses currently employed at [redacted]. Because generalization is not a goal of qualitative research, nonprobability sampling is the method most often used for qualitative research (Merriam, 2009). To that end, purposeful sampling is the most common form of nonprobability sampling and is used because researchers desire to understand and gain insight from a sample from which the most can be learned (Merriam, 2009). Specifically, a type of purposeful sample, a typical case sample, was used because the nurses represented the norm and were in no way atypical (Lodico et al., 2010). Patton (2002) affirmed that when a typical sampling strategy is used, the case reflects the average person, in this case a nurse, who is not in any major way different, extreme, or intensely unusual.

In addition, a segmentation sampling strategy was used to consciously vary the composition of each of the focus groups (Morgan, 1996) therefore separate groups were arranged to include night shift nurses, day shift nurses, and nurse managers. Segmentation offers two advantages: (a) it presents an opportunity for comparison between groups, and (b) discussions may flow more smoothly due to the similarity within the groups (Morgan, 1996).

Number of Participants

A total of 39 nurses contributed to the study: 29 nurses participated in one of three focus groups scheduled during a two-week period and 10 nurses participated in face-to-face interviews. Specific details are outlined in the following paragraphs.

Focus Groups. Twenty-nine nurses attended one of three focus groups. Queeney (1995) stated focus groups typically bring six to twelve participants together with a facilitator to have a semi-structured yet informal discussion however Creswell (2009) recommended six to eight participants in each group. Other authors suggested six to ten or eight to ten participants per group with three to five focus groups per project (Frey & Fontana, 1991; Morgan, 1996; Powell & Single, 1996). Creswell (2012) recommended case sizes of 30 or 40 but cautioned that larger number of cases can become cumbersome and result in shallow perspectives. Ten places were allocated for each focus group as that number allowed for the possibility of no-shows without impacting the viability of the groups. Due to the high probability that some nurses would sign up to attend but invariably not show up at the scheduled time, it was realistic to assume that each focus

group may only have eight nurses in the end. Powell and Single (1996) validated this assumption stating a researcher should anticipate subject losses and therefore should over-recruit participants by 25%. Because I anticipated no shows to occur during the day and night shift focus groups due to the understanding that patient care responsibilities had priority over the focus groups, I scheduled 13 day shift nurses and 11 night shift nurses to compensate.

Once the openings were filled, no additional nurses were needed for the study. However, if I had not reached data saturation by the end of the third focus group, additional groups would have been scheduled until no new information was obtained. Lincoln and Guba (1985) argued that the sampling is terminated when redundancy is reached, that is, when duplication of data is found due to no new information being discovered. Stewart, Shamdasani, and Rook (2007) agreed and added there are no firm guidelines; most studies use at least two groups with few studies using more than four. Morgan (1996) argued that additional groups seldom provide significant new insights. Therefore, the number of nurse participants could have been modified during the course of the study (Merriam, 2009) but was not necessary as data saturation was reached.

Interviews. Ten nurses participated in personal one-on-one interviews. I wanted to include interviews in the research design to strengthen the study's validity and reliability and to supplement the three focus groups. As with the focus groups, the interview participants were a mixture of day and night shift nurses and nurse managers (six on days, two on nights, two managers). Not only did the interviews provide a

different method of data collection from the focus groups, they also triangulated different sources of data with nurses offering diverse perspectives all adding validity to the study (Merriam, 2009). When discussing sample size, a wide variation exists among researchers who engage in qualitative research design (Creswell, 2007; Yin, 2014). Even though these researchers do present argumentative differences in sample size, their rationale is often without explanation (Onwuegbuzie & Leech, 2007). For example, Guest, Bunce, and Johnson (2006) stated the size usually depends on the point of saturation. Bertaux (1981) described how the researcher learns the bulk of information from the first few interviews; by the 15th interview, repeated patterns surface matching previous findings. In a study involving 60 in-depth interviews with women in two West African countries, Guest et al. found that 12 homogenous interviews were all that was required to reach saturation and discovered basic theme elements were present as early as six interviews. The nurses in this study all had responsibilities that were pediatric-related in alignment with this study's focus. With the homogeneity within the group as well as my limited resources, 10 participants were interviewed. I reached data saturation after conducting seven interviews; the remaining three interviews did not garner any new information.

The total sample of 39 nurses included 12 managers, 17 day shift and 10 night shift nurses. There was only one male in the group. Pediatric specialties were equitably represented and included nurses from medical/surgical units, intensive care units, emergency department, operating room, hematology/oncology, radiology, float team, and

ambulatory clinics. See Table 2 for the number of participants of the focus groups and interviews.

Table 2

Participation in Focus Groups and Interviews

	Scheduled	No Shows	Participated
Focus Groups			
Nurse Managers	10	0	10
Day Shift Nurses	13	2	11
Night Shift Nurses	11	3	8
Interviews	10	0	10
Total Nurses in Study			39

Gaining Access to Participants

I obtained permission from the Vice President of Patient Care Services and Chief Nursing Officer at the hospital to recruit the nurses for this case study and I procured a letter of cooperation. After receiving approval to conduct the study by the hospital and Walden University, I sent out electronic email invites, along with information about the study, to the nurses from addresses provided by the hospital. In the email, I explained the purpose of the study, outlined the number of nurses needed for the focus groups and interviews, provided the times and locations, the meal being provided, and attached the consent form. I asked the nurses to volunteer for any of the opportunities provided. If they desired to participate, the nurses sent a replying email to me to reserve a space in the

focus groups or the interviews. See Appendix E for the Recruitment Email for Nurses. One focus group with 10 nurse managers was conducted on Wednesday, November 5, 2014 from 12:30-1:30 pm with lunch provided. A second focus group was conducted for 8 night shift nurses for a morning focus group on Thursday, November 6, 2014 from 5:00-6:00 am and breakfast was provided. This was a convenient time for the night shift nurses to attend, as it is a common time that they are available to take a break and would not interfere with patient care. Finally, a third focus group was conducted for 11 day shift nurses on Tuesday, November 11, 2014 from 1:30-2:30 pm during lunch time and lunch was also provided. This was a suitable time for day shift nurses, as it allowed them the opportunity to participate without impeding patient care. In addition, 10 nurses volunteered to participate in one-on-one interviews that were conducted separately at a time convenient and mutually agreed upon with each of the interview participants. I conducted the focus groups and the interviews within a 2-week timeframe. The participants were asked to read the consent form attached to the email and they were informed that they would be asked to sign the form just prior to the beginning of each focus group and interview after I thoroughly reviewed each item with them for clarity and understanding.

Researcher-Participant Relationship

Establishing empathy and rapport is critical for participants to be open to disclosing information and the quality of the researcher-participant relationship affects the depth of information they are willing to reveal (Knox & Burkard, 2009; Partington,

2001). It was my job as the moderator of the focus groups and interviews to create a nonthreatening and nonevaluative environment in order for participants to feel free to offer opinions and express themselves (Stewart et al., 2007). It was my responsibility to keep the discussions on track, manage the time, and ensure that all participants contributed to the discussions and made their voices heard (Stewart et al., 2007). In addition, I minimized interruptions when a participant was talking, provided supportive nods, avoided judgmental responses, listened to responses, and demonstrated I had listened to the responses by restating what I heard (Partington, 2001). None of my subordinates took part in the study. The eight nurses who report directly to me were excluded from participating in the research study.

Ethical Considerations

I submitted the study protocol to the [redacted]'s Institutional Review Board (IRB) and obtained a letter of cooperation from the CNO. In addition to obtaining IRB approval from the hospital (IRB approval number: [redacted]-14-00365), I gained approval from Walden University (IRB approval number: 10-23-14-0353934). As part of the IRB application process, multiple documents were submitted for review and included a letter of cooperation from the hospital (see Appendix F for a Letter of Cooperation from a Community Research Partner) and the informed consent that was given to the nurses. The informed consent provided full information about the study and culminated in requesting the nurse's signature signifying approval to participate in the study. In addition, the consent delineated how the nurses were protected from harm and how their

confidentiality was safeguarded. Specifically, the study was voluntary, the nurses' decision to participate or not was respected, and no one at [redacted] would treat the nurses differently if they decided not to be in the study. Only specific focus group attendees and myself knew who participated in the study. Consequently, the identity of those participating in the study was not common knowledge and therefore other [redacted] nurses did not know who participated. In addition, the nurses agreed to join the study but could also change their mind at a later time; the nurses could stop participating at any time with assurance that withdrawal would not affect their employment status or annual performance review. Risks were outlined in the consent including that the study did not pose risks to safety or wellbeing. Benefits were described to include helping in the improvement of CPD programs and course offerings at [redacted] and increasing the rate of participation. There was no cost to the participants except for their time and they were provided breakfast or lunch during the focus groups for their participation. All information was kept confidential and I did not use any of the nurses' personal information for any purpose outside of this research study. I did not include the nurses' names or any other identifying information in the study reports. The verbatim transcripts were typed by two secretaries and myself and were reviewed by me. The transcripts were delivered to me with no nurses' names and no identifying information. The transcripts only contained two categories of information: comments made by me and comments made by the nurse participants. The data were stored in a password-protected computer locked in a file cabinet behind a locked door in my office. I completed the human

research protection training course requirements necessary to submit protocols to the IRB (see Appendix G for documentation of a Human Research Protection Training Course).

Data Collection

Focus groups, interviews, and document reviews were the data collection methods used for this research study. Focus groups and individual interviews are frequently combined in qualitative research for greater depth and breadth of the data outcomes (Morgan, 1996). Focus group studies supplemented with interviews allow for exploration into specific opinions and experiences (Duncan & Morgan, 1994). The advantage of this strategy is to uncover experiences and perceptions from the focus groups and then to search for more depth during the interviews (Morgan, 1996). Anonymity was guaranteed to the participants in order to give them the opportunity to freely express their views and encourage them to also address politically delicate issues (Creswell, 2009). To this end, I informed the participants that I would analyze data only after all identifying information had been removed from the audio transcripts.

Focus Groups

Focus groups were used in the research study enabling me to collect data from multiple nurses and also to observe group interactions and dynamics (Lodico et al., 2010). A focus group is a group of individuals comprised of diverse backgrounds and experiences, gathered together to discuss a topic from personal experience (Powell & Single, 1996). The main goal is to use *interaction data* that results from discussion among participants by questioning or commenting to one another on each other's

experiences to increase the strength of the query (Lambert & Loiselle, 2008). According to Merriam (2009), focus groups are appropriate for case study research because the researcher cannot observe how nurses perceive CPD therefore it would be necessary to interview them.

Advantages. Focus groups allow the researcher control over the line of questioning (Creswell, 2009). Also, the focus groups for this study assembled nurses together who had direct knowledge about CPD at the hospital and were able to provide their perceptions. Moreover, group dynamics and evolving relations among group members can be a stimulus to discussion and expression of ideas (Frey & Fontana, 1991). Morgan (1996) stated the unique strength of focus groups lies in the fact that group interaction offers valuable data to the extent of consensus and diversity among the participants and this ability to observe agreement and disagreement is a main strength of focus groups. Data from focus groups can be obtained much faster than would be if members were interviewed one-on-one (Bickman & Rog, 2009). Finally, the focus groups brought me close to the participants who have taken part of CPD in the field, offered a greater depth of understanding about the field context, and permitted considerable probing (Frey & Fontana, 1991).

Disadvantages. Disadvantages of focus groups include that the information is gathered in a designated place rather than in the natural field, the information is filtered through the views of the participants, and not all people are equally articulate or perceptive (Creswell, 2009). Equally problematic, group members may experience the

pressure to conform to ideas expressed by others, there may be a higher ratio of interpersonal conflict that could drain the group energy, false information or irrelevant data may be high, and the moderator could very possibly bias the outcome data (Frey & Fontana, 1991). Morgan (1996) agreed that the behavior of the moderator could have negative consequences in that they may disrupt the group interaction, and they control the agenda and the form of the discussion rather than the ongoing work of the group. Morgan (1996) also believed a weakness of focus groups is due to the impact of the group on the discussion; a polarization effect is sometimes found when the attitudes of the participants become more extreme after group discussions. In addition, the opinions of one participant can sway others in the group and social relations outside the group may influence responses within the group especially since some group members will know each other (Frey & Fontana, 1991). Finally, a very dominant or opinionated member may bias the focus group and more reserved members may be timid in offering their views (Bickman & Rog, 2009).

Conducting the focus groups. After securing a quiet room within the hospital to and providing either breakfast or lunch for the nurses, I reviewed the consent form clarifying the content and answering any questions the nurses had. The nurses were asked to sign the informed consent forms indicating their approval to participate in the study and turn them in to me. I came prepared with a list of questions previously determined but allowing for flexibility to investigate beyond the set questions (Lodico et al., 2010). Creswell (2012) suggested to create an interview protocol form, which is a pre-

established template developed by the researcher guiding the structure of the focus groups with spaces for quickly jotting down notes (see Appendix H for a Focus Group Guide that I developed for this study). This semistructured dialogue approach allowed me to learn from the nurses' views (Creswell, 2012). Open-ended questions were used to allow the participants to freely voice their experiences and minimize my influence in developing the questions or my attitude and previous findings (Creswell 2012). I used effective probes as they sought to clarify what was said or to obtain additional information (Creswell, 2009). Stewart et al. (2007) stated that probes are a critical part of obtaining information in focus groups—good probes garner information without making participants defensive or suggesting answers. I was respectful of the nurses' time and kept the discussion within the agreed upon specified time in order to not disrupt the hospital workday. Other tips and guidelines for conducting focus groups are offered in Appendix I (Frey & Fontana, 1991; Powell & Single, 1996; Stewart et al., 2007).

Interviews

Person-to-person interviews were also used to collect data. According to Fontana and Frey (1994), individual face-to-face interviews are the most common type of interviewing. As in the focus groups, a semistructured interview was implemented and the questions asked followed the same questions used in the focus groups with an additional two questions. The semistructured interview design allowed me to use the interview protocol form as a guide without being concerned about the exact wording or order of the questions (Merriam, 2009). This interview structure was essential, as I may

not have remembered the order or exact words that I used in conducting the focus groups. This format offered flexibility to respond to the immediate situation at hand, to the emerging views of the respondent, and to any new ideas provided on the topic (Merriam, 2009). However, as Stake (1995) cautioned, even though the questions are worked out in advance, deviating from the protocol is limited by design. I asked all the questions of each participant in order to enable comparison across cases but remained flexible allowing for probes to obtain greater detail (Knox & Burkard, 2009). Jacob and Furgerson (2012) advised researchers to be willing to make adjustments during the interview as the modifications allow for the study's design to emerge and for obtaining unexpected data. If a new question garnered useful information, I added it to the interview guide to be asked during the remainder of the interviews (Jacob & Furgerson, 2012).

Advantages. Advantages of semistructured personal one-on-one interviews include that the interview questions are open-ended and focused around a particular topic guided by general questions and probes (Bogdan & Biklen, 2007). This allows the interviewer freedom to engage in a range of topics and the participant with the opportunity to shape the content of the interview (Bogdan & Biklen, 2007). Merriam (2009) added that semi-structured interview questions are not in a rigid and predetermined order, include a mix of more and less structured questions, and uses a flexible list of questions or issues to be explored.

Disadvantages. A disadvantage of the semistructured interview approach is that the interviewer may miss the opportunity to comprehend how the participant constructs the interview topic (Bogdan & Biklen, 2007). In addition, Yin (2014) cautioned that interviews can pose a reflexive threat—the researcher's perspective unknowingly affects the participant's responses and, in turn, those responses influence the researcher's course of questioning. Furthermore, participants' responses may be compromised with bias, poor recall, and poor or inaccurate communication (Yin, 2014).

Conducting the interviews. The interviews took place individually in a centrally located meeting place at the hospital at a convenient and mutually agreed upon time arranged with the 10 nurses who volunteered for the interviews. Prior to beginning the interviews, I reviewed the consent form and explained the purpose of the research, the procedures used to conduct the study, and their rights as participants including the voluntary nature and risks and benefits of the study. In addition, I provided contact information for a [redacted] representative and myself in case the participants had any questions. The right to privacy was explained and that I would keep all information the participants provided confidential. I did not use their personal information outside of the research project nor did I include their name or anything else that could identify them in the study reports. I kept the data stored in a password-protected computer and locked in a file cabinet behind a locked office door. I asked the nurses if they had any questions and had them sign the consent form. Jacob and Furgerson (2012) recommended developing an interview script, to have it readily available, and follow it carefully in order to not

forget to share essential information with the interview participants. See Appendix J for an example of the interview guide. This guide contained a notes section used to document any items that came up during the interview that were worth asking during the remaining scheduled interviews (Bates, Droste, Cuba, & Swingle, n.d.).

Digital Voice Recording and Transcription

All the questions and responses were digitally recorded during the focus groups and interviews utilizing an iPhone and Sony recorder. I took brief notes in case the digital voice recorders failed to record. The use of a digital voice recorder was disclosed on the consent form previously reviewed and signed by the participants. At the beginning of each focus group and interview, I acknowledged the presence of the recording device while reminding the participants that the recording would remain confidential and was only for the purpose to increase the accuracy in reporting the data and any participant who was uncomfortable with this process was given a chance to leave the focus group or interview (Morgan, 1996). Morgan (1996) offered advice to the focus group moderator to not draw attention to the recording equipment by asking the participants to speak up in order for the voice to be captured on the device but instead ask participants to speak up so that the entire group can hear the comments and discussion.

Two administrative secretaries were hired to type a verbatim transcription of the focus groups and interviews and were asked to sign a letter of confidentiality. (See Appendix K for a Confidentiality Agreement Form acknowledging the confidentiality of the participants' names and information and not to disclose any information related to this

study.) In addition, I crosschecked the accuracy of the transcripts by reading through the typed interview while listening to the digital recording (Merriam, 2009). This proved to be a vital aspect of the transcription process as I found many errors and omissions of data that needed to be corrected. In addition, this procedure increased the reliability of the study (Gibbs, 2009). The transcripts only contained two categories of information: comments made by myself and comments made by the nurse participants. I developed a grid to organize the data collection process in order to keep track of the progress of each focus group and interview as it moved from the transcription phase, to accuracy checks, to member checks, and coding. See Appendix L for a copy of this grid. The transcription provided the basis for data analysis.

All information provided in the focus groups and the interviews was kept confidential. All data are stored in a password-protected computer and locked file cabinet behind my locked office door. I placed all the signed consent forms and confidentiality agreements in a sealed envelope and placed them in my locked file cabinet. Data will be kept for a period of 5 years and then destroyed.

Content Analysis of Documents

I accessed a database kept by the hospital's Patient Care Services Education Department cataloging all CPD courses that were approved for continuing education contact hours from 2008 through 2014. Information was filtered to obtain past history of attendance to determine CPD utilization. In addition, policies pertaining to educational content and procedures used within the hospital's education office were reviewed. A data

use agreement was obtained from the hospital (see Appendix M for a Data Use Agreement) in order to secure permission to access this database and other materials. See Appendix N for the Document Review Form and a compilation of results. The data showed a high utilization of CPD classes and five hospital policies and procedures related to CPD.

Role of the Researcher

I have been employed at [redacted] for 20 years and have been in many different roles. My current position is the Director of Clinical Education and Professional Development and I have held this position for the past 8 years. Previous to this I was the Manager of Staff Development, and Project Lead and Curriculum Administrator for the RN Residency program for new graduate nurses. I began my career at [redacted] as a bedside nurse on a toddler unit (0–3-year-olds) and then transferred to the neonatal intensive care unit for 5 years prior to beginning my professional development roles. In order to mitigate any potential bias, I excluded the eight nurses who directly reported to me from participating in the study. My relationship with the remaining nurses who volunteered for the study had only been in a casual, informal association as we had interacted over the years on various hospital committees and other initiatives. To further mitigate any potential bias, I employed multiple validity strategies to establish confidence in the accuracy of the findings.

Data Analysis

The collection of qualitative data through focus groups and interviews requires the researcher to make sense out of the data (Merriam, 2009). The challenge is, according to Patton (2002), to decipher meaning from large quantities of data, condense the quantity of material, classify patterns, and develop a framework for communicating the results. Data analysis in qualitative research is an inductive process and this means that small pieces of data are collected and gradually combined to form broader descriptions and conclusions (Lodico et al., 2010). The data were analyzed simultaneously with the data collection whereby both mutually shaped each other (Merriam, 2009; Sandelowski, 2000). The following sections describe the data analysis process, coding details, written reports, quality and credibility, and data analysis results.

Data Analysis Process

Stake (1995) illustrated that researchers obtain new meanings about case studies in two strategic ways: through direct interpretation of the individual experiences and through the combination of instances until something can be said about them as a case. The researcher's task is to understand the case through a data analysis process that includes discerning relationships, probing issues, and to aggregate categorical data (Stake, 1995).

Lodico et al. (2010) presented a comprehensive process of data analysis by outlining six procedural steps, and I used these steps as a guideline for analyzing the research data. These steps included preparing and organizing the data, reviewing and

exploring the data, coding data into categories, constructing descriptions of people and activities, building themes, and reporting and interpreting data.

Creswell (2012) suggested a similar view of the data analysis process wherein the researcher collects, prepares, reads, and codes the data iteratively and simultaneously. The overall process for data analysis involves collecting, organizing and preparing the data for analysis, moving deeper into understanding the data, representing the data, and making an interpretation of the larger meaning (Creswell, 2009). The approaches to analysis recommended by Lodico et al. (2010) and Creswell (2012) suggested a linear, hierarchical approach, but the various stages are interrelated and it is not necessary to follow them in a sequential order.

Creswell's (2009) six data analysis steps were used in addition to Lodico et al.'s (2010) step-by-step data analysis process. The steps are described in detail as follows.

Step 1. I organized and prepared the data for analysis. The focus group and interview data were transcribed along with information from the document analysis.

Step 2. I read through all the data. I obtained a general sense of the information and reflected on its overall meaning. I wrote notes in the margins and started writing down general thoughts about the data.

Step 3. I began the detailed analysis with a coding process. Creswell (2009) suggested developing a qualitative codebook that consists of a table containing a record of themes, codes, sub-codes and the total number of times the code was found in the transcripts. A computer program, *NVivo*, to enable users to code, retrieve, build themes,

and conduct data analysis, was used for the study (QSR International, 2014). I selected this program because it was compatible with Apple computers and was recommended to me by other researchers.

Step 4. I used the coding to generate numerous codes, reduced overlap, and collapsed into 30 categories. Seven themes emerged from the categories and these are the major findings of the study (Creswell, 2009). See Table 3 for a list of the 30 categories and subsequent seven themes.

Step 5. I decided how the description and themes would be represented in the written narrative and outlined my approach in the Report the Findings section below. See Figure 1 for a visual model of the seven themes that emerged from the data.

Step 6. I asked what were the lessons learned that helped in making an interpretation or meaning of the data (Lincoln & Guba, 1985). This entailed my personal interpretation grounded in the information I discovered during the literature review. I confirmed the findings with past findings but also discovered new questions to consider (Creswell, 2009).

In summary, I used Creswell's (2012) and Lodico et al.'s (2010) data analysis guidelines as a checklist during the data analysis process of the research data in order that the process remained on track, methodical and thorough, and in accordance with proper data analysis procedures. Because the coding process was vital to the data analysis process, it is discussed at greater length in the following paragraphs.

Table 3

Perceptions of CPD - Categories and Themes

Categories	Themes
Conferences	Participation
Life Support Training	
Formal Academic Programs	
Hospital-Wide and Unit-Based Classes	
Teaching	
Research	
Money	Motivators
Time	
Support	
Intrinsic/Extrinsic Value	
Teaching Methodology	
Ease of Learning	
Research	
Money	Barriers
No Management/Leadership Courses	
Time/Workload	
Lack of Resources/Support	
Good/Helpful	Adequacy and Quality
Needs Improvement	
Missing/Lacking	
Supportive Culture	Knowledge Incorporated
Resistance	Into Practice
Lack of Desired Information	
Directly Related	Improves Nursing Practice
Obstacles	and Patient Outcomes
Coordination of Events	Wish List
Technology	
Simulation	
Resources	
Additional Classes/Topics	

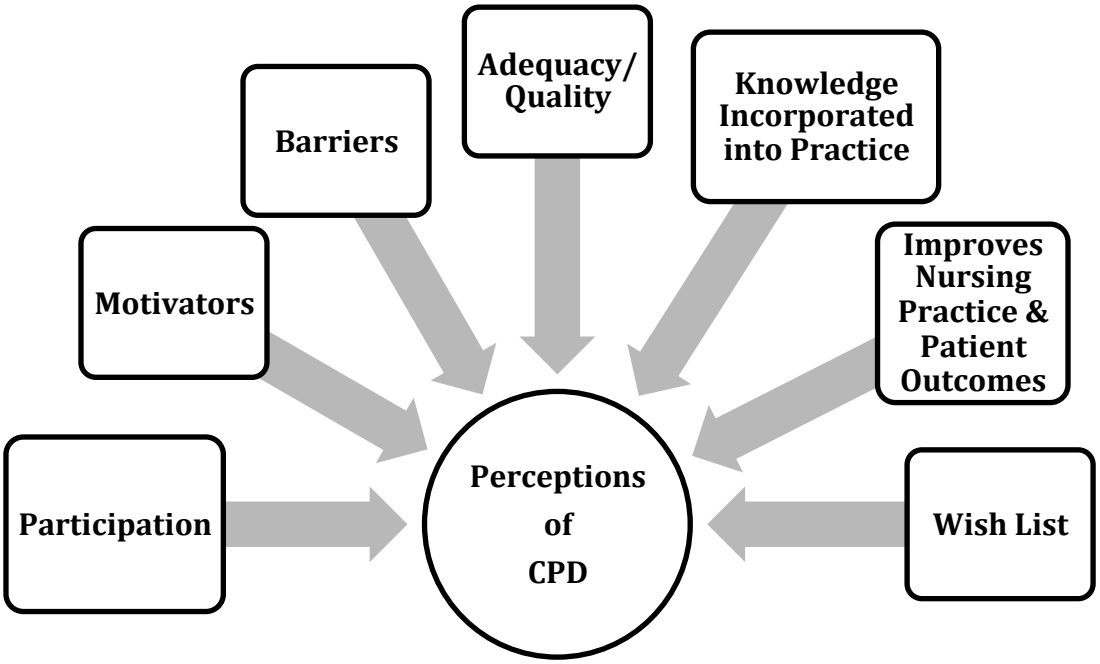

Figure 1. Seven themes that describe pediatric nurses' perceptions of CPD.

Coding

Codes are labels used to describe text segments and includes organizing and synthesizing the data, dividing them into manageable components, coding them, and seeking patterns (Bogdan & Biklen, 2007). Bogdan and Biklen (2007) offered the following advice when coding data: take long, undisturbed periods and carefully read the data at least twice then begin developing a preliminary list of codes. After creating a list of codes, I assigned them to the units of data, reviewed and reformulated the list, decided on major codes or general themes, and developed sub codes or minor themes (Bogdan & Biklen, 2007). I examined the codes for overlap and redundancy and then condensed the codes into comprehensive themes (Creswell, 2012). In Saldana's (2013) coding manual, various coding procedures are provided to illustrate the coding process (e.g., formatting, lumping, splitting) and I incorporated many of these strategies into the coding analysis

process. In addition, I organized all the categories in a table with the corresponding data from the focus groups and interviews (verbatim transcripts) to determine the appropriateness of the coding/themes. As Merriam (2009) suggested, it helped to see how all the parts fit together by visually laying out the basic structure of the findings. I reviewed and revised the codes and categories several times before settling on the final themes that appropriately captured the essence of the focus groups and interviews and answered the research questions.

Reporting the Findings

The main focus guiding the argument of this research in a written report took the form of a topic, which was descriptive of the nurses' perceptions toward CPD (Bogdan & Biklen, 2007). This argument was appropriate for the study because it was directly connected to the focus groups and interview data that I coded and analyzed. I presented an executive summary to the nurses and to the stakeholders including the hospital's administrative and management teams. I did not include the nurses' names or any other information that could identify the nurses in the study reports.

The written reports of the focus groups and interviews followed the suggested outline proposed by Bogdan and Biklen (2007) and included an introduction, core, and conclusion. The following three paragraphs include an explanation of the outline components.

Introduction. The introduction clearly told the audience what I was reporting about. It included a general background, the focus, context, design methodology, and

research techniques (e.g., sample and size, data collection method, analysis procedure) and any other information needed to depict the soundness of the research (Bogdan & Biklen, 2007). Specific to case study research, a detailed description of the setting and individuals preceded the analysis of the themes (Stake, 1995). The report opened with a brief story that captured the spirit of the nurses' perceptions and connected directly to the presentation data as this would, according to Bogdan and Biklen (2007), involve the audience early, ground them in the subject matter, and convey some emotion of the setting.

Core. The format used in this research study for presenting the core data was what Bogdan and Biklen (2007) described as "the use of the colon" (p. 208). The colon denotes that the material rendered after it will illuminate the preceding sentences (Bogdan & Biklen, 2007). Each theme was generalized highlighting rich, thick descriptions obtained from the focus group and interview data followed by several quotes from the nurses; the data was separated from the generalizations. Lodico et al. (2010) affirmed that by using the nurses' own words, researchers increase the audience's confidence that they are accurately reporting the nurses' perceptions on CPD opportunities.

Conclusion. The conclusion was comprised of the study's focus and the implications that I found. In addition, I included a call for further research and a reminder that this research was limited to the nurses at [redacted] and it would be important to consider a broader study of CPD at other hospitals (Bogdan & Biklen, 2007).

Quality and Credibility

Credibility for qualitative studies depends on three elements: rigorous techniques and methods for gathering high-quality data, the credibility of the researcher, and the philosophical belief in the naturalistic inquiry paradigm (Lincoln & Guba, 1985; Patton, 2002). Patton (2002) declared that qualitative researchers have an obligation to report sufficient details of their data collection and analysis processes so that others can judge the quality of the final outcome. I incorporated internal and external validity techniques along with reliability and consistency strategies as outlined by Merriam (2009) and the following sections expand on these in detail.

Internal validity and credibility. I used two types of triangulation: multiple methods and multiple sources of data. Multiple methods included focus groups, interviews, and document reviews. The focus groups and interviews included multiple sources of data as the pediatric nurses had different levels of experience and came from different pediatric specialties (e.g., intensive care, emergency, neonatal). In addition, day and night shift nurses were included as well as nurse managers. Therefore I was able to collect data from people with different perspectives. Saldana (2013) cautioned researchers not to expect everything to turn out the same when using multiple data sources and to understand that different kinds of data will capture different perspectives and may present discrepant cases. When the data present different patterns, it is essential to understand the difference; when the data show consistency, this contributes to the credibility of the findings (Saldana, 2013).

I also ensured internal validity by conducting member checks. According to Merriam (2009), this is the single most important way to rule out the chance to misinterpret the meaning of what the nurses said. To accomplish this strategy, I solicited feedback on the verbatim transcripts from all of the nurses who participated in the study to review for content and intent. Several of the nurses responded with edits for clarification. In addition, I asked some of the nurses who had participated in the focus groups about the accuracy of the findings and if the themes and interpretations were representative of what they said (Creswell, 2012). They confirmed my findings were truthful and fair.

I stayed adequately engaged in the data collection process until my data reached saturation; that is, until I began to see or hear the same things repeated and no new data was being collected. Reporting negative or discrepant case analyses offers strong support and increases confidence in the credibility of the findings and allows for variation in understanding the case (Patton, 2002). I reported alternate views of the nurses wherein some of their perceptions were contrary to one other.

In the Data Collection section of this study, I explained my position as the researcher. I reflected on my various roles held within the hospital and the relationship I had with the study participants. The aim was to inform the reader of the values and expectations I brought to this research study and how my interpretation of the data might have influenced the study's conclusions (Merriam, 2009).

Additionally, I included a peer review of my findings and I asked a PhD prepared nursing colleague to examine the raw data to assess whether the findings were plausible. I provided my colleague with verbatim transcripts and my coding processes from the NVivo software program. She provided feedback and concurred that my themes correlated with the data and were reasonable explanations of the nurses' perceptions. See Appendix O for a signed Confidentiality Agreement Form by the peer reviewer.

Reliability, consistency, and dependability. Merriam (2009) emphasized the importance of being able to replicate research findings and whether the findings are consistent with the data collected. A strategy I used to ensure reliability of my research study was to provide an audit trail of my research methodology. I provided extensive detail in Section 2 of this study of my data collection processes and analysis methods including how I generated categories and themes of my findings. To aid in this strategy, I operationalized, step by step, my data analysis processes (Yin, 2014).

I created a case study database as a secondary approach to ensure reliability in my study. I compiled all the data collected for this case study in a separate database that included all documents (e.g., verbatim transcripts, audio files, the document review) and also the NVivo coding files from the qualitative software program. The purpose of this database was to preserve all the collected data in a retrievable form and is vital because it contains information not presented in the study report and markedly increases the reliability of the case study (Yin, 2014).

A third technique incorporated to ensure reliability of the data analysis process was to make sure there was not a drift in the definition of the codes during my coding (Gibbs, 2009). About halfway through my coding process with NVivo, I re-examined my codes (called nodes in NVivo) and discovered two of them had the same meaning but were being coded separately. I evaluated the definitions I had assigned in a codebook section in NVivo and realigned the definition and collapsed the two codes into one.

External validity and transferability. In order to understand how the outcomes in this study can be applied to other situations, I incorporated rich, thick descriptions in the findings to enhance the transferability of the results to other settings. I provided extensive detail of the study's outcomes and included various quotes from the nurses to demonstrate their perceptions in their own words. This will allow others to determine whether the conclusions can be applied to other settings.

Another strategy I employed to increase transferability was that I purposefully sought maximum variation and diversity in the sample selection (e.g., day and night shifts, managers with various specialty expertise and years of experience) for a greater range of applicability to other consumers of research.

Results of the Data Analysis

The purpose of this case study was to develop research based descriptions of the perceptions of pediatric nurses regarding CPD opportunities at a tertiary freestanding children's hospital in order to develop evidence based CPD programs and course offerings. The importance of participating in CPD is to improve patient care outcomes by

improving nursing practice through educational endeavors so that patients receive care that is founded on best practices. To find out the nurses' perceptions, the guiding research questions probed deep into numerous aspects of CPD. Because this was an instrumental case study, specific concerns dominated the research questions in order to tease out problems that the nurses may have had with CPD (Bogdan & Biklen, 2007). According to Stake (1995), targeted questions provide an effective structure conceptually for organizing the findings from a case. The six guiding research questions established for this study were:

1. What kind of CPD activities do nurses participate in?
2. What factors influence and contribute to nurses' participation in CPD?
3. What are reasons/barriers for nonparticipation?
4. How do nurses perceive the adequacy and quality of CPD courses/programs offered by the hospital?
5. How do nurses perceive the knowledge obtained from CPD being incorporated into their practice?
6. How do nurses perceive that CPD improves the professional practice of nursing and patient outcomes?

Seven themes emerged from the nurses' perceptions: participation, motivation, barriers, adequacy/quality, knowledge incorporated into practice, improves nursing practice and patient outcomes, and a wish list. The findings from this study provided a thorough and in-depth account of CPD within this hospital and provided educators with

evidence based data to develop CPD offerings to support nurses in delivering high quality patient care. The following sections provide a comprehensive examination of the nurses' perceptions supported with details of the findings and quotes from the nurses in order to offer an experiential understanding of the case.

Theme 1: Participation

Nurses verbalized numerous ways in which they participated in CPD. Six categories surfaced from their conversations that included conferences, life support training, formal academic programs, hospital-wide and unit-based classes, teaching, and research. The nurses stated they participated in classes provided house-wide, those sponsored by the education department, and the classes taught in unit-specific venues. House-wide classes consisted of Grand Rounds (1-hour conferences teaching case studies, disease processes, research, and clinical topics) and special topics of interest such as Ebola best practices and how to deal with assaultive behavior. The decentralized education department offered a full education calendar of classes that the nurses took advantage of. These classes included specialty certification review courses, chemotherapy certification, preceptor and charge nurse workshops, and liver transplant classes. All nursing units offered unit-specific education tailored to the needs of the unit. Those mentioned by the nurses included a cardiac symposium, unit skills labs, journal clubs, unit didactics, audits, teaching families, and attending or teaching pull-back classes (special classes offered post orientation period) for nurses with 6 months to 2 years of experience. Collaborative governance councils were talked about many times and the

nurses remarked how much education happens in this environment. The councils are staff driven committees divided into bodies of healthcare practice: research, clinical practice, quality, education and professional development, and recruitment and retention. The following six subcategories within the participation theme provide a synopsis that adds more depth outlining how the nurses answered the first research question of what kind of CPD activities they participated in.

Conferences. Most of the nurses stated that conferences were one of their favorite ways to participate in CPD. Not only did they enjoy attending but many also presented either as a podium speaker or with a poster presentation. All three nursing groups (nurse managers, day and night shift nurses) stated they attended local and national conferences. Some professional organizations present quarterly meetings with educational topics and the nurses said they attend those regularly as well. The new graduate nurses discussed how some conferences have opportunities for the novice nurse and they jump at the chance to present topics or posters and learn in these venues. The hospital develops several conferences every year including trauma, neonatal, and cardiac. Most nurses indicated they attended conferences that contained content relevant to their current practice; some had interests outside of their nursing specialty. They also stated how they enjoy attending them and look forward to them year after year. However, several nurses had expressed being limited to attending local conferences due to childcare concerns and arrangements. The following statements are representative of discussion points obtained during the focus groups and interviews that centered on nurses attending conferences.

> I went to the Magnet Conference this fall and presented our mentorship program so I like going to conferences. We are presenting the program again in poster form at the Society of Pediatric Nurses national conference in April. So going out to conferences and hearing what other people are doing for me is wonderful. (Participant, Day Shift Focus Group)
>
> I go to conferences and attend seminars; just always looking for opportunities to expand my learning. (Participant, Interview #10)
>
> I went to the Pediatric Critical Care Conference last October in Las Vegas and that was great - it was so much information. We actually had 16 of us go from our unit. (Participant, Interview #7)

Life support training. Most nurses attended life support training classes offered by the hospital such as Basic Life Support and Pediatric Advanced Life Support. These two courses are required training and mandated by the hospital for all nurses to take every two years so it is not surprising that the nurses mentioned these. Some of these courses are offered quarterly and others monthly so the nurses find it easy to fit these classes into their working schedule. Only one nurse stated she attended these classes outside of the hospital. Most nurses take advantage of the hospital-sponsored class because they are offered at no cost; if nurses take the class on the outside, they must pay for it. Other life support training classes are offered, which the nurses discussed, including Advanced Cardiac Life Support, hemofiltration, and heart/lung bypass

certification. Quotations are included here from the participants demonstrating their perception of life support training CPD.

> Our routine ones would be PALS (Pediatric Advanced Life Support), which I get CEUs from. I am ACLS (Advanced Cardiac Life Support) certified so I attend these classes every 2 years for renewal; I get my education hours there as well. (Participant, Interview #7)

> The Basic Life Support is very stressful the way they do it here and I learn more on the outside. That's the one thing I don't like here. They don't have enough classes. (Participant, Interview #6)

Formal academic programs. Nine of the 39 nurses in the study were currently enrolled in formal academic programs pursuing an advanced degree. One was enrolled in a Bachelor's program, four were obtaining a Master's Degree, one was working towards a nurse practitioner post-graduate degree, two were working towards a PhD degree, and one was pursuing a DNP. Two of the nurses revealed that they had many small children at home and therefore going back to school was not an option for them at this time but they wholeheartedly stated that this did not mean their learning has ended. They commented on how they look for education outside of their unit and have found there is a lot of learning exponentially within the hospital. Two nurses indicated they had started programs but dropped out due to confidence issues related to English being their second language. Others in the group encouraged them to return and finish. Comments from the nurses are provided here regarding their participation in formal academic programs.

> I'm getting my Master's in Nursing Education and last year I graduated from the RN-to-BSN program and then went straight into the Master's program. (Participant, Day Shift Focus Group)
>
> I'm going for my PhD at UCLA. (Participant, Day Shift Focus Group)
>
> I'm in school at Jacksonville University for my Master's in Nursing Education and I'm going to continue and get my doctorate. (Participant, Interview #2)

Hospital-wide and unit-based classes. Many of the discussions centered on hospital-wide and unit-based classes that are readily available for all staff to attend. Hospital-wide examples given included Grand Rounds, certification courses, book/journal clubs, preceptor classes, annual skills days, collaborative governance (councils), and mandatory education (e.g., fire safety). Unit-based education included annual update courses, pull back classes, unit didactics, work-area leadership teams (WALT), unit education committees, and performance improvement meetings. All of the participants easily recounted the hospital-wide and unit-based classes they participated in and the following quotes are representative of examples they shared.

> All the Councils are learning opportunities. We learn a great deal from our Council reps. When we have our WALT meetings, there is a lot of evidence and different kinds of practices that we hear about; that is a great resource of learning. (Participant, Manager Focus Group)
>
> There is a lot of learning exponentially because there are a lot of things outside the unit where I work that I wasn't familiar with so for me, those are my advanced

> development; my professional development because I cannot to back to school. (Participant, Day Shift Focus Group)
>
> I teach a quarterly set of classes for the nurses in Cardio Thoracic Intensive Care Unit who have been off of orientation for 6 months but under 2 years and so they go to these pull back classes, and while the topics are mostly geared to them, I feel like every single time I run the class, there is a nugget of information that I'm like, 'Oh, now I understand that better'. Some of the stuff are things we don't do as much so it is a really good review for me too. (Participant, Day Shift Focus Group)

Teaching. Many nurses commented on how much they learned from teaching and that teaching was a big part of their professional development. Whether it was teaching staff or patients and families, the managers and the day and night shift nurses mentioned that teaching was how they learned. Some of the nurse managers acknowledged how they teach at monthly staff meetings or they bring in other knowledgeable staff to speak. They stated that every staff meeting is an opportunity for growth and development because of the teaching that is provided. Several units had education committees and the participants commented on how effectives these groups were in imparting information and training. One nurse wrote blogs for the hospital's website and taught healthcare providers, patients, and families on various topics of interest. One nurse reported about their unit having education huddles where the staff all get together at the beginning of the shift with the purpose of teaching staff on a running list of different topics. Many teaching

opportunities were available for nurses to participate in throughout the year that included the Magnet Fair, the 2-day Education Fair, and at Research Day. These are special events focused on teaching and education and are attended by more than 500 staff. Many nurses expressed they taught at various camps for kids around Los Angeles and found that a great source of CPD. One nurse expressed her satisfaction with working the night shift because it allowed her opportunities to do a lot of teaching especially with the new graduate nurses. The following two quotes are representative of the way nurses feel about teaching.

> I think the biggest way I have learned, and I didn't realize it until I started teaching. To teach you have to know it. And if you don't know it, you have to research it and figure it out so that you can teach your students. I'll see them during the day and I'll say 'I don't know what that is' but I'll go look it up before post conference so that I can actually teach them what it is. That is how I think I've grown the most - is through teaching. (Participant, Day Shift Focus Group)
>
> Teaching families is really very good - you have to really explain it to them, make it real to them. (Participant, Day Shift Focus Group)

Research. Several nurses considered conducting research as part of their professional growth. The nurses provided many examples of current research studies on various topics involving their work area. Several nurses in the focus groups were members of the Research Council and indicated that there was an evidence based practice sub group working on performance improvement projects. They enjoyed doing a

literature review together and stated how useful the council was in that they met people from all over the hospital interested in the same research topic as they were. Many nurses mentioned the excellent work done by the new graduate nurses in the residency program as they presented evidence based practice projects, which was a required component of their curriculum and has proven to be a great teaching opportunity enjoyed by all staff. Excerpts from the nurses' conversations follow:

> I'm doing a research study right now and we're going to be studying nitrous oxide in radiology and I'm doing an IRB study on the analgesic effect of it. (Participant, Day Shift Focus Group)
>
> I love research so when the hospital offered the research fellowship, I applied for that and got chosen and I did a lot of research and presentations in relation to that. (Participant, Day Shift Focus Group)
>
> If you do research and present, then there will be support to cover expenses in international/national conferences. If you do not present your research, you are not going anywhere. (Participant, Interview #5)

In conclusion, the nurses were able to offer their perceptions on CPD opportunities that shed light on the research question. They appeared to be in agreement that there was a plethora of CPD opportunities to choose from. This validated the document review of the hospital's database of all the courses offered for continuing education. I found over a 7-year period, 1,573 classes were provided with 28,542 RNs attending.

Theme 2: Motivators

When asked what influenced and contributed to participating in CPD, the nurses provided numerous comments and explanations. The nurses' remarks included categories of money, time, support, intrinsic/extrinsic value, teaching methodology, ease of learning, and research. Several nurses remarked that motivation depended on their own personal initiative to attend CPD and when nurses have the desire and the need for education, they will make it work. Others agreed but added that motivation depended on their specialty certification. One nurse commented that peer pressure was a motivator for her. She stated she saw nurses whom she looked up to and admired and saw them attending CPD events and felt then that she too should be participating. This is evidence of social cognitive theory in practice and how the environment influences behavior.

Money. The nurses expressed appreciation for available money including the tuition assistance offered from Human Resources (HR), for their education allowance, special funds from various donations, free continuing education contact hours, pay differentials, and for the Chief Nursing Officer making endowment funds available for scholarships. Being thankful for the monetary support, one nurse declared leaders at institutions can say they are behind numerous initiatives but when they are supported with money, the nurses know the leaders are behind it. The nurses were appreciative that they get paid while attending classes. Integrated below are quotes regarding monetary support:

> We get tuition reimbursement from Human Resources every quarter and then our CNO has also helped with some reimbursement. There are opportunities to apply for scholarships too. (Participant, Manager Focus Group)
>
> I didn't know that when you get your Master's degree you get a dollar an hour pay differential so that is very influential to make more money. (Participant, Night Shift Focus Group)

Time. Time was a significant motivator to attend CPD and was discussed at length. The nurses were appreciative for having flexible schedules in order to have the time to attend conferences and classes, for having protected education hours, and for having the classes offered in-house as well as the times and days the classes are offered. These all contributed to cutting down the time it takes to attend. Several nurses mentioned their education allowance and that it included 16 hours of time annually to be used for education away from the hospital. Others agreed and stated these education hours are considered part of their work schedule so they do not have to work above and beyond their usual schedule. There were several comments from nurses about clustering education together as no one wanted to drive in for a 30-minute or even a 1-hour class. They were in consensus with the idea of putting everything together in a longer day and felt the educators were better with that type of organization than they had been in the past. The following quotes comprise the nurses' perspectives on how time affects CPD opportunities:

> I think it definitely helps when it is an eight-hour education day as opposed to coming in for one hour especially for night shift because you have to take the night before and the night of off so when you can make it a full day and cut out a shift, it helps a lot to motivate us to go. (Participant, Night Shift Focus Group)
>
> We do have a flexible schedule; we have the flexibility to move things around to be able to attend. (Participant, Manager Focus Group)

Support. The nurses described support they received from their director and manager, from the organization, having great mentors, and learning from others. Some stated their managers brought them ideas for future growth and supported them when they went back to school. Across the board, the managers and the day and night shift nurses felt support to attend CPD opportunities. Many described the culture within the hospital as one in which the nurses are encouraged to learn, to go and develop themselves, to go back to school, and how can the management team help them to do that. Several nurses said how much they were supported when they needed leadership opportunities related to obtaining an advanced degree. They were required to meet with a mentor for a substantial number of hours and it was always met with support from their supervisor. This was perceived as a huge motivator and source of encouragement for the nurse managers. In addition, nurses commented about the support they felt from their managers when going back to school and that their work schedule was adjusted, they could go part time if needed, whatever the nurses needed to do they felt their mangers were always there to help them make it work. It was also stated how managers supported

staff in conducting their thesis or dissertation work within the hospital. The following passages embrace the positive support received from managers:

> On my unit the managers come to us and say 'look what so and so has to offer, look at what is going on here and have you thought about this', five years plans and things like that, and I say, ok sure, and that is a good feeling to have. (Participant, Night Shift Focus Group)
>
> I talk to some other of my classmates at school and they definitely don't have that type of support at the organizations they are at. I remember one summer semester I had classes every Saturday and Sunday and I worked night shift and I was never able to work Friday, Saturday or Sunday night. The whole weekend thing was already so tense with nurses and I remember going to my manager and saying I'm really sorry but for the next two months I can't work a single weekend, and he was like 'you're in school, it's not like you're in Hawaii' so I just feel that not making you feel guilty because you already do, so that really took it off the table and made it so much easier being in school. (Participant, Night Shift Focus Group)
>
> I am supported in any sort of continuing education I want to do. (Participant, Interview #10)

Intrinsic/extrinsic value. Intrinsic motivation was found in personal desire, need and initiative to attend, self-interest and motivation, passion for learning, and wanting more knowledge. Other contributors to attending CPD included the nurses' love of teaching, being productive, the value and relevance of the topic and how applicable it was

to their job. Extrinsic motivators included having to participate in mandatory education and for doing well on their annual performance review. Statements follow demonstrating the nurses' intrinsic and extrinsic values for participating in CPD opportunities:

> I think a lot of this depends on your own personal initiative to attend and when you really have the desire and the need for that education or that component, you'll make it work. (Participant, Manager Focus Group)
>
> My #1 thing is that I want the knowledge. So that it what influences me. And also just to grow as a nurse. (Participant, Interview #7)
>
> In my case, it is passion for learning; passion for my progression. (Participant, Day Shift Focus Group)
>
> Self-interest and motivation - I am fascinated with learning. (Participant, Interview #9)

Teaching methodology. The teaching methodology of instructors proved to be a motivator for many nurses as they remarked that they loved instructors who made nurses understand why they do the things they do and those instructors who explain the rationale behind changes in practice. Others mentioned they enjoyed having instructors who love to teach and can engage an audience, those who provided hands on demonstration instead of lecture classes, and are able to impart knowledge through simulation, interaction and fun. Examples are provided here of nurses' satisfaction with experiential CPD environments:

> I know for me that if it is a skills day with a hands on demonstration where we are playing with things, I am more inclined to look forward to the day as opposed to an 8-hour day of lecture after lecture that I am not so excited to go to. (Participant, Night Shift Focus Group)
>
> Simulation makes you actually be able to practice your job and with real life scenarios, it's practical. It's not just talking about it, or theorizing about it. You're in a situation that you would really be in at the bedside and it's set up exactly how it would be. You don't get to cheat and you don't get to phone a friend. You have to do it. (Participant, Interview #2)

Ease of learning. Ease of learning emerged as a category with many nurses affirming they participated because of easy access or quick learning. Examples included how they learned from emails every day, from the electronic journal database, receiving education from a newsletter, and from webinars and self-study/online learning. It is important for educators to take note of these comments as this category holds great significance for incorporating education throughout a large nursing staff and especially those nurses who have a long commute. Many nurses commented how hard it is to make time for continuing education with having such busy lives but being provided remote opportunities by the hospital was great and helpful. Having a set schedule due to childcare arrangements made it difficult for some nurses to attend many of the instructor-led classes. Having other options available to them made learning easier and they are appreciative of anything that can be done online. One nurse stated that she enjoyed

attending webinars because they are easy to do and she frequently gained valuable information form them. She said it required the least amount of effort to gain in return and considered webinars a good resource. The following extracts are representative of the nurses' perceptions on the ease of learning in CPD offerings:

> I feel that the extra knowledge is so great. I am a very big advocate of continuing education because I feel it keeps us so updated and provides us so much knowledge; to have to do continuing education and being provided the opportunities is so great. (Participant, Interview #7)
>
> I like that we get continuing education units (CEUs) for most of the classes we attend because most of my friends from nursing school, their organizations don't offer them classes so they have to take outside classes to fulfill their CEUs. I feel like I am the only one out of all of my friends who is able to fulfill my CEUs at my own organization. (Participant, Night Shift Focus Group)
>
> I think we learn a great deal from emails; there is new stuff that comes to our email every day that gives us information for our staff and for ourselves; we are learning things all the time every day. (Participant, Manager Focus Group)

Research. Finally, research appeared to be a motivator with many nurses stating that being able to participate in research influenced their participation in CPD, to being able to publish, and to conduct research every year. One nurse was the recipient of a $5,000 grant and she discussed how this was a big motivator to her as she worked on a research study. She also had protected time to write an article and create a poster. Others

were appreciative just to be able to participate in research and to make a difference. The opportunity to publish was given as a reason by a nurse for her passion for research in that publishing offers opportunities for collaboration with others around the world. She posted a DVD on ventilation on the website that had over 60,000 hits on it and is surprised her how it has positioned her as a leader on the topic. In agreement, one nurse felt that research and publishing were her lifelines. She did not do research just to improve service but that it was an opportunity for her to get her name out in healthcare and that it really was a service to whole population of patients worldwide. Research comments made by the nurses include the following:

> Getting the electronic journal database has helped us a lot. (Participant, Manager Focus Group)
>
> Just to be able to be a part of research and make a difference. That is my big motivation. (Participant, Interview #7)
>
> My thing is that if nurses open up their eyes, they can see the need for research. If you don't have the answer, just go and research it. It's as simple as that. (Participant, Interview #5)

In summary, the nurse participants were able to identify numerous motivators that stimulated them to attend CPD learning. They were appreciative of monetary support as well as the consolidated education days to cut down on the time it took to attend classes. Manager support and intrinsic and extrinsic value played a role in their motivation. The

teaching methodology, ease of learning, and research offered persuading ideas to inspire CPD attendance.

Theme 3: Barriers

Even though the nurses found numerous motivators in attending CPD classes, they also found a number of barriers as well. The four key barriers uncovered were money, no management/leadership courses, time/workload, and lack of resources and support. Nurse managers complained that a major barrier to CPD was that there was no organized timeline for rollouts of new education initiatives and that staff were constantly bombarded with just in time education regarding policy updates, new equipment, and changes in practice. They requested that a process be put into place to centrally monitor education roll out due dates in order to ensure an orderly and thoughtful timing of all required education. Another barrier to CPD that was only mentioned by the managers was that they were not allowed to work a 4/40 work week. They protested that working Monday through Friday hinders their availability to attend CPD as they are continuously working. If they were allowed a 4/40 week, they could use the fifth day for CPD and to maintain work/life balance. One day shift nurse commented a barrier for her was not knowing what classes were being taught by other units and it would be beneficial for nurses from other areas to attend each other's training if applicable. Another stated she felt she had to jump through hoops to implement projects and two nurses criticized the lack of available classes and educational opportunities. This goes against the discussion produced from the question about participation in CPD opportunities when it appeared

there were adequate classes to choose from. The following four subcategories within the barrier theme provide a summation on how the nurses perceived the barriers to participation in CPD activities.

Money. A major barrier discussed was the lack of money available to attend classes. Although money was found as a motivator, the lack of it contributed to nonparticipation. The nurses stated the cost of some conferences was prohibitive, the department's education budget was cut, and that nursing did not have money to cover the costs. Most nurses agreed that the dollar allotment for attending conferences was not adequate to cover the costs and sometimes the nurses pay out of their own pocket. In addition, complaints were mentioned that there is very little financial support to go back to school, the education allowance is not enough, and there is a lack of money for nurses who work in clinics. For those nurses who worked in the outpatient clinics, this category resonated throughout the focus groups and interviews. It appears that the outpatient areas have smaller education budgets than inpatient units. The same can be said for medical divisions as the nurses perceived that physicians have access to funding sources that nursing does not have. The following are nurses' sentiments regarding how money is perceived to be a barrier to participating in CPD:

> I think there is more money put towards the development of bedside staff nurses. When you get to the middle level, then the development drastically falls off. (Participant, Manager Focus Group)

> In the past, we've had really good dynamic speakers come to the hospital but I haven't seen that lately. You know, great speakers come to Grand Rounds every Friday for the doctors. I think the priority isn't for nursing development - it is for physicians. And we know that we are always challenged when we have events to try to get a speaker that we can afford so I don't think the money is put forth for nursing development in this organization. (Participant, Manager Focus Group)
>
> Medical divisions have money that nursing doesn't have and that varies very much across the board. (Participant, Manager Focus Group)
>
> The allotment for attending conferences is not adequate to cover the costs - not even close most of the time and a lot of it is coming out of our own pockets. (Participant, Manager Focus Group)

No management/leadership courses. The managers were the most vocal during a discussion disclosing that there was very little opportunity for leadership or management classes; those conferences and classes had to come from outside the hospital, as there was nothing offered in house. The managers objected to the fact that there were no classes on how to handle issues on the units, how to help nurses on the unit who were having problems clinically, and what can the managers to do help their staff, and commented that these types of issues were always a struggle. Previous requests to bring in an expert to teach these topics were denied. Further complaints were there was nothing for education managers to increase their teaching ability, how to design curriculum, and teach adult learners. Several nurses discussed the lack of computer

classes and grumbled at the expectation that they should know how to use a spreadsheet software program but how are they supposed to learn it when classes are not available. Another barrier to CPD was that there were no outside speakers brought into the hospital except for the physicians and the priority was not for nursing development. The nurses discussed how difficult it was to bring in speakers that they could afford and felt the money was not put forth for nurses. Quotes provided here offer concise perceptions of the negativity perceived by nurses of having no access to leadership and management training and education classes for experienced managers.

> The things that Human Resources thinks are important are not the things we think are important. Some of the manager classes we think 'where are you coming up with the ideas for these'. They aren't even relevant with what we need help with. (Participant, Manager Focus Group)
>
> There is not a good source of management classes for us. There are classes for new managers but for those of us who have been managers for a while, we would like more sophisticated classes. (Participant, Manager Focus Group)
>
> I am a pretty seasoned manager/leader and in some classes I've gone to, I could teach the class! I really felt the classes were great for a novice leader - not at all what I was looking for. There is certainly so much to learn that I just want to be engaged at a higher level. (Participant, Interview #9)

Time/workload. Furthermore, some nurses found it hard to get time off, workloads were too heavy to take time away, required too much time to attend

conferences that are not local, needed advance notice of classes, and doing more than one person's work did not allow them time to participate. Several nurses did not have the time to travel to conferences outside of the Los Angeles area. Distance was a factor and each conference had to be looked at as to whether it was offered 10 miles away or on the East coast. One manager confessed that taking time away from work made her too stressed and she just makes the decision to not go because it takes too much time to get caught up after being away. Several other managers were working on units with open manager positions and commented that whoever is working short a manager or two is doing extra and more than one person's work and they do not have the time to take on any additional activities. Exhaustion and fatigue were mentioned by the nurse managers and deserves recognition as a barrier to CPD. The common thread of the discussion was that the managers were tired and could not take on one more thing, one more class, or one more conference. There were differences of opinion between day and night shift nurses. Some day shift nurses found it easy to get time off for CPD, however, one night shift nurse stated that she was often refused her request to take time off and she often found it difficult to get other nurses to trade shifts with her. The nurses' feelings regarding time and workload constraints can be seen in their perceptions below:

> The time constraints; how can I fit that into my day and how can I go when there are too many other things, competing priorities. So even if they had more offerings here at the hospital, I'm not sure how many of us would actually take

> advantage of it because of the time constraints and all the work and demands that are put on us. (Participant, Manager Focus Group)
>
> Ultimately, when you think about it, all this stuff that is piling up and piling up, it takes away your drive to want to do more, it takes away your incentive to step out on your own to do something because you just don't have the time and to be really honest, sometimes you just flat out don't have the energy. (Participant, Manager Focus Group)
>
> Sometimes it is just scheduling; being on night shift, just trying to get two days off in a row for a two day conference you need three nights off, or even four because honestly, in order to switch your sleep adequately in order to stay awake for an eight-hour day, I need more than just one night off. Sometimes that is a struggle. (Participant, Night Shift Focus Group)

Lack of resources and support. The category of lack of resources and support garnered an equal number of complaints. Nurses referred to the lack of support for evidence based practice (EBP) projects, no education structure during the night, lack of references or resource books, lack of a good research program, no dedicated person for research, and no grant monies. Some of the new graduate nurses mentioned that they start EBP projects during their residency program but find it difficult to continue the projects once they complete the program. Night shift nurses lamented about the lack of education provided during the night saying that at 2 a.m. when everyone is asleep and quiet, that would be a great time to have someone come in and provide educational in-services.

They also mentioned a desire to have a research mentor at night to roam through the units to help nurses with research during quiet periods of patient care in the night. The lack of books, journals, and scholarly resources on their individual units were brought up by some of the nurses. Many units only had a couple resource books; others had more but they seemed to have disappeared from the collection of books. Other nurses wanted more research mentors, help with getting through the IRB, a librarian that could help them search for articles, research classes, and paid time to support conducting research. One nurse stated that money is the key for research and that the hospital should have someone looking for research grants and making them available to the staff. Quotes cited here demonstrate perceptions of lack of resources and support:

> Within the hospital, the timing of educational opportunities is a barrier. We don't have an hour off so all of Grand Rounds are an hour long but we don't have an hour break. Even if you want to use your break time to go, you can't and the reality is most of the time the floors aren't staffed to allow floor nurses to leave to go participate; it's just too hard to get people out for educational things. (Participant, Day Shift Focus Group)
>
> Staffing is a barrier for me. In our department, it's so small that sometimes I can't leave. (Participant, Interview #4)
>
> We need to get grant money and have a dedicated person to do that for nursing. (Participant, Night Shift Focus Group)

In review, the nurses were aptly able to convey their perceptions in reference to the fourth research question probing for barriers they found to CPD. No management and leadership courses were the most significant of the barriers as witnessed in the passionate discussion during the nurse manager focus group. The consensus demonstrated in that discussion clearly identified the dissatisfaction felt within the group.

Theme 4: Adequacy/Quality

When asked how the nurses perceived the adequacy and quality of CPD, they responded with responses that fell into three categories: good/helpful, needs improvement, and missing/lacking. Overall, most nurses were pleased with the quality stating that the pediatric expertise of the course instructors is what made the classes excellent. Comments were made that most of the classes are research based and the topics are appropriate. The nurses enjoyed the unit based skills labs and the certification classes. They commended the educators for reading the course evaluations and making changes to the classes based on that feedback. One nurse manager criticized the presenters of the HR leadership classes stating they did not have the experience needed for caliber of leaders that are at the hospital. The nurses commented as follows on the adequacy and quality of CPD opportunities within the hospital:

Good/helpful. Many nurses felt the courses were excellent, good, or have improved over time. They cited many classes they enjoyed (e.g., skills day, Grand Rounds, heart symposium) and stated the life support training classes were excellent due to the pediatric experts teaching the courses. Several nurses commented on the heart/lung

bypass certification course and the simulation exercise were excellent. One nurse stated that the hospital has an awesome culture that it is ok to ask questions and found that built into the classes promoting patient safety even in the training environment. Other comments were made that everything the hospital presents has high standards, Grand Rounds are always great, and the IRB classes offered are exceptional. The nurses expressed their opinions as follows:

> If you are talking about the classes that are provided here, I think they are great. I think our PALS courses are good. I have always encouraged our people to take it here because as [redacted] practitioners, we should know PALS and we should know it very well. All of our life support training courses are wonderful because the subject matter experts are on the front line - they are us. The quality of those classes are good and we need more types of those kinds of classes. It is experts teaching. (Participant, Manager Focus Group)
>
> The CTICU does have a lot of really good skills day - it was an eight-hour day and four hours of it was hands on practice. (Participant, Night Shift Focus Group)
>
> Regarding adequacy, I couldn't get to more if they offered more. I pretty much have to force a time out on my schedule as it is to get to classes now. The length is good. (Participant, Interview #8)
>
> All I want to say is to keep doing what you're doing. Keep pushing to things being available for our staff to make our staff better because the better our staff are the better our patients are going to be. (Participant, Interview #4)

Needs improvement. However, several classes were recommended as needing improvement. The electronic medical record course provided for new employees does not teach documentation well as gaps in practice have been found during chart audits. One nurse commented that the vendor classes on new pump equipment were not helpful and found it to be a waste of time. Courses on the hospital's learning management system were considered inadequate and that the search feature was useless. A few night shift nurses reviewed the training found during the annual Education Fair and felt there were too many posters for staff to learn and anything. Justifiably, the nurses stated that learning is not effective when the learner cannot remember what was taught. The nurses made several comments on how the classes needed improvement:

> They are not adequate and I can give you a good example. When I started here, they put me in the management class, which was utterly useless. I have management experience but I had no idea how things functioned in this hospital, everything is different - even the way you read a budget and I got none of that. (Participant, Manager Focus Group)
>
> I just recertified today and we got to use full simulation in our new simulation lab and that was exquisite education. I learned so much. It was very beneficial and hands on and very adequate. I'm really excited to see much more of that. But then again we have many areas of education that we aren't quite to that level yet and may have aspirations of getting there and I know money is expensive to run these programs and put everything on this time line but the hands on learning is huge

> and having the ability to simulate is a wonderful opportunity for us. (Participant, Interview #2)
>
> I think I have more of an issue with the adequacy than quality. I have heard a lot of quality presentations but I still don't think, when I think of what makes it, the value is when I leave the session, did I learn something that I can apply and use. What am I going to do differently because I have been there. Most things are good reminders; rarely is it new knowledge. (Participant, Interview #9)

Missing/lacking. The nurse managers voiced very clear concerns when the discussion turned to what was missing and lacking from the hospital's CPD offerings. The general consensus was that the courses were not adequate due to the lack of any management classes for managers with experience. In addition, the nurses found the manager orientation was for novice leaders, there was no formal mentorship program for managers, and no classes were offered on how to prepare a budget. Additional comments made by the managers included that the management classes had no information specific to the hospital, some classes changed over time wherein the content was taught differently and the content experts did not know the answers, and the union class was redundant. The nurses' sentiments were conveyed in the following quotations:

> The manager orientation was not practical - you do not get information that is specific to this organization that will help you do your day-to-day work and there is nothing beyond. There should be a mentorship program. There should be someone you are hooked up with that you can go to and say 'walk me through

> this, I don't know how to do this at this place'. (Participant, Manager Focus Group)
>
> I went to the original manager orientation here and I really felt that was great for a novice leader - not at all what I was looking for. There is certainly so much to learn that I just want to be engaged at a higher level. (Participant, Interview #9)
>
> No one gives us the information to do a budget; no one gives us the tools to do a budget. (Participant, Manager Focus Group)
>
> But again, it comes back to what educational courses are being offered for management. I don't see anything being offered to us. To judge the quality of classes that we could go to, they are nonexistent. (Participant, Manager Focus Group)

The nurses were very candid in their responses as to which CPD offerings were good, needed improvement, or lacking altogether. Their input was invaluable for developing suggestions for changes in the education and training of CPD offerings within the hospital.

Theme 5: Knowledge Incorporated into Practice

Nurses replied mostly positively when queried about their perceptions of whether the knowledge they learned in CPD activities could be incorporated into their nursing practice. The discussion centered around three categories: supportive culture, resistance, and lack of desired information. Many nurses have supportive cultures in the work area and had positive attitudes about being able to incorporate CPD knowledge into their

practice. Other nurses encountered resistance from other staff, managers, and physicians. The nurse managers had much to say about the lack of desired information and this centered on their great desire for leadership and management training and education.

Supportive culture. The nurses talked about the hospital's supportive culture in bringing back ideas and saw changes in behavior after attending classes. All agreed that the life support training classes get incorporated back into practice as well as the skills practiced during skills labs. Several nurses gave examples of practice changes including using pagers for families and changing medication protocols. Critical care nurses conducted a research study and found that pagers for families were not helpful. A group of nurses informed their unit physicians about a research idea they heard about at a conference and now their unit is doing their own research. A day shift nurse was appreciative that CPD provided her the opportunity to be involved in something else besides bedside nursing and she found other areas of nursing that she was passionate about. Another nurse found an opportunity through CPD to create her own project and make a difference in her nursing practice. A nurse manager brought back some great tips on giving presentations from a Magnet Conference and is using them in her practice. The nurses shared their viewpoint in the following views:

> Within the Pediatric ICU, we talk to each other on where we've been and where we're going and what excites us; we get people involved, we get Performance Improvement projects going. Change is good, I like it; we embrace it. (Participant, Manager Focus Group)

I feel like the environment is open to it and the truism with evidence based practice is that it also needs to fit into your institution. There are some things that are 'gosh, that is a great idea' but even structurally we don't have the set up to do that. But I never felt that the management was unwilling to hear things. There are always staff who complain about the new things but it doesn't mean that you can't bring ideas back. The culture seems to support it, at least for me. (Participant, Manager Focus Group)

Our managers love it when you bring back new ideas. And they give you the opportunity to show the staff and see what they think. (Participant, Night Shift Focus Group)

I have to say I am very lucky that I work in a unit where my managers at least acknowledge when I take something to them and listen to it and help me brainstorm whether it will work or not. It's not an instant shut down. I have heard though of other of my peers throughout the facility who may go get some information and bring it back and they get shut down immediately. I can't say that I have ever personally experienced it. I've also have gotten ideas and taken them house wide and have had great support with my nursing leadership. (Participant, Interview #1)

When we went to the Vegas conference, there was a big topic and research about somenetics, the way they monitor renal and brain perfusion. When we came back, we told our doctors about the research, and now our unit is doing research

> very similar. Just to be able to be part of research and make a difference is my big motivation. (Participant, Interview #7)

Resistance. Some nurses spoke about the resistance they felt in bringing back ideas; these were related to cost, difficulty gaining approval through the IRB process, and frustration when trying to change a hospital policy. Cost is always a factor but the nurses were aware of how to prioritize changes they desire to make in order to fit fiscally into the plans of the units. Some nurses ran into barriers in gaining IRB approval and they were able to seek out mentors to help them through the process. Changing hospital policies can be a long process requiring approval from multiple committees and councils along the way. Depending on the nature of the change, some nurses get frustrated with the multiple hurdles.

> When I came back from my first transplant conference, I had lots of ideas to talk about but they cost money. We did some of them anyway that I could do without having to invest anything besides paper and toner. So we did do that with some resistance but among my colleagues no. They were very excited to get the materials. I downloaded everything and I split it up and parceled it out to the people that I thought would be able to use it. I think you have to. That's part of being a colleague. (Participant, Interview #4)

> When you try to change an actual policy or procedure or when it involves more than one unit, it's very frustrating to try to change. (Participant, Day Shift Focus Group)

> I have two poster projects that I want to do research on but I'm finding it difficult to get through the IRB and who could help me with that. I love research and I'm willing but it's getting passed that point of who to go to. (Participant, Day Shift Focus Group)

Lack of desired information. Once more, the managers expressed displeasure with the HR leadership classes saying there was nothing worthwhile to bring back to practice. The nurse managers argued that they bring back clinical issues to their practice but there are no leadership issues to incorporate because they cannot go to those conferences to learn the new technology and best practices. One manager commented that she had not had any CPD in the 4 years that she had been a manager and that professional growth needed to come from them as she felt the hospital was not supporting her. Dissatisfaction was expressed in the following nurse quotes:

> We bring clinical issues but there are no management or leadership issues done here to bring back. (Participant, Manager Focus Group)
>
> There aren't any management classes presented here that we can actually take. I don't know of any management conferences. There are some but they are outrageously expensive. (Participant, Manager Focus Group)
>
> I went to those leadership classes in HR and I wrote a scathing review. (Participant, Manager Focus Group)

Theme 6: Improves Nursing Practice and Patient Outcomes

The nurses were divided in their perceptions when they talked about whether their CPD knowledge improved nursing practice and patient outcomes. The nurses' perceptions were categorized as either being directly related or finding obstacles. Nurse managers agreed that the CPD they attended directly related to patient outcomes because it encouraged ideas of specific issues they could look at to improve care. They remarked that is was antidotal until someone decided to put numbers to it. The nurses remarked that the work that the new graduate nursing residents and staff do plus the committee and council work that takes place all improve nursing practice and patient outcomes. Day shift and night shift nurses concurred they saw a direct relationship between PALS classes and patient outcomes and how much more comfortable they are during a code blue after having been certified in the advance life support class. One nurse commented that she was able to directly see what nurses have learned affects patient outcomes as her manager provides rates of infection and other metrics and they can see the changes in their practice and that the patient outcomes improve very rapidly across the board. The nurses enjoyed learning changes in nursing care as a result of research at conferences and brought back best practice ideas to incorporate into their nursing practice. Night shift nurses had the most negative response to this question, faulting physicians as being barriers to the nurses in bringing back new ideas and putting them into practice.

Directly related. Many nurses felt that CPD knowledge was directly related to patient outcomes and gave examples of changes in practice that had positive patient

results. Numerous nurses agreed that being involved in research helped them bring evidence-based practices (EBP) into everything they did. Other nurses did not agree and stated that sometimes practice was not based on EBP. Positive references can be seen in the following excerpts:

> It directly relates to patient outcomes because it spurs some ideas of specific things we could look at to improve care. (Participant, Interview #8)
>
> Much of the education that I have received or that I receive working here at [redacted] is research based. So whether it's a change in ventilator related pneumonia education they've done research on keeping head of bed up, suctioning in the closed system, that was education received and based on research that's been done out there and we have decreased our ventilation related pneumonia rates. So I directly am able to see what I have learned and actually see data statistics that my manager in the hospital actually publishes out for us to see and we can see statistics and rates of infections. There is constant education for us. We can actually see the changes in our practice happening and the patient outcomes improve very rapidly across the board in almost everything. (Participant, Interview #1)

Obstacles. Some nurses remarked that physicians were obstacles in using their knowledge to improve patient care. The nurses mentioned they have encountered some physicians who have a variation in practice that is not supported by evidence and is counterproductive in producing the best results. Ineffective education was noted as

negatively impacting nursing practice and patient outcomes. Negative perceptions are noted in the quotes following:

> We have a bunch of new physicians right now and some of them are so closed-minded because they think they know everything and you can't reason with them. (Participant, Night Shift Focus Group)
>
> We get a lot of lectures on how to deal with end of life and palliative care, so as nurses at the bedside who see these patients actively passing and wanting to do more for them and their family, we really push for comfort care and making them as comfortable as possible, but sometimes we have doctors who don't hear those lecture or have that training. (Participant, Night Shift Focus Group)
>
> I think some of our doctors have a variation in practice that is anecdotally supported but is not supported by the evidence. Yet they continually say the evidence supports it and you say what is the evidence and they show you like one study. But we have 15 studies over here. I think some of it is that the doctors have a different level of training and I respect that and they are in a different place and they have more experience dealing with the masses of patients, where mine is more focused on the inpatient care and not the entire continuum. (Participant, Night Shift Focus Group)

Theme 7: Wish List

The nurses offered an abundance of ideas to improve CPD within the hospital. Lively discussions took place in the focus groups as the nurses contemplated ideas,

activities, and better ways of learning to enhance CPD opportunities. This list became a golden opportunity for nurse educators to enhance CPD opportunities to the fullest and incorporate heart-felt feedback into new technology in order to provide state of the art education and training. All the nurse participants engaged with lively discussions during the focus groups and interviews and provided a list of everything they could think of in order to improve CPD within the hospital. Five categories emerged from the focus groups and interviews: coordination of events, technology, simulation, resources, and additional classes/topics. No one category surfaced as more important than the others but all provided ideas, suggestions, and recommendations of areas of enhancements and expansion. Not surprising, technology appeared to be at the forefront of conversation and the nurses wished for the hospital to move rapidly in making changes that keep up with the advances developed in media and technical expertise.

Coordination of events. Several urgent pleas were made for a process to be put in place to oversee education rollouts. Too many competing projects and agendas caused a bombardment of education initiatives to happen simultaneously causing overload on the staff. The nurses suggested a central clearinghouse with clear timelines to instill an orderly and organized education calendar. The nurses also felt the hospital should help units in offering conferences, bring in outside speakers, and offer days of mini-conferences consisting of 30-minute classes that staff could pick from to attend. Nurses provide their thoughts to make CPD better with the following ideas to coordinate events:

> Streamline the approach; all these education ideas need to come to one body and not 20 different bodies to decide the timeline; it comes through one avenue. It should go through a process to decide when it should roll out instead of 50 things at once. (Participant, Manager Focus Group)
>
> All the literature talks about how planning is so important and what we do is that we educate, and then the education is not consistent. What would help is a clearinghouse that has to have teeth to say no when someone tries to roll something out and someone says no. It is not only that but having enough back up that if you say something is not ready, then to stop. They need to listen when we say that it isn't ready and then they say yes it is and it needs to be done by Friday. And then you're in the middle of four other things that you are trying to teach and you can't throw one more thing on top of that. They are not listening to the educators who are supposed to be the experts on it. (Participant, Manager Focus Group)

Technology. Technology was thoroughly discussed and nurses wished for more online courses, webinars, and live streaming of classes and educational events. Several references were made to developing a video library. The nurses requested the hospital to videotape all or most courses and catalog them in a convenient place on the intranet for 24-hour access and availability to staff. Many of the nurses imagined state of the art CPD classes with improved technology as seen in the quotes below:

> I think that the issue of technology is so important. And for me taking courses online and doing my own studying at my own self-pace is really worth it. So in our case that we are bedside nurses and our schedule is made three months in advance, it would be great to have this kind of opportunity to get access to these kinds of courses that we are interested in online. In my case, I really learn more on my own time. (Participant, Day Shift Focus Group)
>
> I think we need to be using technology to our benefit. The webinar idea that I can be sitting at my desk and see what is going on. I think that should always be offered. We still have a ways to go. (Participant, Interview #9)
>
> We should not have to go to a common place to hear it or see it. The technology is there and that makes it easier for me to do it. I think we should do more than that. We should have a library so once it has been recorded, I want to know what was being said and I want to be able to digitally check it out and watch it at my convenience. I want the knowledge so make it easier for me to access on my timeline. Help me learn by making it easy for me. (Participant, Interview #9)

Simulation. Many suggestions were made to enhance current CPD classes including making them interactive and adding simulation to the teaching methodology. Adding real-world problems via a simulation scenario was described as a win-win situation and something educators should methodically strive for in many more of the classes. Quotes supporting simulation utilization are included:

> We can definitely use more simulation. That would really improve our lifelong learning. (Participant, Interview #1)
>
> Add more simulation lab classes or turn our current classes into using more simulation exercises because it's such a great opportunity to enhance learning. (Participant, Night Shift Focus Group)

Resources. The lack of resources surfaced and nurses requested more money for scholarships, tuition reimbursement, and funding for conferences. In addition, numerous recommendations were made to hire support staff to help with education (e.g., during night shift), and to have research mentors available to help staff with literature reviews and research endeavors.

> At two in the morning when patients are asleep and quiet, that would be a great time to have somebody come in to do education with us and that is not something that is really structured to happen. (Participant, Night Shift Focus Group)
>
> I've worked with some of the people doing research and there are all these different levels of what people understand, and how to access stuff and how to put together questions. It would be nice to have point people who have some relief time to go in to support projects and helping and nurturing and has the expertise. (Participant, Night Shift Focus Group)
>
> It would be great to have people like a roving person. On some night shifts, we have time and we are sitting at a computer and we could do research, we could actually put our heads together. We have an opportunity, it is unpredictable of

> course, but it would be a good way to use some quieter time on the night shift and pull up some journals and have someone who might be available on a given unit and can make themselves available for a window of time during the night. (Participant, Night Shift Focus Group)

Additional classes/topics. The nurses requested slide presentation and spreadsheet software classes, time management for managers, and mock codes in the simulation center on a regular basis. The nurses' perceptions of what was needed to enhance CPD learning offered substantial and concrete ideas for improved professional development and education opportunities. They expressed their desires as follows:

> We used to do mock codes on a somewhat regular basis but since we've moved into the new hospital, it has been inconsistent. We need to bring this back and reeducate everyone. (Participant, Day Shift Focus Group)
>
> Time management for the middle layer would be a wonderful class. Excel and PowerPoint would also be helpful. (Participant, Manager Focus Group)
>
> I think it is interesting that we are the 5th ranked children's hospital in the United States (U.S. News & World Report) and I see all these other conferences put on by hospitals. We should be putting on pediatric conferences! (Participant, Day Shift Focus Group)
>
> I would love to see some Spanish or medical Spanish classes. (Participant, Day Shift Focus Group)

Cross-Case Analysis

Because I used a single-case embedded design in this study, subunits (day/night shift nurses and nurse managers) of data were collected along with the single case study. The purpose of the subunits is to enhance the insights of a particular case and offer significant opportunities for additional analyses (Yin, 2014). In cross-case analysis, researchers group together answers from the subunits cases and organize them by common questions or perspectives from the instrumental case study issues (Patton, 2002). I used an interview guide during the data collection and this approach allowed for the nurses' answers to be grouped by topics from my interview questions (Patton, 2002). Therefore I was able to aggregate findings from the series of focus groups and individual interviews for standard comparison among groups. In order to examine the cross-site data, I created tables based on the seven themes that emerged from the coding process and compiled data from the three subunits of analysis: day shift and night shift nurses, and nurse managers. See Appendix P for a compilation of the cross-case analysis. This allowed for the cross-case pattern analysis of the individual cases to be a major part of the case study data (Patton, 2002). Similarities and differences are outlined according to themes in the following paragraphs.

Participation in CPD. Similarities were found among the nurse managers, day shift and night nurses in that they all participated in life support training courses offered by the hospital. This was to be expected as these courses are offered free of charge and are mandatory education required for the job. All three groups stated they attend local

and national conferences, Grand Rounds, are in school for advanced degrees, and attend various hospital-wide class offerings. All the nurses mentioned teaching as part of their CPD and they also had in common a joy of reading (e.g., books, nursing journals).

Differences were discovered in the amount of courses attended with the day shift nurses listing significantly more classes that they participate in. This could be because there were more day shift nurses in the study but it also might be because day shift nurses have more opportunities than the other two groups. Night shift listed the least amount of opportunities, which matches the literature review findings that night shift nurses have additional barriers to attendance including less opportunity due to decreased flexibility in their schedules. The nurse managers listed participating in fewer classes than day shift nurses likely related to their busy management roles. All three groups had nurses currently enrolled in academic programs but day shift had four enrolled, night shift had three with the manager group only having one. See Appendix P Table 1 for additional information.

Motivators. All three groups had similar perceptions of what motivated them to participate in CPD. These included time, money, support from their supervisor and an interest and relevance of the topics. Nurse managers and night shift nurses agreed that if they were motivated enough, they could get through any barriers and make the time to attend professional development opportunities. Day and night shift nurses mentioned the social aspect of CPD and stated how they liked interacting with others and spending time with staff outside of work.

Differences were subtle between the groups but it appeared that the night shift nurses were more extrinsically motivated than either the day shift nurses or nurse managers. This was demonstrated through comments they made about obtaining advanced degrees because of pay differentials, peer pressure and those around them attending classes, getting credit in their professional ladder work, and doing well on the annual performance reviews. The nurse managers and day shift nurses did not make reference to any of these extrinsic motivators. Day shift nurses listed the most motivators, followed by night shift nurses; nurse managers listed the least. See Appendix P Table 2 for additional information.

Barriers. All three groups were in agreement that barriers presented were not enough money, not enough time, distance and location of conferences impacted attendance, and scheduling/coverage. Most of these barriers were also listed as motivators.

Differences were apparent between the groups and included day shift and night shift having barriers with the timing of the classes. Either the classes were scheduled at busy times during the day causing the day shift nurses difficulty in attending or the time of classes catered to day shift causing the night shift nurses not being able to attend. The 12-hour shifts of the day and night shift nurses produced many barriers of attendance. Nurse managers listed twice as many barriers as the day and night shift nurses with their number one complaint being that there were no leadership or management classes to attend. They made a significant number of comments regarding having no professional

development for managers. In addition, they were the only group who declared numerous times that their workload was too heavy to attend due to time constraints and competing priorities. The night nurses were the only group to have issues with rate of pay; understandably so due to night shift receiving time and a half after eight hours of work (night shift differential). This rate was impacted when attending education courses during the day. See Appendix P Table 3 for additional information.

Adequacy and quality. Generally speaking, most of the nurses in all three groups agreed that most of the CPD offerings were adequate and of good quality. All the nurses mentioned several specific courses that were good and helpful. However, after this acknowledgement was made in the focus groups and interviews, the conversation quickly turned to the lacking or missing content of CPD.

All three groups listed specific courses that needed improvement but only one night shift nurse felt the life support training classes were inadequate. By far, the nurse managers complained of courses lacking from the CPD offerings and verbally compiled a list: no management classes for managers with experience, no information specific to the hospital, no formal mentorship for managers, no classes on how to do a budget, and no support for new managers. Their perceptions of CPD were obviously different than those of the day and night shift nurses and it was clearly seen when comparing the comments of the three groups. See Appendix P Table 4 for additional information.

Knowledge incorporated into practice. All three groups cited similar examples of being able to incorporate the knowledge they obtained through CPD activities back to

their nursing practice. Day shift nurses appeared to have more success with this transfer of knowledge than the other two groups. Day shift nurses also had more positive comments regarding their perception than night shift nurses. Nurse managers had a different perspective to offer because they were the ones that were facilitating the knowledge transfer in many of the circumstances mentioned by the day and night shift nurses.

The nurse managers mentioned that in reference to leadership and management knowledge, they had nothing to bring back to their practice, as the new knowledge remained nonexistent for them. Night shift nurses were less optimistic about the opportunities to bring back their knowledge to the bedside. See Appendix P Table 5 for additional information.

Improves nursing practice and patient outcomes. Nurse managers and day shift nurses had many positive comments and agreed that CPD improves their nursing practice and patient outcomes. They recounted many examples of how they directly see that education impacts patient outcomes and they can visibly see positive results. The day shift nurses had almost double the comments than the other two groups.

The night shift nurses were less positive and faulted some of the physicians for being a barrier to them in changing practice based on evidence and thereby impacting patient care and results. This pessimism may be attributed to one of the disadvantages of focus groups in that once some vocal voices speak out on a topic others easily follow or

have difficulty in speaking up. The reasons for the negativity remain unknown. See Appendix P Table 6 for additional information.

Wish list. The wish list was full of productive and creative ideas from the nurse managers, the day shift and the night shift nurses. All three groups provided great ideas to improve CPD at the hospital. They mentioned many of the same ideas: bring in dynamic speakers, offer more simulation, make the courses more interactive and fun, and offer more research classes. Technology was the focus of attention of all three groups - everyone wanted more online courses, webinars, and a video library. This proved to be a fruitful and valuable interchange of ideas. See Table 4 for a detailed look of the wish list and Appendix P Table 7 for additional information.

Summary

Through the focus groups and interviews, the pediatric nurses were able to methodically and completely answer the research questions posed in this study regarding their perceptions of CPD opportunities. The nurses provided a detailed composite of CPD within the hospital that they illustrated through seven themes: participation, motivation, barriers, adequacy/quality, knowledge incorporated into practice, improves nursing practice and patient outcomes, and a wish list. The six guiding research questions established for this study and a synopsis of the results are as follows:

Table 4

Cross-Case Analysis - Wish List

Nurses	Items	Items
Managers	Outside speakers	Protocol for education roll-outs
	Mentorship program	A children's hospital consortium
	Live stream webinars	Pool of presenters
	Simulation	Virtual learning
	More funds for school	Video library
	Scholarship funds	Research grants
	Web-based courses	Time management, spreadsheet and slide presentation software classes
Day Shift	More simulation	Share education between units
	More funds for education	Sponsor outside webinars
	Video library	Utilize needs assessment for changes
	More research classes	Offer 4 PCS Grand Rounds in a row
	On-line courses	Hospital conferences
	Live stream classes	Research mentors
	Marketing and advertising	Increase education allowance
	Medical Spanish	Hard to find topics for certification
	Advanced EKG	Turn current classes into simulation
Night Shift	More mock codes	Roving night shift research expert
	More research support	30-minute class options
	Videotape classes	Video library
	Research courses	How to conduct research classes
	Interactive classes	Multimedia presentation classes

- What kind of CPD activities do nurses participate in? The nurses agreed there were a plethora of CPD opportunities available including life support training classes, formal academic programs, hospital-wide and unit-based classes, teaching opportunities, and research.
- What factors influence and contribute to nurses' participation in CPD? Nurses perceived many motivators to participate in CPD involving money, time, support, intrinsic/extrinsic value, teaching methodology, ease of learning, and research.
- What are reasons/barriers for nonparticipation? The nurses discussed several barriers to participating in CPD consisting of money, no management or leadership classes, time/workload, and lack of resources and support. See Table 5 for a comparison of motivators and barriers to CPD contrasted across cases.
- How do nurses perceive the adequacy and quality of CPD courses/programs offered by the hospital? For the most part, the nurses found the classes to be adequate and helpful but disclosed that some courses needed improvement and some were missing and lacking altogether.
- How do nurses perceive the knowledge obtained from CPD being incorporated into their practice? The nurses described how a supportive culture helped them to incorporate new knowledge into their nursing environment but also expressed instances of resistance from others and the lack of desired information they needed to use in their practice.

- How do nurses perceive that CPD improves the professional practice of nursing and patient outcomes? Many of the nurses felt that the CPD knowledge did improve their nursing practice and patient outcomes and recounted several examples of positive results. Other nurses did not agree and felt sometimes the practice was not supported with evidence based best practices.

Table 5

Cross-Case Analysis - Motivators and Barriers to CPD

Nurses	Motivators	Barriers
Managers	Tuition assistance Scholarships Time to attend Flexible schedule Value/relevancy	Inadequate Funds Heavy workload Distance/location Competing priorities No leadership professional development
Day Shift	Time to attend Funds to attend Desire to learn Free CEUs Growth as a nurse	Inflexible schedule Location Lack of funds Time of classes Staffing
Night Shift	Availability of classes Loss of pay differentials Scholarships Manager support Simulation	No financial support Overtime is not allowed Time off of schedule No education structure during the night

Furthermore, I drew upon the social cognitive theory framework to make meaning of the data findings. The seven themes reflected the attributes of the theory especially in

relation to self-efficacy beliefs, self-regulation, incentives, expectancies, modeling, and social persuasion. See Table 6 for an association between the social cognitive theory concepts and the CPD themes.

Table 6

Social Cognitive Theory and CPD Themes

Social Cognitive Theory	CPD Themes
Personal	Improves Nursing Practice and Patient Outcomes
Self-efficacy beliefs	Knowledge Incorporated into Practice
Self-regulation	
Behavioral	Motivators
Incentives	Barriers
Expectancies	Adequacy/Quality
	Wish List
Environmental	Participation
Modeling	
Social Persuasion	

The literature review conducted for this research study found many other studies from across the United States and from around the world that provided numerous accounts of how others, including various healthcare providers and nurses, perceived CPD. Many similarities were observed and it appears that nurses encounter many of the same motivators and barriers to CPD no matter the physical location or practice setting. However, this study was able to provide information specific to this hospital that would have remained unknown had the study not been conducted. Precise and detailed

information such as was found in this study is needed by every institution to be able to custom fit the CPD needs to the individual requirements and requests of its nurses.

The information provided in this study fulfilled a commitment I made to the Chief Nursing Officer to investigate how to build a culture of commitment to CPD. The data and resulting ideas are invaluable to me, as an educator, and will be helpful in improving CPD opportunities and participation of staff.

Conclusion

Pediatric nurses' perceptions of CPD opportunities were examined in this study. A qualitative, case study approach was used on a sample of pediatric nurses employed at a Southern California hospital. The data were collected via focus groups and interviews and the resulting outcomes were analyzed through coding into categories and building themes. Motivators and barriers were identified that influenced the nurses' involvement in CPD activities and most nurses found they were able to incorporate new knowledge into their practice and change patient outcomes. The programs were found adequate by the nurses however they recommended areas for improvement including a gap in leadership development. From these findings, I created a project aimed at providing nurse managers with leadership and management professional development to address improving CPD opportunities at [redacted] and is presented in Section 3. A professional development/ training curriculum project genre was selected for this project and provides a 3-day advanced workshop for nurse managers. This project is based on the findings illuminated by the nurse managers and their expressed need of having access to this type of training

and education in order to better meet the demands of their management role within the hospital.

Section 3: The Project

Introduction

The purpose of this case study was to develop research based descriptions of the perceptions of pediatric nurses regarding continuing professional development opportunities in order to develop evidence-based CPD programs and course offerings. From the findings of this research study, I created a project to provide an advanced professional development program targeted at nurse managers to increase their proficiency and efficacy in leadership competencies and strategies.

Nurses in management roles have distinctive education needs and typically their academic backgrounds have not prepared them adequately for leadership roles. Most nurse managers with expertise in clinical care lack the leadership, communication, problem solving, and negotiating skills necessary to perform their management roles (Shaffer, 2003). Weston et al. (2008) found that clinical education was the focus of most leadership education rather than improving leadership skills and this lack of knowledge can lead to frustration, increased levels of stress, and possible resignation from management jobs. This validates the frustration voiced by nurse managers during the focus group in this study as they stated numerous times that there were no leadership professional development options available to them. Shaffer (2003) confirmed that even when courses are offered, they are periodic, taught by non-nurses, and not tailored to meet the needs of today's managers. This matched a major complaint expressed by the

nurse managers in that the few classes the hospital did offer, the courses were conducted through the HR department and were severely lacking in relevancy.

Through the focus groups and interviews, the nurses articulated in numerous conversations their displeasure with the lack of professional development opportunities afforded to them that they felt they needed in order to flourish and grow within their nursing careers. They expressed these concerns in four of the seven themes: barriers to CPD, adequacy and quality of CPD, knowledge incorporated into practice, and in the wish list. They conveyed this dissatisfaction through five of the category findings including no management/leadership classes, classes need improvement, classes are missing/lacking, lack of desired information, and included on the wish list the desire for leadership education and training that they were not getting from the hospital.

Within the identified project chosen for this doctoral study, I examined the need for continuing professional development of nurse managers and created an advanced workshop to increase their proficiency and efficacy in leadership competencies and strategies. The workshop consists of a 3-day training program comprised of 10 intensive breakout sessions and culminates with an interactive exercise in order to apply the concepts learned. Included in Section 3 is a description and goals of the project, an overview of the instructional design process, and a rationale outlining the need for advanced education for nurse managers. A literature review provides the current state of research found in the literature including leadership development models and programs, nurses' perceptions of leadership, retention, and methodologies to enhance leadership

learning. The project description describes the curriculum outline and implementation plan as well as the identification of key stakeholders. Potential organizational structures affected by the workshop included financial considerations and possible resistance from some nurse managers to attend the workshop. The section concludes with the project evaluation plan and implications for social change. The doctoral project and supporting content materials are included in Appendix A. By providing nurse managers with advanced education, this will support nurses in delivering high quality patient care that could lead to positive social change by touching the lives of children and their healing and wellbeing within the community.

Description and Goals

An advanced workshop was developed and will be implemented targeting nurse managers with a program goal to increase their proficiency and efficacy in leadership competencies and strategies. The curriculum was designed with face-to-face instruction and built in activities to apply learned content to specific situations encountered by the managers in their work environment. The genre selected for this training is in the category of professional development/training curriculum and materials. It will include a 3-day workshop with 10 sessions designed to strengthen the skill set of nurse managers. This professional development program has numerous desired outcomes (see Table 7 for a complete list) and 10 of the topics are selected for program goals for the advanced workshop and are italicized.

Table 7

Desired Outcomes for Advanced Nurse Manager Workshops

Competencies	Strategies
Knowledge	Critical thinking
	Leadership
	Experiential learning
	Media/technology design
	Research
	Adult learning principles and theories
	Curriculum development
	Learning tasks
Skills	*Communication/public speaking*
	Decision-making
	Interpersonal
	Program planning
	Delegation
	Writing
	Designing four levels of evaluation
	Computer
	Listening
	Budget analysis
	Facilitation/leading discussions
Attitudes	Resilience
	Flexibility
	Objectivity
	Accountable
	Advocate
	Self-reflexive

Note. The 10 topics selected for the workshop's program goals are italicized.

These topics are compiled from previous leadership curricula found in literature reviews, from current topics being offered in contemporary leadership conferences, from comments made in the focus groups and interviews, and from personal knowledge I have from knowing the nurse managers' individual strengths and weaknesses. Identifying program ideas through a variety of techniques is in accordance with Caffarella and Daffron's (2013) interactive model of program planning. Caffarella and Daffron cautioned program planners that in most situations, they cannot use all of the program ideas that were generated and therefore require a needs assessment to further identify and prioritize program content. A needs assessment will be conducted several months prior to the workshop to validate and determine which topics are actually offered. As a culmination to the workshop, a putting it all together exercise is planned to practice what was learned with problems from the nursing environment.

Desired outcomes (program goals) refer to broad statements of purpose or intent for educational programs (Caffarella & Daffron, 2013). The desired outcome of a new educational program targets the nurse managers and their need for increased leadership development and will increase their proficiency and efficacy in leadership competencies and strategies.

Knowledge, skills, and attitudes are key factors that provide a composite overview of leadership attributes that were generated for program content ideas. The specific topics chosen for the workshop will depend on the results of a needs assessment.

Knowledge

The knowledge component of the program is multi-faceted and includes public speaking, leadership, research, learning tasks, and curriculum development aspects of a leader's role. In addition, topics such as media/technology design, experiential learning, and adult learning principles and theories will receive equal consideration into the workshop curriculum.

Skills

Advancing the skills of the nurse managers is of paramount importance in increasing their proficiency and efficacy. Managers need effective communication, interpersonal, decision-making, facilitating and delegation skills in order to function at a higher level of expertise. Furthermore, they need good computer, writing, listening and budget analysis abilities and talents in order to better prepare them for their management roles.

Attitudes

Attitudes are key factors that are central to the manager's learning environment. It is critical for the manager to possess approaches and outlooks that consist of resilience, flexibility, directive, objectivity and accountability positions. Additionally, nurse managers must be advocates, pro-active and self-reflective to become experts in leading staff and unit initiatives.

Instructional Design

The backward design is an approach to curriculum development that uses the learning needs as the basis for developing instructional processes and input (Richards, 2013). This process starts with a statement of the desired results and ends with planned learning experiences and instruction to obtain successful outcomes (Richards, 2013). Wiggins and McTighe (2003) described a model consisting of three stages. Stage one identifies the program goals/outcomes outlining what the learners should know and be able to do. Stage two considers the evidence of learning and answers the following questions:

- How will we know if students have achieved the desired results and met the content standards?
- How will we know that students really understand the identified big ideas?
- What will we accept as evidence of proficiency? (Wiggins & McTighe, 2003, p. 11).

Stage three involves the learning event with planned learning experiences and instruction.

Kelting-Gibson (2005) compared teachers who developed their lesson plans using the backward design model with those who used a traditional model of curriculum design. After obtaining data on six curriculum development components, the results included evidence that using the backward design model outperformed the traditional model on all six components (Kelting-Gibson, 2005).

This advanced workshop's identified outcomes and objectives are in alignment with the backward design process in that the learning outcomes are the basis for curriculum planning.

Rationale

Historically, the educational backgrounds of nurses have not prepared them for management roles (Staykova, 2012). Health care managers are often promoted because of clinical or technical knowledge and many times are deficient in knowing how to make management level decisions (Crenshaw, 2012). Perhaps McLarty and McCartney (2009) summed this up best when they stated that too often, nurse managers do not receive the specialized, continuing professional development training needed to help their units and their organization flourish. Furthermore, the managers' leadership effectiveness is a significant influence of nurses' job satisfaction (Heller et al., 2004). Because of the inadequate role preparation of nurse managers for leadership positions, it is imperative that education programs be developed to fill the gap that exists between training and the complex requirements of current practice settings.

Nurse managers at [redacted] oversee each of the inpatient units and outpatient clinics that consist of 15 different pediatric specialties and are responsible for the educational, clinical, and operational components of each area's nursing staff. In addition, approximately 1,600 nurses are employed in these areas that are directly affected by their managers' competence and knowledge.

The relevant background of this problem can be described through comparable experiences found in the literature. Other researchers experienced a similar gap in nurse manager skill sets. Ramsburg and Childress (2012) explored differences in skill acquisition among nurse educators based on variables such as clinical experience, professional development, and educational background. In addition, Zori and Morrison (2009) affirmed that managers need formal education and support in order to effectually perform in their position in today's health care environment. Wilson (2005) agreed that nurse managers receive little or inadequate education and support when they assume a managerial role. McLarty and McCartney (2009) cautioned that while promoting clinical staff nurses to management positions is a positive move, promoting them without proper preparation and training "is risky business, at best" (p. 76). Schoening (2013) studied the difficult change from nurse to nurse educator and the nurses in their study reported that the lack of formal pedagogical training hampered their role transition.

Curtis, Sheerin, and de Vries (2011) believed that undergraduate degrees do not prepare nurses for leadership. In fact, other authors considered a formal graduate-level education as essential to the nurse manager development as baccalaureate programs usually offer only one or two leadership courses (Gallo, 2007; Shaffer, 2003). Heller et al. (2004) affirmed that nurse managers have not been adequately prepared from their nursing academic programs. In looking at the educational levels of nurse managers at [redacted], statistics from the hospital's formal education database show that 52% of the nurse managers possess a Bachelor of Science in Nursing (BSN) degree. See Table 8 for

percentages of Associate Degree in Nursing (ADN) degrees, BSN degrees, and Master's of Science in Nursing (MSN) degrees among the nurse managers.

Table 8

Roles and Degrees

Nurse Manager Role	N	Highest Nursing Degree ADN	BSN	MSN
Inpatient	56	2	28	26
Outpatient	9	2	6	1
TOTAL	65	6%	52%	42%

It is evident from these numbers that almost 60% of the nurse managers have undergraduate degrees. Out of the 12 nurse managers who participated in the study's focus group and interviews, all but two had a MSN degree, yet they were still pointing to the need of organizational commitment and support in advancing their leadership and management education.

Healthcare organizations can provide supplemental education by developing and promoting leadership programs. Mahoney (2001) advised that leadership skills could be advanced through programs, workshops, and professional education seminars. Curtis et al. (2011) suggested that healthcare organizations should develop and support leadership training and seek ways to transcend this training into practice. Paterson, Henderson, and Trivella (2010) echoed this response underscoring the importance of application to

practice and stated that nurses must be given opportunities to apply new knowledge to their practice environment. The advanced 3-day workshop developed in this study incorporates practice into the training, and the nurse managers are required to work on problems from their work environment during the workshop sessions. Curriculum development is an appropriate genre for this project as the content fills a knowledge gap and provides essential CPD opportunities to the nurse managers.

Review of the Literature

A review of the literature provides an insightful look at the education, training, and leadership skills for nurse managers from research across the globe. Four literature review categories are discussed grounded in research: leadership development models/programs, nurses' perceptions of leadership, retention, and methodologies to enhance leadership learning.

The literature search strategy included the following electronic databases: Academic Search Complete, Education Research Complete, Education from Sage, Educational Resource Information Center (ERIC), Cumulative Index to Nursing and Allied Health Literature (CINAHL), MEDLINE, Health and Medical Complete, Ovid Nursing Journals, SAGE Premier, and Cochran. Searches included the following keywords: *nurse manager, leadership development, front line manager,* and *nurse manager competence*.

Leadership Development Models/Programs

Numerous research studies were found from the United States, Canada, and the United Kingdom detailing leadership models and programs all aimed at preparing nurses for leadership roles. These studies support the genre chosen for the project in this study showing that developing a professional development training curriculum is an effective way to provide leadership development education.

Mackoff, Glassman, and Budin (2013) developed a model of leadership development drawing upon the perspectives of nurse managers' lived experiences of learning to design and select learning activities. Their model consisted of five components: diagnose, data gathering, interpret, taking action, and evaluate outcomes. The authors envisioned a cyclical process with cycles of inquiry, action, and ongoing evaluation (Mackoff et al., 2013). A one-year research pilot was developed beginning with a focus group and needs assessment to determine the lived experiences and meaning of the nurse managers. The evaluations validated unique value of the program and participants stated they were able to learn from the facilitator and one another and appreciated learning from real day-to-day experiences of a nurse manager's role and responsibilities.

In addition, Phillips and Byrne (2013) designed a leadership program containing two key factors: a didactic program to enhance knowledge and skills with an action learning component to aid in applying to the work environment. The inclusion of action learning into the curriculum focused the importance of work-based learning and solving

real work issues in order to find ways to overcome challenges and identify a range of options about how to problem-solve (Phillips & Byrne, 2013). The authors felt strongly about offering the course within their own hospital and not removing the managers to go off-site for a generically prepared course; the program needed to be conducted within the organizations' own environment in order to effectively transfer skills into practice. Phillips and Byrne showed that this program provided opportunities for education that a customary course could not deliver and it reinforced deeper learning for course participants as exhibited by the nurse managers' commitment to their own area of practice and to clinical management.

Other programs also demonstrated quality outcomes. Fennimore and Wolf (2011) created a program built on key knowledge, skill, and attitude competencies focused on three domains: managing business, leading people, and crafting a leader in yourself. Twenty-five nurse managers participated in the pilot and more than 100 leaders completed the course over the next 2 years. Participants received extensive value from group interactions and the opportunity to share their own experiences with others.

Additionally, an educational needs assessment was used as the foundation for a program developed at a hospital in New York. Crosby and Shields (2010) queried 76 nurses for their perceptions of conditions that facilitate or constrain leadership development. The conditions that were reported were used to guide the development of an education course agenda. Although financially resource intensive, Vitello-Cicciu, Weatherford, and Gemme (2014) brought in nationally known leaders to present and

facilitate teaching at a program that was implemented in Boston. The study's conclusions found that participants were able to identify increased self-awareness and incorporate new knowledge into behavior within six to nine months after program completion. This study was the only one found that used Kirkpatrick's (Kirkpatrick & Kirkpatrick, 2006) four levels of evaluation.

Several other researchers developed leadership programs based on healthy work environments, measuring and evaluating basic leadership skill, and empowerment (Chappell & Willis, 2013; Galuska, 2012; MacPhee, Skelton-Green, Bouthillette, & Suryaprakash, 2011). All the programs recorded positive outcomes including changes in leadership styles, improved conflict resolution/negotiation skills, and personal development. The researchers agreed that not only must hospitals provide education to nurse managers to increase their knowledge and skills but the education must also include opportunities to apply the course content to the practice environment.

Other hospitals developed programs aimed at specific nursing groups within the organization. Ray and Overman (2014) developed a model of care program to enhance communication between nurses and nursing assistants with the intent to forge stronger relationships between the two roles to enhance communication and positively affect patients' experiences and outcomes. The researchers found the program's outcomes increased communication and also improved employee satisfaction scores. Dyess and Sherman (2011) felt that leadership development needed to begin in the first year of practice so they designed a program targeted at new graduate nurses. Twenty course

sessions were designed to help novice nurses develop a leadership mindset early in their careers. A major component of the program was that the nurses developed an evidence-based intervention related to their specific practice setting. The findings indicated improved confidence, demonstrated leadership skills, and more global and systems perspective of nursing validating the importance of including new graduate nurses in leadership education. Another perspective of leadership development was instituted by Titzer, Shirey, and Hauck (2014) with their development of a formal nurse manager succession planning program. They instituted a yearlong program with monthly leadership workshops and the nurse managers were appointed mentors who helped with the experiential learning activities. Program results revealed that 100% of the participants agreed the program increased their leadership skills and management competencies. The managers valued the knowledge gained through actual, real-world examples and appreciated the tools they could use in other leadership endeavors.

Finally, Hewison and Morrell (2014) looked at leadership development policy in the United Kingdom and cautioned that there are limitations associated with relying on a competency based leadership program. They found evidence that suggested competency based approaches to leadership development alone will not improve the quality of leadership but that transformational and relational leadership methods are needed as adjunct teaching methodologies.

Nurses' Perceptions of Leadership

Many studies were found that focused on nurses' perceptions of managers and their staff. In a research study conducted in a medical center in North Carolina, Baker et al. (2012) asked nurse managers what their perceptions were of what they did in their job. The researchers felt it was imperative for senior leadership to comprehend the difficulty of the nurse manager's role. A major finding of the research was the tasks the managers expended most of their time on and those felt to be most important were very different indicating that managers are devoting a bulk of their time on issues that are not ranked as top priorities. The findings of this study have notable implications for developing a leadership curriculum. Researchers in Finland asked 252 nurses their perceptions about leadership styles, knowledge, and skills (Vesterinen, Suhonen, Isola, Paasivaara, & Laukkala, 2013) and recommended that educators focus program planning on strategic issues, leadership, job satisfaction, challenging leadership situations, and work unit management in order to fully develop a robust educational program.

In other studies focused on nurses' perceptions, Casey (2012) examined nurses' leadership development needs and their views on leadership. After conducting 22 focus groups, Casey found that leadership development need was greatest in the area of 'developing the profession', which included influencing clinical decision-making and health policy. The participants stated that their clinical leadership role was often underused and their contributions were unrecognized. Similarly, Suhonen and Paasivaara (2011) studied the perceptions of the challenges found from nurse managers in project

management and found less than positive results. The nurses perceived their main challenges as an apathetic organization and management team, a paralyzed work community, and discouragement of cooperation between individuals. These findings should be used with caution as the sample contained only nine nurses and the researchers did not go through any ethical approval process prior to conducting the interviews.

Two studies were conducted with Canadian nurses regarding nurses' perceptions of predictors to aspire to management roles and career aspirations (Laschinger et al., 2013; Wong et al., 2013). Conclusions were found that personal factors were more strongly associated with career aspirations than situational factors and that there was a steady decline in interest in leadership roles with increasing age. Furthermore, although the nurses perceived the management role as positive opportunities, they did not perceive the rewards to be big enough to outweigh their concerns. These findings have implications related to succession planning and filling open leadership positions within healthcare. Bulmer (2013) found that management aspirations of staff nurses in a Pennsylvania hospital are low. Highest aspiration scores were found in nurses with less than 2 years of experience and lowest in nurses with Associate degree level nursing education.

The emotional health of nurse managers is a key aspect to consider and two groups of researchers investigated nurses' perceptions of stress and burnout related to their leadership roles. Lee et al. (2010) surveyed 179 managers to determine the impact that a leadership development course had on the managers' emotional wellbeing. While

the course affected individual leadership capacity, it was not significantly able to improve burnout among the leaders. Shirey, McDaniel, Ebright, Fisher, and Doebbeling (2010) found that 67% of the nurses cited people and resources, tasks and work, and performance outcomes as the major sources of stress. Four factors were identified that decreased stress (focusing on the positives, having support from others, completing work and achieving targets, and incorporating quality downtime) but only 86% of the managers used these strategies to aid in their leadership role.

Retention

Three systematic reviews were found in the literature providing supplemental information to the nurse manager leadership role in relation to nurse manager retention, staff retention, and nurse job satisfaction. Brown, Fraser, Wong, Muise, and Cummings (2013) reviewed 13 studies exploring factors known to influence retention of nurse managers and found three factors: organizational, role, and personal. Organizational culture and values were the most common organizational factor influencing retention. Role factors included lack of support and empowerment as significant factors related to intent to leave. Other role factors identified were difficulty in combining responsibilities, insufficient time to complete tasks, and work/life imbalance. The most frequently cited personal factor was the importance of feeling valued by the hospital, colleagues, and staff. In a review of studies exploring the relationship between managers' leadership and staff nurses' intent to leave, Cowden, Cummings, and Profetto-McGrath (2011) found that managers who practice relational leadership are more likely to retain their staff. This

has a profound effect on the manager's leadership skill and their ability to retain their staff. In a related study, Cummings et al. (2010) screened 53 studies and compared leadership styles and outcomes in work environments. They found that nurse managers who are focused on relationship or people leadership practices have improved outcomes for the nursing environment and increased productivity for the organization. In contrast, task focused leadership styles led to negative outcomes, are not focused on developing or maintaining relationships with staff members, and are associated with lower nurse job satisfaction.

Methodologies to Enhance Leadership Learning

Four innovative educational strategies have been used in developing leadership courses: blogging, coaching, mentoring, and experiential learning. All four methods are effective in enhancing leadership training. Levine (2014) explored the effectiveness of using a blog to enhance reflective learning in a nurse manager leadership development course. Although the findings were not statistically significant, the study did show that blogging was an effective reflective tool. The managers in the study indicated they were able to use a high level of self-reflection skills used in the teaching strategies of the course. Levine recommended that educators use reflection as a vital step of the learning process when planning and implementing leadership training learning activities. Karsten, Baggot, Brown, and Cahill (2010) instituted a pilot study with coaching to front-line managers in an effort to impact management turnover, staff turnover, and employee satisfaction. The results indicated a positive impact on those managers being coached as

well as on the outcomes of their teams. Pedaline et al. (2012) designed a program to create a model of nurse manager engagement that included a 360-degree assessment and individual mentoring sessions. The post project interviews received a positive response to the program and the managers identified increased awareness, focus, and clarity of insights into their leadership skills. The individual mentoring sessions were well received and valued. Experiential learning was the focus of a study conducted by Cathcart, Greenspan, and Quin (2010) when they had 32 managers write and interpret first person narratives of their leadership practice. The authors provided a personal exemplar to showcase the power of a group narrative experience. Cathcart et al. demonstrated that complex leadership challenges are sources of significant experiential learning for nurse managers.

Project Description

Program planning is an essential skill for educators to acquire in an adult education teaching environment. It is imperative that educators plan education and training programs that provide opportunities for adults to apply what they have learned in their own practice environment (Caffarella & Daffron, 2013). Planning effective and engaging educational programs requires a carefully planned development process. The components required for successful program planning of the advanced workshop for nurse managers are methodically outlined and are divided into five sections: needs assessment overview, needs assessment plan, program outcomes and learning objectives, transfer of learning, learning tasks, and program structure.

Needs Assessment Overview

Conducting a needs assessment is an early step in the program development process (Caffarella & Daffron, 2013) and can greatly increase the likelihood that an educational activity will meet its intended goal (Queeney, 1995). The social and organizational context of the learning environment includes the stakeholders, contextual factors, environmental strengths/opportunities, and alignment with the organizational mission.

Stakeholders. Building a solid base of support for the advanced workshop will involve various stakeholders throughout the hospital. From the Chief Nursing Officer (CNO), to the Patient Care Services (PCS) Directors, to the nurse managers, support for the program will need to take the form of both commitment and action to dynamically endorse and be involved with the education endeavor (Caffarella & Daffron, 2013). The following three groups have been identified as essential stakeholders for the proposed program: CNO, PCS Directors, and the PCS Joint Managers.

Chief nursing officer. [redacted]'s CNO is the top ranking nurse and has ultimate authority over the nurses in the hospital. Nothing is sanctioned without her approval and she has the power and ability to influence the Board of Trustees of the hospital. She has a vested interest in the results of the proposed program.

PCS directors. The PCS directors report to the CNO and have responsibility over all departments within PCS. In this role, the PCS directors supervise the nurse managers depending on the area of specialty practice. As such, the directors will be in a position to

know the leadership needs, requirements, and gaps of the nurse manager job role and will be a vital part of the needs assessment process. In addition, it is most likely that some of these directors will be co-instructors in the advanced workshop.

PCS joint managers. The PCS joint managers are a group comprised of all the nurse managers who come together once a month to collaborate and network on hospital issues. In an advisory capacity, this manager group discusses current problems and concerns and recommends courses of action. These managers will be the participants and key focus for the workshop. As primary stakeholders, it is critical to include PCS joint managers in the planning process.

Contextual factors. Discerning the context in which nurse managers practice is a major component in designing educational programs (Caffarella & Daffron, 2013). The following two facets of the planning context are explored: organization and people.

Organization. Limited financial resources are a concern to take into account when designing the advanced workshop. The hospital's chief financial officer will not approve any variances to the current budget. Training will need to be configured around existing funds.

People. A point needing consideration in the planning process is the fact that this new program may encounter resistance from the intended audience – the nurse managers themselves. They hold enormous responsibilities, are overworked and under stress, and may find it difficult to fit a 3-day workshop into their schedule. Also, even though the managers in this study's focus group voiced concerns regarding the lack of leadership

development, some managers (especially those prepared at the baccalaureate level) may not perceive the value of this kind of program in that some may be content with their current skills. To mitigate this potential obstacle, the managers will be administered a competency assessment tool in order to help them recognize their own gaps in knowledge and skills.

Environmental strengths/opportunities. The CNO is committed to support this workshop as she values education and is knowledgeable of and in agreement with the findings of this research study.

Strengths. Lifelong learning and knowledge acquisition have a long history of support at this hospital and are major tenets of the nurses' professional practice model that include family-centered care, teamwork, and lifelong learning. A variety of teaching modalities are available and utilized such as classroom, web-based, education fairs, posters, and journal clubs.

Opportunities. It is crucial to leverage the significant support for education and continuing professional development to identify, deliver, and evaluate education and professional development programs to assure comprehensive, strategic, prioritized and mission-critical programming for the nursing managers.

Alignment with the organizational mission. The proposed program directly relates to two of [redacted]'s (2015) mission and values declarations: "advancing knowledge" and "we are learners leading transformation" (para 4). The program to train nurse managers is in alignment with these values and provides an active example of how

the hospital incorporates them into all aspects of learning. Not only will the managers transform their own professional development but they will also transform the lives of our patients and families with their increased knowledge and skill base.

Needs Assessment Plan

Assessment is the beginning point for all patient care activities and it is also the place to start when developing a leadership educational program (Swearingen, 2009). Swearingen (2009) asserted that the stakeholders must be assessed to establish what topics need to be taught and the timing and priority of when they need to be introduced into the curriculum.

Data collection strategies and tools. An educational need is defined as a discrepancy or gap between a current state and a desired state (Caffarella & Daffron, 2013). Three methods will be utilized to perform a needs assessment to identify the desired content of the advanced workshop designed especially for nurse managers:

- Two formal self-report surveys will be administered: the Nurse Manager Competency Instrument (Chase, 2012) tool utilizing a 4-point Likert scale and the Nurse Manager Leadership Learning Needs Assessment survey with seven open-ended questions asking the managers about leadership and the kinds of learning experiences they believe will contribute to their development as a leader (Mackoff et al., 2013). These tools will help the nurse managers recognize their own gaps in knowledge and skills as well as provide foundational input into the course construction.

- An informal nominal group process will be facilitated targeting the nurse managers to ensure that all their voices are heard. Several small groups will be convened and asked to respond to a specific question such as 'What knowledge and skills are you needing in order to take your manager role to a higher level' (Queeney, 1995). The purpose of the nominal group process is to provide the nurse managers equal opportunity for input and all their ideas receive equal consideration. This strategy involves the people most likely to be affected by the decisions in the decision-making process and are representative of the target audience (Queeney, 1995). This strategy may foster a sense of ownership for the program.
- A formal interview process will be conducted focusing on the CNO and the PCS directors. Face-to-face interviews establish rapport with respondents often yielding longer and more detailed information (Queeney, 1995). The intent of the interviews will be to elicit information from participants who will not be the focus of the new proposed program. Because they are key supporters and stakeholders in the organization, it is vital to involve them in gaining their input in the needs assessment. This method will allow for a different perspective and perhaps a higher level of understanding of the current state versus desired state.

Program Outcomes and Learning Objectives

Program outcomes and learning objectives are essential components in the program planning process. Program outcomes focus on what learners are expected to learn as a result of attending the educational event. This learning causes changes in the participants (Caffarella & Daffron, 2013). Learning objectives describe what participants will learn as a result of the training program (Caffarella & Daffron, 2013). An overview showing alignment between the desired outcome, program outcomes, and learning objectives as well as a complete instructional plan listing program planning components for each session of the 3-day advanced workshop in included in the project materials. The actual course topics and objectives may change depending on the results of the needs assessment.

Transfer of Learning

Transfer of training is applying what is learned in an education or training program to the work environment (Caffarella & Daffron, 2013). It is imperative to develop a transfer of learning plan to aid the nurse managers to apply what they have learned. This section outlines the components required for successful transfer of learning including transfer elements, strategies and techniques, and the monitoring processes during and after the implementation of the program.

Transfer elements. In order to increase nurse managers' leadership proficiency and efficacy, knowledge and skills need to be transferred to the work environment to meet the program's goals and objectives. Specifically, acquiring knowledge of the various

topics included in the 3-day workshop is valuable information needed by nurse managers. Since many managers do not have educational backgrounds that prepare them for leadership roles, it is imperative that the knowledge and skills provided in the advanced education program are applied on the job. Reports have been published that very little of what is learned in training is applied on the job (Saks & Burke, 2012). Saks and Burke (2012) emphasized that transfer of learning is a serious problem for organizations because more often than not, employees are not improving their performance following costly training programs. It is crucial that learned behaviors be passed on to the job context and maintained over a period of time (Burke & Hutchins, 2007).

Strategies and techniques. Transfer of learning techniques have been deliberately and strategically designed and placed within the workshop curriculum. This is in alignment with Caffarella and Daffron's (2013) belief that it is imperative for program planners to plan for the transfer of learning as an integral part of the planning process.

Managers. As course participants, the nurse managers must utilize the 'putting it all together' skills practice activity at the end of the workshop to work on real life issues and begin applying the course content to actual projects. They will have a laptop and will work on a specific problem identified from their work area. Self-efficacy of the trainee is positively related to transfer generalization and maintenance (Burke & Hutchins, 2007). After the workshop, the managers must commit to continue applying the new knowledge and skills to their work environment and will be supported by (a) creating an individual

learning plan, (b) developing portfolios, and (c) follow up sessions with their supervisor for accountability and progress reporting.

Course instructor. I have committed to teaching the advanced leadership workshops (with co-instructors as appropriate) and will provide learners with opportunities to develop specific application plans during each of the workshop sessions. I incorporated multiple transfer of learning strategies beginning with a lecture and multimedia presentation and then offering various interactive methods including group discussions, role-playing activities, suggestion circles, buzz groups, and reflective practice techniques. I will provide follow up assistance to the attendees and their supervisors and will be available to offer coaching and mentoring after the workshop is over.

Supervisors. The directors who supervise the course attendees will be asked to provide follow up sessions with their managers for accountability purposes and status updates on the progress being made in utilizing course content in solving work environment leadership and management issues. Burke and Hutchins (2008) reported training professionals most frequently report supervisory support and providing coaching and opportunities to practice new skills and knowledge as best practices in training transfer. The directors will monitor the managers' construction of a portfolio and the progress of the managers' individual learning plans.

Monitoring process. Burke and Hutchins (2008) found that training professionals identified the time during and time after training interventions as most pivotal for

affecting transfer. The advanced workshop for nurse managers will provide opportunities for transfer of learning during and after implementation.

Monitoring during implementation. The most frequently reported best practice strategies for transfer during a program is the use of interactive activities to encourage participation (Burke & Hutchins, 2008). In particular, collaborative activities, role-plays and small group exercises are planned to facilitate transfer. Lecture should be minimized and the focus should be having managers complete exercises designed to engage them and to collaborate with peers (Burke & Hutchins, 2008). Job aids will be utilized as well as development of specific action plans to assist and support learning transfer from the workshop to the job. Instructions and a checklist are included in the project materials for how to create a clear action plan for learning transfer (Halsey, 2011; Learning & Development Roundtable, 2006).

Monitoring after implementation. Burke and Hutchins (2008) identified the top two most frequently reported best practice strategies for transfer after a program:

- Supervisory support and reinforcement: recognize and reinforce use of new knowledge and skills on the job, and
- Coaching and opportunities to practice: time to practice skills immediately when returning from training (Burke & Hutchins, 2008, p. 117).

The instructor and supervisors will provide follow-up assistance through a variety of techniques including feedback, coaching and mentoring and various informal methods (e.g., e-mail reminders, coffee chats, phone reviews). A list of informal transfer of

learning strategies (Halsey, 2011) is provided in the project materials. Attendees will complete a portfolio that can address different types of learning outcomes. Portfolios provide direct evidence of learning through a collection of carefully selected materials and are powerful learning tools (Caffarella & Daffron, 2013). Course attendees will implement their individual action plans that were drafted during the workshop and meet with their supervisors periodically.

Learning Tasks

Learning tasks are essential educational components in the program planning process. Selecting appropriate learning activities depend upon multiple learning situations: the manager's self-awareness, the learning content, context, and situation (Galbraith, 2004). Learning tasks are designed to involve learners with new facts and skills in a dynamic fashion to comprehend and apply the subject matter (Hsu & Malkin, 2011). Revell and Wainwright (2009) agreed saying that learning tasks are any kind of activities that cause students to think for themselves, interact with each other, and engage with the lecture material. Learning tasks are powerful ways to encourage deeper approaches to learning. Examples of two learning tasks interwoven into the advanced workshop curriculum (a consensus board activity and a critical panel debate) are included in the project materials.

Program Structure

A program's structure supports the transfer of learning and provides overall order to the course. The program structure defines the format, timeline, and resources.

Format. The education and training activities are structured and organized around a workshop program format. A workshop format is an appropriate venue for this learning event as it provides a structure allowing for application of new knowledge. Workshops are intensive group activities that emphasize the development of individual skills and competencies with a focus on group participation and the transfer and application of new knowledge (Caffarella & Daffron, 2013). This 3-day workshop includes face-to-face instruction (via lecture) but also incorporates small group work consisting of case studies, suggestion circles, reflective practice, buzz groups, and role-playing activities. Varying the format throughout the workshop will cater to multiple learning preferences as well as engage the nurse managers. The workshop culminates with a 'putting it all together' component that will allow dedicated time for managers to work on individual projects applying the course content to real work problems and educational issues. During this work period, coaches will be available to provide one-on-one learning with immediate feedback.

Timeline. The program is tentatively scheduled for Monday, Tuesday, and Wednesday, September 21, 22, and 23, 2015, and this timeline allows for ample advanced notice to the managers and comes after summer vacations and the Labor Day holiday will all be completed. I will reserve this workshop time directly into the managers' Outlook calendar as I find greater compliance of staff attending activities when the event is electronically placed in their calendar. By scheduling the workshop to fill 3 days that includes breakfast and lunch, the managers are less likely to get pulled into

activities on their unit. History has shown me that many times, if managers have long breaks or downtime in a course, they leave and go back to their work area to check on their staff and patients and end up getting involved with work and do not come back to the class. A sample program agenda of the 3-day advanced workshop is as follows:

- Day 1: Session #1: Experiential Learning
- Session #2: Curriculum Development
- Session #3: Leading Discussions
- Session #4: Four Levels of Evaluation
- Day 2: Session #5: Adult Learning Theories and Principles
- Session #6: Program Planning Process
- Session #7: Media/Technology Design
- Session #8: Learning Tasks Designed for Deeper Learning
- Day 3: Session #9: Improving Communication and Public Speaking Skills
- Session #10: Budgets and Fiscal Planning
- Putting It All Together

An additional justification for offering a 3-day workshop is that higher numbers of continuing education contact hours are allowable. The California Board of Registered Nursing (2014) grants one contact hour for every 50 minutes of instruction. This workshop is scheduled for 1,140 minutes of training thereby generating 22.8 contact hours. Nurse managers value contact hours and this will be seen as a worthwhile use (and reward) of their time. The value they place on the training, in turn, influences transfer of

learning; learners who perceive training as necessary to their practice had higher levels of skill transfer (Burke & Hutchins, 2007).

Resources. Program planners need to understand that budget management and other resource considerations and tasks are integral components of the planning process and are the impetus behind program development efforts (Caffarella & Daffron, 2013). People, fiscal, space, marketing and advertising, and instructional plans are crucial resources needed for successful program planning.

People. Staff members design, coordinate, conduct, and evaluate education and training programs (Caffarella & Daffron, 2013). The tasks and roles for the workshop are identified and divided as follows:

- Program designer and manager role - director, clinical education.
- Event coordinator role - administrative assistant to the director, clinical education.
- Instructor/learning facilitator role - director, clinical education and other staff members to be determined.
- Program evaluator role - director, clinical education.

Fiscal. The advanced workshop for nurse managers will be provided at no cost to the managers and therefore no revenue will be produced. Total expenses for the 3 days are projected to be approximately $6,005.00. This cost includes a textbook for the managers to use during the workshop and keep as a reference (Roussel, 2013). See Table 9 for an estimation of program expenses.

Table 9

Estimation of Program Expenses

Budget Item	Costs per Day	Total
Internal Staff	-0-	
• Program planner		
• Instructors/facilitators		
• Technology specialists		
• Clerical/support staff		
External Staff	-0-	
• None used		
Textbook (for 40 staff)		$ 3,080
• Management and Leadership for Nurse Administrators ($77/each)		
Instruction Materials	$ 250.00	
• Color flyers for advertising		
• Job aids		
• Handout materials		
Facilities	-0-	
• Conference room		
• Tables/chairs		
• Computer access		
• Audio/visual equipment		
• Parking		
Food		
• Breakfast (for 40 staff)	$ 275.00	
• Lunch (for 40 staff)	$ 350.00	
• Afternoon snack	$ 100.00	
	$ 975.00 x 3 days =	$ 2,925.00
TOTAL		$ 6,005.00

The instructors all have exempt employment status, which means their salaries will be absorbed by their individual department's cost center and not charged as salary to the educational event. The hospital is known as a teaching hospital and thus it is expected that teaching is a part of everyone's job. All indirect costs are supplied by the hospital. The cost of this program will be paid for out of special funds; these are funds that have been donated and earmarked for education purposes by generous supporters and patrons of the hospital.

Space. This workshop will take place in a state-of-the-art conference room located centrally within the hospital that can accommodate approximately 40 occupants with tables and chairs. This room was built 3 years ago and is furnished with a speaker podium, computer, projector, large screen, microphones, and audio-visual capability. In addition, there is a wall-mounted video camera that allows for video taping of the workshop. The room is furnished with movable tables and comfortable chairs that are very conducive to a classroom style-learning situation. An advantage of this type of configuration is that managers have their own table offering a good workspace during the application activities. Electrical power strips will be placed strategically throughout in order for managers to bring their laptops to the workshop. The room has two thermostats that are easily adjustable to allow for a comfortable temperature throughout the educational event. There is a room divider at the back of the room that can be opened to provide space for an additional 40 tables and chairs.

Marketing and advertising. Communicating a message that a course is useful and meaningful to the nurse managers is critical in ensuring their participation (Caffarella & Daffron, 2013). A flyer will be circulated via email and handed out during various meetings advertising the workshop 6 months prior to the event. A copy of the course flyer is included in the project materials. Furthermore, for 30 days prior to the workshop, a running banner will be displayed on the hospital's intranet website announcing the workshop and the event will be included in the hospital's calendar of events.

Instructional plans. Instructional plans are an invaluable resource to include in program planning and according to Burke and Hutchins (2008), the intervention design and delivery of the plans influence transfer of learning. By developing a plan, instructors and course planners can concretely map out the course curriculum and make sure that the transfer of learning techniques, monitoring processes, and program structure directly connect to the program outcomes and learning objectives. Ten instructional plans for the sessions included in the Advanced Workshop for Nurse Managers are provided in the project materials. The 3-day workshop sessions are delineated with the following components included within the plans: program outcomes and learning objectives, content/topic outline, timeframe, instructor, transfer of learning techniques and monitoring, format, and resources. The plan serves as a visual check to make sure methods are in place to engage the course participants in the learning process and that planned activities will link to successful achievement of the learning objectives. A fully

developed instructional plan depicts all the elements of program planning and demonstrates a thorough approach to design.

Project Evaluation Plan

Program evaluation is a process used to ascertain whether an educational event was effective and if the program outcomes were achieved (Caffarella & Daffron, 2013). Douglah (1998) defined the term *evaluation* as the activity of systematically collecting, analyzing and reporting information that can then be used to change attitudes or to improve the program. Douglah stipulated that the word *systematic* means that the evaluation must be planned.

Four Levels of Evaluation

Ultimately, the emphasis of this evaluation process is to produce evidence demonstrating the success of the workshop. To ensure continual quality improvement, stakeholders and participants will evaluate the workshop using Kirkpatrick's four levels of evaluation. Four levels of appraisal should be obtained: (a) evaluate learner's reaction with offering of the program; (b) evaluate whether learning has occurred; (c) evaluate learner's behavior of learning in the work setting; and (d) evaluate what results occurred because of attendance and participation in the educational program (Kirkpatrick & Kirkpatrick, 2006). See Figure 2 for a model depicting the four levels.

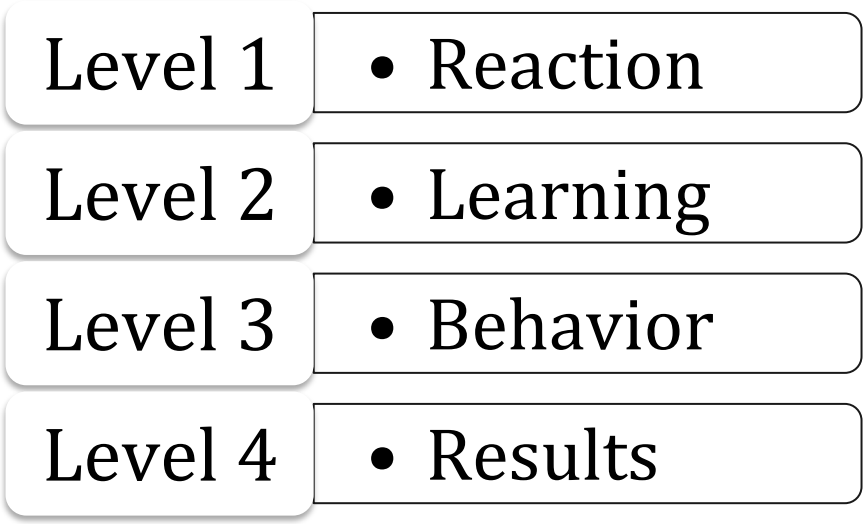

Figure 2. Kirkpatrick's four levels of evaluation.

According to this model, evaluation should always begin with Level 1, and then, as time and budget allows, should move sequentially through Levels 2, 3, and 4. Information from each prior level serves as a base for the next level's evaluation. It is worth noting that the transfer of learning methods and strategies outlined in the monitoring processes during and after program implementation in the instructional plans of the proposed advanced workshop fit into Levels 1, 2, and 3. The evaluation process becomes more difficult and time-consuming when moving from one level to the next but it also provides more valuable information (Kirkpatrick & Kirkpatrick, 2006).

Reaction. Evaluation at level one measures how the course attendees who participated in the workshop react to it and is a measure of customer satisfaction. Questions will be aimed at obtaining reactions to both the subject (content) and the instructors/leaders. In addition, questions will be asked regarding the handouts, the use of technology, relevance to practice, and teaching methodology.

Learning. Learning is the extent to which the attendees change attitudes, improve knowledge, and/or increase in skill as a result of attending the workshop (Kirkpatrick & Kirkpatrick, 2006). In order to evaluate learning at this level, the specific program outcomes and objectives must be assessed. Questions at level two will be determined by obtaining data about what knowledge was learned, what skills were developed or improved and what attitudes were changed (Kirkpatrick & Kirkpatrick, 2006). A test will be administered at the end of the workshop specifically assessing the knowledge and attitudes delineated in the program learning objectives. Evaluation of skills performance is necessary and will be accomplished by observing the participants' performance during the workshop through the role-plays, skills practice exercises, simulations, case scenarios, and their work during the 'putting it all together' exercise.

Behavior. Behavior is the extent to which change in behavior has occurred because the nurse manager attended the training program. According to Kirkpatrick and Kirkpatrick (2007), behavior metrics are usually seen as the most difficult, expensive and resource-intensive to obtain. However, they firmly believed that this is not necessarily the case and found that effective level three evaluation acts as a reinforcer of new behaviors (Kirkpatrick & Kirkpatrick, 2007). Guiding questions at this level will be focused on reviewing portfolios created by each of the participant managers. This work review is reviewing actual work that has been completed by the managers on the job without actually observing them doing it (Kirkpatrick & Kirkpatrick, 2007).

Results. Results are the final outcomes that occurred because the nurse managers participated in the educational event. Kirkpatrick and Kirkpatrick (2007) believed that level four evaluations are the most valuable to learning professionals and stakeholders. Questions at this level are focused on illustrating the value of the training workshop. A guiding question should be asked of the supervisors: What kind of results are the managers hoping to see come from this training? (Kirkpatrick & Kirkpatrick, 2007, p. 114). The answer may lie in connecting the training outcomes back to the mission statement and values of the hospital. Did the managers achieve their best together, become transformational leaders, or advance knowledge? Data collection can be accomplished in two ways: (a) focus groups by asking specific questions about outcomes and results from stakeholders, and (b) personal chats with the nurse managers.

Data Collection Strategies and Tools

Numerous data collection strategies will be utilized to evaluate the advanced workshop each having a different perspective and procedural method for conducting evaluation (Caffarella & Daffron, 2013). Four approaches to program evaluation are described as follows:

- The first data collection tool utilized for evaluation will be a formal 6-point Likert scale self-report questionnaire. It is essential for instructors and course organizers to know how the participants feel about the program and also to obtain feedback to make whatever changes are necessary to improve it (Kirkpatrick & Kirkpatrick, 2007). This type of survey is also known as

reaction sheets and should be used for every program. These questionnaires have great importance and value as they measure customer satisfaction and indicate the attitude and feelings of participants as they leave the training.

- The second data collection tool utilized for evaluation will be a formal test. The purpose of administering a test is to measure what knowledge was learned, what skills were developed and what attitudes were changed. A combination of test items will be used including true or false, multiple choice, sentence completion, and matching.
- The third data collection strategy is to have the managers create a portfolio. Portfolios are a collection of material that describes a manager's professional approach, strengths, and accomplishments outlining leadership successes and supporting those claims with evidence (Schmalz & Goldman, 2006). It includes material that collectively support the quality of a manager's leadership performance (Reece, Pearce, Melillo, & Beaudry, 2001). Portfolios are effective to document and evaluate the nurses learning from the workshop (Suskie, 2009). The nurse manager will have 3 to 6 months following the workshop to assemble a portfolio demonstrating the utilization of leadership strategies and techniques within their work environment. The portfolio will be assessed using evaluation criteria developed by me in the form of a descriptive rubric (Suskie, 2009). An instructional rubric will be incorporated into the evaluation process in that it will be handed out to the manager, used to

facilitate self-assessment and teacher feedback, and used for teaching purposes (Andrade, 2006).

- The fourth data collection method is two-fold incorporating two informal approaches: a focus group to stakeholders (CNO and PCS directors) and a personal chat with nurse managers who attended the workshop. The purpose of the focus groups and personal chats is to determine the final outcomes that occurred because the nurse managers participated in the workshop. These informal collection methods from both stakeholders and participants can provide invaluable tangible evidence that training efforts produced desired outcomes.

Examples to obtain Level 1, 2, 3, and 4 data from stakeholders and participants from the advanced workshop are included in the project materials. Also included is a comprehensive action plan compiling four levels of data collection utilizing a template provided by Wall (n.d.). The triangulation of four different data sources (questionnaires, tests, portfolios, focus groups/personal chats) is an effective technique that provides a meaningful and compelling chain of evidence demonstrating a program's value to stakeholders (Kirkpatrick & Kirkpatrick, 2007).

Reporting Strategy

Using a slide presentation software format, an executive summary will be presented to the stakeholders (CNO and directors) at one of their weekly meetings. The same information will be provided to the nurse managers at their monthly PCS Joint

Managers meeting. Kirkpatrick and Kirkpatrick (2007) offered advice when presenting results:

> We believe the best way to demonstrate the value of learning to stakeholders is to present a 'show-and-tell' that goes something like this: Here are the data that show that our learners were engaged in the training and found it relevant (level 1), which led to an increase in knowledge and skills (level 2), which with the support and involvement from your fine leaders helped lead to significant changes in behavior (level 3), which ultimately contributed to the results you were looking for (level 4). (p. 83)

This reporting strategy is very effective as executives and leaders are more convinced by multiple sources of evidence that learning has made a significant contribution to their results (Kirkpatrick & Kirkpatrick, 2007).

Project Implications for Social Change

Walden University (2014) defined positive social change as involvement in activities that improve the lives of individuals and communities locally and around the world and includes educating others about a particular issue or cause. This advanced workshop for nurse managers has implications for social change at the organizational, community, and global levels of humanity.

Local Community

I believe the social change in the nursing population and hospital can be far reaching throughout the community. I have a great responsibility in making sure the

nurse managers are competent and confident to deliver the utmost in safe and quality patient care. The only way to ensure these skills is through offering high quality continuing professional development opportunities. Truly the effectiveness of the teaching and programs will have a direct impact on the nurses' development and their ability to pursue lifelong learning within my facility. Not only will the nurses benefit but so also will our patients and families. The patients in the hospital do not come because they just happen to live in the neighborhood. They choose the hospital because of the high level of pediatric services that are offered and they come from all over Southern California and beyond. In addition, the payer mix is 70% Medicare (CHLA, 2014a) and represents a large underserved population in Los Angeles. Because the ultimate goal in healthcare is to provide safe and competent care to patients, it is imperative to develop an advanced curricula targeted exclusively for nurse managers. This is necessary in order to teach how to apply effective leadership techniques and methodologies made for adults and experiential learning strategies in the classroom. Therefore, by providing nurse managers with experiential and active ways of knowing and doing to increase their knowledge and skills, I can indirectly touch the lives of children in the Southern California area and well beyond. Furthermore, it is only by implementing an advanced workshop for nurse managers that the hospital will have the resources necessary to establish an environment that supports delivery of exquisite, high quality patient care through vitalizing leadership skills into the nurses' practice. This, in turn, will showcase

the hospital's ability to organize, to educate, and to mobilize in order to effect social change at an organizational and community level.

Far-Reaching

The hospital has established a Center for Global Health that has far-reaching effects for reaching sick children across the world especially to the Middle East, Asia and Europe. As a top pediatric health care provider in the US, [redacted] provides comprehensive care to children and adolescents globally in various specialty clinics and have treated patients from across six continents and 47 countries (CHLA, 2014b). The nurse managers see many of these patients on their units and in the clinics and directly oversee their hospital experience during the time they are with us. Increasing the managers' leadership skills will benefit this patient population and the nurses who take care of them as they all work together to ensure quality and safe healthcare outcomes.

Included in the international services that the hospital provides are consultative expertise for the design, planning, and development of new healthcare facilities, development of new programs for different clinical specialties, and development of education and training programs for physicians, nurses, and allied health professionals. This opens the door to a multitude of educational possibilities and the advanced workshop for nurse managers could be a very needed and sought after program to extend to a wider audience. The workshop could be videotaped and packaged with the course content and materials and offered to groups and facilities in other countries who desire leadership training for their nursing staff.

Conclusion

The proposed project was derived from findings from the research study and will fill a gap in knowledge and provide much needed continuing professional development for nurse managers in the area of leadership and management. The project was described in detail with a supportive literature review of previous research. Program planning is a necessary skill for educators who design programs for adult learners. The advanced workshop for nurse managers proposed in this section fully integrated the program planning process into curriculum development. It included an assessment of the learning context both socially and organizationally along with a needs assessment plan. Also provided were program outcomes and learning objectives that are essential components in the program planning process. Transfer of learning techniques, monitoring strategies and program structure were included as well as a detailed and comprehensive instructional plan setting a solid direction and path in providing a valued educational event. An evaluation plan provided careful planning to measure and substantiate program evaluation and outcomes with recommendations on how to present to stakeholders. By careful consideration and attention to the program planning process, the proposed advanced workshop for nurse managers is projected to be a high-quality program with successful outcomes with implications for social change.

Section 4 concludes the project with its strengths and limitations, recommendations for alternative approaches, scholarship, project development,

leadership and change as well as reflections on the importance of the work. Additionally, implications, applications, and directions for future research are addressed.

Section 4: Reflections and Conclusions

Introduction

Section 4, which provides a reflective conclusion to this doctoral project study, includes the following components:

- A self-reflective analysis of the strengths and limitation of the advanced workshop I planned in Section 3.
- Alternative approaches to the research study and project with solutions for ways I could have addressed the problem and project differently.
- An analysis of what I have learned from the process specific to the research and project workshop as they relate to scholarship, project development and evaluation, and leadership and change. I present a self-reflection examining my personal learning and growth as a scholar, practitioner, and project developer, as well as reflect on the importance of the work. Finally, I offer implications, applications, and directions for future research.

Project Strengths and Limitations

Strengths

In this project study, I developed an advanced workshop for nurse managers. The following three are its greatest strengths: the project came directly from findings in the study, the program planning process, and the needs assessment planned for the stakeholders.

First, during the focus group with the nurse managers in this research study, I recall vividly when the conversation turned to the lack of leadership professional development for nurse managers. It started with one nurse and then another and another as if the group reached an unintentional consensus on that topic. They all agreed it was a devastating void to have to learn on the job without proper knowledge and appropriate tools. I remember it was a somber conversation and although I made no comments or showed any emotion, my heart was breaking with the heaviness of the dialogue. When I heard it come up again and again during other focus groups and interviews, I knew something needed to be done. The project afforded me the opportunity to develop a workshop targeted specifically at this identified gap. I have a pragmatic and progressive educational philosophy that seeks to inquire and to then do what works best with a concern for individual differences and for problem solving (Conti, 2007). This offered me an awareness of why I enjoy empowering learners for greater success.

Second, another strength of the study is founded in the solid program planning process and I used the interactive model of program planning as a guide (Caffarella & Daffron, 2013). I became aware of this model during my doctoral coursework and I instantly saw the value in that it focused on what learners need to learn and how this learning results in changes of the learner and organization (Caffarella & Daffron, 2013). I used this model as a template in developing the advanced workshop for nurse managers and believe it to be a solid foundation to the workshop's structure and processes.

Third, I felt a highly structured needs assessment was warranted for this project development as I needed more in-depth knowledge about the managers' perceptions of leadership development (Caffarella & Daffron, 2013). I did not want the 12 nurse managers who volunteered to participate in the focus groups and interviews to speak for all 65 nurse managers within the hospital. I plan to conduct two survey assessments with the managers as well as conduct an informal nominal group process. I will prioritize and rank the ideas generated during the nominal group dialogue. In addition, I intend to conduct formal interviews with the CNO and directors. The 10 intensive workshop sessions will be patterned after the needs assessment results and hopefully will garner a commitment by the managers as they see the workshop based on their recommendations.

The assessment process is crucial to me as an educator and to the educational process because it targets the core of my teaching skills. Because I am responsible for CPD at the hospital, it is vital that I meet the educational needs of my staff. A needs assessment can provide information that can greatly increase the likelihood that an educational activity will meet its intended goals and the data obtained can assist in selecting a focus and content, choosing appropriate instructional methods and delivery formats, and scheduling activities (Queeney, 1995). Because the needs assessment produces solid data to base decisions on, it significantly increases the possibility that educators will succeed in assisting learners achieve desired outcomes (Queeney, 1995). Performing needs assessments allowed me to base education programs on data—which is critical to my success as a director of education—instead of relying only on my instinct.

Limitations

The workshop has limitations centered on financial issues and resources of the hospital. A 3-day workshop does not provide enough hours to cover all the topics required in a leadership development program. At best, the 3-day workshop will be a good starting point and will need to be continued with additional phases teaching supplementary topics over a period of time. Also, the 3 days in a row format may prove difficult for some managers to attend and it might be more feasible to offer monthly 8-hour classes throughout the year in an ongoing course design. What is more, the literature review revealed that many organizations hire outside facilitators and experts to come in and teach the leadership courses. This would not be possible with the current education budget I have to work with. Solutions to mitigate these issues would be to apply for funding via educational grants or be a benefactor to a donor who earmarks special funds dedicated to training our managers.

Recommendations for Alternative Approaches

Alternative Approaches to the Research Study

An alternative approach to this study's research design would allow for a change in the design methodology. A qualitative, case study approach was able to answer the research question but a mixed-method strategy could have provided additional information regarding the nurses' perceptions of CPD opportunities. The literature review listed multiple quantitative survey tools that can be used to reach a larger sample of nurses surveying for perceptions of issues related specifically to CPD.

Another approach might be to narrow the focus of CPD. I took a very broad look at CPD opportunities offered within the hospital and the findings revealed multiple areas of needed improvement. Another viewpoint to the local problem of nurses needing continuing education in order to provide safe patient care is to look at particular segments of CPD. For example, I could examine the nurses' perceptions of the use of technology in their lifelong learning in order to know much more precisely how to improve that venue of teaching. I could also research teaching methodologies and in particular experiential learning to determine the nurses' perceptions of an active learning approach to CPD. The study did find information about these gaps in learning but not near as much if technology or experiential learning had been the sole focus of the study's research question.

Alternative Definitions and Solutions of the Project

By changing the definition of the topic under study in the research question, this would open up different solutions to the local problem. Examining technology use would certainly provide findings that would point to a different project genre of professional development training. Perhaps a workshop dedicated to teaching educators on how to incorporate technology and social media concepts into their teaching environment would be an alternative project from the research outcomes. Accordingly, if I researched teaching methodologies and how they impact CPD, a possible workshop might be to teach instructors how to improve learner outcomes with active learning teaching methods. Changing the focus of the definition of CPD offers varied possibilities for training.

In looking at alternative solutions to the professional development training project, I can offer two different recommendations and options for the workshop project. First, I could offer to partner with the human resources (HR) department to collaboratively revise what they currently offer the managers for training. The director of organizational development spearheads this initiative and would need feedback garnered from the study's outcomes in order for the HR department to understand the great need the managers have in receiving relevant leadership education. Because the hospital does not have a centralized education department, the education is typically done in silos with HR conducting some general training and my education department conducting clinical education. These joint endeavors are typically burdened with resource and program planning issues (e.g., who plans, who teaches, etc.), but it would be possible to come together and work collaboratively in order to fill this identified gap in leadership development.

Another option could be to find a valuable and worthwhile course outside the hospital and provide the managers that source of education instead of providing it in-house. To illustrate this possibility, I suggest the Leadership Laboratory, a class provided by the American Organization of Nurse Executives (2014). This leadership development course is offered two times per year and is an online training class offering nurse managers education and practical application in six key leadership practices. See Appendix Q for additional information. The price of registration to attend this course is $1,250/person and is cost prohibitive for all 65 of the hospital's managers to attend.

Several managers could attend but it would most likely be only a few at a time. While outside classes will always be an option, the associated costs are difficult to get approved fiscally, which relegates this to a low priority alternative.

Scholarship, Project Development, and Leadership and Change

This section includes an analysis about the lessons I learned regarding the processes of the research study and project workshop as well as what I discovered about myself. The doctoral journey produced personal and professional growth in scholarship, project development and evaluation, and in being a leader and change agent within my profession.

Process

Scholarship. The scholarly process to obtain a doctorate in education degree has been a life altering experience culminating in this dissertation/project study research. Three years ago, I selected this degree at this institution because I wholeheartedly desired to earn my degree in an environment that would nurture my passion for education. The Richard W. Riley College of Education and Leadership at Walden University (2013) provided me that milieu and delivered on its mission statement promise: "To provide access to high-caliber programs that prepare learners as scholar-practitioners and leaders who can inspire, influence, and impact their diverse communities by helping to meet the challenges and opportunities of education worldwide" (p. 4). I thoroughly enjoyed the coursework and cultivating a deeper knowledge of education theorists, adult learning,

curriculum development, and research. The process of obtaining a doctorate degree has been fruitful and rewarding.

Moreover, the process of conducting this formal research project was profound in that it provided a wonderful growth opportunity but it has also sparked a passion to conduct research. I had previous quantitative research experience but had never undertaken a qualitative research study so I welcomed the chance to learn this very valuable skill. I found as I progressed through the prospectus to the proposal and then to the study itself, I could not wait to conduct the research and use the outcomes to apply to my teaching and education environment. The process was painful at times and always was a time management versus work–life balance concern but nonetheless proved rewarding, beneficial, and critical to my growth as a scholar. When I started working on this degree, I was much more interested in teaching than research. Now I find I am looking forward to conducting more research studies and have several ideas in mind. I am already looking at tools available to conduct a mixed methods study on lateral violence (bullying) in healthcare workers.

Project development and evaluation. I have always enjoyed developing projects and curriculum and this advanced workshop proved no exception. The program planning process I learned during my doctoral coursework has proven invaluable and I have used this process multiple times since learning it in class. One of the things I have learned to appreciate about structuring learning environment formats is the benefit from creating communities of practice to learn in. I created numerous communities throughout the

advanced workshop for nurse managers allowing them to learn together. My project development skills were greatly enhanced because I have changed my teaching practice after learning about communities of practice. Weissner, Sheared, Kucharczyk, and Flowers (2010) expressed how diverse communities of learners could only survive through relationships, partnerships, and inter-dependencies of individual members. They stimulate change rather than maintain status quo and embrace diverse perspectives instead of encouraging inward-looking thinking. This revised my thinking about community and the role I played in cultivating it. I was intrigued by the authors' suggestion "that the role of adult educators includes sustaining community by embracing its richness" (Weissner et al., 2010, p. 431) as it is a reminder of all the positive outcomes a community can produce. Previous to the doctoral coursework, I had not embraced the communities of practice philosophy in my own practice but now realize I was operating under a flawed assumption. Weissner et al. (2010) underscored this importance for educators in that the communities they create in the transfer of learning will become intentional interventions about growing and developing together. Community is intended for learning and this is one of the most influential lessons that I have learned. As an educator, this change in practice will have far reaching implications for me because of the powerful outcomes the diversity within communities produces, how they reciprocate information and support, how much nurses learn from each other in learning communities that they might be a part of or establish, and how the communities produce changes in behavior.

Learning the importance of embedding evaluation plans into a course curriculum has been another valued lesson that I have learned. I had on my list of goals for many years to learn the four levels of evaluation and institute that as a standard of practice in the hospital. It was not until this subject came up in my doctoral coursework that I actually made progress toward that end. Learning Kirkpatrick's four levels of evaluation (Kirkpatrick & Kirkpatrick, 2007) was a major milestone in my acquisition of adult education skills and has now changed how I create classes and evaluate learning.

Leadership and change. I have gained many new ideas and ways of thinking during my doctoral journey but one that has impacted me greatly was learning about critical reflection. Brookfield (as cited in Laureate Education, Inc., 2012) impressed me when he said good leaders are people who are always trying to learn about themselves and their own practice. He believed educators should find ways to critically reflect as part of their daily practice. This is something I had not considered before but do now as I have added this exercise to my teaching practice to become aware of the assumptions I work and teach under. This is a principal lesson that I have learned - to look through the lenses of colleagues and research to see deeper inside myself.

Becoming a leader is a process and my doctoral journey and research study have been a prominent part of my progressive maturity. Learning about my practice and myself has enabled me to lead in my profession in new ways. I believe that good leadership is fundamental to change in that leaders inspire and guide others in expanding their vision and take on new initiatives to change the work environment to be a better

place to teach and learn. I have credibility and experience to capitalize on as I mentor others to use research and knowledge to make positive change in their nursing practice. I am grateful for the inspiration to self-reflect on my own education practice and for the opportunity to make transformative changes in my approach in leadership to effect change.

Reflective Analysis of Self

Scholar. Many of my nursing colleagues are pursuing PhDs and doctorates in nursing-related fields. I chose to not follow in their footsteps in order to pursue my passion for education, teaching and learning culminating in an EdD degree. Helping adult learners grow and develop through active learning strategies energizes me and this is why I chose the field of education as my professional career. During my doctoral journey, my progressive philosophical orientation has solidified and become part of my persona. The main purpose of this orientation is to promote individual effectiveness in society and to provide learners with real-world and hands-on education and problem-solving skills. This is congruent with my nursing career as I have used these characteristics with the many nurses I have taught and the curricula I have developed.

I look forward to graduation and being called Dr. Taylor. I feel I have earned the title academically but it will take some time to earn it professionally. Other staff in the hospital are already coming to me for mentorship and research advice but it will require more experience to feel that I am worthy. As I continue conducting further research, my self-efficacy as a scholar and researcher will soar. I have grown so much over the past 3

years and I now problem solve differently and see things through a research and social change lens. I feel my peers and colleagues treat me differently and I have more authority when I speak.

I am proud of the scholarly work that I produced along my doctoral journey and especially as it has culminated in my doctoral project study. I thoroughly enjoyed obtaining this advanced education and when people would ask me how school was going, I would always reply, "It's great!" and I think that surprised a good many of my friends. I honestly did enjoy it and the research study was my favorite part. I saw each step of the process as a challenge. First the prospectus stage, then the proposal, and finally the study and project. I tackled each area with organization and perseverance and most of it was not a struggle because I found it all so very interesting. I was intrigued by the IRB process and found it took me 5 days to get through the hospital's IRB and 9 days to complete Walden's process. I originally had proposed to hire a consultant to conduct the focus groups but found that would not pass through the IRB and that I had to conduct them myself. How fortunate for me that this happened, as I loved the focus group process and found I was better at it than what I had originally thought. The focus groups were so enjoyable and information producing that I wish they could have been for 2 hours each instead of one. The nurse participants felt the same way too and they were so pleased to have been able to participate in this research. I totally underestimated how difficult the transcription process proved to be. I hired a secretary to transcribe the three focus groups and 10 interviews, but it quickly overwhelmed her and I ended up hiring a second

secretary, plus I transcribed several of the recordings myself. This was probably the least enjoyable part of the entire study. The data analysis process was intimidating at first but my organization skills and the computer software were invaluable in bringing mounds of paper to a sensible and thematic conclusion.

Practitioner. As the Director of Clinical Education and Professional Development, I have the responsibility of providing life-long learning to approximately 2,500 hospital patient care services employees. I have always been grateful to God for making me to be a nurse; to be able to get up every day and come to work and teach is rewarding beyond measure. My love of teaching and helping staff members learn is deeply entwined with who I am and what I love to do. Most importantly, I have a great passion to actively engage adult learners and believe this to be my defining principle. In a time when hospitals have multiple federal and state regulatory agencies monitoring patient safety and mandating various kinds of standards, they require fastidious documentation to prove that I have taught and educated the staff to provide the utmost competent and safe care. In order to do this, I must have highly developed and innovative teaching skills to be able to design active learning experiences that will meet the needs of my diverse learners. Therefore, there has never been a more crucial time to make certain that healthcare providers have learned what they have been taught. Because there is strong empirical evidence that active involvement in the learning process is key for effective learning (Center for Faculty Excellence, 2012), educators must understand this philosophy and incorporate it into their curriculum and teaching methodologies. It is for

this reason that active learning is at the core of my educational beliefs and values and my doctoral coursework has provided a strong and solid foundation for this to become part of my teaching methodology and practice.

Project Developer. Twenty years ago I began my healthcare career as a new graduate registered nurse and over the course of this time, I have been promoted to various positions. All of these positions had a large teaching component that over the years has fed and fueled my passion for education. Even during my first year of being a nurse at the bedside, I soon found that I had a love to teach parents and my fellow staff members. One of the beautiful things about being a pediatric nurse is that along with every infant and child patient also came a family with parents. I learned very fast that the quickest way to empower parents to take care of a sick child was to teach and instruct them and give them the knowledge to do what they needed to do. I also soon discovered how much I liked to develop courses and teach my peers.

My doctoral coursework has culminated in the development of an advanced workshop for nurse managers. The program planning included in this project is based on active learning strategies and is what will change behavior when the workshop is over. To me, experiential learning is the most importance part of developing a project. According to the Association for Experiential Education (2012), experiential education is a philosophy in which educators purposefully engage with learners in direct experience and focused reflection to increase knowledge, develop skills and clarify values. This is accomplished through active learning that promotes instructional activities involving

learners in doing things and thinking about what they are doing (Bonwell & Eison, 1991). Experiential education is essential to adult education because students learn more when they are asked to actively participate in the process of learning (Center for Teaching and Learning, 2012). This importance was strongly emphasized in Lindeman's (2011) belief that the learning process focuses on situations that require learners to draw on their experiences as they participate in problem solving.

According to Galbraith (2004), the role of the teacher in a progressive adult education orientation is that of an organizer who guides learning through educative experiences. The educator utilizes problem solving, activity, experimental, project (cooperative learning) and inductive teaching strategies and methodologies (Galbraith, 2004). Galbraith added that progressive teachers have democratic ideals, are life-long learners and are pragmatists. This unequivocally matches with my philosophy and practice. I agree with Conti (2007) that the effective instructor capitalizes on the learners' feelings in the learning environment to accomplish learning objectives, identify the needs of the learner, and to serve as a resource - all major components of project development. In the end, it is my responsibility as an educator to make sure my teaching and project development supports the mission and goals of the hospital and nursing excellence of patient care delivery (Dickerson, 2014).

My doctoral education has enhanced and fine-tuned my teaching skills and I now base every project I develop on a new perspective focused on enabling adult learners to maximize every learning moment and experience. The solid foundation I have in adult

learning theorists and the research behind the theory is manifested in every project. The doctorate has given me confidence as an educator but most importantly, it has guided me in obtaining successful learner outcomes in the classes I develop and teach.

Reflection on the Importance of the Work

To know where a healthcare facility stands in educating its workforce takes paramount importance in vision planning for future educational development. This is especially true when it comes to educating nurses who require CPD to maintain and increase their knowledge base in order to provide safe, patient care. The work of assessing CPD opportunities within an organization is essential and the data outcomes of this research study has afforded one Southern California pediatric hospital current knowledge of where they stand in educating their nurses. Educators should never become complacent about CPD and take for granted that what they have done is good enough. The nursing profession aspires to excellence and good enough should never be accepted or tolerated. Moreover, educators should never be satisfied with the status quo and should be conducting ongoing assessments to determine areas of strengths and weaknesses in their CPD offerings and opportunities. The literature is full of great ideas to implement but until an educator knows specifically what is needed based on evidence, all the great ideas in the world will not be able to fill a gap in knowledge that is not based on research. Educating nurses is not done on a whim or by providing classes that sound great or fill a need of the instructor. The education must be based on practical and real experiences of the nurses involved in order to determine if their CPD needs are being met. This research

study has provided invaluable outcomes to me as an educator as I now have evidence-based data providing direction on how to strengthen CPD within my hospital. Every hospital should have this kind of firsthand knowledge of where their areas of opportunities are for improvement in CPD. Nurses in today's healthcare arena deserve the very best education possible.

Implications, Applications, and Directions for Future Research

Implications for Social Change

Educators must actively involve learners and engage them in problem solving activities in order to improve their professional achievement. Even though it is known that active learning teaching methods produce improved learner outcomes among diverse adult learners, many educators are slow to incorporate this into their teaching practice. Bedgood et al. (2010) found that almost half of instructors are less than satisfied with their teaching style; only 25% were familiar with learner-centered teaching methods, 66% reported low student engagement, and 69% were less than satisfied with student achievement in their classes (p. 12). This indicates a profound need to make a difference by teaching instructors to modify curriculum and course design to utilize the principles of active learning. I can provide the educational foundation to promote this transformation by teaching instructors who co-teach with me in the advanced workshop for nurse managers how to teach with active learning strategies. This will have a domino effect to the managers as they will learn to provide experiential learning to their staff. The staff will realize the benefits of learning in this manner and role model some of these

techniques when they teach their patients and families. This shift in behavior should be the main focus of educators as they develop CPD classes for their staff. Change is impacted at multiple levels and reaches far beyond this study and workshop.

The reform of instructional practice in adult education needs attention and it is therefore imperative to promote learning strategies that involve learners actively and engage them in problem solving activities (Malik & Janjua, 2011). Educators need to teach managers and staff about the value of experiential education and the benefits and methodologies of active learning. Through this instruction, educators can transform learning environments to provide the best possible education experiences for all. Dickerson (2014) captured this point succinctly when she said:

> With the current focus on outcomes of patient care and nursing practice, it has never been more important for the [educator] to adhere to high standards in promoting quality education for fellow health care providers. The safety of our patients and the quality of our health care delivery system depend on lifelong learning by all of us. (p. 288)

This study and workshop have allowed me to be an agent of positive social change promoting the worth, dignity, and development of multiple healthcare staff, the hospital, and the community beyond.

Applications

The importance of CPD for nurses cannot be understated. The significance lies in the effectiveness and availability of CPD opportunities and if they meet the needs of the

nursing staff and their professional development. Even though the data from this case study are limited in generalizing the outcomes to other nursing populations, the study does offer detailed explanations and descriptions allowing educators to glean information that may be usable in their facility. The data from this study suggest several areas in which educators can improve their practice and conduct similar studies in order to obtain evidence based research on a facility's strengths and weaknesses of CPD opportunities. The motivators and barriers to CPD need to be identified and are useful in knowing which courses are working and which ones need revising. It is also crucial to know if nurses are able to incorporate what they learn back into their practice. If not, a further investigation needs to be done to find out what obstacles are in the nurses' way that inhibit the transfer of learning. Finally, the wish list that this study produced offers numerous ideas for areas of improvement that should be helpful as a guiding template of ideas to educators in organizations around the country. The results from this study provide helpful information for educators to use to improve CPD opportunities in supporting nurses to provide excellent patient care.

Directions for Future Research

This study was conducted to examine pediatric nurses' perceptions of CPD opportunities. Several recommendations for future research can be made as a result of the study's findings. First and foremost, a hospital's mission statement and philosophy should support CPD for all healthcare professionals and be explicitly stated as such. To that end, a periodic assessment should be instituted to measure the success of meeting this

expectation. Numerous survey tools were mentioned in the literature that could be used to reach a larger sample of the nursing population that could garner additional information regarding CPD perceptions. As an example, a new tool was recently published that measures continuing professional development of nurses. Brekelmans, Maassen, Poell, and van Wijk (2015) developed a questionnaire that measures four constructs: nurses' CPD motives, importance attached to CPD, conditions deemed necessary for CPD, and actual CPD activities undertaken. The information garnered from this questionnaire can help support the professional development of nurses (Brekelmans et al., 2015).

Furthermore, it would be interesting to look deeper into teaching methodologies used throughout healthcare facilities to determine which methods work best and which strategies do the nurses' find the most helpful. Because research was mentioned as a motivator to attend CPD courses, it would be beneficial to ascertain why this is and what can be done to leverage that positive result. Additionally, more information is needed about what constitutes a supportive culture and healthy work environment that facilitates nurses incorporating knowledge into practice is needed, and it would be valuable to identify best practices found in other healthcare facilities. Finally, technology and simulation offer vast opportunities for future research in order capture the power these approaches to learning can provide to improve CPD.

Conclusion

This research study, advanced workshop project, and self-reflection analysis comprise a body of work that I am proud to submit as partial fulfillment of the

requirements for the degree of Doctor of Education. This education has been a goal and a dream of mine for many years in the making and I now possess knowledge and skills only made possible by pursuing a doctorate level degree. By keeping the goal in sight, my drive and focus were continually renewed. My motivation over the years can be summed up by a quote by a Presbyterian minister and a professor of literature at Princeton who was a popular writer of essays, poems, and short stories in the early part of the 20th century. He penned the following:

> It is only by thinking about great and good things that we come to love them, and it is only by loving them that we come to long for them, and it is only by longing for them that we are impelled to seek after them; and it is only by seeking after them that they become ours. (Van Dyke, 1921, pp. 99-100)

These words eloquently reflect my approach to all educational endeavors and initiatives. It was a privilege to conduct this case study and for the nurses to have allowed me into their 'inner sanctum' of thoughts and conversations as they relayed to me their perceptions of CPD within the hospital. I asked them to tell me their perceptions and indeed they did. I sincerely hope I have done justice with their words and I am indebted to them with a deep sense of gratitude for allowing their story to be told.

More importantly, the information garnered in this study of nurses' perceptions of CPD opportunities will allow me to effect change in nursing professional development and build a culture of commitment to CPD. Now that I have seen CPD through the nurses' lenses, I am in an informed position to continue teaching the classes that were

helpful, change those offerings that were identified as needing updating, and put into place processes that will capitalize on the motivators and mitigate the barriers found in CPD. The data gathered will allow educators to develop CPD offerings to better meet staff needs and increase opportunities and participation. That will, in turn, increase staff competence and directly impact patient safety, care, and outcomes. I firmly believe that employers should do everything possible to ensure their nurses have choices and access to numerous CPD offerings and to find creative and progressive fiscal ways to make this education as easy as possible for nurses to attend and participate in. Simply stated, educators need to provide this learning environment because nurses and patients deserve nothing less.

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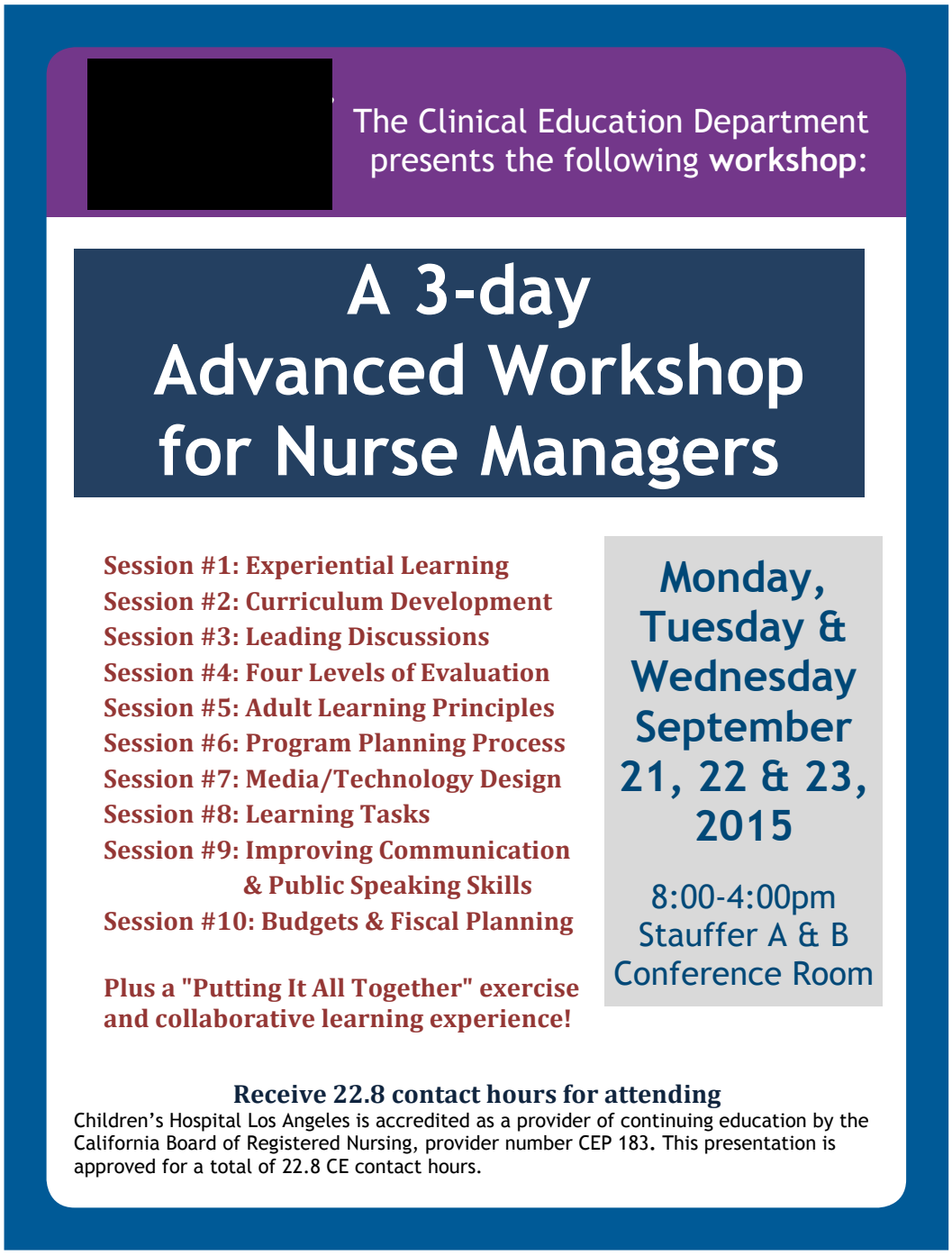
Appendix A: The Project

Advanced Workshop for Nurse Managers



Alignment Between Desired Outcome, Program Outcomes, and Learning Objectives

Desired Outcome	Program Outcomes	Learning Objectives
To provide an advanced professional development program targeted at nurse managers to increase their proficiency and efficacy in leadership competencies and strategies. 1. Knowledge Critical thinking Leadership Experiential learning Media/technology design Research Adult learning principles and theories Curriculum development Learning tasks 2. Skills Communication/public speaking Decision making Interpersonal Program planning Delegation Writing Designing four levels of evaluation Computer Listening Budget analysis Facilitation/leading discussions	Session #1: Experiential Learning Nurse managers will learn how to develop experiential learning environments utilizing games and interactive teaching strategies. Session #2: Curriculum Development Nurse managers will be able to demonstrate they know how to develop a curriculum for a course, workshop, in-service or class. Session #3: Leading Discussions Nurse managers will acquire knowledge and proficiency in facilitating small and large group discussions.	By the end of the workshop, the learner will be able to: 1. Identify four reasons for using games and interactive teaching strategies as an adjunct to traditional teaching methodologies. 2. Explain the dilemma 'gaming' causes for educators and acknowledge ways to mitigate. 3. Examine three advantages and three disadvantages of using games as a teaching strategy. By the end of the workshop, the learner will be able to: 1. Analyze three curriculum development models. 2. Identify five learning activity designs justifying the advantages and disadvantages of each. 3. Apply the four steps in Kolb's Learning Process to a specific learning need in your work environment. By the end of the workshop, the learner will be able to: 1. Compare and contrast the top ten tips for leading effective discussions. 2. Demonstrate three methods to structure discussions that encourage learner participation. 3. Create four situations through role-play that deal with difficult learners.

(*table continues*)

Desired Outcome	Program Outcomes	Learning Objectives
3. Attitudes Resilience Flexibility Objectivity Accountable Advocate Self-reflexive	Session #4: Kirkpatrick's Four Levels of Evaluation Nurse managers will learn how to evaluate training programs according to Kirkpatrick's Four Levels of Evaluation.	By the end of the workshop, the learner will be able to: 1. Identify the four levels of evaluation and rationale for using each one. 2. Explain why reporting results to stakeholders are important. 3. Develop an evaluation plan (using the template provided in class) to a real-world work project.
	Session #5: Adult Learning Principles Nurse managers will learn various adult learning theories and apply to practice environment.	By the end of the workshop, the learner will be able to: 1. Identify at least three adult learning theories that resonant with your personal beliefs. 2. Evaluate, in depth, one learning theory and how it applies to a real-world learning situation from your work environment. 3. Argue the pros and cons of self-directed learning as it relates to your nursing staff.
	Session #6: Program Planning Process Nurse managers will learn how to develop a program using the program planning process.	By the end of the workshop, the learner will be able to: 1. Describe the steps in the program planning process. 2. Compose transfer of learning strategies for four learning situations. 3. Create a course curriculum using each step of the program planning process from your real-world work environment.
	Session #7: Media/ Technology Design Nurse managers will learn how to design media and technology online courses.	By the end of the workshop, the learner will be able to: 1. Describe the steps involved in designing a technology-enhanced course.

(*table continues*)

Desired Outcome	Program Outcomes	Learning Objectives
		2. Explain digital media and how to incorporate it into online learning. 3. Construct an online course with a course curriculum.
	Session #8: Learning Tasks Designed for Deeper Learning Nurse managers will learn how to design learning tasks that result in an increased depth of learning.	By the end of the workshop, the learner will be able to: 1. Identify four learning tasks that would move a learner into deep learning of a topic. 2. Design a learning task targeted at solving a real-world problem in your work environment. 3. Demonstrate or role-play a learning task with other learners in the workshop.
	Session #9: Improving Communication and Public Speaking Skills Nurse managers will learn how to develop sound communication strategies and techniques for effective public speaking.	By the end of the workshop, the learner will be able to: 1. Evaluate different communication strategies and wen to use it each one. 2. Create a speech related to a real-world problem in your work environment. 3. Present speech in front of class and listen to feedback provided by the audience.
	Session #10: Budgets and Fiscal Planning Nurse managers will learn how to master basic business skills in order to improve their work environment.	By the end of the workshop, the learner will be able to: 1. Identify five budgeting principles of an effective fiscal planning process. 2. Analyze examples of budget variances and how to report them. 3. Demonstrate access to the hospital's electronic budget system and various reports.

Agenda for Advanced Workshop for Nurse Managers

Time	Schedule
Day 1	
8:00-8:30	Registration and Breakfast
8:30-10:00	Session #1 - Experiential Learning
10:00-10:15	Break
10:15-11:45	Session #2 - Curriculum Development
11:45-12:30	Lunch and Networking
12:30-2:00	Session #3 - Leading Discussions
2:00-2:15	Break
2:15-3:45	Session #4 - Kirkpatrick's Four Levels of Evaluation
3:45-4:00	Wrap Up and Evaluations
Day 2	
8:00-10:00	Session #5 - Adult Learning Theories and Principles
10:00-10:15	Break
10:15-11:45	Session #6 - Program Planning Process
11:45-12:30	Lunch and Networking
12:30-2:00	Session #7 - Media/Technology Design
2:00-2:15	Break
2:15-3:45	Session #8 - Learning Tasks Designed for Deeper Learning
3:45-4:00	Wrap Up and Evaluations
Day 3	
8:00-10:00	Session #9 - Improving Communication and Public Speaking Skills
10:00-10:15	Break
10:15-11:45	Improving Communication *(continued)*
11:45-12:30	Lunch and Networking
12:30-2:00	Session #10 - Budgets and Fiscal Planning
2:00-2:15	Break
2:15-3:45	Putting It All Together
3:45-4:00	Wrap Up and Evaluations

Instructional Plan - Advanced Workshop for Nurse Managers

<table>
<tr><th>Program Outcomes & Learning Objectives</th><th>Content/Topic Outline</th><th>Timeframe</th><th>Instructor</th><th>Transfer of Learning Techniques</th></tr>
<tr><td rowspan="4">Session #1: Experiential Learning

Nurse managers will learn how to develop experiential learning environments utilizing games and interactive teaching strategies.

By the end of the workshop, the learner will be able to:

1. Identify four reasons for using games and interactive teaching strategies as an adjunct to traditional teaching methodologies.
2. Explain the dilemma ‘gaming’ causes for educators and acknowledge ways to mitigate.
3. Examine three advantages and three disadvantages of using games as a teaching strategy.</td><td rowspan="4">I. Opening Video
II. Background
A. History of Gaming
B. John Dewey
C. 3 Models of Instruction
D. Digital Natives
E. Educational Practices of the Millennials
III. Dilemma for Educators
IV. Circle of Learning
V. Ten Reasons Why Games are High-Outcome Techniques
VI. Benefits & Disadvantages
VII. Proper Use of Games
VIII. Strategies
A. Case Method
B. Songs
C. Case Scenarios
D. Interactive Internet Sites
E. Radio Lollipop
F. Interactive Teaching Ideas
G. Teasers and Energizers
H. Role Playing
I. Mock Trial
J. Drills
K. Education Fairs
L. Theme Ideas
M. Bingo
N. Critique
IX. Closing Video</td><td>90 minutes</td><td>Suzanne Taylor</td><td>Lecture

Demo of Internet Sites

Case Studies

Suggestion Circles

Reflective Practice

Handouts/ Printed Materials

Question & Answer Session</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>Format</td><td>Resources</td><td>Transfer of Learning Monitoring</td></tr>
<tr><td>Face-to-Face

Workshop</td><td>Laptop

Projector

Screen

Podium

Microphone

Pointer

Room Set-up: Classroom Style

Breakfast</td><td><u>During</u>:
- Provide opportunity to develop specific application plans
<u>After</u>:
- Implement Individual Learning Plans
- E-mail reminders
- Podcasts
- Portfolios
- Follow-Up sessions with Supervisor accountability</td></tr>
</table>

<table>
<tr><th>Program Outcomes & Learning Objectives</th><th>Content/Topic Outline</th><th>Timeframe</th><th>Instructor</th><th>Transfer of Learning Techniques</th></tr>
<tr><td rowspan="3">Session #2:
Curriculum Development

Nurse managers will be able to demonstrate they know how to develop a curriculum for a course, workshop, in-service or class.

By the end of the workshop, the learner will be able to:

1. Analyze three curriculum development models.

2. Identify five learning activity designs justifying the advantages and disadvantages of each.

3. Apply the four steps in Kolb's Learning Process to a specific learning need in your work environment.</td><td rowspan="3">I. Overview
A. Theoretical Approaches
B. Curriculum Development Models
II. Purpose of the Curriculum
A Instrumental and Developmental Competence
B. Three Models
III. Objectives of the Curriculum
A. Sources
IV. Selection and Organization of Learning Experiences
A. Continuity
B. Sequence
C. Integration
V. Course Objectives
A. Types of Objectives
VI. Resources Employed and Utilization of Time/Space
A. Resources
B. Time
C. Space
VII. Design of the Learning Activities
A. Experiential Learning
B. Kolb's Four-Step Learning Process
VIII. Curriculum Evaluation
A. Gathering Data
B. Interpreting Data to Improve the Curriculum
IX. Application</td><td>90 minutes</td><td>Suzanne Taylor</td><td>Lecture

Group Discussion

Consensus Boards
Learning Task

Skill Practice Exercise

Handouts/ Printed Materials</td></tr>
<tr><th>Format</th><th>Resources</th><th>Transfer of Learning Monitoring</th></tr>
<tr><td>Face-to-Face

Workshop</td><td>Laptop

Projector

Screen

Podium

Microphone

Pointer

Room Set-up: Classroom Style

Lunch</td><td><u>During</u>:
- Provide opportunity to develop specific application plans
- Skill Practice Exercise
<u>After</u>:
- Implement Individual Learning Plans
- Coffee chat time
- Tip of the Week
- Portfolios
- Follow-Up sessions with Supervisor accountability</td></tr>
</table>

<table>
<tr><th>Program Outcomes & Learning Objectives</th><th>Content/Topic Outline</th><th>Timeframe</th><th>Instructor</th><th>Transfer of Learning Techniques</th></tr>
<tr><td rowspan="2">Session #3:
Leading Discussions

Nurse managers will acquire knowledge and proficiency in facilitating small and large group discussions.

By the end of the workshop, the learner will be able to:

1. Compare and contrast the top ten tips for leading effective discussions.

2. Demonstrate three methods to structure discussions that encourage learner participation.

3. Create four situations through role-play that deal with difficult learners.</td><td rowspan="2">I. Why Discussion is Important to Learning
A. Comprehension and Recall
B. Higher Levels of Cognition
II. Recommendations for Leading
Effective Discussions
A. Preparation and Planning
B. Develop a Questioning Strategy
C. Initiating and Maintaining the Discussion
D. Concluding the Discussion
E. 10 Tips for Leading Effective Discussions
F. Large Group Discussion
G. Small Group Discussion
H. Forums for Discussion
I. How Discussions Can Be Structured
J. Exemplar
III. The Art of Questioning
A. Personal Perspective
B. Functional Perspective
C. Critical Thinking Perspective
D. Probing Perspective
E. The Playground Question
F. The Focal Question
G. The Brainstorm Question
IV. Application</td><td>90 minutes</td><td>Suzanne Taylor

and
a Co-Facilitator to be determined</td><td>Lecture

Group Discussion

Interactive Activities

Role Playing Activities

Demo with return demo

Observation

Behavior Modeling

Handouts/ Printed Materials</td></tr>
<tr><td>Format</td><td>Resources</td><td>Transfer of Learning Monitoring</td></tr>
<tr><td></td><td></td><td>Face-to-Face

Workshop</td><td>Laptop

Projector

Screen

Podium

Microphone

Pointer

Room Set-up: Classroom Style

Afternoon Snack</td><td><u>During</u>:
- Provide opportunity to develop specific application plans
- Skill Practice Exercise
<u>After</u>:
- Implement Individual Learning Plans
-Phone review sessions
- Portfolios
- Follow-Up sessions with Supervisor accountability</td></tr>
</table>

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<tr><th>Program Outcomes & Learning Objectives</th><th>Content/Topic Outline</th><th>Timeframe</th><th>Instructor</th><th>Transfer of Learning Techniques</th></tr>
<tr><td rowspan="3">Session #4: Kirkpatrick's Four Levels of Evaluation

Nurse managers will learn how to evaluate training programs according to Kirkpatrick's Four Levels of Evaluation.

By the end of the workshop, the learner will be able to:

1. Identify the four levels of evaluation and rationale for using each one.

2. Explain why reporting results to stakeholders are important.

3. Develop an evaluation plan (using the template provided in class) to a real-world work project.</td><td rowspan="3">I. The Four Levels

II. Evaluating Reaction

III. Evaluating Learning

IV. Evaluating Behavior

V. Evaluating Results

VI. Creating an Action Plan During Curriculum Development

VII. Evaluate Case Studies</td><td>90 minutes</td><td>Suzanne Taylor</td><td>Lecture

Case Studies - Review and Critique

Suggestion Circles

Reflective Practice

Handouts/ Printed Materials

Question & Answer Session</td></tr>
<tr><th>Format</th><th>Resources</th><th>Transfer of Learning Monitoring</th></tr>
<tr><td>Face-to-Face

Workshop</td><td>Laptop
Projector
Screen
Podium
Microphone
Pointer
Room Set-up: Classroom Style</td><td><u>During</u>:
- Provide opportunity to develop specific application plans
<u>After</u>:
- Implement Individual Learning Plans
- E-mail reminders
- Podcasts
- Portfolios
- Follow-Up sessions with Supervisor accountability</td></tr>
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<table>
<tr><th>Program Outcomes & Learning Objectives</th><th>Content/Topic Outline</th><th>Timeframe</th><th>Instructor</th><th>Transfer of Learning Techniques</th></tr>
<tr><td rowspan="3">Session #5:
Adult Learning Principles

Nurse managers will learn various adult learning theories and apply to practice environment.

By the end of the workshop, the learner will be able to:

1. Identify at least three adult learning theories that resonant with your personal beliefs.

2. Evaluate, in depth, one learning theory and how it applies to a real-world learning situation from your work environment.

3. Argue the pros and cons of self-directed learning as it relates to your nursing staff.</td><td rowspan="3">I. Adult Learners

II. Five Orientations to Learning
A. Behaviorist
B. Humanist
C. Cognitivist
D. Social Cognitive
E. Constructivist

III. Andragogy

IV. Self-Directed Learning

V. Transformational Learning

VI. Experience and Learning

VII. Traditional Learning Theories</td><td>120 minutes</td><td>Suzanne Taylor</td><td>Lecture

Job Aids

Applications Notebook

Reflective Practice

Handouts/ Printed Materials

Question & Answer Session</td></tr>
<tr><th>Format</th><th>Resources</th><th>Transfer of Learning Monitoring</th></tr>
<tr><td>Face-to-Face

Workshop</td><td>Laptop
Projector
Screen
Podium
Microphone
Pointer
Room Set-up: Classroom Style

Breakfast</td><td><u>During</u>:
- Provide opportunity to develop specific application plans

<u>After</u>:
- Implement Individual Learning Plans

- Follow-Up sessions with course facilitator</td></tr>
</table>

<table>
<tr><th>Program Outcomes & Learning Objectives</th><th>Content/Topic Outline</th><th>Timeframe</th><th>Instructor</th><th>Transfer of Learning Techniques</th></tr>
<tr><td rowspan="3">Session #6:
Program Planning Process

Nurse managers will learn how to develop a program using the program planning process.

By the end of the workshop, the learner will be able to:

1. Describe the steps in the program planning process.

2. Compose transfer of learning strategies for four learning situations.

3. Create a course curriculum using each step of the program planning process from your real-world work environment.</td><td rowspan="3">I. Overview of Program Planning

II. The Seven Design Steps

III. Developing Program Objectives

IV. Designing Instructional Plans

V. Transfer of Learning Strategies

VI. Program Format

VII. Program Schedule

VIII. Budgets and Marketing Plans

IX. Evaluation

X. Implementation</td><td>90 minutes</td><td>Suzanne Taylor</td><td>Lecture

Develop a plan and present to class

Case Study Examples

Reflective Practice

Handouts/ Printed Materials

Question & Answer Session</td></tr>
<tr><td>Format</td><td>Resources</td><td>Transfer of Learning Monitoring</td></tr>
<tr><td>Face-to-Face

Workshop</td><td>Laptop
Projector
Screen
Podium
Microphone
Pointer
Room Set-up: Classroom Style

Lunch</td><td><u>During</u>:
- Provide opportunity to develop specific application plans
<u>After</u>:
- Implement Individual Learning Plans
- E-mail reminders
- Podcasts
- Portfolios
- Follow-Up sessions with Supervisor accountability</td></tr>
</table>

<table>
<tr><th>Program Outcomes & Learning Objectives</th><th>Content/Topic Outline</th><th>Timeframe</th><th>Instructor</th><th>Transfer of Learning Techniques</th></tr>
<tr><td rowspan="3">Session #7:
Media/ Technology Design

Nurse managers will learn how to design media and technology online courses.

By the end of the workshop, the learner will be able to:

1. Describe the steps involved in designing a technology-enhanced course.

2. Explain digital media and how to incorporate it into online learning.

3. Construct an online course with a course curriculum.</td><td rowspan="3">I. Planning a Technology-Enhanced Course

II. e-Learning Program Planning

III. Legal Issues

IV. Developing Course Materials and Documents

V. Classroom Technology

VI. Customizing Blackboard Sites

VII. Digital Media

VIII. Building a Community in the Cyber Classroom

IX. Course and Program Evaluation

X. Teaching Online</td><td>90 minutes</td><td>Suzanne Taylor

and

Manager, Hospital Systems & Technology Education</td><td>Lecture

Case Studies

Podcast Follow-Ups

e-Freshers in Virtual Classrooms

Handouts/ Printed Materials

Question & Answer Session</td></tr>
<tr><th>Format</th><th>Resources</th><th>Transfer of Learning Monitoring</th></tr>
<tr><td>Face-to-Face

Workshop</td><td>Laptop
Projector
Screen
Podium
Microphone
Pointer
Room Set-up: Classroom Style

Afternoon Snack</td><td><u>During</u>:
- Provide opportunity to develop specific application plans
-Skill Practice Exercise
<u>After</u>:
- Implement Individual Learning Plans
- Podcasts
- Portfolios
- Follow-Up sessions with Supervisor accountability</td></tr>
</table>

<table>
<tr><th>Program Outcomes & Learning Objectives</th><th>Content/Topic Outline</th><th>Timeframe</th><th>Instructor</th><th>Transfer of Learning Techniques</th></tr>
<tr><td rowspan="3">Session #8:
Learning Tasks Designed for Deeper Learning

Nurse managers will learn how to design learning tasks that result in an increased depth of learning.

By the end of the workshop, the learner will be able to:

1. Identify four learning tasks that would move a learner into deep learning of a topic.

2. Design a learning task targeted at solving a real-world problem in your work environment.

3. Demonstrate or role-play a learning task with other learners in the workshop.</td><td rowspan="3">I. Definition and Purpose of Learning Tasks

II. Size of Group

III. Timeframe

IV. Learning Activity
A. Instructional Methods
B. Learning Accommodations
C. Resources and materials

V. Practice and Feedback
A. Practice
B. Feedback format
C. Instructor responsibilities
D. Learner responsibilities

VI. Application Assignment
A. Rubric</td><td>90 minutes</td><td>Suzanne Taylor</td><td>Lecture

Critical Panel Debate

Discussion

Course Portfolios

Handouts/ Printed Materials

Question & Answer Session</td></tr>
<tr><th>Format</th><th>Resources</th><th>Transfer of Learning Monitoring</th></tr>
<tr><td>Face-to-Face

Workshop</td><td>Laptop
Projector
Screen
Podium
Microphone
Pointer
Room Set-up: Classroom Style</td><td><u>During</u>:
- Provide opportunity to develop specific application plans
<u>After</u>:
- Implement Individual Learning Plans
- Portfolios
- Follow-Up sessions with Supervisor accountability</td></tr>
</table>

<table>
<tr><th>Program Outcomes & Learning Objectives</th><th>Content/Topic Outline</th><th>Timeframe</th><th>Instructor</th><th>Transfer of Learning Techniques</th></tr>
<tr><td rowspan="3">Session #9: Improving Communication and Public Speaking Skills

Nurse managers will learn how to develop sound communication strategies and techniques for effective public speaking.

By the end of the workshop, the learner will be able to:

1. Evaluate different communication strategies and wen to use it each one.

2. Create a speech related to a real-world problem in your work environment.

3. Present speech in front of class and listen to feedback provided by the audience.</td><td rowspan="3">I. Communication Strategies
A. Concepts and Definitions
B. Examples

II. Techniques for Effective Public Speaking
A. Prepare
B. Symptoms of fear
C. Speed and volume
D. Know your material
E. Names and facts
F. Know and listen to your audience
G. Openings and Closings

III. Videos of What <u>Not</u> To Do

IV. Create a 10-Minute Speech

V. Present Speech in Front of Class

VI. Provide Feedback to Classmates</td><td>210 minutes</td><td>Suzanne Taylor

and

a Co-Facilitator to be determined</td><td>Lecture

Videos

Develop and deliver a speech

Reflective Practice

Handouts/ Printed Materials

Question & Answer Session</td></tr>
<tr><th>Format</th><th>Resources</th><th>Transfer of Learning Monitoring</th></tr>
<tr><td>Face-to-Face

Workshop</td><td>Laptop
Projector
Screen
Podium
Microphone
Pointer
Room Set-up: Classroom Style

Breakfast & Lunch</td><td><u>During</u>:
- Provide opportunity to develop specific application plans
- Award contest

<u>After</u>:
- Implement Individual Learning Plans
- E-mail reminders
- Video submissions</td></tr>
</table>

<table>
<tr><th>Program Outcomes & Learning Objectives</th><th>Content/Topic Outline</th><th>Timeframe</th><th>Instructor</th><th>Transfer of Learning Techniques</th></tr>
<tr><td rowspan="2">Session #10:
Budgets and Fiscal Planning

Nurse managers will learn how to master basic business skills in order to improve their work environment.

By the end of the workshop, the learner will be able to:

1. Identify five budgeting principles of an effective fiscal planning process.

2. Analyze examples of budget variances and how to report them.

3. Demonstrate access to the hospital's electronic budget system and various reports.</td><td rowspan="2">I. Business Skills Overview

II. Financial Management
A. Terminology
B. Reading and Understanding Budget Reports
C. Develop a Budget
D. Monitor and Analyze Budget Variances
E. Relationships with the Finance Department

III. How to Use the Electronic Budget System
A. Kaufman Hall
B. Special Funds

IV. Human Resources
A. Identify and Develop Recruitment & Retention Programs
B. Informal and Formal Processes to Monitor Employees
C. How to Handle Conflict, Negotiation, and Delegation

V. Strategic Management</td><td>90 minutes</td><td>Suzanne Taylor

and

a Co-Facilitator to be determined</td><td>Lecture

Lunch and Learns

Suggestion Circles

Create a budget

Took Kit

Handouts/ Printed Materials

Question & Answer Session</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td>Format</td><td>Resources</td><td>Transfer of Learning Monitoring</td></tr>
<tr><td></td><td></td><td>Face-to-Face

Workshop</td><td>Laptop
Projector
Screen
Podium
Microphone
Pointer
Room Set-up: Classroom Style

Afternoon Snack</td><td><u>During</u>:
- Provide opportunity to develop specific application plans
<u>After</u>:
- Implement Individual Learning Plans
- E-mail reminders
- Portfolios
- Follow-Up sessions with Supervisor accountability</td></tr>
</table>

How To Create a Clear Action Plan for Learning Transfer

1. Participants will practice and apply their knowledge in skill practice exercises.

2. After the practice, participants will set up very clear action plans; emphasize clarity.

3. In the action plan, participants will articulate clearly and specifically what their next steps are for using the new content.

4. Participants will target key areas and focus on moving forward.

5. Participants will think about what their strengths are so that they can leverage them and keep doing what they do well.

6. Participants will mitigate the things they are not doing well that might be negatively impacting the people around them or their ability to actually use what they have just learned.

7. Participants will create a clear learning path for moving forward while focusing on their targets (Halsey, 2011, p. 129).

   When participants have completed a draft of their plan, use the checklist below to ensure the action plan focuses on the right goals, provides concrete action steps, and allows the participant to measure progress (Learning and Development Roundtable, 2006).

Category	Step	Completed
Development Goals	1. Have I shared the plan with my manager and incorporated his or her feedback?	
	2. Do I focus on skills I'll need to successfully do my job now and those I'll need to achieve my career goals?	
	3. Do I focus on continuing to build my strengths at least as much as I focus on closing any gaps?	
	4. Does this development plan push me to the edge of my "comfort zone"?	
Action Steps	5. Have I identified a clear action plan that will help me reach my development goals?	
	6. Have I made sure that at least 80% of my action steps are tied to my day-to-day job responsibilities and project assignments and fewer than 20% are training programs?	
Success Measures	7. Have I shared by development goals with others so I can measure my progress along the way?	
	8. Have I created realistic and achievable metrics to measure my progress?	
	9. Have I tied the metrics to realistic deadlines to assess my progress?	
	10. Have I created milestones to ensure I'm on track?	

Informal Transfer of Learning Strategies

- E-mail reminders
- Buddy up for accountability
- Success case studies/stories
- Business impact contest; show results in action
- Giving each person a buddy
- Getting managers/supervisors involved
- Letter to self - mailing a letter the attendees wrote themselves during the educational intervention with their intentions/goals
- Awards contests for best use
- Podcast follow-ups
- E-freshers in virtual classrooms (30 minute drill downs on key concepts)
- User teams
- Job aids as a reminder
- Phone review sessions
- Posters with key model, strategies
- "Tip of the Week"
- Lunch and Learns
- Video contest
- Coffee chat time
- Interviews with stars in newsletter
- Peer nominations for awards
- Team support groups
- Have an impromptu picnic or meet for lunch
- Survey Monkey - Ask "What has been the value of this learning?"
- Conference call - Ask "How have you been applying this learning?"
- Video encounter

Example of a Course Evaluation to Measure *Reaction* (Level 1)

[redacted]

COURSE EVALUATION

Title of Class: Advanced Workshop for Nurse Managers **Date: 09/21/2015**

Circle the number that best describes your evaluation of that item:

		POOR					EXCELLENT
1.	Course met stated learning objectives	*1*	*2*	*3*	*4*	*5*	*6*
2.	*Class content*	*1*	*2*	*3*	*4*	*5*	*6*
3.	*Did the handout:*						
	a. help in note taking?	*1*	*2*	*3*	*4*	*5*	*6*
	b. facilitate learning of the material?	*1*	*2*	*3*	*4*	*5*	*6*
4.	*Audiovisual/Use of Technology*	*1*	*2*	*3*	*4*	*5*	*6*
5.	*Teaching Methods Appropriate*	*1*	*2*	*3*	*4*	*5*	*6*
6.	*New information is applicable/useable*	*1*	*2*	*3*	*4*	*5*	*6*
7.	*Relevance to my practice*	*1*	*2*	*3*	*4*	*5*	*6*
8.	*Suzanne's mastery of subject & teaching methods*	*1*	*2*	*3*	*4*	*5*	*6*
9.	*Overall presentation*	*1*	*2*	*3*	*4*	*5*	*6*

10. What did you get out of the experiences you had in this workshop?

11. What ideas/suggestions are you taking away from today's workshop?

12. Describe how you plan to utilize the advanced workshop material. (What are possible problems/issues in your area that you could use leadership strategies to problem-solve?)

13. General comments and/or suggestions for improvement of the workshop:

Sample Test to Evaluate *Learning* (Level 2)

Advanced Workshop for Nurse Managers

Session #1: Experiential Learning

1. True or False
   - T or F Games are not intended to present new knowledge but to complement and reinforce present knowledge
   - T or F Games are fun with a purpose
   - T or F Games give learners valuable feedback
   - T or F Games give trainers feedback
   - T or F Games are experiential
   - T or F Games motivate learners
   - T or F Games improve teamwork
   - T or F Games lower the threat level in the learning environment
   - T or F Games reveal real-world relevance
   - T or F Games accelerate learning
   - T or F Games give you choices in your classroom

2. Circle the advantages of using games as a teaching strategy.
   1. Creates community among learners
   2. Enhances learners' critical thinking abilities
   3. Promotes active, learning-centered activities to solve problems collectively
   4. Promotes learning in a non-threatening environment
   5. Allows the person to learn through experience of real work problems
   6. Reduces the risk of failure

3. Which is <u>not</u> a disadvantage of using games as a teaching strategy.
   1. The length of time and effort required to design games appropriate to most learning situations.
   2. Because learners differ in the learning styles, they may not learn equally from games.
   3. Provides open-ended opportunities.
   4. An increased risk exists when the participants experience untoward reactions and uncontrollable emotions. These reactions are especially noticeable in games that involve competition.
   5. Reinforces understanding.
   6. The unsuitability of reusing identical games with the same participants once the content becomes familiar.

4. List the steps in the *Assure Model of Instruction*:
   - **A**_____
   - **S**_____
   - **S**_____
   - **U**_____
   - **R**_____
   - **E**_____

Example of a Portfolio Rubric to Evaluate *Behavior* (Level 3)

	Proficient - 3 (Consistent, convincing evidence)	Basic - 2 (Evidence uneven in depth and scope)	Insufficient - 1 (No evidence)
Title Page	Indicates the name of the portfolio owner; is kept simple and uncluttered.	Title page contains too much information and is cluttered or chaotic.	Title page is missing.
Table of Contents	Lists each section of the portfolio. In an electronic form, this page can provide the links to each section.	Some sections are missing; no section page numbers have been provided. If electronic, no section links are provided.	Table of Contents is missing.
Qualifications and Experience	Some biographical data may be included. Details of relevant qualifications, including a current CV.	Incomplete biographical data and/or missing current CV.	No qualifications and experience are listed.
Philosophy of Leadership	The leadership philosophy is a statement of a manager's beliefs, values, and attitudes toward leadership and management.	Leadership philosophy is incomplete or lacking substance (e.g., manager's beliefs, values, and attitudes).	Philosophy of Leadership is missing.
Use of Curriculum Development, Experiential Learning, Adult Learning Theories, Public Speaking, Budget Development, Leading Discussions	Courses developed Courses taught Course materials Course evaluations Involvement with curriculum design and four levels of evaluation	Incomplete coursework is included; few examples of courses taught, materials used and evaluations were provided.	There is no listing of coursework.
Appendices	The evidence to support the claims made in the portfolio will be listed in this section. Some examples include: Papers Presented Poster Presentations	Some appendices are missing; only partial evidence is included to support claims previously made in the portfolio.	No appendices are included.

(Ohio State University, 2013; Reece et al., 2001; Sinclair, Bowen, & Donkin, 2013)

Example of Methods to Evaluate *Results* (Level 4)

Focus Group Questions for Stakeholders

1. Have you noticed any change in the nurse managers during the past six months in regard to their proficiency and efficacy in leadership strategies with their staff? If so, please provide specifics.

2. To what degree do you attribute the change to the nurse manager's learning and teaching environment to the advanced workshop your nurse manager went through? What makes you think the training workshop had something to do with the change?

Quick Win Score Sheet for Personal Chats with Participants

1. What are you doing differently as a result of what you have learned from the advanced workshop? Have you noticed a change in how you lead your staff? (Please provide specifics).

_____

_____

_____

2. Have these actions improved:

a. Your effectiveness as a leader? Yes _____ No _____ Not sure _____
b. Your staff's learning? Yes _____ No _____ Not sure _____
c. Your unit/department's performance? Yes _____ No _____ Not sure _____

3. If you feel that your actions have improved education in your learning environment, please indicate in what areas:

_____ Curriculum development
_____ Incorporating games and interactive teaching strategies
_____ Facilitating group discussions
List other topics as appropriate

4. What other benefits have you realized so far from the advanced workshop?

_____

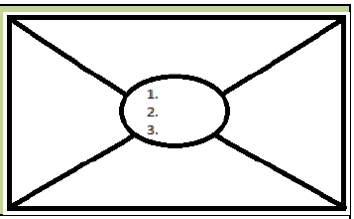
_____

_____

Four Level Evaluation Data Collection - Action Plan

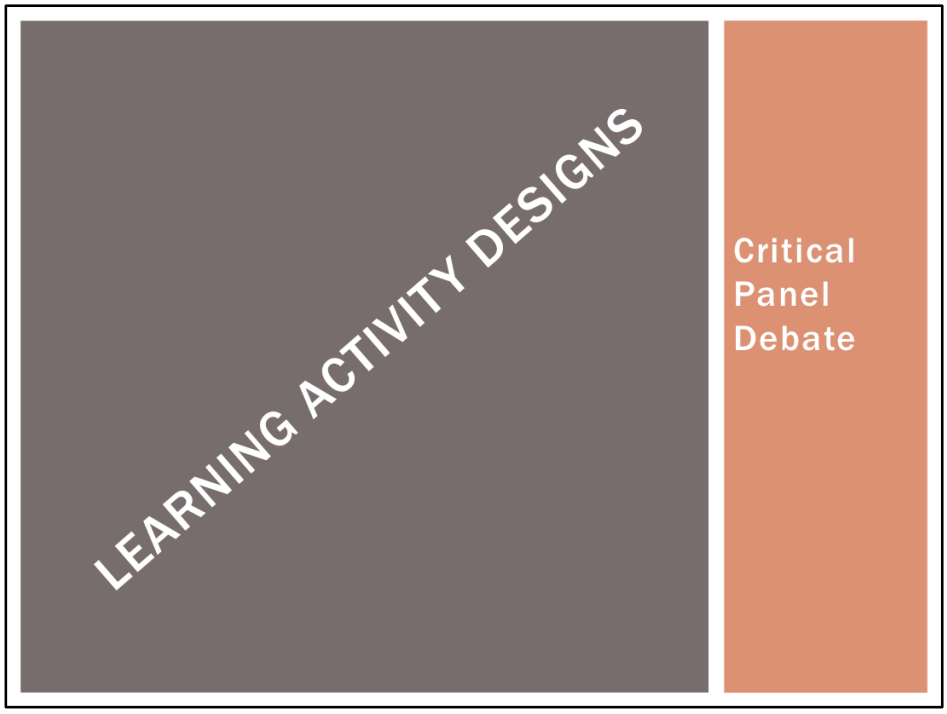
Level 1 **Reaction**	**What is Collected** How participants reacted to the workshop; customer satisfaction	**How Collected/What Technique** Questionnaire
From Whom/Data Sources Workshop Participants	**When Collected and By Whom** At the end of the workshop; by the course organizer	**How Data are to be Analyzed** Frequency Counts Means Narrative Patterns & Themes Constant-Comparative Method
Level 2 **Learning**	**What is Collected** What knowledge was learned, what skills were developed and what attitudes were changed	**How Collected/What Technique** Test/Survey
From Whom/Data Sources Workshop Participants	**When Collected and By Whom** At the end of the workshop; by the course organizer	**How Data are to be Analyzed** Percentages of Correct Test Answers
Level 3 **Behavior**	**What is Collected** What change in behavior has occurred because of attending the training program	**How Collected/What Technique** Portfolio
From Whom/Data Sources Workshop Participants	**When Collected and By Whom** Between 6 months to one year depending on the opportunities found in the working environment; by the course organizer	**How Data are to be Analyzed** Work Review Descriptive Rubric
Level 4 **Results**	**What is Collected** Final outcomes that occurred because the nurse managers participated in the workshop	**How Collected/What Technique** Focus Groups Personal Interviews/Chats
From Whom/Data Sources Stakeholders Workshop Participants	**When Collected and By Whom** Between 6 months to one year depending on the opportunities found in the working environment; by the course organizer	**How Data are to be Analyzed** Narrative Patterns & Themes for Changes or Differences

Instructor Notes for Consensus Boards Learning Task

Task Completed	Task 
☐	Strategically place pre-drawn board diagrams on post-it or flip chart paper (per the format shown in the picture above) around the classroom leaving enough space between the boards conducive for group work. Place 4 markers at each board.
☐	Divide the class into groups of four and have them move to gather around a board located around the classroom. If there are an uneven number of learners, it is ok for some groups to have 3 participants instead of 4.
☐	Announce assignment to the entire group: 1. *Identify five learning activity designs that speak to you personally. Which ones do you like and would use for a learning activity?* 2. *What are the advantages and disadvantages of each?* 3. *Brainstorm your ideas individually on your section of the paper.* 4. *Then share your ideas to reach a group consensus of the three most important designs you have learned. These should be listed in the center of the consensus board.* 5. *Report out to the whole class your top three choices and be prepared to justify why these were selected.*
☐	Each student takes a section of the board (post-it or flip chart paper) where he or she writes about information learned about learning activity designs.
☐	After each learner has individually filled their quadrant with learning activity design information, the group will share their ideas in order to reach a group consensus on the top 3 ideas to write in the middle of the board.
☐	Have each group report out to the larger group their top three choices and why they selected these designs.
☐	Wrap up learning activity with a brief discussion on the similarities and/or differences found within the groups. Ask for learner input on what they perceived (e.g., could differences be contributed to learning styles, etc.).

(Hsu & Malkin, 2011)

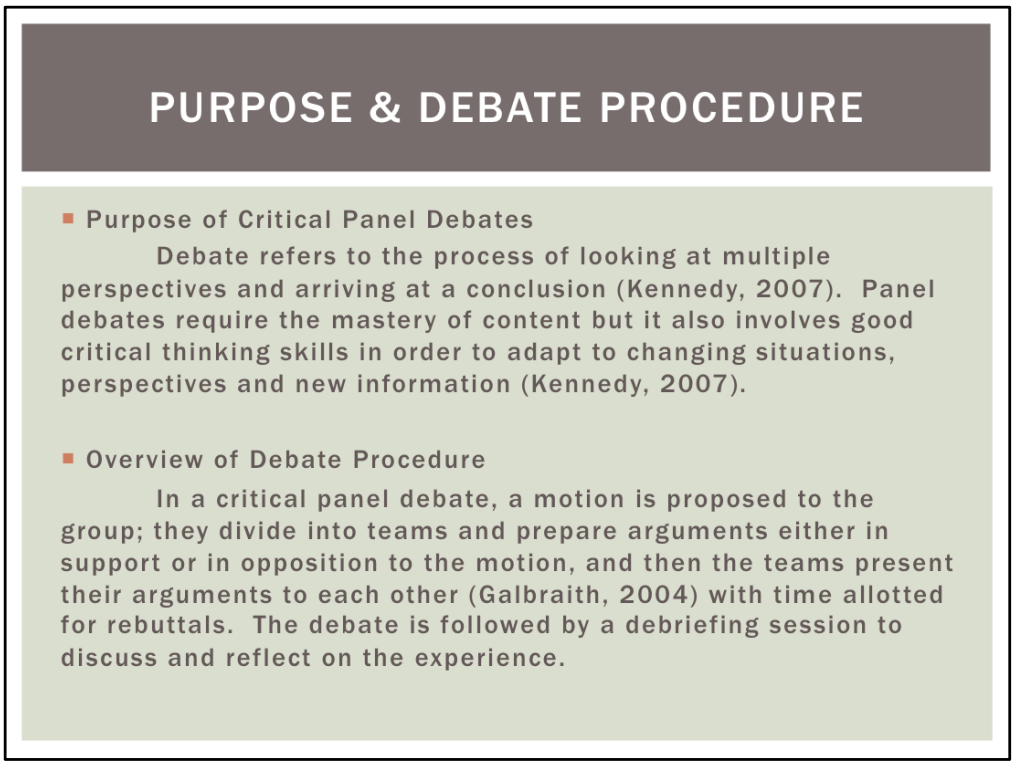
Instructor Notes for Critical Panel Debate Learning Task



Notes to Instructors:

The Critical Panel Debate is organized through a power point presentation wherein each slide represents a task to be completed by the instructor and/or learner. The power point serves as a visual organizer so each member of the large group will know exactly what is going on and expected of them at any given moment during the critical panel debate.

It is advisable to have access to additional facilitators if needed during the debate. As the size of group increases, it will be necessary to have other facilitators available to help in the classroom to manage the multiple tasks required of a larger group.



Notes to Instructors: Overview of Debate Procedure

1. Find a contentious issue that would cause a divided opinion among the group.

2. Frame the issue as a debate motion:
    - *Debate the advantages and disadvantages of three (or four, depending on size of group) learning activity designs.*

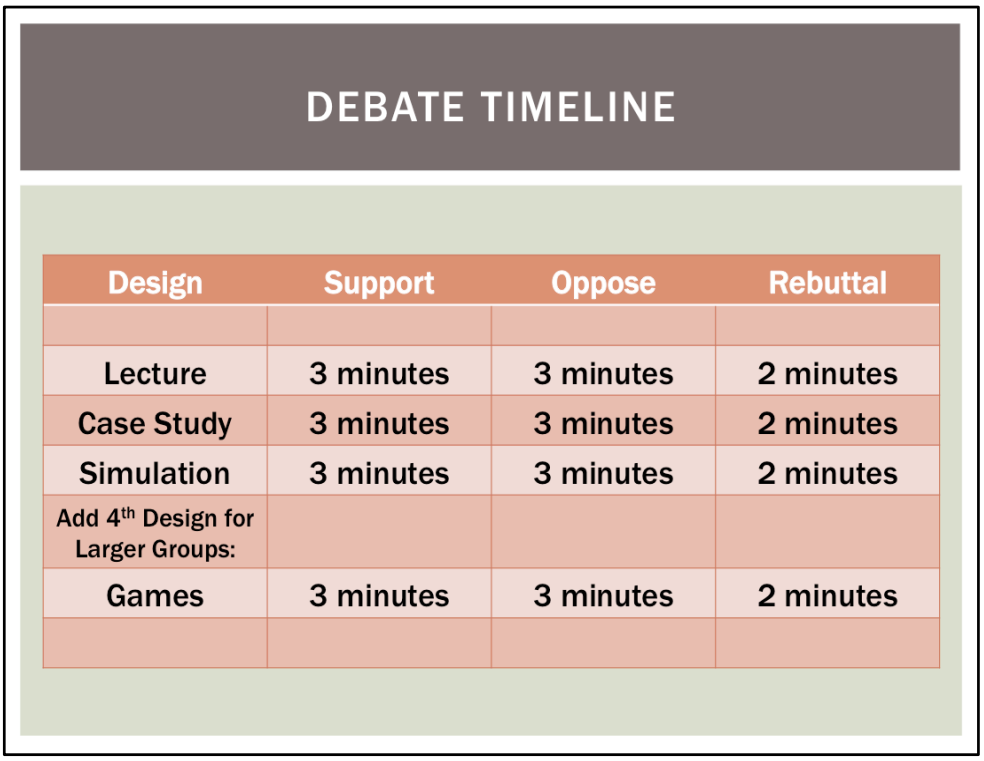
3. *Divide the large group into sub-groups supporting and opposing learning activity designs.*

4. *Prepare for the debate.*

5. *Conduct the debate.*
    - *Support*
    - *Oppose*
    - *Rebuttal*

6. *Debrief the debate.*

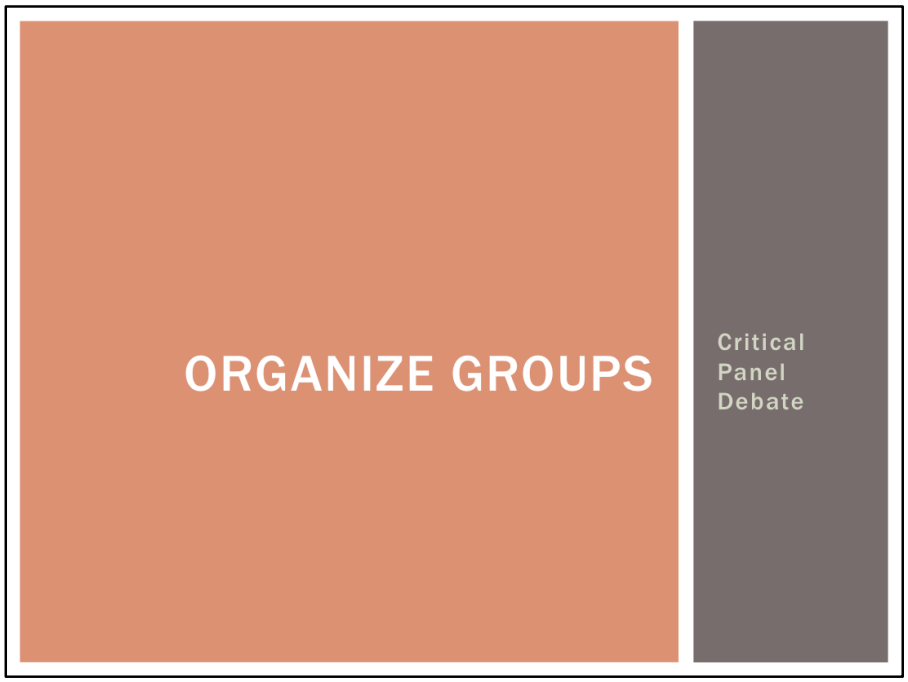
7. *Reflection and evaluation (Galbraith, 2004).*



Notes to Instructors:

Timeline based on 60 or 80 participants:

	60	80
Propose motion to learners; explain process and procedure	10 min	10 min
Organize groups	5 min	5 min
Group preparation of case	25 min	25 min
Conduct the debate	30 min	40 min
Debrief the debate	10 min	15 min
Total Time	80 min	95 min



Notes to Instructors:

Depending on the group size, different configurations can be made to accommodate a critical panel debate. For example:

60 Participants:

Lecture
10 Support/10 Oppose
Case Study
10 Support/10 Oppose
Simulation
10 Support/10 Oppose

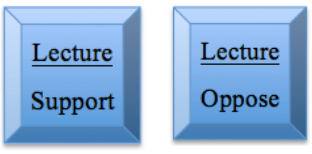
Totals: 30 Support/30 Oppose

80 Participants:

Lecture
10 Support/10 Oppose
Case Study
10 Support/10 Oppose
Simulation
10 Support/10 Oppose
Games
10 Support/10 Oppose

Totals: 40 Support/40 Oppose

Randomly distribute pre-prepared index cards assigning participants to either a support or oppose group for the lecture, case study, simulation and games learning activity designs. For example:



Notes to Instructors:

All participants need to move to different parts of the classroom and meet in their assigned subgroup.

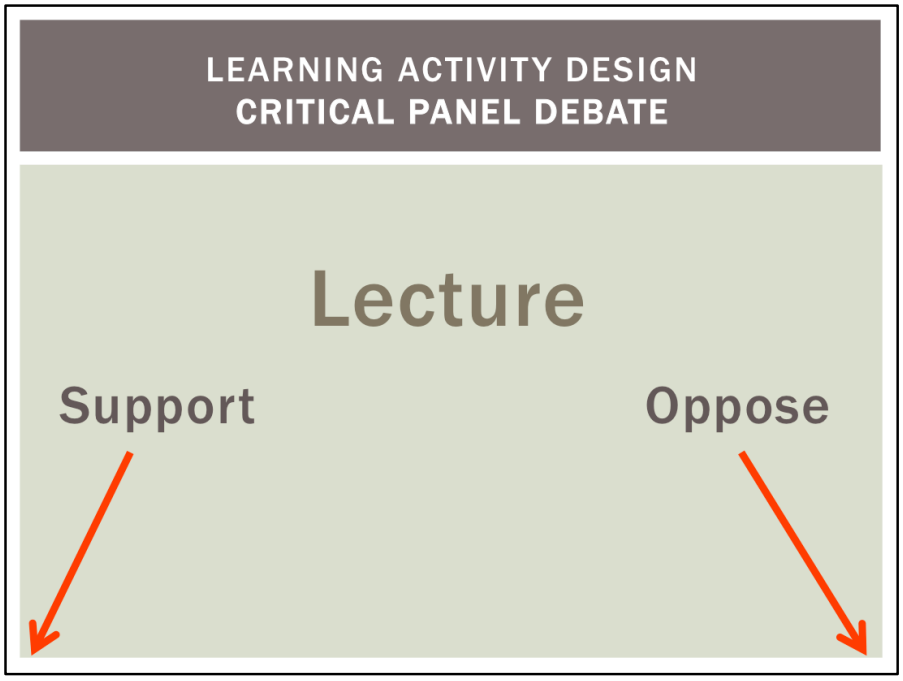
The 10 members of each group will have 25 minutes to prepare their case for debate.

Participants may use course material, handouts, or any other resources (e.g., the internet, iPad, laptop) to develop their case.

Each group will select three members who will present their case in front of the class at the designated time.

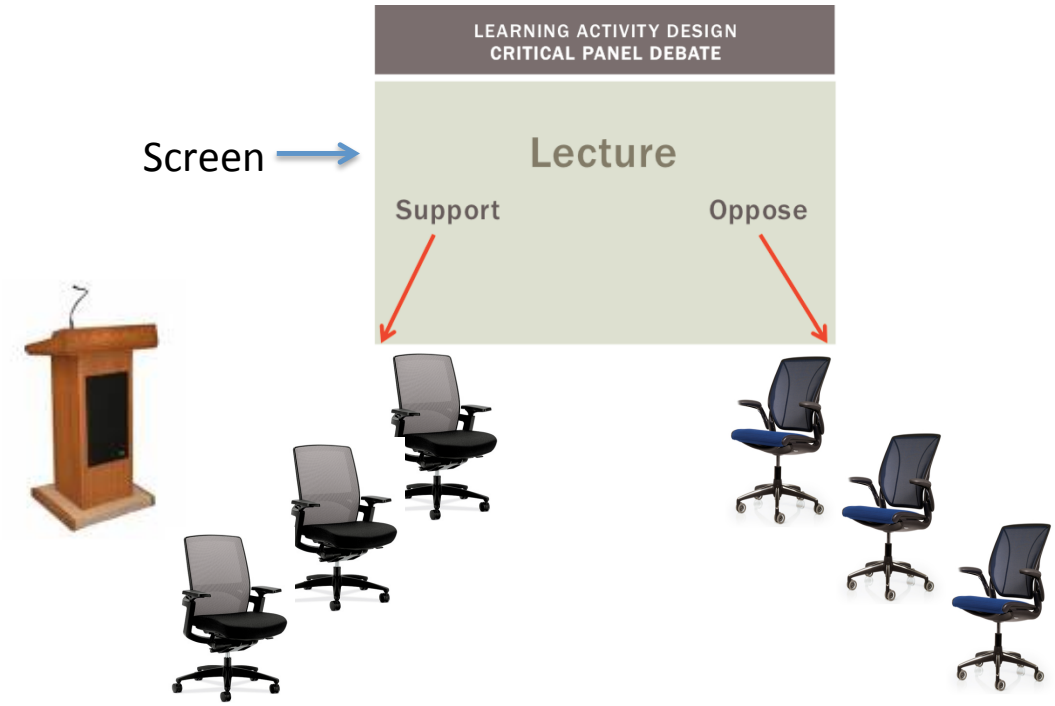
Group presenters may use notes and take notes during their presentation and rebuttal.

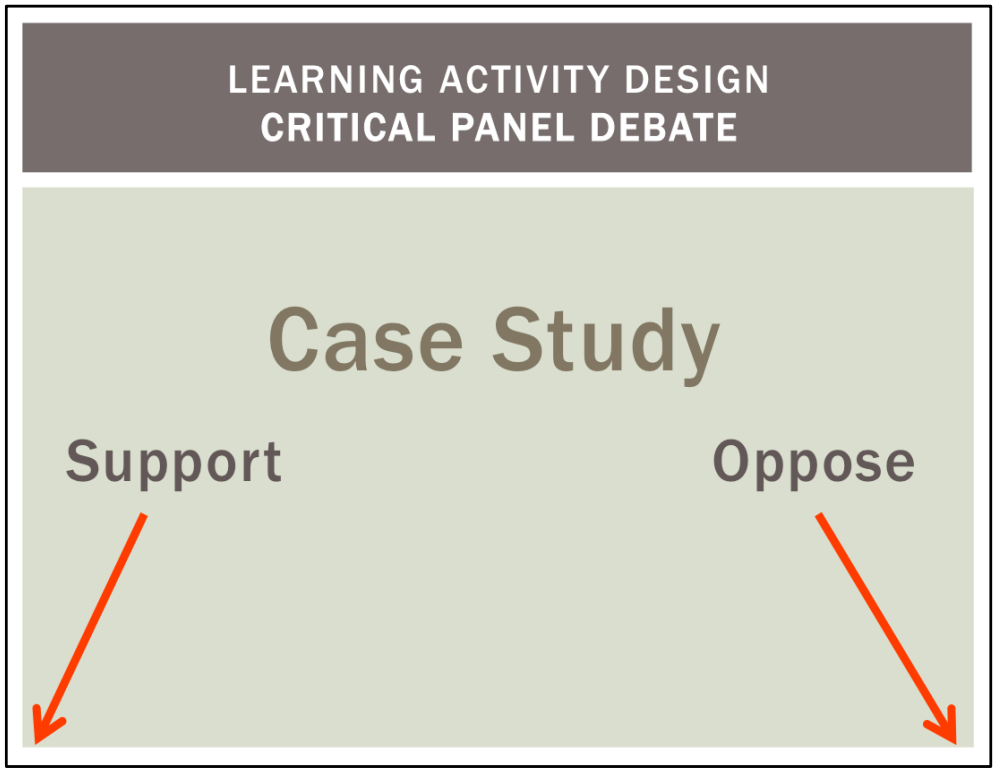
Each group will have three minutes to present a supporting case, three minutes to present an opposing case and two minutes for a combined rebuttal for each learning activity design.



Notes to Instructors:

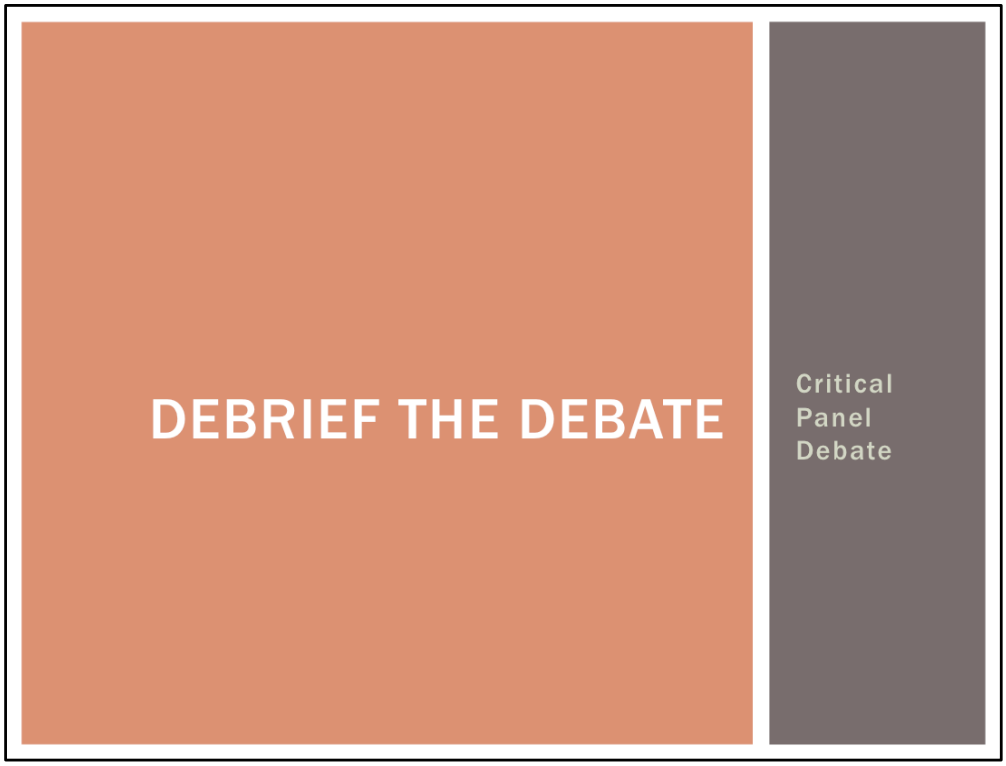
The classroom will have one large screen for the power point projection. Arrange chairs as follows to organize the panel debate:





Notes to Instructors:

Continue in same fashion as previous slide setting up each learning design for case study, simulation and games. Each design will have its own power point slide in order to organize each section of the debate.



Notes to the Instructors:

Discuss with participants their experience with the debate.

- How did it feel to argue against positions you didn't agree with?
- What new ways of thinking about the learning activity designs were opened up?
- Did you come to new understandings regarding the designs?
- Did it change your mind on the value of a particular design? If so, why?
- In what ways were your existing assumptions challenged by the debate?

(Galbraith, 2004)

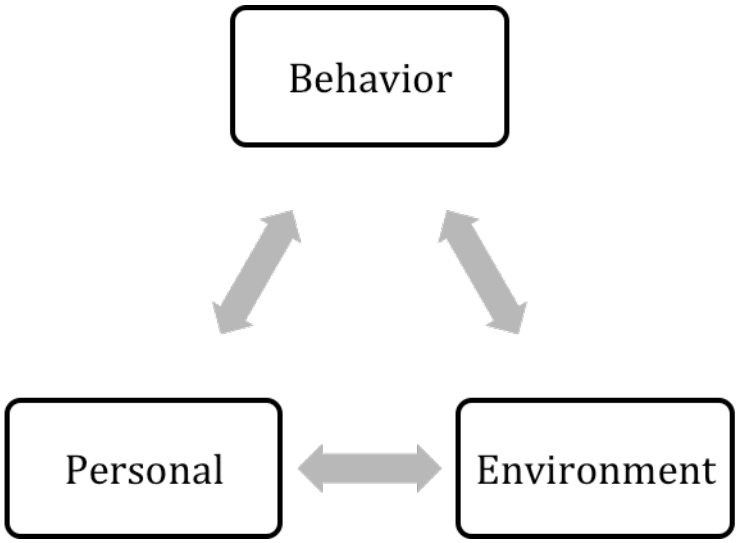
Appendix B: Staff Issues Regarding Training and Classes

From: [redacted]
Sent: Thursday, July 03, 2014 6:40
To: Taylor, Suzanne
Subject: Issues about training and classes

- Never any education on nights
- All education is during the day, hard to get off the floor, hard to get coverage
- The Noon PCS Grand Rounds are catered to managers and not the staff
- Ridiculous to drive in for a 30-60minute education
- I wish that they could do 4 PCS Grand Rounds back to back – I would drive in for 4 hours of education
- I am the only one in my department so I can't leave for in-service training or classes unless I get coverage
- It is easier for night shift to stay over for an am class but the managers get mad about paying double time
- Not enough resources on nights to get coverage so get off the unit to attend training or classes
- As a night shift employee if we come in for a day long class, we lose at least 2 days of work since we can't work the night before or the night of the class
- I actually prefer to do education on CHEX or any computer system, and then I can do it at my pace and when my schedule allows
- I would get more involved in committee's and projects if they offered more support on nights
- The Sim Center is not in an ideal location for us to get to when we are working, takes too long to get there
- Education should happen on the unit to allow more people to attend and less distance to travel
- Manager's need to cover the unit to allow us to get to mandatory training, otherwise we are out of compliance with ratio's or we just don't attend
- I feel like I am told to use my lunch/break time to attend a class or training, I don't think that is fair

[redacted]

Appendix C: Triadic Reciprocal Causation of Social Cognitive Theory



Behavior (of the person)

- Incentives (value of outcome)
- Expectancies (powerful influence on behavior)
  1. Environmental cues (ability to perform behavior)
  2. Outcome (expected results of behavior)
  3. Self-efficacy
     - Performance accomplishments (mastery)
     - Vicarious experiences
     - Verbal persuasion
     - Physiological state (emotional arousal)

Personal & Cognitive Factors

Self-efficacy beliefs
- Cognitive (knowledge and the skills for acting on that knowledge)
- Motivational (self-motivation, purposive action)
- Affective (anxiety, frustration, depression)
- Selection processes (biological events, action)

Self-regulation
- Self-observation (deliberate attention to one's behavior)
- Self-judgment (comparison of present performance with goals)
- Self-reaction

Personality

Physical characteristics (age, sex, race, size, physical attractiveness)

Environment (within which the behavior is performed)

Modeling

Instruction

Social Persuasion

Appendix D: Deterrents to Participation in CPD Education

- I don't always have the discipline to set my learning priorities.
- It was often difficult to arrange for childcare.
- I tend not to be much of a participant in outside activities.
- Sometimes I lack confidence in my learning abilities.
- My family/spouse objects to my outside activities.
- The programs tend to be geared to the wrong level (too high or too low).
- My employer does not assist with the cost of attending such programs.
- I'm not willing to sacrifice what little leisure time I have.
- Attending these programs usually means a loss of income for me.
- Sometimes I just don't have the energy or stamina.
- Sometimes I'm just tired of lectures and formal schooling.
- The programs tend to be of poor quality.
- I don't like to attend programs alone.
- I tend to feel guilty when I spend time away from my home/family.
- There is little encouragement for participation from my peers.
- The methods of instruction used in the programs are unsatisfactory for me.
- I tend not to be active in professional affairs.
- I am already attending too many meetings.
- I generally do not find participation in these programs to be personally satisfying.
- I'm already getting a bit burned out.
- I don't always have the discipline to set my learning priorities.
- I generally keep up-to-date on my own.
- Other things happen to have a higher priority in my life.
- My previous experiences with these programs have been disappointing.
- The program content was not relevant to my practice needs.
- There are few incentives or rewards for my participation.
- There are no monetary benefits to be gained by my attendance.
- I can't afford the registration or course fee.
- I was unaware of the availability of the program.
- There are better things to spend my time or money on.
- Attendance generally infringes upon my family time.
- The programs were scheduled at inconvenient times.
- The program sponsors had a poor reputation.
- There was insufficient lead time prior to the program to make arrangements.
- What's available tends not to fit my schedule.
- The indirect costs (food, travel, etc.) tend to be excessive.
- The program locations are often inconvenient.
- A majority of my learning needs are satisfied by on-the-job or in-service education.
- With all my other commitments, I just don't have the time.
- It is difficult to get others to cover for me in my absence.
- The demands of my practice (patient load/schedule) leave no time. (Fahnestock, 2012)

Appendix E: Recruitment Email for Nurses

Recruitment of Nurse Participants for Research Study

Taylor, Suzanne
Sent: Friday, October 24, 2014 16:24
To: [redacted]Nurses
Attachments: Consent Form with [redacted]App~1.pdf (134 KB)

I will be conducting a research study at [redacted]s partial fulfillment of the requirements for the degree of Doctor of Education. I am looking for nurses who would like to participate in my study. The purpose of this study is to develop research-based descriptions of the perceptions of pediatric nurses regarding continuing professional development opportunities at [redacted]to develop evidence based continuing professional development programs and course offerings.

I am looking for nurses who would like to participate as follows:

- **Focus Groups** - I would like for thirty (30) nurses to volunteer for the following focus groups:
  - 10 **night shift nurses** for a morning focus group that will be conducted on Thursday, November 6 from 5-6am in the Northern Trust Conference Room. Breakfast will be provided.
  - 10 **day shift nurses** for a lunch time focus group that will be conducted on Tuesday, November 11 from 1:30-2:30pm in the Stauffer A Conference Room. Lunch will be provided.
  - 10 **nurse managers** for a lunch time focus group that will be conducted on Wednesday, November 5 from 12:30-1:30pm in the Holden Conference Room. Lunch will be provided.
- **Interviews** – I would like for ten (10) nurses to volunteer to participate in one-on-one (face-to-face) interviews. The interviews will be conducted separately at a time convenient and mutually agreed upon with each of the interview participants.

If you would like to participate in any of the categories outlined above, please contact me and sign up for one of the focus groups or interviews. For more information about the research study and to view the Informed Consent, please see the document attached to this email.

Suzanne Taylor, EdDc, MSN, RN-BC
[redacted]

Appendix F: Letter of Cooperation from a Community Research Partner

[redacted]

[redacted]

September 22, 2014

Dear Suzanne Taylor,

Based on my review of your research proposal, I give permission for you to conduct the study entitled *Pediatric Nurses' Perceptions of Continuing Professional Development Opportunities* within [redacted]. As part of this study, I authorize you to email [redacted] conduct focus groups and interviews with the nurses, and disseminate the results to the nurses, managers/directors and the executive team of the hospital. Individuals' participation will be voluntary and at their own discretion.

We understand that our organization's responsibilities include providing: (a) email addresses of all nurses currently employed, and (b) a quiet room for the focus groups and interviews within a one-week period of time. We reserve the right to withdraw from the study at any time if our circumstances change.

I confirm that I am authorized to approve research in this setting.

I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the research team without permission from the Walden University IRB and [redacted]

Sincerely,

[redacted]

[redacted]

Appendix G: Human Research Protection Training Course

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI)

HUMAN RESEARCH CURRICULUM COMPLETION REPORT

Printed on 01/18/2014

LEARNER	Suzanne Taylor [redacted]
DEPARTMENT	[redacted]
PHONE	
EMAIL	
INSTITUTION	
EXPIRATION DATE	04/12/2016

SOCIAL/BEHAVIORAL : Researchers and research staff (including faculty, staff, and students) who are engaged, primarily or exclusively, in research in the Social and/or Behavioral Sciences.

COURSE/STAGE:	Refresher Course/2
PASSED ON:	04/13/2013
REFERENCE ID:	10165319

REQUIRED MODULES	DATE COMPLETED
Defining Research with Human Subjects - SBE	04/13/13
The Regulations - SBE	04/13/13
Assessing Risk - SBE	04/13/13
Informed Consent - SBE	04/13/13
Privacy and Confidentiality - SBE	04/13/13
Research with Prisoners - SBE	04/13/13
Research and HIPAA Privacy Protections	04/13/13
Unanticipated Problems and Reporting Requirements in Social and Behavioral Research	04/13/13

For this Completion Report to be valid, the learner listed above must be affiliated with a CITI Program participating institution or be a paid Independent Learner. Falsified information and unauthorized use of the CITI Progam course site is unethical, and may be considered research misconduct by your institution.

Paul Braunschweiger Ph.D.
Professor, University of Miami
Director Office of Research Education
CITI Program Course Coordinator

Appendix H: Focus Group Guide

Topic: Pediatric Nurses' Perceptions of Continuing Professional Development Opportunities
Time of Focus Group: TBD
Date: TBD
Place: TBD
Moderator: Suzanne Taylor
Focus Group Participants: Night Shift Nurses
Position of Participant: Registered Nurse at [redacted]

The purpose of this case study is to develop research based descriptions of the perceptions of pediatric nurses regarding continuing professional development opportunities a[redacted] in order to develop evidence based CPD programs and course offerings. I will ask you six questions about your perceptions of CPD opportunities at [redacted], which should take approximately 60 minutes for focus groups. You have been given an informed consent form that outlines the study. I will digitally record our conversation and produce transcripts for the research study. I will not release your name to protect your identity and the data will be stored in a password-protected laptop.

Review the Consent Form with participant; answer any questions; have participant sign the consent form.
Turn on the digital voice recorder.

Questions:

1. What kind of CPD activities do you participate in?
2. What factors influence and contribute to your participation in CPD?
3. What are reasons/barriers for your nonparticipation?
4. How do you perceive the adequacy and quality of CPD courses/programs offered by the hospital? Please give me some examples.
5. How do you perceive the knowledge obtained from CPD being incorporated into your practice? Please give me some examples.
6. How do you perceive that CPD improves the professional practice of nursing and patient outcomes at [redacted]? Please give me some examples.

Thank the participant for his/her cooperation and participation in this focus group.

Appendix I: Tips and Guidelines for Conducting Focus Groups

Physical Arrangement of the Group

- Seat the group in a way that has maximum opportunity for eye contact.
- A circular set up is preferred.
- Most participants feel more comfortable when seated around a table.

Two Roles of the Moderator

- Passive, non-directive approach where the moderator asks only enough questions or probes on a limited basis to keep a discussion going.
- Directive and active; moderator is very involved with the direction of the discussion and exercises considerable control with structured and a highly ordered set of questions.

Purpose of Focus Groups

- The purpose of this focus group is to gain insight into pediatric nurses' perceptions of continuing professional development opportunities at [redacted].
- I need your input and want you to share your honest and open thoughts.

Continuing Professional Development - What do I mean?

- Lifelong learning
- Continuing education
- Continuing professional development
- Staff Development
- Education is continuous learning

Ground Rules

- I want you to do the talking.
  - I would like everyone to participate.
  - I may call on you if I have not heard from you in a while.
- There are no right or wrong answers.
  - Every person's experiences and opinions are valuable.
  - Speak up whether you agree or disagree.
  - I want to hear a wide range of opinions
- What is said in this room stays here.
  - I want everyone to feel comfortable sharing when sensitive issues come up.

Beginning the Interview

- The moderator should attempt to create an atmosphere of trust and openness.
- The moderator should establish the agenda for the discussion and outline ground rules for the session.
- Introductions of group members are a good way to build rapport and a sense of group cohesion.
- After the introductions are completed, the moderator should introduce the topic for discussion.
- Introduce the topic in its most general form and leave more specific questions and issues for later questioning; move from the general to the specific.

Ensure Participation

- Encourage all members of the group to speak.
- Make the participants feel that their presence and opinions are not only valued but they are necessary for the success of the group.
- Ask shy members to speak if they have not spoken during the first half of the focus group.

Time Management

- The moderator must gage the extent to which a topic has been exhausted and further discussion will yield little new information.
- Knowledge of the relative importance of various specific questions to the research agenda is also helpful because it provides some guidance with respect to the amount of time that should be devoted to each question and which ones might be eliminated if time runs short.
- End the focus group at the previously determined time.

Probing

- "What I heard you say was . . . "
- "Tell me more."
- "I don't quite understand. Can you explain what you mean?"
- Ask for an illustration, an example, or a story.
- "Does anyone have an example of that?"
- "Is this anyone else's experience?"
- "Does anyone have a similar (different) perspective?"
- "Can you show me?"
- "Tell me what it is like."
- "You look puzzled. Why? What don't you understand?"

Appendix J: Interview Guide

Topic: Pediatric Nurses' Perceptions of Continuing Professional Development Opportunities
Time of Interview: TBD
Date: TBD
Place: TBD
Interviewer: Suzanne Taylor
Interviewee: TBD
Position of Interviewee: Registered Nurse at [redacted]

The purpose of this case study is to develop research based descriptions of the perceptions of pediatric nurses regarding continuing professional development opportunities a[redacted]n order to develop evidence based CPD programs and course offerings. I will ask you eight questions about your perceptions of CPD opportunities at[redacted], which should take approximately 30 minutes. You have been given an informed consent form that outlines the study. I will digitally record our conversation and produce transcripts for the research study. I will not release your name to protect your identity and the data will be stored in a password-protected laptop.

Review the Consent Form with participant; answer any questions; have participant sign the consent form. Turn on the digital voice recorder.

Questions:

1. What kind of CPD activities do you participate in?
2. What factors influence and contribute to your participation in CPD?
3. What are reasons/barriers for your nonparticipation?
4. How do you perceive the adequacy and quality of CPD courses/programs offered by the hospital? Please give me some examples.
5. How do you perceive the knowledge obtained from CPD being incorporated into your practice? Please give me some examples.
6. How do you perceive that CPD improves the professional practice of nursing and patient outcomes at[redacted]? Please give me some examples.
7. How do you perceive that CPD provides new knowledge, skills, and competencies to manage changing patient population needs?
8. What are your perceptions of the mechanisms that would enable effective implementation of lifelong learning?

Thank the participant for his/her cooperation and participation in this interview.

What items came up in this interview that would be worth following up on during subsequent interviews?
(a) _____
(b) _____
(c) _____
(d) _____

Appendix K: Confidentiality Agreement Form - Transcription

Confidentiality Agreement Form

Name of Signer:

Administrative Secretary: [redacted]

During the course of my activity in collecting data for this research: *Pediatric Nurses' Perceptions of Continuing Professional Development Opportunities*, I will have access to information, which is confidential and should not be disclosed. I acknowledge that the information must remain confidential, and that improper disclosure of confidential information can be damaging to the participant.

By signing this Confidentiality Agreement I acknowledge and agree that:

1. I will not disclose or discuss any confidential information with others, including friends or family.
2. I will not in any way divulge, copy, release, sell, loan, alter or destroy any confidential information except as properly authorized.
3. I will not discuss confidential information where others can overhear the conversation. I understand that it is not acceptable to discuss confidential information even if the participant's name is not used.
4. I will not make any unauthorized transmissions, inquiries, modification or purging of confidential information.
5. I agree that my obligations under this agreement will continue after termination of the job that I will perform.
6. I understand that violation of this agreement will have legal implications.
7. I will only access or use systems or devices I'm officially authorized to access and I will not demonstrate the operation or function of systems or devices to unauthorized individuals.

Signing this document, I acknowledge that I have read the agreement and I agree to comply with all the terms and conditions stated above.

Signature: [redacted] Date: 9/22/14

Appendix L: Coordination of Transcription, Member Checks and Coding

Focus Group or Interview	iPhone Recording ID#	Sony Recording ID#	Approximate Audio Length	Typed By	Date Completed	Reviewed for Accuracy	Sent to Participants (Member Check)	Coded in *NVivo*
Focus Group #1: Nurse Managers	20141105 123206.m4a	141105_003.mp3	1 hr 10 min	Suzanne	11/08/2014	✓	11/17/2014	✓
Focus Group #2: Night Shift Nurses	20141106 050828.m4a	141106_001.mp3	58 min	Suzanne	11/9/2014	✓	11/17/2014	✓
Focus Group #3: Day Shift Nurses	20141111 133201.m4a	141111_001.mp3	1 hr	Suzanne & Doris	11/14/2014	✓	11/17/2014	✓
Interview #1: [redacted]	20141030 152320.m4a	N/A	34 min	Doris	11/6/2014	✓	11/17/2014	✓
Interview #2: [redacted]	20141107 073231.m4a	141107_001.mp3	38 min	Doris	11/14/2014	✓	11/17/2014	✓
Interview #3: [redacted]	20141107 082937.m4a	141107_002.mp3	22 min	Crystal	11/18/2014	✓	11/18/2014	✓
Interview #4: [redacted]	20141107 093102.m4a	141107_003.mp3	31 min	Doris	11/19/2014	✓	11/19/2014	✓
Interview #5: [redacted]	20141107 100542.m4a	141107_004.mp3	55 min	Crystal	11/18/2014	✓	11/18/2014	✓
Interview #6: [redacted]	20141110 060504.m4a	141110_003.mp3	40 min	Suzanne	11/16/2014	✓	11/17/2014	✓
Interview #7: [redacted]	20141112 131853.m4a	141112_002.mp3	36 min	Suzanne	11/15/2014	✓	11/17/2014	✓
Interview #8: [redacted]	20141110 142957	141110_005.mp3	24 min	Suzanne	11/16/2014	✓	11/17/2014	✓
Interview #9: [redacted]	20141111 110349	141111_002.mp3	45 min/23 min (Sony stopped recording)	Suzanne	11/15/2014	✓	11/17/2014	✓
Interview #10: [redacted]	20141111 084035	141111_001.mp3	28 min	Doris	11/20/2014	✓	11/20/2014	✓

Appendix M: Data Use Agreement

Data Use Agreement

This Data Use Agreement ("Agreement"), effective as of September 22, 2014 ("Effective Date"), is entered into by and between Suzanne Taylor ("Data Recipient") and [redacted] ("Data Provider"). The purpose of this Agreement is to provide Data Recipient with access to a Limited Data Set ("LDS") for use in research **in accord with laws and regulations of the governing bodies associated with the Data Provider, Data Recipient, and Data Recipient's educational program.** In the case of a discrepancy among laws, the agreement shall follow whichever law is more strict.

1. Definitions. Due to the study's affiliation with Laureate, a USA-based company, unless otherwise specified in this Agreement, all capitalized terms used in this Agreement not otherwise defined have the meaning established for purposes of the USA "HIPAA Regulations" and/or "FERPA Regulations" codified in the United States Code of Federal Regulations, as amended from time to time.

2. Preparation of the LDS. Data Provider shall prepare and furnish to Data Recipient a LDS in accord with any applicable laws and regulations of the governing bodies associated with the Data Provider, Data Recipient, and Data Recipient's educational program.

3. Data Fields in the LDS. **No direct identifiers such as names may be included in the Limited Data Set (LDS).** In preparing the LDS, Data Provider shall include the **data fields specified as follows,** which are the minimum necessary to accomplish the research: Patient Care Services Education Department - Excel database of all courses that were approved for continuing education contact hours within the past five years and policies and other documents pertaining to educational content and procedures used within the hospital's education office.

4. Responsibilities of Data Recipient. Data Recipient agrees to:

    a. Use or disclose the LDS only as permitted by this Agreement or as required by law;

    b. Use appropriate safeguards to prevent use or disclosure of the LDS other than as permitted by this Agreement or required by law;

    c. Report to Data Provider any use or disclosure of the LDS of which it becomes aware that is not permitted by this Agreement or required by law;

    d. Require any of its subcontractors or agents that receive or have access to the LDS to agree to the same restrictions and conditions on the use and/or disclosure of the LDS that apply to Data Recipient under this Agreement; and

    e. Not use the information in the LDS to identify or contact the individuals who are data subjects.

5. Permitted Uses and Disclosures of the LDS. Data Recipient may use and/or disclose the LDS **for its Research activities only.**

6. Term and Termination.

   a. Term. The term of this Agreement shall commence as of the Effective Date and shall continue for so long as Data Recipient retains the LDS, unless sooner terminated as set forth in this Agreement.

   b. Termination by Data Recipient. Data Recipient may terminate this agreement at any time by notifying the Data Provider and returning or destroying the LDS.

   c. Termination by Data Provider. Data Provider may terminate this agreement at any time by providing thirty (30) days prior written notice to Data Recipient.

   d. For Breach. Data Provider shall provide written notice to Data Recipient within ten (10) days of any determination that Data Recipient has breached a material term of this Agreement. Data Provider shall afford Data Recipient an opportunity to cure said alleged material breach upon mutually agreeable terms. Failure to agree on mutually agreeable terms for cure within thirty (30) days shall be grounds for the immediate termination of this Agreement by Data Provider.

   e. Effect of Termination. Sections 1, 4, 5, 6(e) and 7 of this Agreement shall survive any termination of this Agreement under subsections c or d.

7. Miscellaneous.

   a. Change in Law. The parties agree to negotiate in good faith to amend this Agreement to comport with changes in federal law that materially alter either or both parties' obligations under this Agreement. Provided however, that if the parties are unable to agree to mutually acceptable amendment(s) by the compliance date of the change in applicable law or regulations, either Party may terminate this Agreement as provided in section 6.

   b. Construction of Terms. The terms of this Agreement shall be construed to give effect to applicable federal interpretative guidance regarding the HIPAA Regulations.

   c. No Third Party Beneficiaries. Nothing in this Agreement shall confer upon any person other than the parties and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

d. Counterparts. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

e. Headings. The headings and other captions in this Agreement are for convenience and reference only and shall not be used in interpreting, construing or enforcing any of the provisions of this Agreement.

IN WITNESS WHEREOF, each of the undersigned has caused this Agreement to be duly executed in its name and on its behalf.

DATA PROVIDER

Signed: [redacted]

Print Nam[redacted]

Print Title[redacted]es

Date: 9/22/14

DATA RECIPIENT

Signed: [redacted]

Print Name[redacted]

Print Title: [redacted]t

Date: 9-22-2014

Appendix N: Document Review Form

Document Review Form

Document #1

Type of Document:

Continuing Education Contact Hours Data Base

This document contains all the classes approved through the Board of Registered Nursing. [redacted] is an approved provider of California continuing education contact hours.

Information Found:

Year	Number of Classes Provided	Number of RNs in Attendance
2014	157	1,768
2013	305	6,224
2012	312	4,438
2011	271	4,876
2010	247	5,258
2009	173	3,527
2008	108	2,451

Over seven years, 1,573 classes were provided with 28,542 RNs attending.

Document #2

Type of Document:

Policy and Procedures

These are policies pertaining to education benefits, differentials in pay, and scholarship opportunities.

Information Found:

Policy #: CC-029.0 Education Benefit
Policy #: HR-52.0 Tuition Assistance
Policy #: CC-020.0 Patient Care Services Special Pay Practices
Policy #: CC-337.0 The John E. Anderson Endowment for Scholarships in Nursing
Policy #: CC-024.0 Terry Varatta Memorial Scholarship

Appendix O: Confidentiality Agreement Form - Peer Review

Confidentiality Agreement Form

Peer Review

Name of Signer: [redacted]

During the course of my activity in collecting data for this research: *Pediatric Nurses' Perceptions of Continuing Professional Development Opportunities*, I will have access to information, which is confidential and should not be disclosed. I acknowledge that the information must remain confidential, and that improper disclosure of confidential information can be damaging to the participant.

By signing this Confidentiality Agreement I acknowledge and agree that:

1. I will not disclose or discuss any confidential information with others, including friends or family.
2. I will not in any way divulge, copy, release, sell, loan, alter or destroy any confidential information except as properly authorized.
3. I will not discuss confidential information where others can overhear the conversation. I understand that it is not acceptable to discuss confidential information even if the participant's name is not used.
4. I will not make any unauthorized transmissions, inquiries, modification or purging of confidential information.
5. I agree that my obligations under this agreement will continue after termination of the job that I will perform.
6. I understand that violation of this agreement will have legal implications.
7. I will only access or use systems or devices I'm officially authorized to access and I will not demonstrate the operation or function of systems or devices to unauthorized individuals.

Signing this document, I acknowledge that I have read the agreement and I agree to comply with all the terms and conditions stated above.

Signature: [redacted] Date: 12/18/2014

Appendix P: Cross-Case Analysis

Table P1

Participation in CPD

Nurse Managers	Day Shift Nurses	Night Shift Nurses
PCS Grand Rounds Hem/Onc Grand Rounds Mandated Classes CHEX classes for ongoing requirements New things that come in (e.g., Ebola training) PALS, PCAR Sickle Cell Conference Annual unit skills days We teach classes National and local conferences (both patient type and leadership type) Teach unit based classes Charge nurse classes Certification courses Preceptor workshop Mentorship opportunities when you are in an advanced degree program Performance improvement monthly meetings All the Councils are learning opportunities WALT meetings - lots of evidence and different kinds of practices Journal clubs Monthly staff meetings - every meeting that staff are involved in becomes an opportunity for growth and development Medical Grand Rounds Member of Professional organizations Academic programs: • BSN	Academic programs: • Master's in Nursing Education • Master's for a NP • PNP program • PhD program Magnet Conference Present/speak at conferences BLS, PALS, ACLS, PCAR Conducting a research study Conferences; In-services Certification, Chemo certified WALT groups; unit committees Collaborative governance Professional ladder work Research fellowship Journal Club, read articles Unit specific classes Teaching is the biggest way I learn Writing - you have to research to write Teaching families; Teach pull back classes Critical care leadership program Being a preceptor; Preceptor classes Policies & Procedures Annual skills fair, CHEX, Fire Safety Assaultive behavior classes Yearly re-orientation Emails/presentations; EBP projects Grand Rounds; Night Rounds education ECMO, CRRT, iCARE Pediatric Critical Care Conference Cardiac Symposium Transplant/trauma conferences Doing research for classes I teach Education huddles at change of shift I learn a lot preparing classes to teach parents Member of Professional organizations	ECMO Unit specific patient population education Cardiac Symposium Pull Back Classes Education huddles at the beginning of the shift Unit specific learning deficits Annual update courses Local and national conferences Certification review course Self-study Liver transplant classes Academic programs: • PhD program • Master's in Nursing Education • MSN in education Unit skills lab Nursing journals Teaching new grads Teach unit didactics Teach PALS I teach others for my professional development Professional Ladder I read a lot I teach people Certification review class Book Club Chart audits

Table P2

Motivators

Nurse Managers	Day Shift Nurses	Night Shift Nurses
Tuition assistance from HR	Time; Desire	Special funds from donations
CNO provides some reimbursement	Passion for learning; for my profession	Availability of in-house classes (house-wide and unit specific); CEUs
Opportunities to apply for scholarships	Admiration for nurses doing research	The mandatory aspect
Time	Receiving education from newsletter	Protected education hours
Interest in the subject	Knowing the opportunities or conferences are out there	It is helpful to come in for an 8-hour education day instead of one hour classes
Availability	Encouragement from leadership	Hands on demonstration instead of lecture classes
Cost/money	Classes that are applicable/pertinent to us	Having instructors who love to teach and can engage you
Depends on the support of your Director	Money'funds for conferences	Peer pressure - others around me are learning/growing
Having a flexible schedule	PCS grants for research	Changes the routine
Getting to go to a conference and getting paid our salary	Support of Director level leadership	Makes you understand why you do the things you do
Personal desire and need	Journal Clubs; Free CEUs	Learning the theory behind it
Coverage by other managers w	Mandatory education	Pay differentials for degrees and certs
Self-education	Wanting more knowledge	Spending time with staff outside of work
Motivated depending on your specialty certification	Interest; pertinent to my job	CNO funds some education
Learning from emails daily	Improving oneself	Scholarships available
Electronic journal database	To stay current	Managers bring you ideas for future growth
I am supported to do whatever I want to	Getting paid for the time to take classes	I am supported in any continuing education I want
There is a culture of learning at this hospital	Protected education days	Participating in simulation
Everyone is very supportive when you are self driven to learn more about your specialty or interests	Education allowance - hours and money	Interactive & fun learning
Role modeling to our staff	That our hospital offers renewal courses and I don't have to go outside to take it	Interesting instructors
Mandatory education	Local education or provided onsite	Professional ladder work
Involvement with the community	Knowledge and to grow as a nurse	Relevance to my practice
Self interest and motivation	Times and days of classes	Knowing the rationale behind changes in practice
Role modeling for staff	Unit provides opportunities to learn	Knowing that your participation matters
Support from the organization	Everyone is involved in unit projects	Online learning
The value of the topic	I want to be involved in doing something else in addition to bedside nursing.	Doing well on the annual Performance Review
Webinars	Interacting with others	
I enjoy learning	I love teaching classes for staff & parents	
Applicable to my job	Exciting/engaging speakers	
	Lunch time lectures	
	Complex patients	
	When people are open to learning	
	Getting ideas from programs/classes	
	Learning from others	
	Having great mentors	
	To be able to publish - to get your name out there to network and collaborate	
	To do research every year	

Table P3

Barriers

Nurse Managers	Day Shift Nurses	Night Shift Nurses
Very little opportunity for leadership or management classes	Not knowing what other floors are doing in teaching classes	Hard to get time off or find someone to replace you
Educational courses we need for advancing our skills need to come from outside conferences - there is nothing offered in house.	My schedule is more difficult and less flexible	Not being supported
Cost of some of these conferences are prohibitive.	Not much money	No financial support years ago to go back to school
Education budget got cut	No money for Master's degrees	Other facilities offer more financial support to go back to school
Inadequate funds	Children at home have priority over my formal education	Scheduling - it is hard for night shift to adjust their schedules
Too much time to catch up after being away at a conference	Location makes a big difference	Class times to not cater to night shift
Workload	Times of courses/classes; units are not staffed to allow other nurses to attend	You can't work overtime for a class.
Time constraints and competing priorities	I won't come in for a one hour class	Feels like we are here every day between working shifts or attending meetings, etc.
HR is not a good source of classes/not relevant	Staffing/schedule - safe staffing comes first	If you want to be involved in prof dev, there are sacrifices you have to make
Nothing for Education Managers to increase their teaching abilities	Advance notice of classes - most need 3 months advance notice	Education pay was at a higher rate than it is now - you make less with your education hours than if you were working a shift.
No computer software classes	How to search the database for articles and not enough time to use it	Everything happens during the days.
No outside speakers	Lack of support for EBP projects	No education structure to be done during the night
No money put towards middle level management	You have to jump through hoops to implement projects	Lack of references or resource books; no current clinical books
No ongoing development for managers	Not enough time to do research when working at the bedside	Education allowance not enough
Open manager positions	Timing of Grand Rounds is usually not good	Lack of a good research program, no grant monies
Intense workload from Quality Department	Scheduling/child care issues	We need a dedicated person for research
Competing agendas	Traffic	No dedicated time for research
Workload takes the drive away; no energy	Schedule/kids	We don't have very good mentors for research.
Not allowed to work 4/40	Not local conferences	Life support classes are too stressful to take here - I go outside.
Doing more than one person's work; chairing a committee	Times of classes	Not enough PALS classes.
Lack of Director support	Lack of availability of classes	
No centralized education for mandatory classes	Work/life balance	
No professional development available for managers	Lack of hospital wide/division educational opportunities	
Not much advance notice when rolling out education	No time	
No one asks for our input or support of education projects	Staffing	
	Funding	

Table P4

Adequacy and Quality

Nurse Managers	Day Shift Nurses	Night Shift Nurses
Not adequate - no management classes for managers with experience No information specific to [redacted] No formal mentorship for managers No budget classes ACLS, TNCC are wonderful It's experts teaching Same class changes over time - content is taught differently and the content experts don't know the answers Union class was excellent/I thought it was repeat information and redundant No support for new managers I see no connection to the Learning Moments Management and leadership classes are not easy to find. Manager orientation is for a novice leader. HR leadership classes are not framed in the right way. The presenters don't have the experience for the caliber of leadership that is at [redacted] I have more of an issue with the adequacy than quality. Most content is a good reminder but not new knowledge I think what has been done is adequate and it is quality but I don't think it is reaching the level it needs to reach	Heart Symposium was good; so is PCS Grand Rounds The adequacy and quality has improved over time Our nurses don't know how to use our KIDS system as they should; I see gaps in documentation. We are very inadequate from a healthcare informatics stand point. Depth of information provided at the Cardiac Symposium was overwhelming. Annual skills lab on our unit is very good and helpful PCS Grand Rounds are always great. The social media one was very helpful I couldn't attend more even if more were offered - I don't have the time. I liked the Senn Delaney team building activities. I don't see as much general education being offered. I think the quality is great, most are research based. Quality is good and the topics are good.	ECMO recert is excellent; simulation was excellent - we need to do more of that. CTICU skills day is really good [redacted] has an awesome culture that is ok's to ask questions. Helpful to have PALS here; you are able to keep up a lot of certifications here. Evaluations are read and changes made to classes because of them. New pump classes were a waste of time. Vendors were not helpful at all. The Education Fair - I just remember posters - don't remember anything else. Learning is not effective when you can't even remember. Everything we present and do at [redacted] has high standards. Too much mandatory and not enough informational for the staff and for my own professional development. The CHEX are ridiculous; the search feature is useless. I like Tea with the IRB PALS is difficult to take here - we should have more classes offered; I take BLS outside and learn a lot more.

Table P5

Knowledge Incorporated into Practice

Nurse Managers	Day Shift Nurses	Night Shift Nurses
Managers bring back exciting things and we try to institute them	It is frustrating when trying to change an actual policy or procedure	The culture supports bringing ideas back sometimes we don't have the structure for it.
We embrace change	I've run into barriers getting approved through the IRB	I have never felt the management was unwilling to hear things
We talk to each other on where we've been and where we're going, we get PI projects going.	I saw how iCare was incorporated into our practice and saw a very positive change in the behavior of people	Our managers love when you bring back new ideas; they give you the opportunity to show the staff and see what they think
We get information from council reps on what is being done on other units	Precepting classes are given to new and experienced preceptors and I can see it applied to practice	PALS
These are all clinical issues; I don't know of any management conferences.	Life Support Training classes all get incorporated back into practice.	It would help staff to incorporate things into practice if they understood why changes are made.
We bring clinical issues back to practice but there are no mgmt or leadership issues done here to bring back	My managers listen to my ideas and help me brainstorm; I've had great support with my nursing leadership. Superkids is a great example of this.	No, you would have to go through a lot of approvals. They want to learn everything but they don't want to learn it from you.
We can't bring back new things because we can't go to those conferences to learn the new technology	We told our doctors about research we heard about at a conference and now our unit is doing their own research.	
HR Leadership classes - nothing to bring back into practice	Pagers for families; we did research and found they were not helpful; we changed our practice.	
Professional growth needs to come from yourself; the hospital is not supporting us	PALS; I'm definitely more comfortable during a code	
The work that the RN Residents do is brought back into practice	What I learn in skills labs I bring back to the bedside	
I was able to incorporate the Senn Delaney classes to understand teams.	We love rounding and some of our nurses created that. CPD provides you with the opportunity to become involved and do your own project and actually make a difference.	
I taught a class on Crucial Conversations and I incorporate that every day	We changed medication protocols because of research learned at a conference.	
I bring back ideas to my staff and say, "What about this?".	Some of my ideas can't be done because of cost but I'm able to implement some. I bring back a lot of information to share	
I brought back many ideas from the Magnet conf.	Just being reminded about how quality of care is so important - I bring that back - to be careful and be accountable.	
	Example of home vent emergency education. Came from an idea and is now part of practice.	

Table P6

Improves Nursing Practice and Patient Outcomes

Nurse Managers	Day Shift Nurses	Night Shift Nurses
A lot of emphasis on quality outcomes and how it relates to your area and what you do. We need to do more lit searches. My CPD directly relates to patient outcomes because it spurs some ideas of specific things we could look at to improve care. This is all antidotal until somebody decides to put some numbers to it. Yes, for as simple as pregnancy screening, kind of a no brainer. Nitrous oxide is going to be phenomenal. I think everything applies; if it doesn't, it wasn't worth doing. The work that our residents and staff do, the committees that they are on and the work that they do. If our staff sees us participating in CPD, it then motivates them as well and that is how we get them more involved to do things and to improve the unit.	Yes, PALS for example. Sometimes because of our policies and procedures, it takes a long time to change; it's not always the easiest; just really depends on what level you're trying to implement something. Yes, I am directly able to see what I have learned and see data stats that my manager gives to us to see our rates of infection, etc. We can see the changes in our practice and the patient outcomes improve very rapidly across the board in almost everything. The opposite side is how ineffective education (i.e. documentation) can negatively impact our practice and patient outcomes. When I hear something that's working and we're not doing it, I want to try it. Yes, I think just being abreast to the different changes in research, bringing back evidence-based practice into what you do. Taking what we're doing in the practice and making it a standard. We have CHEX - there are a lot of things to read there. I learn things apart from my own practice that I want to know more about. If you want change, you must get your stakeholders together; you need to mobilize everyone together.	No - because of the physicians. Sometimes we have doctors who don't hear the lectures we do on palliative care and we don't agree on end of life care. Our doctors have a variation in practice that is not supported by evidence. I think there is a double standard; it is not ok for the nurse to have an independent practice that is supported by evidence that might counter them. For the most part. Sometimes practice is not based on EBP. Yes, PALS and the EKG classes; the RNC class preparation was very good.

Table P7

Wish List

Nurse Managers	Day Shift Nurses	Night Shift Nurses
What would help is a clearing house which is what the education council tried to do and PDAB tried to do but it has to have teeth to say no when someone tries to roll something out and someone says no.	We need more simulation. We can definitely use more simulation and not just hypothetical simulation.	Mock Codes are inconsistent - we need them on a regular basis.
Bring dynamic speakers into the hospital	Offer more paid classes.	At 2 in the morning when patients are asleep and quiet, that would be a great time to have somebody come in to do education with us.
Time management for middle management would be a wonderful idea	More tuition reimbursement for advanced degrees.	Have a structure in place to help research projects; have a pool of people (or database) who would love to do that topic too and then could brainstorm a question together.
Excel, multimedia presentations	More money to pay for entire conferences.	It would be nice to have point people who some relief time with the idea of going in to support projects and helping and nurturing and has the expertise; even helping to search for studies.
A mentorship program for managers	Utilizing the needs assessment to make changes in education.	multimedia classes, how to write an abstract or conduct a literature review, how to start a research study.
Streamline approach to education roll outs; it should come through one avenue; should go through a process to decide when it should roll out instead of 50 things at once.	Live stream classes/events; have a video library.	It would be great to have a roving person on night shift to brainstorm with, pull up journals, be a point person who could be available for a window of time during the night.
Virtual learning; live streaming	Ask people what they prefer and then build that into the classes.	Video library
Having the ability to get information on topics that crossover between divisions/units that are relevant and emerging.	Online cert review courses; Apps for education	Video tape classes.
More lunchtime lectures.	Ask each division or floor what their unique education needs are. Then look at the level and how to support those ideas.	
One day offsite lectures/seminars	Do Grand Rounds quarterly and offer 4 in a row on the same day.	
More support to help people afford to go back to school.	Target courses with CEUs on difficult topics to find - those needed by cert renewals that are hard to find (e.g., ethics/diversity).	
More of an orientation for managers.	Journal Clubs that produce research or PI projects.	
Generational workers in the workplace - need more help in how to work together	Have a list of mentors and champions within the hospital that can help you move your projects forward.	
Live stream webinars; host for staff in conference room so all could attend; video library.	Video library - I just want the information.	
	It would be interesting to know what other units are doing for CPD.	
	Online courses; offer Spanish or medical	
	More information on what conferences are out there. Help in getting funding for the conferences.	
	Add more sim lab classes or turn our existing classes into simulation	
	Adding more education days to the existing 16 hours so you can go to a conference without having to take vacation time.	

Appendix Q: Leadership Laboratory

Leadership Development for Nurse Managers

A live online peer community of practice

AONE is excited to announce a series of six live online leadership laboratories for nurse managers that will begin in February 2015.

The Leadership Laboratory, facilitated by Dr. Barbara Mackoff, is a fresh format for the leadership development of nurse managers. Grounded in peer-to-peer consultation, this program will maximize opportunities for managers to advise each other and convey wisdom and best practices in dealing with shared leadership issues.

Each laboratory will be organized around one of six key leadership practices. Attendees will explore the latest research from Dr. Mackoff as she illustrates each practice by drawing upon their submitted case examples and experiences.

The leadership laboratory, in contrast to instructor focused seminars and webinars, is designed to allow both the facilitator and the participants to advise, educate and coach each other. In this way, nurse managers can connect with a community of shared practice with colleagues across the country.

Course Facilitator
Barbara Mackoff, EdD
AONE Senior Faculty

Barbara is a consulting psychologist, author and educator and a recognized authority on nursing management and leadership. She is currently AONE senior faculty and a Fulbright specialist.

Six Key Leadership Practices

Motivation
Strategies to energize and engage staff

Communication
Tools to build alliances and resolve conflict

Strategic Time Management
Techniques to protect time for work priorities

Team Building
Approaches to encourage collaborative and creative teamwork

Emotional Mastery
Techniques for achieving self-restraint, boundary clarity and gaining strategic lessons from experiences

Change Agility
Strategies to cope with–and create–change and innovation

(American Organization of Nurse Executives, 2014)