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THE NURSE AS A LIFELONG LEARNER

**An Exploration of Nurses' Perceptions of Lifelong Learning within
Nursing, and of Nurses as Lifelong Learners**

by

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A thesis submitted in partial fulfilment of the requirements for the
degree of Doctor of Philosophy in Continuing Education

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An Exploration of Nurses' Perceptions of Lifelong Learning within Nursing, and of Nurses as Lifelong Learners
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As required, I declare that this thesis constitutes my own work, and has not been submitted for a degree at another university.

SCHOLARLY PEER-REVIEWED ARTICLES ARISING FROM THIS STUDY	
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2002	'Human and social capital as facilitators of lifelong learning in nursing'. <u>Nurse Education Today</u> , 22, pp. 608-616.
2002	'Impact of continuing professional education - analysis of a management course'. <u>Nursing Management</u> , 8, 9, pp. 21-25.
2001	'Lifelong learning in nursing – perceptions and realities'. <u>Nurse Education Today</u> , 21, pp. 607-615.
2001	'Nurses' perceptions of PREP'. <u>Professional Nurse</u> , 16, 6, pp. 1139.
2001	'The role of peer assessment and peer review in nursing'. <u>British Journal of Nursing</u> , 10, 2, pp. 115-121.
2001	'Understanding nursing roles to facilitate collaboration'. <u>British Journal of Therapy and Rehabilitation</u> , 8, 1, pp. 6-11 (with Scullion, P and Mills, N).
2000	'Self-assessment and the concept of the lifelong learning nurse'. <u>British Journal of Nursing</u> , 9, 11, pp. 724-729.
1998	'Lifelong learning in health care: who will pay?' <u>British Journal of Therapy and Rehabilitation</u> , 5 (Editorial), 3, pp. 116-117.

ABSTRACT

The arrival of lifelong learning within nursing constitutes a major conceptual shift that every qualified nurse is expected to adopt to be able to function as a Registered Nurse (RN) throughout their career. In the 1990s, lifelong learning had been appearing sporadically within nursing literature as a *fait accompli*, and with a seemingly general assumption that there was a shared understanding and acceptance of the concept amongst all nurses.

The literature review revealed that lifelong learning is closely linked to the evolving nature of healthcare delivery in the National Health Service (NHS), and that it comprises of a number of related components. However, there was a dearth of empirical literature with regards to its application to day-to-day nursing practice at the time this study started. The study focused on examining the assumptions that seemed extant at the time and the areas that were not documented in the literature. It sought to ascertain the nature of RNs' perceptions of lifelong learning, and took into consideration the underlying philosophy, principles and practicalities of the concept. It also sought to identify both the formal structures required for effective implementation of lifelong learning as well as the day-to-day factors that might facilitate uptake and continuation of learning. Furthermore, the study endeavoured to ascertain the current and likely future impact of lifelong learning on nursing.

To explore these issues, the study involved collecting, analysing and interpreting data from twenty-six individual interviews and two focus group discussions along with a comprehensive documentary analysis. The findings revealed that there are positive perceptions as well as reservations about lifelong learning amongst RNs, the latter mainly because mandatory continuous professional development (CPD) is resented by a number of nurses. This could be due to their lack of experience and apprehension related to studying in a university. The study found that structural mechanisms could be more firmly anchored and equitably available. Numerous day-to-day factors such as profession-based and personal networks tend to influence levels of engagement in formal learning. For instance, CPD in the form of work-based formal and informal learning is relatively widely utilised. Additionally, the impact of attitude change towards continuing development of own knowledge and competence yields favourable outcomes for the RN and for patient care.

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LIST OF ABBREVIATIONS USED IN THIS THESIS

AP(E)L	Accreditation of Prior (Experiential) Learning
CPD	Continuing professional development
CPE	Continuing professional education
CNS	Clinical nurse specialist
DH	Department of Health
DipHE	Diploma in Higher Education
EAU	Emergency Assessments Unit
EBHC	Evidence Based Healthcare
ENB	English National Board for Nursing, Midwifery and Health Visiting
HCA	Health Care Assistants
HE2	Level of study equivalent to 2 nd year of an undergraduate course in England
HRD	Human Resource Development
IPR	Individual Performance Reviews
MCE	Mandatory Continuing Education
NHS	National Health Service
NMC	Nursing and Midwifery Council
NMET	Non-Medical Education and Training
ODL	Open/Distance Learning
PAM	Professions Allied to Medicine
PCA	Patient Controlled Analgesia
PCG	Primary Care Groups
PCT	Primary Care Trusts
PSM	Professions Supplementary to Medicine (used interchangeably with PAM)
PREP	Post-registration Education and Practice
RCT	Randomised Controlled Trials
RN	Registered Nurse (i.e. any qualified nurse on parts 1 to 15 of the NMC's professional register)
SDL	Self-directed Learning
TENS	Transcutaneous Electrical Nerve Stimulation
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting
UNESCO	United Nations Educational, Scientific and Cultural Organization
WDC	Workforce Development Confederations

The thesis refers to the nurse as 'she' and 'her' only because almost 90 per cent of nurses are females. As a male nurse myself, this notion does not offend or bother me and I feel that it will not offend others.

KEY TO QUOTES FROM INDIVIDUAL INTERVIEWS AND FOCUS GROUPS

The following symbols are used in quotes from interviews (Morse and Field, 1996:144)

- .. Two words in the first part of a quote have been excluded
- ... Three or more words in the first part of a quote have been excluded
- An irrelevant sentence in the middle of the quote has been removed
- A pause

INTRODUCTION

Aims of the study

As the title of this thesis indicates, this study set out to explore nurses' perceptions of lifelong learning in nursing at two levels: conceptual and pragmatic. At the former level, it examines the nature of the notion of lifelong learning as perceived by key writers as well as by registered nurses (RN). At the latter level, it seeks to ascertain the mechanisms and other elements that would be necessary for the realisation of lifelong learning as a practical activity in nursing. This introduction presents the focus and aims of the study, the context and reasons why it was felt necessary to explore lifelong learning in nursing, an analytical framework for data analysis and interpretation, and the contents of the chapters where the various components of the study are discussed.

To examine lifelong learning in nursing, this study initially drew on the literature on lifelong learning, nursing and nurse education as well as on my own experience and reflections as a nurse for more than 30 years, approximately half of this in the capacity of a nurse teacher or lecturer. This is supported by a thorough analysis of the study data from semi-structured interviews and focus group discussions. The expected overall outcome of the study was that it would contribute to further understanding of lifelong learning at both philosophical and pragmatic levels within nursing. The specific aims of the study were:

- 1 to explore nurses' perceptions of lifelong learning within nursing, of the perceived characteristics or attributes of the concept, and of the nurse as a lifelong learning professional.

- 2 to identify the perceived and the current institutional, funding, educational and other structures that instigate and facilitate effective realisation of the concept, and those that hinder.
- 3 to identify the factors, other than formal structures, that lead or enable nurses to become lifelong learners, and those that might obstruct.
- 4 to analyse the effects of lifelong learning on nursing, and on the individual as a professional and as a person.
- 5 to investigate which actions could be taken to facilitate and advance the concept and practice of lifelong learning.

The context of the study and reasons for exploring lifelong learning in nursing

In the late 1980s and early 1990s, the term lifelong learning had been appearing sporadically in nursing literature (e.g. UKCC 1986, ENB 1994) as an agreed requirement for nursing, but there was a paucity of empirical evidence at the time as regards its meanings or implications (as also noted by Knapper and Cropley [2000] more recently). The literature seemed to assume that there was a shared understanding of the concept and practice of lifelong learning within nursing. This situation was supported by writers on the subject such as Sir Christopher Ball (1991) who suggested that people learn all the time because learning attracts several benefits. But Knapper and Cropley (2000 p. 176) warned against the situation where 'proponents of the idea proclaim its (lifelong learning's) virtues as an act of faith ... (that) lifelong learning is self-evidently a good thing'.

Through exploring lifelong learning, the study first addresses the questions of whether nurses are lifelong learners; how nurses' understanding of the concept compares with that found in the general education literature; and the level of congruence between the development of nurses as lifelong learners and the professionalisation process of nursing. It also aimed to establish a profile of the factors that could facilitate and support continuing professional and personal learning, and to identify those that need to be developed. These were to include mechanisms as well as non-formal structures and processes required for RNs to become and remain lifelong learners.

To achieve these aims, a thorough literature review was conducted to establish the current level of knowledge of lifelong learning in nursing, and to identify the probable specific areas and gaps in existing knowledge that need to be addressed by the study. The literature showed that the notion that nurses should be lifelong learners has been suggested for some time (e.g. Altschul 1982, ENB 1994, UKCC 1986, UKCC 2001c). The impression given is that nurses must become lifelong learners, and that they either already are, or about to inevitably become so. Before this, lifelong learning had been developing as a significant concept in the field of general education especially since the early 1970s through the work of Dave (1973) for instance, and later Knapper and Cropley (1991). Its practical application to education has also been debated over the years by these and other authors. More recently, we have seen the publication of key documents contributing to the debate in the UK. These include for instance the *Dearing Report* (National Committee of Inquiry into Higher Education [NCIHE] 1997) and *Creating Learning Cultures*

(National Advisory Group for Continuing Education and Lifelong Learning [NAGCELL] 1999).

There are several factors that indicate that the concept's standing within nursing should be explored. Firstly, the concept was mooted for nurses two decades ago when Altschul (1982) recommended that basic nurse education programmes should prepare the nurse for lifelong learning and for questioning current practice. Jarvis (1987), who analysed the relevance of lifelong learning to nursing and nurse education, provided a more substantial discussion. For nursing, he argued that nurses who are '... self-directed lifelong learners may be keeping abreast of changes that are occurring in nursing for no other reason than a commitment to their work, since these embody some of the ideals of professionalism just by virtue of this quest to keep up to date (p. 51).

Jarvis (1987) refers to several key authors on lifelong learning in the context of general education principles, and argues for preparing nursing students to become lifelong learners. He points out that 'if learners become both self-directed and effective they will be able to acquire that knowledge more efficiently and by themselves, so that there will be less need to overload the time-table' (Jarvis 1987 p. 51).

Whilst continuing learning and updating of knowledge and competence have been important for nurses to remain professional practitioners, nursing as a vocation finds itself on a protracted path to professionalisation, and it has been conscious of its

emerging professional status for decades (e.g. Moloney 1992, Davies 1996). As argued by Jarvis, professionalism provides an impetus for continuing learning. This consciousness includes the relatively recent re-location of nurse education provision within the UK higher education sector, although the former had been adopting general higher education principles for some time. The idea of lifelong learning has cumulatively gathered momentum in the 1990s because of changes in healthcare (UKCC 1986) and with concern over professional regulation of healthcare professionals (e.g. DH 1994), and consequently it has become an essential component of the nursing world.

A second reason for exploring lifelong learning is associated with the arrival of mandatory continuing education (MCE) for nurses (known as Post-registration Education and Practice [PREP]) that came into effect on 1 April 1995 as professional self-regulation (UKCC 1994). PREP ruled that every practitioner has to declare and be able to show evidence of professional updating to be able to retain the title Registered Nurse (RN). Although the present requirement is that updating should be for a minimum of 35 hours every three years it is increasingly becoming apparent that this amount of learning is not sufficient for any practitioner to remain competent in her professional practice (e.g. UKCC 1995a). Therefore, continuing professional learning throughout one's career, or lifelong learning, becomes inevitable. The UKCC (1994) recognises this and has indicated that lifelong learning goes beyond CPD in that it entails a different approach and attitude, and a different culture. Hinchliff (1994) adds that lifelong learning is associated with such factors as freedom to learn, responsibility for self, an enquiring mind, ability to think critically,

and the importance of self-fulfilment. It therefore also demands particular skills or competences.

Thirdly, health professionals, including nurses, are subject to changes in the social and economic structure of society because of technological advances and the general expansion of knowledge within society, the profession and healthcare in general (Mullins 1999). One landmark was reached through the publication of the pre-registration course syllabus in 1994 with the title *Creating Lifelong Learners* (ENB 1994), which was followed in 1995 by another document by the same title for post-registration nurse education courses (ENB 1995a).

The principal functions of the ENB [which ceased to exist after 31st March 2002] included approving nurse education courses as well as the educational institutions that would conduct them (ENB 1997). Prior to detailing guidelines for the content of nurse education courses, *Creating Lifelong Learners* delineates the characteristics of RNs who are lifelong learners, the outcomes resulting from having acquired the skills to be lifelong learners, and the key features of a learning organisation (ENB 1994).

With the relocation of nurse education within the higher education sector in the UK in the 1990s, both pre-registration and CPD courses were eased into a new era and medium that required a certain degree of adjustment (e.g. Glen 1995). A few years earlier, a radically re-structured new pre-registration programme known as Project 2000 or the Diploma in Nursing (Higher Education) (DipHE) (e.g. Elkan and

Robinson 1991) had been implemented in stages within all previous colleges of nursing. One of the aims of Project 2000 type programmes was to equip practitioners during initial preparation with the skills to become lifelong learners (UKCC 1987). This was to be done through pre-registration programmes aiming to enable students to acquire critical thinking and problem solving skills, for instance, so that they can continue learning and therefore adapt to meeting the changing healthcare needs of society. Its other purpose was to accelerate the professionalisation process of nursing (Elkan and Robinson 1991, UKCC 1986).

One of the main reasons for relocating nurse education from hospital settings into higher education institutions was based on the realisation by the UK government that 'countries where occupational qualifications are obtained through the institutes of higher education are economically more successful', and this also contributed to expansion of higher education sector itself (Glen 1995 p. 91). Some of the professional documents that had recommended this change include the *Briggs Report* (Briggs 1972), *Judge Report* (RCN 1985) and *Project 2000: A new preparation for practice* (UKCC 1986). In endeavouring to accelerate the professionalisation of nursing, these reports deduced that this move would make nursing more attractive, the attrition rate would be reduced, and more RNs would stay in nursing after qualifying (Bentley 1996).

There were several other issues that impinged on the developing state of nursing in the 1990s. The arrival of evidence based health-care (EBHC) requiring professionals to base their practice on 'best evidence available' was one of them

(e.g. McInnes et al 1998). By implication, EBHC exhorts the continuing quest for new knowledge and skills, as this requires finding evidence on which current practice is based, (or even counter-evidence), resulting in continuing improvement in patient care. A second issue was that in the effort to reduce the number of hours junior doctors work, a number of patient care tasks which used to be undertaken by doctors were now placed within the 'expanded' role remit of nurses (UKCC 2000a). Additionally, the continuing changes and developments within the NHS signalled that the skills required for undertaking these tasks had to be regularly updated.

Another issue that necessitates lifelong learning is identified in McCleod Clark's (1998) indication that, in the near future, even greater responsibility is to be vested in nursing roles along with greater autonomy. Greater responsibility through expanded roles was empirically examined by the UKCC (2000a), and the findings were largely positive. Furthermore, one of the *Creating Lifelong Learners* publications (ENB 1994 p. 1) declares the ENB's 'belief that education for registration enables nurses, midwives and health visitors to acquire a zest for learning ... which in turn will achieve quality care for patients, clients and their families'. In the foreword of this document, the then Department of Health's Chief Nursing Officer for England, Yvonne Moore, and the Director of Human Resources at the NHS Executive, Ken Jarrold, jointly supported the ENB's beliefs, and saw clinical supervision as an essential component 'if the culture of a learning organisation is to be achieved' (ENB 1994 p. 3). These supportive statements from such influential personnel reflect the values of the organization they represent, in

this case the Department of Health's, which determines health policies and the funding associated with them.

In 1996, when campaigns were set up across Europe at national and local levels to publicise the European Year of Lifelong Learning, the UKCC supported the project's activities and organised a conference to raise awareness and consolidate the place of lifelong learning among nurses (UKCC 1995b). This reflects the UKCC's appreciation of nursing's position within the wider economic and political trends.

Yet another reason for exploring lifelong learning was that nursing research has itself contributed to identification of a need for continuing learning. For instance, influential researcher and author Patricia Benner (1984) identified the acquisition of skills by nurses on a novice to expert continuum. In this, nurses become competent RNs on qualifying, but substantial further learning is required throughout their professional careers to achieve higher levels of practice, that is at 'proficient' or 'expert' levels.

However, the literature review up to the time of data collection revealed that research on lifelong learning had been scarce (e.g. Knapper & Cropley 2000 p179). Those that had been published had tended to focus on inherent or related features of lifelong learning, such as widening participation and access to further and higher education (e.g. McGivney 1990, Sargant et al 1997); effectiveness of andragogy as a theory of adult education (e.g. Janhonen 1991, Oduaran 1993, Swindell and Mayhew 1996); self-directed learning (e.g. Heath 1996); continuing professional education (e.g. Dowswell et al 1998, Nolan et al 1995, Hogston 1995, Waddell

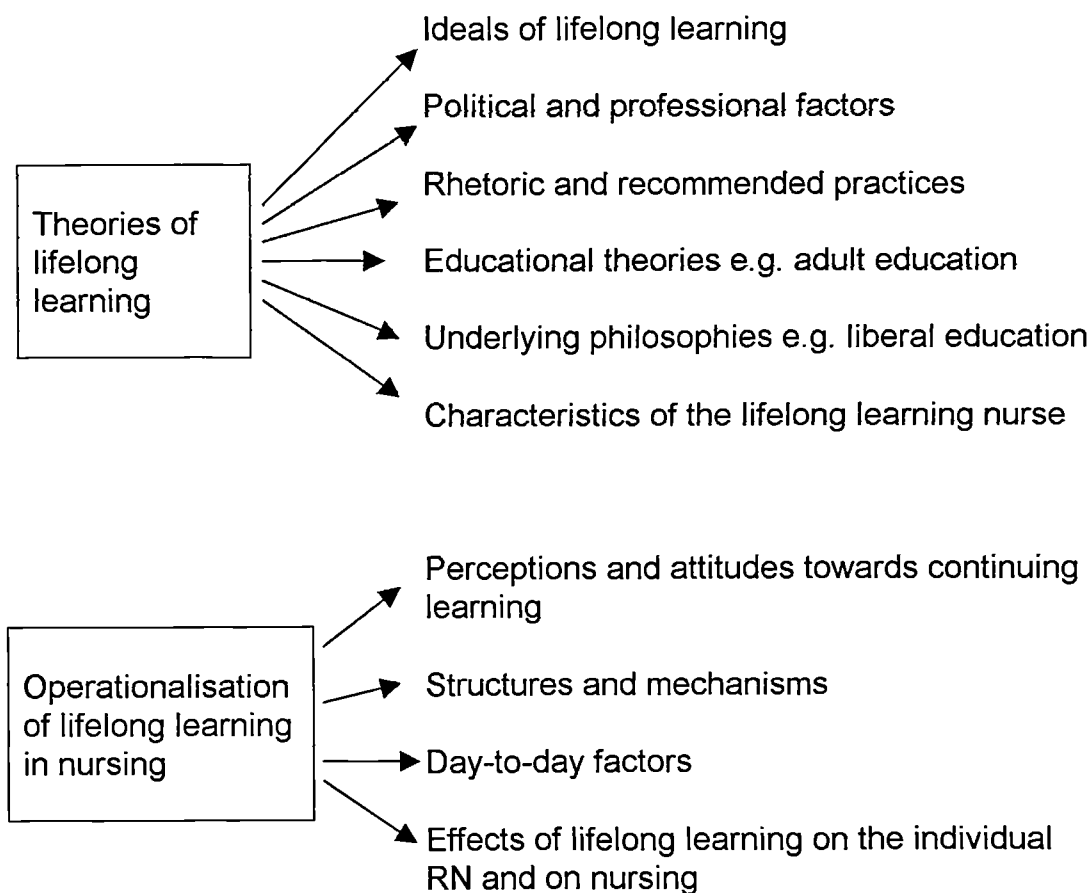
1991); problem-based learning (e.g. McGowan 1995, Foldevi et al 1994); social factors and the motivation of adults (e.g. Kwong et al 1997); and roles and social positions as factors that influence lifelong learning (e.g. Wagner (1989). However, there didn't appear to be any research-based evidence that directly indicated how nurses perceived the concept, that is whether they have accepted lifelong learning, agreed to become lifelong learners, as well as how they felt the notion is realised in practice.

The discussion on these reasons for exploring lifelong learning in nursing also indicates that nursing and healthcare need to be viewed not as detached microcosms, but in the context of the wider society and employment trends (Knapper and Cropley 2000).

An analytical framework for lifelong learning in nursing

Based on the literature review and the consequent aims of this study, it emerges that although the theories of lifelong learning have been explored in great detail, very little documentation surfaces on how these theories can be applied at the practical level in nursing. Wain (1987) notes that both of these aspects are essential constituents of any educational programme. The writings on the theories of lifelong learning indicate that it consists of such components as ideals and ideologies of lifelong learning (e.g. Ball 1991, Gelpi 1985, Faure et al 1972, Wain 1987); political and professional factors (e.g. Dave 1976, Titmus 1999); rhetoric (Wain 1987, Knapper and Cropley 2000, Morton-Cooper and Palmer 2000); educational theories such as adult education (e.g. Knowles 1990); characteristics of the individual as a

lifelong learner (e.g. ENB 1994); and a mosaic of plausible educational philosophies (e.g. Wain 1987, Dewey 1916). This study sought to make connections between these two strands, that is between the ideals, theories, underlying philosophies and the rhetoric of lifelong learning, and the means of its actual systematic application in nursing. It seems that this application would comprise of, to start with, how RNs perceive this activity - in theory and in practice, the structures that would facilitate it, other day-to-day factors that might have influence on it, and the effects it might have on nurses and nursing. This two-strand feature is illustrated diagrammatically below.



This illustration also constitutes a framework that is utilised to analyse and interpret the data, and is discussed in detail in chapter eight. The intention of the literature review was to ascertain specific gaps in this area, and it was anticipated that data

analysis would lead to the generation and synthesis of an effective framework for the implementation of lifelong learning in nursing.

Outline of the thesis

Chapter one of this thesis examines the current context of healthcare delivery in the UK and how it impacts on nursing, and includes discussion on developments in clinical supervision, professionalism and nurse education. These components are included because the literature on lifelong learning in nursing seemed to view these as components that interact with it. Chapter two constitutes a critical review of the literature on lifelong learning, which is the focal concept in this study. It surveys the development of the notion within adult education and latterly its advent within nursing and nurse education up until the period of data collection, which was completed in early 1999.

Chapter three discusses the methodology used for this study and the research design. Qualitative data was collected through semi-structured interviews, focus group discussions and documentary analysis. A critique of the study focusing on the concepts of rigour, and the validity and reliability of findings is also presented.

Chapter four, five, six and seven discuss the findings of the study focusing on aims 1, 2, 3 and 4 respectively. An analysis of nurses' perceptions of the concept is presented in chapter four; that of the structures necessary for facilitating, realising and sustaining the concept are discussed in chapter five; and the non-formal mechanisms or day-to-day factors affecting learning are discussed in chapter six.

Chapter seven explores the effects of lifelong learning on nursing and nurse education, and focuses principally on the impact of attitudinal change on learning, as well as on the role of the nurse as facilitator of (lifelong) learning. These four chapters also seek to address aim 5 of the study, which is to determine the actions that can be taken to facilitate and advance the concept within nursing.

Chapter eight provides an analysis and a discussion on the emerging themes and findings of the study in the context of the policy and other literature to date, and examines the implications of these components and issues. A new conceptual framework, which draws the essential threads evidenced in education, health and nursing literature along with the data findings together constitute a suggested model for facilitating lifelong learning in nursing. This is followed by recommendations for further research.

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Chapter One

THE CURRENT CONTEXT OF NURSING

Introduction

In order to achieve the aims of the study such as identifying the mechanisms and day-to-day factors that could facilitate (or hinder) lifelong learning in nursing, the literature was searched to ascertain the key structures and processes, the educational, socio-political, individual and various other contexts within which healthcare is delivered in the UK, and which interface with the concept and practice of lifelong learning in nursing. This search is recommended by Hart (1998) for when a thorough review of the literature is being conducted prior to determining which aspects of an area need researching. From an organisational management viewpoint, Howkins and Thornton (2002) approach such exploration as a STEP [or PEST] (social, technological, economic and political) analysis. For this study, it was felt relevant to focus on ascertaining all these contexts and ethos of healthcare delivery as they were at the end of the 20th century when lifelong learning was being strongly advocated for nursing. By doing this, it was expected that a broader and more comprehensive picture could be established within which lifelong learning in nursing figures.

The literature indicated that nursing care delivery does not occur in isolation from the dynamics of, or changes in society, and epidemiology, which subsequently tend to determine healthcare policies and guidelines (e.g. DH 1999b). These dynamics include increasing public expectations, changes in patterns of disease, and developments in pharmaceuticals and technology, as identified by the Department of Health (1999b) in its strategy for nursing. Ongoing demands for improvements in the

health service, and the most directly relevant healthcare policies and guidelines are discussed shortly, but one of the most significant effects of these elements is that the RN needs to engage in new learning continuously. Moreover, this has to occur in the context of partnerships and working within a multi- and inter-professional framework, and also in a medium that involves a career structure that also requires continuing acquisition of new knowledge and competence (DH 1998, 1999b).

The literature also shows that the requirement for continuing learning occurs in a medium of insufficient individual support and guidance from the RN's seniors and peers (e.g. Wright 1990, Faugier and Butterworth 1994). There seems to be a lack of mechanisms or media through which RNs can verbalise novel ideas, experiences and problematic decisions they might encounter in their daily professional lives. Continuing learning also seems to be spurred on or sustained by the RN's own professionalism (e.g. Jarvis 1987), and in the context of developments in current pre- and post-registration nurse education (Bentley 1996).

The literature review therefore indicated that the components of the contexts and ethos that RNs as lifelong learners were most likely to experience in the second half of the 1990s, were that of:

- Developments in healthcare delivery in 'The New NHS'
- Working as a nurse in contemporary healthcare
- The role of clinical supervision as a support mechanism for professional development
- How professionalism and continuing learning affect each other

- The nature of contemporary pre- and post-registration nurse education

These components are therefore now examined in some detail and will be taken into account wherever appropriate during analysis of the study data in the findings chapters.

Healthcare delivery in *The New NHS*

One of the key issues related to lifelong learning is the current context in which healthcare is delivered within the NHS. Nursing, as an evolving profession, is influenced by major healthcare paradigm shifts such as evidence-based healthcare (EBHC) and clinical governance as well as by major government policies. Some of the recent more influential government policies include:

- *The New NHS - Modern, Dependable* (NHS Executive 1997) – which ended the internal market system of managing healthcare and replaced it by ‘integrated care’.
- *A First Class Service - Quality in the New NHS* (DH 1998) – emphasises quality and standards of care with clinical governance across the whole of the NHS.
- *The NHS Plan - A plan for investment, A plan for reform* (DH 2000) - is the Labour government’s strategy for the NHS with emphasis on ‘modernisation’ of various components of the health service.
- *Making a Difference - Strengthening the nursing, midwifery and health visiting contribution to health and healthcare* (DH 1999b) - is the Labour government’s strategy for nursing and nurse education.

The first document identified above emphasises the need for ‘modernisation’ of the NHS, which includes taking into consideration the current context of nursing that

encompasses issues such as nursing leadership, difficulty with recruitment of qualified staff, an ageing workforce, the sharp rise in the number of Healthcare Assistants (HCAs), expanded roles, another overhaul of the pre-registration programme, and the replacement of the nurses' professional regulatory body (the UKCC) by the Nursing and Midwifery Council in April 2002.

The New NHS (NHS Executive 1997) addresses a number of issues that indicate the need for lifelong learning in healthcare delivery itself. Firstly, the internal market system established by the preceding government was replaced by a system called 'integrated care', which laid the foundation for different healthcare professions to work in partnership. The NHS, the document indicates, is influenced by three categories of pressures namely growing public expectations, medical advances and demographic changes, all of which indicate the necessity for ongoing learning.

The document set out to introduce new mechanisms such as primary care groups, health improvement programmes and health action zones, and clinical governance, each one of these involving nurses, amongst other healthcare staff, and which therefore implies new functions, new roles, and therefore new learning. Lifelong learning plays a central role within the clinical governance framework (DH 1998). The latter is defined as 'A framework, which helps all clinicians - including nurses - to improve quality and safeguard standards of care' (RCN 2000 p. 2).

The primary focus of *A First Class Service - Quality in the New NHS* (DH 1998) is on clinical governance, the purposes of which are the establishment of clear standards of

service, dependable local delivery and the monitoring of standards of the service. Inherent within the quality programme are the key elements, processes and support infrastructure identified in table 1.1, which the RCN sees as components of a framework, which clinicians can utilise to develop clinical governance in their own work settings. However, these components also embody several other concepts. For instance, clinical supervision includes reflective practice and peer support; and information sharing and networking includes concepts such as benchmarking and critical appraisals. The components in table 1.1 could all be seen as closely associated with lifelong learning in that they include CPD, EBHC and the quest for improvement in the quality of care.

Three years after *The New NHS*, the government published details of further plans for healthcare provision in the NHS as documented in *The NHS Plan* (DH 2000). This document provides further information on a range of provisions to be achieved in subsequent years. It enunciates the nature of a modernised NHS on the basis of ten NHS 'core principles' that are identified to 'reshape the NHS from the patient's point of view' (p. 3). *The NHS Plan* indicates that there have been failures in healthcare delivery because of decades of under-funding, and the government is acting to rectify this through increased investment for new hospitals and primary care centres, and an increased number of staff.

Table 1.1: Key elements, processes and support infrastructure for clinical governance (RCN 2000).

<i>Elements of Clinical Governance</i>	<i>Processes for Clinical Governance</i>	<i>Infrastructure to Support Clinical Governance</i>
<ul style="list-style-type: none"> • Clinical supervision • Multi-professional clinical audit • Evidence-based practice • Clinical risk management • Clinical incident reporting • Continuing professional development • Clinical leadership development • Patient/client feedback systems 	<ul style="list-style-type: none"> • Information sharing and networking • Patient/client- focused approach • Integrated approach to managing and improving quality • Effective multi-professional teamwork • Open culture; learning from mistakes 	<ul style="list-style-type: none"> • Time for staff to get involved • Access to continuing professional development • Access to evidence to underpin practice e.g. libraries and information databases

Section 9 of *The NHS Plan* addresses changes for nurses and (non-medical) NHS staff, and asserts that 'Best practice can no longer be an option (as) managers and clinicians across the NHS must make change happen' (p. 82). This clearly signals that to achieve these aims, continuing professional learning is essential for all staff. Furthermore, appropriately qualified staff are to be empowered to undertake a wider range of clinical tasks, e.g. running clinics and prescribing drugs. Mechanisms are to be set up and funding designated to support continuing staff development (p. 84). Continuing professional learning can be seen as central to all these sub-issues.

Working as a nurse in contemporary healthcare

Another feature related to lifelong learning revealed by the literature is the nature of the nursing workforce in the NHS, which has been changing for some time in the broader context of employment and changes in society (Birchenall 2000, Davies 1990). In nursing, staffing currently entails:

- Increasing use of 'bank staff' (i.e. RNs within the specialism who are willing to do paid extra shifts, in case of sudden illness by rostered staff);
- Reduction in number of RNs on higher clinical grades (NB: RNs are employed on grades D, E, F, G, H or I, with D being the most junior grade and I the seniormost);
- Increase in the number of HCAs due to difficulty in recruiting qualified staff; and
- 12-hour shifts and internal rotation.

The number of nurses, midwives and health visitors on the UKCC's register in the year ending March 2000 was 634 529, of which 73 per cent lived in England, 10.5

per cent in Scotland, 5 per cent in Wales, and 3 per cent in Northern Ireland. The total figures are said to have been decreasing as nurses have been leaving the NHS in larger numbers than those who are returning and new ones qualifying as RNs (Meadows et al 2000). Reduced numbers of staff having to provide the same or increased amount of overall care in the NHS could affect staff motivation towards their vocation and towards ongoing learning.

Nurses are employed in the 390 or so NHS Trusts (some trusts are in the process of merging) and consume 25 per cent of the NHS yearly budget in salaries (Bond and Thomas 1991). Because of this, it is not surprising that efforts are constantly being made to make the management of services more efficient. Part of this venture has included several management restructurings, particularly at middle management level. In doing so, the NHS paid a substantial amount of money in redundancy payments particularly in the late 1980s and early 1990s. This era has seen shortage of employment for newly qualified nurses, short-term contracts for new employees, and detailed skills analysis with a view to devolving duties to lower paid staff where seen as appropriate. Such moves appear to lead to disillusionment, as found for instance by a joint Royal College of Nursing (RCN)/Institute of Employment Studies (IES) (Secombe 1995) survey of employment trends for nurses which revealed that a substantial number of NHS nurses would leave the NHS if reasonable job opportunities existed outside (26 per cent, but 44 per cent of those who have been in the same post for five or more years).

In 1986, the UKCC estimated that 100 000 RNs who were on the UKCC register were not practising as nurses (UKCC 1986). The picture changed quite dramatically in the second half of the 1990s as the shortage of qualified nurses in the NHS led to major efforts to attract those not practising back to work. To explore why so many RNs are not practising as nurses in the NHS, Secombe (1995) asked nurses if they thought that nursing continued to be a job for life. He found that while in 1992, 20 per cent of qualified nurses thought it wasn't, by 1995 this figure had reached 53 per cent. Concerns over job security were more prevalent among nurse managers (67%) and nurse teachers (80%). Job insecurity seemed to be a reason for low morale amongst nurses, and as a result they might not get a feeling of accomplishment from work, nor see nursing as a rewarding career. A greater level of responsibility and accountability required by professional regulation bodies on the one hand, and for expanding roles on the other by employers put more pressure on nurses (UKCC 2000a). Expanding roles mean new learning and added dimensions to one's post, but this is not necessarily complemented by extra remuneration (Schuller 2000).

Additionally, Buchan (1999) reports that the population of nurses is getting older and smaller in number. Consequently, an increased number of RNs will be required when these RNs retire in a few years time, both to avoid the above-mentioned difficulties worsening and also to ensure provision of an even safer service. Previous research (Buchan 1995) had shown that older nurses were more likely to want to work part-time and less likely to be geographically mobile.

The 1995 RCN/IES survey also found that those in higher grades were much less likely to work part-time; and 40 per cent of NHS nurses expressed concern about possible redundancy. At the time, 83 per cent already thought that nurses were poorly paid in comparison with other professional groups, which could be another cause for concern. This argument is supplemented by a King's Fund Centre report (Meadows et al 2000) on reasons for nursing shortages in the NHS. The researchers found that nurses leave the NHS as a result of low pay, poor working conditions, lack of resources, discrimination and harassment, a feeling that their views are ignored, inflexible working hours, a grading system that makes career progression difficult and insecurity caused by organisational changes within the service.

Despite this, as for CPD, the RCN/IES (Secombe 1995) survey found that 60 per cent of respondents had applied for at least one place on a post-registration course. However, this varied from 77 per cent in GP practice to only 12 per cent among agency nurses. The study also found that the predominant reason for not applying was lack of financial support, although a third had contributed to the costs of their CPD. The researchers felt that these figures were likely to have been much lower a few years back. They also claimed that the sample in the survey were representative of the UK qualified nurse population, and one of the reasons for this substantial pursuance of CPD could have been the widespread feeling that lifelong learning needed to be a valued aspect of nursing.

Maslin-Prothero (1997) explored the prevailing literature on employment in organisations in relation to healthcare, and concluded that the 'concept of job for life

no longer exists' (p. 432). This is because organisations want an adaptable workforce of individuals who are prepared to be lifelong learners, and who adapt and change as required by the organisation (ENB 1994). The development of a variety of transferable skills include skills in critical thinking, problem-solving and reflective practice, as well as the ability to undertake both self- and peer-assessment (Maslin-Prothero 1997 p. 432), and are seen as necessary skills for the lifelong learning nurse (Maslin-Prothero 1997, ENB 1994).

Expanded roles, accountability and the nurse's career trajectory

In addition to the state of nursing workforce, the role of the nurse itself changed markedly in the 1990s. Two policy publications have had prominent impact. The first was the *New Deal* (NHS Management Executive 1991), which aimed to reduce junior doctors' working hours; and the second was the *Scope of Professional Practice* (UKCC 1992) which led to expansion of nurses' roles in various specialisms. Consequently, nursing intervention or patient care now includes activities previously performed by doctors only. Role expansion means that during their career, the nurse learns new patient care activities such as intravenous administration of drugs or performing minor surgery. An inherent part of this new role would be the need to keep knowledge and competence up to date through continuing learning as new drugs and the findings of randomised controlled trials indicate changes in various aspects of pharmacology and clinical practice. Role expansion and accountability are critically analysed in chapter seven in the findings of this study.

There are four main components of nursing, namely clinical practice, organisation of care and management, research and teaching (Wright 1990), and the nurse can develop her career in either of these components, or a combination of these. On choosing a pathway predominantly in clinical practice, one's career can follow a relatively simplistic path, which entails the following.

Pre-registration student nurse → Preceptee → Primary Nurse → Specialist practitioner → Advanced practitioner

The Department of Health (1999b) nursing strategy identifies a very similar pathway as a career trajectory. Both sequences presented here correspond broadly with Benner's (1984) research findings on patterns of 'skill acquisition' during one's career, which tends to entail the following progression:

Novice → Advanced Beginner → Competent → Proficient → Expert

Career progression and skill development in this way would require the ongoing development of knowledge and competence. The necessary knowledge base for practice has been categorised in a number of ways by various authors such as Carper (1978), Heron (1990) and Conway (1996). Benner (1984) for instance distinguished between practical knowledge and theoretical knowledge, and between what was required at the different stages of skill acquisition identified above.

Clinical supervision as a support mechanism for professional development

Clinical supervision has been consistently recommended in the nursing literature and government policy documents as a major peer support and learning mechanism for nurses which consequently constitutes a measure for safeguarding and

enhancing standards of patient care based on continual reviewing of one's professional competence and knowledge (e.g. DH 1993, DH 1999a). Several nurse commentators have documented the need and uses of clinical supervision, and presented models or frameworks for its implementation (e.g. Nicklin 1997).

Clinical supervision is defined by the UKCC (1996 p. 2) as:

A process based on a clinically-focused professional relationship between the practitioner engaged in clinical practice and a clinical supervisor. It complements, but does not take the place of formal programmes of education at pre- and post-registration levels. The relationship involves the clinical supervisor applying clinical knowledge and experience to assist colleagues to develop their practice, knowledge and values.

This definition clearly shows that the focus of clinical supervision lies in professional learning, formal and informal, with the ultimate aim of improving the quality of patient care. It was being widely recommended in the 1990s for RNs as a result of increasing demands being made on practitioners in terms of accountability, which coincided with decreasing support networks. There has also been an increase in the number of nursing specialisms, with consequent pressure on RNs to undertake further academic courses specific to the specialism (Secombe, 1995). It was also felt that as the nursing management structure in the NHS was being flattened, the immediate line managers' (such as ward sisters') time was taken up by several roles such as budget management, regular performance reviews and efficiency savings, and therefore they are not as available or accessible for support as before (Faugier and Butterworth 1994).

However, community nurses and health visitors, for instance, have had an *ad hoc* informal form of clinical supervision for some time, and clinical supervision was also

formally recommended for them in *New World, New Opportunities* (NHS Management Executive 1993). The document notes that the destruction of support networks among community nurses came about as the service moved away from working in small teams to working individually in GP surgeries. This resulted in isolation from nursing peers, management support and advice.

As for newly qualified staff, individuals would have had support during their initial nurse preparation programme from mentors to facilitate their learning, as identified by earlier advocates of the concept (e.g. Faugier and Butterworth 1994), but after qualifying, this support tends to be unavailable, as found by Bick (2000), for instance. To rectify this, the UKCC (1994) had earlier urged the introduction of a preceptor system to be provided for a duration of 4 to 6 months after qualifying, although there is little evidence to demonstrate the extent to which it has been introduced (Hardyman and Hickey 2001).

As to the functions of clinical supervision, Thomas (1995) suggests that although at the *macro level*, clinical supervision aims to promote enhanced nursing practice, at the *micro level* it is seen as encouraging practitioners to examine their own practice so that weaknesses and mistakes can be recognised and alternatives considered. Thomas (1995) adds that clinical supervision is also seen as a catalyst for consolidation of knowledge, which should lead to positive change and professional development. Furthermore, Proctor (1991) delineates 3 main functions of clinical supervision:

A formative function: the educational process of developing knowledge and

competence.

A restorative function: which provides supportive help for those working with stress and distress; enabling practitioners to manage the emotional stress of nursing practice.

A normative function: in which the quality assurance aspects of practice are monitored; managerial aspect promoting compliance with policies and procedures, developing standards, and contributing to clinical audit

The formative function of clinical supervision includes statutory education, in-service training, mentorship, preceptorship and personal development (Nicklin 1997).

Stanton et al (2000 p. 14) report on the findings of a study conducted by action research, which indicated that clinical supervision brings several benefits which includes identifying staff training needs for ongoing CPD and managers becoming more aware of these. There are several other recent studies highlighting the benefits of clinical supervision. Sloan (1999) for instance reports on a study using questionnaires and focus groups, which indicates that supervisees viewed supervisors as role models, that is someone who they regarded highly for their clinical practice and knowledge base. However, the limitations of clinical supervision, they found, were that there were instances when clinical supervisors were allocated to RNs (rather than being self-selected), and at times the supervisor was also the manager who documented and stored the content of the supervision sessions.

Bowles and Young (1999) evaluated Proctor's (1991) 3-function model of clinical supervision through a questionnaire survey. The results indicate clinical supervision benefits RNs in all three areas although this varied according to length of service. However, as regards the formative function, this study also notes that indications from an earlier study by the same authors that contract use enables goals for professional development to be articulated, was not supported.

Wheatley (1999) reports on a pilot project on the implementation of clinical supervision and note that the formative function of clinical supervision can be based on Individual Performance Reviews (IPR) wherein RNs identify their CPD needs in the context of the NHS trusts' objectives. Furthermore, Webb (1997) evaluated a 3-day clinical supervision training programme on which course attendees reported that one of the benefits of the course was that it enabled the development of their reflective practice skills, although the author also reports difficulties in the implementation of the concept.

The formative and normative functions clearly indicate that continuing learning is an inherent component of clinical supervision. The normative function of clinical supervision has been questioned in the literature by Smith (1995) for instance, who concluded a recent conference report by noting that soon there would be questions asked in relation to 'patient outcomes' as a way of measuring the effectiveness of clinical supervision. This question was also asked following a study (entitled *It is good to Talk*) by Butterworth (1997), wherein a co-researcher claimed that despite

the benefits to staff 'what we really need to prove is that it improves patient outcomes' (Coombes 1997 p. 7).

Nicklin (1995 p. 38) and others still indicate that the focus of clinical supervision should be to enable 'Existing practice (to) be continuously evaluated to ensure that every nursing activity is demonstrably beneficial to individual patient outcome and population health gain.' This involves being open to new learning all the time. However, Ayer et al (1997) report on a study of supervised practice in a number of clinical areas, wherein they found positive outcomes, including staff subsequently being able to see their practice and their roles in a much wider context, that is from trust-wide and national perspectives. This broader perspective, it could be argued, also necessitates openness to continuing learning.

In another study of clinical supervision, Bishop (1998 p. 50) concluded that 'while much has been achieved, lack of resources, training and competing priorities have hampered progress'. She found that the benefits of clinical supervision were overwhelmingly seen to include 'a strong reflective practice element', as well as 'enabling people to take action and believe they can make a difference' (p. 50).

Professionalism and continuing learning

On analysing three major reports on the reform of nurse education (RCN 1985, ENB 1985, UKCC 1986), Bentley (1996) concludes that one of the purposes of locating nurse education from schools and colleges of nursing to universities was to raise the professional status of nursing. This transition has been a novel experience for a vast

number of nurses, particularly through the requirement to demonstrate appropriate levels of critical thinking in nurse education course assignments.

Larson (1990) believes that the level and length of formal education undergone by practitioners is regarded as a crucial ingredient of professionalism. On the other hand, Glen (1995) warns against academic drift, through which some believe that in the 1970s teacher education was 'highjacked' by academics with adverse results for practice. Consequently, in the 1990s there was substantial shift away from university-centred professional preparation for teachers to school-based provision (Furlong and Maynard 1995). However, nursing has single-mindedly pursued the strengthening of the position of nurse education within the higher education sector, and it seems that there is no going back, especially with the government-initiated nurse education guidelines identified in *Making a Difference* (DH 1999b) which standardised pre-registration education in England, and includes the concept of university-NHS trust 'partnership'.

The professionalism of nurses does not seem to be questioned markedly in healthcare literature as healthcare managers and the professional self-regulatory body (that is the NMC) tend to deal with instances of malpractice relatively swiftly. However, the degree of professionalism felt by individual nurses might itself be an issue. For instance, Moloney (1992 p. 3) explains that:

... although nurses have enjoyed being called professional, "as much out of courtesy as tradition", full professional status is claimed by few today. If nursing has not been successful to date in reaching a high level of professional status, perhaps one of the reasons might be nurses' inability to reach agreement on the definition of the profession and the responsibilities required.

What seems to be questioned is whether the RN sees nursing as a profession, an occupation or in some other category. Thus if she sees nursing as a profession, and herself as a professional, then she will constantly and reflexively seek to achieve clinical excellence in all her nursing interventions for its own sake (e.g. Davies 1996, Wright 1992a). She treats her vocation as artistry, a concept discussed by Schon (1991) as the bedrock of continuing learning in the workplace. Alternatively, the nurse might perceive nursing as simply a job, which takes up 37.5 hours of her time each working week and provides a reasonable income. However, professionalism is not about being well-paid or climbing the hierarchical tree, according to Iveson-Iveson (1981), but about controlling one's own practice and making one's own decisions. This seems to be one of the strongest reasons for nurses having to be lifelong learners.

The social perception of the professional status of an occupation or vocation seems to be one of the most critical determinants of whether individuals wish to belong to it or not (Meadows et al 2000). In a study of 17 occupations that have been most concerned with professionalisation, Houle (1980) identified fourteen common characteristics of the professionalisation process, including:

- Mastery of theoretical knowledge
- Capacity to solve problems
- Self-enhancement beyond the speciality to maintain perspective

Continuing learning would seem imperative to be able to develop and sustain such characteristics in the professionalisation of nursing. Furthermore, Houle found that some occupations were more typical providers of continuing learning opportunities,

and had generally accepted ways of addressing program-development practices and policy issues for learning than others.

Autonomous practice

Porter (1992), who explored nursing professionalism in the UK, observes that the most notable attempt to promote autonomy, and thereby counter nursing's diagnostic subservience to medicine, was the arrival of the nursing process in the late 1970s. This is because this mechanism, which still forms the basis for nursing activity formally authorises nurses to collect their own data and plan appropriate actions based on the data. The nursing process demarcates the clinical activities that belong specifically to nursing and provides marked autonomy in terms of independent thinking and clinical practice (Porter 1992). Rationales inherent in the planning and delivery of care are constantly reviewed and therefore this also implies self-assessment of knowledge and competence by the RN and further professional learning as appropriate. An inherent component of the nursing process is the use of nursing models or frameworks, which in turn are based on theories of nursing.

However, when the nursing process was being introduced, some medical staff objected to this and expressed anxiety regarding contemporary changes in nursing (Mitchell 1984 p. 217). Nevertheless, Porter (1992) notes that although there are instances where nurses are trying to alter the power gap and to create some autonomous space to work within, efforts to promote this change are hampered by a social and institutional situation that militates in support of medical dominance.

'New professionalism'

Since being a professional itself leads the individual to be a lifelong learner (Jarvis 1987), then what is professionalism? The literature on professionalism indicates that the criteria that need to be satisfied for an occupation to become a profession were initially documented by sociologists (e.g. Flexner 1915), and in the 1990s the relevance of these criteria for nursing was being questioned (e.g. Cook 1992, Davies 1996). They are seen as externally imposed, and consequently according to Casey (1996), the raised professional status of nurses would not be recognised by management and medical profession, since this could imply request for reward on a par with the more established professions.

Along the same lines, Wright (1992a p. 46) had earlier suggested that 'Perhaps nurses should judge themselves less on what others say a profession is, and redraw the boundaries of professionalisation for themselves'. He asserted that the nature of professionalisation can be re-defined in an image jointly determined by nurses and those who have need of them. Complementarily, Cook (1992) and Purdy (1994) claim that if professionalisation entails a method of restricting access to useful knowledge and establishing and maintaining a monopoly over its utilisation in practice, and therefore operate as a method of restricting and limiting public scrutiny of its activities then this is a less attractive goal. This is because it would distance nurses from patients, and so contradict the values of patient-centredness.

Davies (1996) argues that the promotion of continuing professional education is a model of lifelong learning that in part confronts the idea of complete and once-for-all

mastery of knowledge that underpins the old model. Consequently, one of the key characteristics of 'new professionalism', Davies speculates, is reflective practice, which essentially constitutes continuing learning based on experiences in the workplace. Reflective practice also implies that knowledge could not be completely mastered (a feature of old professionalism) because of the open-mindedness inherent in this activity (Goodman 1984). The other facets of new professionalism also imply continuing learning. For instance, interdependent decision-making by involving other professionals as well as the patient also implies being receptive to new and different perspectives of other health professionals and therefore new knowledge.

The arguments discussed in this section indicate that the nurse as the professional needs to be fully confident about her knowledge base and competence, which in turn needs to be evidence-based. The acquisition and maintenance of such confidence and competence makes continuing professional learning and lifelong learning imperative. However, even in current times, a King's Fund Centre study (Meadows et al 2000) still reports that the main reason why nurses are leaving the profession at a fast rate is the lack of status that nurses hold in society.

Contemporary pre- and post-registration nurse education

In exploring the context where lifelong learning features in healthcare, in addition to the four key concepts discussed so far there seem to be several issues currently being considered within nurse education provision itself that impact on the profile of learning that the nurse engages in. Nursing is subject to various changes that are

triggered by such factors as technological advances, the general EBHC ethos and new clinical developments.

Additionally, new knowledge is often being generated by the wide range of nursing research being undertaken. Nurse education needs to respond to these changes, but some of the current issues in nurse education are the result of its transfer to the higher education sector in the 1990s. The merging of nurse education within HEIs is seen as a positive step for nursing to enhance the professional standing of nursing (UKCC 1986), which also partly coincides with Moloney's (1992) report for instance, that when this happened to medicine in USA some years ago, the prestige, status, income and power of the medical profession were enhanced far beyond expectations.

The changing nature of pre-registration programmes

Contemporary issues related to pre-registration programmes include: the aims and purposes of these programmes; mentoring; whether nursing should be a graduate profession; and multi-professional education. Over the years, nurse education has seen various changes in pre-registration programmes. Those offered up until late 1980s were generally referred to as 'traditional' courses and were designed for the achievement of nine competencies (DH 1983). This was followed by a major reform of nurse education based on the UKCC's (1986) *Project 2000: A New Preparation for Practice* directives, wherein the UKCC asserted that the changes would address various prevailing anomalies, and that they were required for the development of a more 'knowledgeable doer'. It would also foster a more scientific approach to

nursing. This new curriculum, which entailed the achievement of thirteen UKCC course outcomes to qualify as a RN, gradually replaced the traditional programme, and was to be delivered in the higher education setting. Students were also to be awarded a diploma in higher education (DipHE), but equally importantly, the programme also aimed to enable students to develop critical enquiry and an analytical approach to nursing practice (UKCC 1986). It was expected that skills in these areas would enable RNs to adapt to the ongoing changes in nursing and in healthcare and therefore to become lifelong learners. This could imply that the traditional courses did not necessarily include this aim, but there seems to be no basis for this assumption.

However, research on Project 2000 programmes (e.g. Macleod Clark et al 1996) began to show that although there were several positive aspects to them, e.g. practitioners demonstrating a more questioning approach to practice, RNs completing these programmes were not as clinically competent as those from the previous traditional courses.

Despite these concerns, in a later study comparing the expectations of 139 senior nurses regarding the competence of newly qualified nurses, O'Connor et al (2001) report that the former's expectations were consistently lower than the actual level of competency demonstrated by the latter. The researchers used specifically designed instruments and the newly qualified RNs were assessed by their preceptors after eight weeks of qualifying. Moreover, Macleod Clark et al (1996 p. 3) note that the student nurses' and diplomates' commitment to lifelong learning was particularly

evident. However, an extensive study of the 'fitness for purpose' of Project 2000 programmes (University of Warwick 1996) shared similar concerns. Furthermore, on reviewing the research literature on Project 2000, Elkan and Robinson (1995) concluded that another area of concern was whether there are sufficient and appropriate placement areas available with adequate and appropriately prepared RNs to mentor students and support supernumerary status. They also found that the aims of 'diploma' level education needed clarifying more fully.

Most of the difficulties articulated in these studies were identified again in a recent study by Howard (2001). This study is based on a relatively small sample of students, and therefore the author comments that although this compromises external validity, student nurses at other institutions may be facing similar difficulties. One of the implications of those difficulties is that they could have been the cause of high drop out rates such as the 27 per cent reported by Munro (1999).

However, because of the reported weaknesses in Project 2000 programmes, in 1998, the UKCC set up the UKCC Commission for Education to review the content of pre-registration programmes. The Commission's remit was 'to prepare a way forward for pre-registration nursing and midwifery education that enables fitness for practice based on healthcare need' (UKCC 1999 p. 2). Following wide consultation, this culminated in the publication of the report entitled *Fitness for Practice* (UKCC 1999), which constitutes the latest change in the pre-registration programme after Project 2000 (UKCC 1986). It contains 33 recommendations for changes.

The *Fitness for Practice* recommendations also endorsed several aims asserted in the 'Strengthening education and training' section of the current government's nursing strategy document *Making a Difference* (DH 1999b), which was published two months earlier. In recommending a UK-wide common programme, the UKCC (1999 p. 2) asserts that the 'climate is right to ... ensure that entrants to nursing and midwifery are adequately prepared for a career of changing roles, lifelong learning and continuing professional development (CPD)'.

Subsequently, other guidance was published by the ENB (2000), and further details in terms of outcomes and objectives to be achieved for entry to branch programmes, and competencies and sub-competencies for entry to parts 12 to 15 of the UKCC professional register were published by the UKCC (2001b). This new pre-registration course has been implemented in the whole of England since September 2000 and has therefore replaced the Project 2000 programme and its course outcomes. It is expected that it will constitute a more standard national pre-registration curriculum, which is fit for purpose, practice and award (UKCC 1999 p. 34).

These issues also contrast with the repeated recommendation in the nursing literature (e.g. UKCC 1995a, UKCC 2001c) that newly qualified RNs should be supported for 3 to 6 months by a named preceptor. However, even where the NHS trusts were willing to install the preceptor mechanism, they found this to be a problematic enterprise because of difficulty in recruiting sufficient numbers of RNs to be able to free staff time for preceptoring. The conclusions that can be derived from these research findings are that although there are several positive elements

identified, the areas of concern tend to reflect a negative reason for continuing learning by newly qualified RNs, which is learning to rectify perceived competence deficits for instance. As for RNs who qualified through 'traditional' courses, one of the reasons for continuing learning is to gain the qualifications that their mentees or students are already studying for.

When Professor of Nursing Macleod Clark (1998 p. 14) was asked to comment on how the nature of nurse education programmes should change in the future, she explained that 'it is not possible to talk about the future of nurse education without talking about the future of nursing'. She recommended a symbiosis between nursing education and nursing practice, which would take the form of true partnership between universities and NHS trusts to rectify the prevailing problems. On 'best-guessing' the future of nursing, she indicated that she thought that there would be greater responsibility vested in nursing roles and greater autonomy; and that healthcare would reflect enhanced interdisciplinarity. Macleod Clark (1998) argued that these developments in nursing offer opportunities and challenges, and that the agenda for education must focus on 'fitness for purpose'. She indicated that to achieve this in multi-disciplinary healthcare means that the RN needs to be flexible, confident, competent, knowledgeable and motivated. These characteristics, she suggested, equate with graduateness. She therefore proposed a 'three plus one' model programme consisting of the 3-year pre-registration course following one year as a preceptee or intern to achieve this (Macleod Clark 1998).

Increasingly, nursing is becoming a graduate profession. One significant reason for RNs studying for a degree is that RNs who are not graduates may not be appropriately academically qualified to mentor nursing undergraduate students. According to Thompson (1998), there are a number of forces pulling nursing towards becoming an all-graduate profession. These include the increasing complexity of clinical decision-making in nursing, the very low drop-out rate and high competition to get on graduate pre-registration courses, as well as the high likelihood that nurses from graduate programmes would stay in clinical practice, rather than pursuing their careers in management or other areas of the profession.

However, this debate remains a relatively sensitive one as some might argue that by having an all-graduate profession, we could be preventing interested applicants with appropriate aptitude for nursing but lesser entry qualifications having access to pre-registration courses. This is partly because the entry requirement to pre-registration degree courses is usually higher than those for diploma programmes. From the UKCC's (2001b) perspective, pre-registration programmes can be offered at DipHE or degree level.

Yet another aspect of pre-registration nurse education that interfaces with lifelong learning is the concept of multi-professional or inter-professional education (MPE or IPE) (e.g. UKCC 1999, UKCC 2001d). Current nurse education literature repeatedly refers to IPE as a desirable mechanism whereupon in both university settings and the clinical setting, healthcare students on different professional courses learn professional knowledge and competence while interacting with each other. Such

programmes are still at the debate stage in nursing circles with a few pilot programmes currently in operation (Sanders 2000, Salmon and Jones 2001). IPE has earlier roots as it was recommended in the UKCC (1986) Project 2000 initial document for instance. The reason for inclusion of IPE is that there is a core of knowledge and competence that all health professionals need to develop, and interchangeability of perception can only enrich each other's perspectives (UKCC 2001d). The criterion for the inclusion of IPE in a course programme is that it should ultimately benefit patient care along with benefiting the student's education (UKCC 1986). However, currently there are reservations related to this concept, which is critically analysed in chapter seven in the context of the study findings.

More recently, lifelong learning for RNs has been further endorsed by the UKCC (2001c p. 6) in the assertion that the competencies of the new pre-registration programme 'must include the capacity to extend the scope of practice and to address lifelong learning skills within all programmes of preparation'.

Post-registration programmes

Features of post-registration nurse education that entail lifelong learning include trends in CPD, Post-registration Education and Practice (PREP), the nurse's career trajectory, critiques of CPE especially in terms of their impact on clinical practice, and evaluation of and research on various nurse education programmes, amongst others.

In nurse education, lifelong learning was brought to the fore by the ENB (1994, 1995a) in *Creating Lifelong Learning* documents, which identified the specific content of pre- and post-registration programmes to prepare RNs to become lifelong learners. It was reinforced in *A First Class Service* (Department of Health 1998) and *Making a Difference* (Department of Health 1999b) and is cursorily referred to in various other government and statutory body documents as an inevitable feature of nursing. The nursing literature tends to reflect the impression that RNs have consented to and adopted the requirement to be lifelong learners, that is to continue professional learning for the rest of their nursing careers. This was not a requirement prior to PREP, but studying for these qualifications would also fulfil PREP requirements.

For professional development aimed at extending the 'scope of practice', the UKCC (2001b p. 6) envisages that RNs should engage in career-long continuing professional development and develop the ability to adapt to change as well as identify the need for and initiate change. For post-registration programmes this is also endorsed through PREP (UKCC 2001c) for instance, which details the essential roles of preceptorship and clinical supervision in facilitating this.

Post-registration programmes in the form of CPE, have been developing consistently since the 1970s, and a landmark was reached with the publication of a series of ENB sponsored project papers between 1990 and 1992. The first one of these is entitled *The Collapse of the Conventional Career* (Davies 1990), and the sixth paper *Continuing Professional Education in the Context of Healthcare* (Orme 1992). As the

latter title indicates, this was a major review of CPE and led to the establishment of a new *Framework* for post-registration nursing education (ENB 1991).

Thereafter several courses for a very wide range of nursing and midwifery specialisms were developed, and they each had an identifying ENB number. Since the time when nurse education moved into the higher education sector, these qualifications have had the potential for being 'accumulated' into university diploma or degree qualifications as well. Research into CPE (e.g. Owen et al 1998) indicates that there is recognition of the value of CPE in terms of maintaining a suitably knowledgeable and skilled workforce, but that there are also concerns related to resourcing of CPE and barriers to equitable provision. However, there has been remarkable increase in uptake of CPD and CPE in the last decade (e.g. Jordan 2000). This is examined in some detail in chapter two.

Nevertheless, questions have been raised about the extent to which patient care benefits from RNs attending CPE courses in terms of the development of practical competence (e.g. Bignell and Crotty 1988, Jordan 2000). The study of CPE by Owen et al (1998) appears to suggest that the focus of CPE programmes needs to be on their 'fitness for purpose, practice and award', which is recognised by the ENB (1997 p. 30) as essential. The ENB (1997) document identifies the standards and criteria that all nursing and midwifery education programmes need to address, which essentially forms part of the quality assurance processes of professional education and practice in nursing. To ascertain the effectiveness of these processes, a study is being conducted by Pope et al (2002), and the results are awaited.

Conclusion

This chapter examined the broader context of nursing and healthcare delivery in the UK in the mid-1990s when lifelong learning for nurses was most recommended. The literature was explored to ascertain features that interact with lifelong learning. These include the general ethos of healthcare delivery itself in the *New NHS*, the notion of being a nurse employee in the NHS, clinical supervision, the professionalisation of nursing, and contemporary pre- and post-registration nurse education. Other relevant contemporary issues include clinical governance, the nature of the nursing workforce and their career trajectories, expanded roles and accountability, autonomous practice and tentative redefinition of professionalism, and the changing nature of nurse education programmes. These constitute evolving features, some of which are in their early days of development while others have been developing over several years. These will be further discussed in chapters four to seven in relation to the study findings.

The first feature explored in this chapter was contemporary government policies indicating that lifelong learning is an important component of clinical governance as well as an inevitable result of societal and technological changes, and that it is likely to affect all health professions in the NHS. The whole way that healthcare is delivered in *The New NHS* indicates that continuing learning becomes an imperative for the nurse which includes continuing professional development and evidence-based healthcare.

Secondly, the nature of the nursing workforce and the work practices of nurses impact on lifelong learning significantly especially with expanding roles and increasing awareness of accountability, the nurse's career trajectory, and the increasing levels of interest in CPD by RNs. These clearly relate to continuing learning.

The third feature is the role of clinical supervision, which is a peer support mechanism for determining CPD requirements with the ultimate purpose of improving and enhancing standards of patient care, and is strongly recommended. It also acts as a facilitator of professional development and a mechanism for encouraging and facilitating awareness of own CPD needs. However, after almost a decade of recommendations for its availability for all RNs, it is increasingly becoming available in the clinical areas. There seems to be support for more universal availability of this mechanism.

Fourthly, there is the issue of promoting nursing professionalism, which includes increasing degrees of autonomy and ability to control one's own practice. Nursing's professional status appears to be on a protracted process with even recent studies showing that society is unwilling to recognise nursing as a fully mature profession as the more established ones are. Some nursing commentators argue that the criteria of professionalisation itself need to be redrawn. Reflective learning is increasingly playing a more fulsome role in both classroom-based and practice-based learning activities, as it seems to be doing in the professional education of other professions such as teaching and engineering.

Fifthly, current thinking in nurse education itself identifies the need to continue professional development from the very point of qualifying as a RN, and also subsequently the responsibility of the mentoring role. This is accentuated by the need to meet PREP requirements to be able to keep one's status as a RN. The suggestion that nursing should be a graduate profession and the notion of IPE also entail constant review of one's qualifications and therefore professional knowledge and competence. Features of nurse education that interface with lifelong learning indicate that it will continually evolve (e.g. Birchenall 2000).

Analysis of relevant documents and articles shows that the five key areas discussed in this chapter constitute key issues that interface with the notion of lifelong learning, and yet the literature does not explore how RNs delivering patient care perceive the arrival and assimilation of this notion as a norm within nursing. Lifelong learning and continuing professional development as concepts most central to this study are critically reviewed in chapter two.

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Chapter Two

LIFELONG LEARNING AND ITS SIGNIFICANCE FOR NURSING**Introduction**

This chapter constitutes a critical review of the literature on lifelong learning and lifelong education and its significance for nursing. An extensive critical examination of publications was conducted covering the time span up to the beginning of data collection in Spring 1999. It aimed to ascertain the rationales for the inclusion of lifelong learning in the educational system, the debates in society and in nursing, the directions the concept of lifelong learning seemed to be taking, and the factors that needed to be addressed to ensure effective implementation. The search for both conceptual and empirical literature on these areas encompassed relevant databases, such as CINAHL (Cumulative Index to Nursing and Allied Health Literature), ERIC (Educational Resources Information Centre), ASSIA (Applied Social Sciences Index and Abstracts), the Cochrane database of systematic reviews and Medline. It also included manual search and scrutiny of relevant journals such as *International Journal of Lifelong Education*, *Adults Learning*, etc for research on continuing education, adult education and nurse education, and related topic areas. All publications on lifelong learning by healthcare organizations were examined, as were relevant reports and policy documents by DfEE, NAGCELL, NIACE and others.

This examination of the literature revealed that the majority of the publications are 'conceptual' in nature, in that they address the theories underpinning the concept and its various facets as identified by key thinkers in the subject area. Very little empirical literature was found.

The aim of this literature review was consistent with Carnwell and Daly's (2001 p. 57) view of its purpose, which is 'to critically appraise and synthesise the current state of knowledge relating to the topic under investigation, as a means of identifying gaps in the knowledge that a new study would seek to address'. Of the four main methods of structuring the review that they identify, the one seen as the most appropriate approach for reviewing the literature related to nurses' perceptions of lifelong learning was that which entails 'examining the theoretical literature and then the methodological' (p. 60). This is because this method is used when there is a scarcity of empirical literature on the topic area, which was the case with lifelong learning in the latter half of the 1990s when this study was conducted. The purposes of the literature review were then to review the theories on the subject, and to consider the implications of these theories for selecting the appropriate research methodology.

The main issues revealed by the literature are discussed under the following headings:

- Definitions of, and distinctions between, lifelong learning and lifelong education.
- The philosophy underlying lifelong education.
- Learning society and learning organization.
- Educational theories underpinning lifelong education.
- Deterrents, obstacles and reservations about lifelong learning.
- CPD and CPE as components of lifelong learning.
- Lifelong learning in nursing.
- Research on lifelong learning and closely related concepts

These areas reflect key concepts within lifelong learning and how they could be implemented. The literature review led to the identification of the main issues that need exploring, which in turn determined the aims and reasons of the study.

There are distinctions between the terms lifelong learning and lifelong education, which are discussed in the next section in this chapter. However, the term lifelong learning will be used throughout the thesis, and terms such as lifelong education, adult education etc are only utilised when referring specifically to them.

Definitions of, and distinctions between, the concepts lifelong learning and lifelong education

As noted in the Introduction of the thesis, the 1990s saw the production of several documents emphasising the value, needs and the mechanisms for implementation of lifelong learning in education (e.g. Tight 1998a), as well as in nursing (e.g. ENB 1994). Some of the more prominent general policy statements are listed in table 2.1, but in addition to these, an increasing range of books and journal articles continue to be produced. Publications that appeared after the data collection period are referred to in chapters four to seven where the findings of the study are discussed.

Both the review of the NHS, *The New NHS – Modern, Dependable* (NHS Executive 1997), which the current ruling political party issued soon after taking office, and the quality assurance document *A First Class Service - Quality in the New NHS* (DH 1998) issued the following year, also emphasise the importance of lifelong learning for health care staff.

Table 2.1: Some of the key documents on lifelong learning informing policy

- *Higher Education in the Learning Society (Dearing Report)* (NCIHE 1997) - a review of HE provision in England.
- *Learning Works: widening participation in further education (Kennedy Report)* (Kennedy 1997) - a vision of lifelong learning for all.
- *Learning for the Twenty-First Century (Fryer Report)* (Fryer 1997) - creating a culture of lifelong learning for all.
- *The Learning Age* (DfEE 1998) - the government's Green Paper and its apparent support of the concept.
- *Creating Learning Cultures: Next Steps in Achieving the Learning Age* (NAGCELL 1999) - suggests actions for the realisation of lifelong learning.

The Department of Health (1998 p. 84) document defines lifelong learning as:

A process of continuing development for all individuals and teams which meets the needs of patients and delivers the healthcare outcomes and healthcare priorities of the NHS and which enables professionals to expand and fulfil their potential.

The government's strategy for nursing document *Making a Difference* (DH 1999b p. 14) notes that 'Lifelong learning is more than a slogan, and access to education, training and development is no longer an aspiration for the few but a necessary part of jobs and careers in most sectors'. The nurses' professional body the Royal College of Nursing (1997) asserts that CPD should be seen 'as a way of life'. However, the learning undertaken by the professional is not solely profession-related because it tends to occur in the context of life in general. The UKCC (1994) recognises that lifelong learning goes beyond CPD in that it entails a different culture, and a different approach and attitude.

The related concept lifelong education is defined by Dave (1976 p. 34) as 'a process of accomplishing personal, social and professional development throughout the lifespan of individuals in order to enhance the quality of life of both individuals and their collectives'. This definition addresses three key areas of lifelong education, i.e. personal, social and professional, the purpose of which is to achieve a better quality of life for all. Dave (1976) elaborates upon this definition to explain that it is a comprehensive and unifying idea, which includes formal, non-formal and informal learning so as to attain the fullest possible development, growth and social progress. It is therefore connected with both individuals and educational organizations.

Knapper and Cropley (1991 p. 18) indicate that lifelong education is 'a set of organizational, financial and didactic principles established with the aim of fostering lifelong learning'. Lifelong education is therefore seen as the system and lifelong learning is the content, the goal and the result. The authors acknowledge that although different writers have used the term lifelong education in different ways, the pattern indicates that it refers to administrative, methodological and procedural measures for seeking to promote lifelong learning. The emphasis on 'principles' and 'procedural measures' is based on what earlier educationists had described as a continuing crisis in education due to inequalities in access to higher education (Knapper and Cropley (1991). This suggests that HEIs should explore how they can establish the appropriate measures for facilitating lifelong learning as well as overcoming the perceived inequality of access for different social groups.

Jarvis (1987 p. 50) quotes the French educationist Lengrand's (1975) perception of lifelong education as 'l'education permanente', which the latter saw as 'any planned series of incidents at any time in the lifespan, having a humanistic basis, directed towards the participant's learning and understanding'. Furthermore, Knapper and Cropley (1991 p. 17) suggest that the term lifelong learning may be no more than 'a unifying principle' that links existing trends and tendencies in education, and which therefore takes a more holistic perspective than lifelong education. However, it now appears to be more familiar term, conveying the increasingly accepted view that education should not end with school or college, but be a normal and realistic expectation throughout life.

Characteristics of lifelong learning as a concept

Following an exploratory study conducted for UNESCO, Dave identified a number of concept characteristics of lifelong education, which he used to describe the concept's meaning, functions, goals, relationships and other attributes. One of the concept characteristics refers to lifelong education as including formal, non-formal and informal patterns of education. The first relates to school, college and university education; the second refers to organised educational activity that does not fall neatly within formal education; and the third relates to learning about life generally during normal daily living activities.

Dave (1976) attempted to provide further clarification of the concept by putting forward a formal statement for a lifelong education programme. He suggested that education should be seen as covering the entire life-span of the individual, and that there were two kinds of understanding and strategic interpretations of lifelong education. These are that lifelong learning can either be taken to mean that the educational process is to be conceived as continuous and uninterrupted throughout the individual's life, or as a stop-start process that does continue regularly throughout the individual's life but at intermittent periods interspersed with other activities that are non-educational. This is supported by Longworth and Davies (1996), who note that the lifelong learning process needs to be seen on a 3-axis framework: lifelong, learning and the learner. Figure 2.1 portrays in some detail how 'lifelong' encompasses learning through pre-school education that starts on a formal basis to increasingly informal learning that occurs in the 'third age'. This is complemented by the learner assessing his or her own personal learning needs,

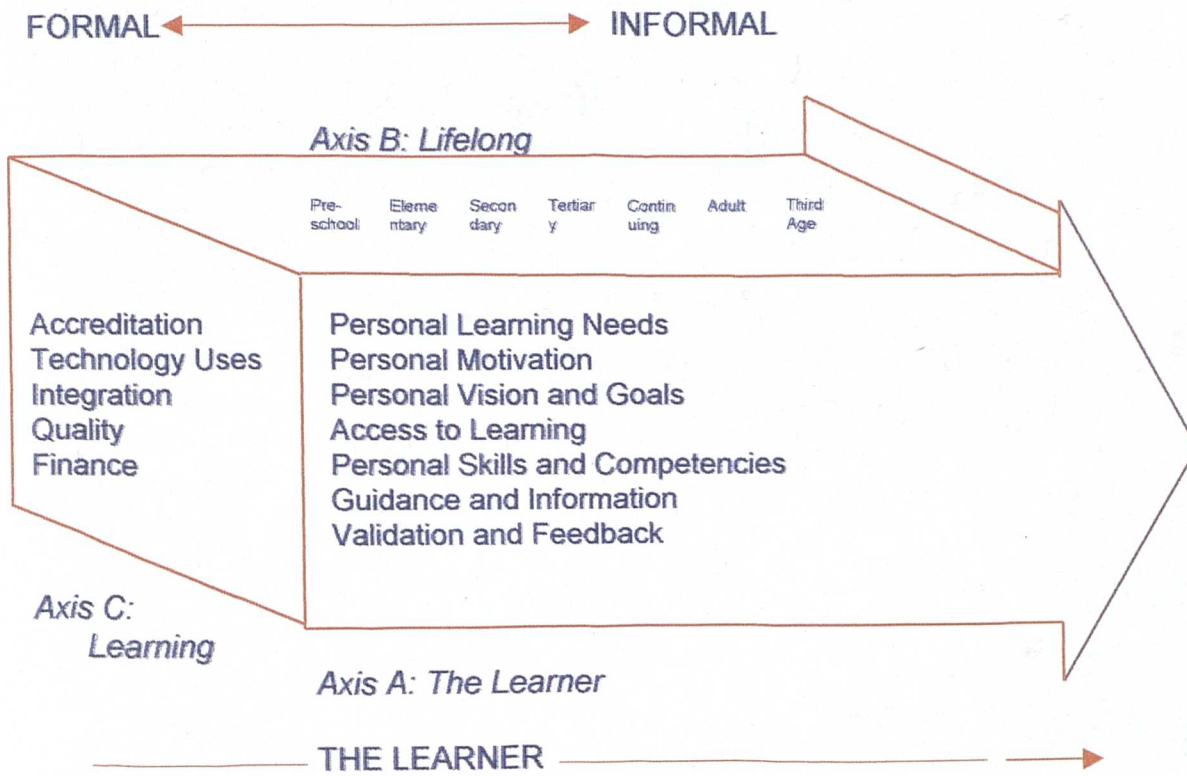


Figure 2.1: The learning process (Longworth and Davies 1996)

related to knowledge, competence and vision, for instance (Axis B); and on the third dimension by accreditation of learning, integration, etc (Axis C).

Transition from initial education to adult education

Titmus (1999) sees the division between initial education and adult education as constituting a very neglected obstacle in the way of achieving lifelong learning and lifelong education. He observes that in an ideal world lifelong learning, in its pure or extreme form, might be seen as an essential constituent of life, throughout life, not merely a valuable tool for living, but one of its purposes. However, this is difficult to achieve because working life currently seems to take place under intense pressure of time. Furthermore, Titmus (1999 p. 351) notes that 'placing initial education and adult education end-to-end, tidying up where they overlap and calling the result lifelong education would change nothing but the label. Consequently, ... both initial education and adult education need to undergo important modifications, if lifelong education/ learning is to be achieved' because pre-initial education and third-age learning are not accounted for.

Knapper and Cropley later (2000 p. 6) agreed with this view and recommend 'a simultaneous renewal of school and higher level education' in such a way that the two form one continuous learning system and therefore a continuous scheme of lifelong education. This can also be connected with the distinct concepts of 'education for leisure' and 'education as leisure' (Parker 1976). Clearly both involve learning, the former possibly more formal than the latter. The reason for this, Titmus (1999) argues, is that a large proportion of young people view the end of

compulsory education with relief and value their freedom from educational obligation more highly than the continuation of learning. Titmus (1999 p. 353) also asserts that he does not see initial education as adequate 'due to ill-chosen or an over-crowded curriculum, or inappropriate or incompetent teaching', as well as institutional short-termism, which requires teachers to concentrate on the immediate to the neglect of the lifelong perspective. He observes that there is little sign of effective action on the part of policy makers, education providers or scholars in adult education who, he suggests, should act more anticipatorily by getting together with those in initial education to resolve the transition to, and participation in, post initial education.

Evolution of lifelong learning

Knapper and Cropley (1991) indicate that the term lifelong learning has existed since ancient times, but lifelong education appeared approximately 75 years ago, with more consistent interest sustained over the last 30 years. Wain (1987) explains that the origins of the term lifelong education are unknown, having appeared in official documents since 1919, but by 1973 it was recognised as the 'master concept' for all of UNESCO's educational planning. Wain (1993) reiterates Cropley's (1979) view of lifelong education as an 'elastic concept' with no precise meaning. Cropley (1979) further explains that although there are a number of well-defined operational principles that express the practical implications of lifelong education that must be common to all, there is no 'universal blueprint'

Gelpi (1985) argues that the concept of lifelong education, like all central concepts, is temporary, and as an active concept will undergo a continuous process of

enrichment in terms of interpretation, conception, definition and practice. Lifelong education is therefore at once seen as a concept, a policy, a practice, a process, a goal and an ideal.

Reflecting on the current developmental stage of lifelong learning as a concept, Edwards (1999 p. 12) observes that ‘.. lifelong learning seems to be all encompassing. New centres for and of lifelong learning are cropping up throughout the UK, as are professors and directors of the subject’. He concludes that the concept is here to stay despite changes and shifts in policy and practice during recent years. Lifelong learning was said to have come of age in 1976 when in the USA the 'Lifelong Learning Act' was passed onto law. This authorised the expenditure of \$40 million each year from 1977 to 1982 on lifelong learning. With the current numerous activities related to the concept, Knapper and Cropley (2000 p. 2) later concluded that ‘it is tempting to assume that lifelong learning has well and truly arrived’.

The definitions, concept characteristics and evolution of lifelong learning and lifelong education represent different facets and perceptions of these concepts, which it could be assumed underpin one part of the theoretical knowledge that had led to advocating lifelong learning for nursing. However, the literature does not show how nurses working in the clinical area perceive and define the concept.

The philosophy underlying lifelong education

Jarvis (1987) observes that, traditionally, intellect has been regarded as something that develops early in life, and reaches a peak in adolescence. Then, after a plateau period of slow decline throughout early and middle adulthood, it falls off sharply in later years. However, Jarvis (1987) also notes that more recent knowledge suggests that the growth of intellect throughout life is better understood in qualitative than in quantitative terms. Dewey (1916) argued that human beings instinctively find the idea that they cannot grow any more repugnant, if this is suggested to them even in old age. He suggested that the mind does not stop growing, it simply starts to grow predominantly in another direction, whereupon formal operational thought gives way with old age to dialectical operational thought [as reported by Wain 1987 p241].

In agreement with this mode of thinking, the Association of Lifelong Learning (ALL) 'rejects the common assumption that education equals school' (ALL 1992 p. 59) and believes that knowledge is the basis of democracy and is therefore the right of all citizens. Wain (1987 p. 238) suggests that we can no longer envisage education as a finite thing, a 'preparation' for life, and that it needs to be conceptualised as part of life itself. Faure et al (1972) referred to the notion of 'permanent incompleteness of man' - and explain that lifelong education is required by human nature itself. Ball (1991 p. 10) also indicates that 'Learning is lifelong. There is no such thing as sufficient initial education'.

Consequently, the concept of adult education evolved, which constitutes 'a large measure of self-directed learning' that Titmus (1999 p. 352) perceives as essential

for any realistic scheme of lifelong learning. This therefore implies that the individual must have the desire and ability to take responsibility for their own learning and that the education system should endeavour to develop an attitude and enthusiasm as well as the skills necessary for individuals to take responsibility for their own continuing or lifelong learning. Various commentators on lifelong education and adult education have discussed the beliefs underpinning these concepts. For instance, Ball (1991 p. 10) indicates that:

Learning pays. ... Learning also civilises and empowers. I assert that training (at its best) will make nations and their citizens wealthier, societies more content, individuals freer and more able to determine their lives in the ways they choose.

The philosophy underlying lifelong education is largely based on humanism and seems to agree with Dewey's views. In his analysis, Wain (1987) explored different philosophical positions, namely humanism, existentialism, liberal philosophy of education and pragmatism, and concluded that lifelong education covers aspects of each one of these. Lifelong learning is at times also associated with liberal-democratic values (Knapper and Cropley, 1991 pp. 59-60) and then is manifested in course outcomes such as: 'communication skills, ability in critical thinking, understanding of the local culture and differences between cultures, interpersonal skills (including empathy and tolerance) as well as knowledge and skills necessary for working life and the ability to learn how to learn'.

According to Gelpi (1985) courageous endeavours have been taking place and continue to do so in formal and non-formal education to meet educational and cultural demands, and these developments show that educational innovation and

creativity are possible when at school, university and in daily life. The expansion of leisure time and the increase in the number of educational premises reflect the possibility of education for all, and it could occur from the earliest childhood to old age, at work and in leisure, in the school and in the community.

Cropley (1979) discussed the question of whether lifelong education comprises a philosophy of education at all. He argues that the majority of writers in the area have indeed accepted, implicitly or explicitly, certain beliefs about the nature of man, society and education, and that if such an agreement constitutes having a philosophy, then there is an identifiable philosophy of lifelong education. This philosophy is 'loosely humanitarian, and humanistic in nature'. Its main tenets are that education should (Cropley 1979 p. 101):

- a. involve learners as actors in their own learning rather than as passive recipients;
- b. foster the capacity to play this role;
- c. lead to democratisation of society; and
- d. improve the quality of life of men and women.

It seems therefore that there is a common understanding between a number of theorists that lifelong education has a common philosophy, which essentially makes it a movement, as it addresses broader social issues such as the rights of man, empowerment, democratisation of society and civilisation.

The learning society and the learning organization

Based on the arguments on lifelong learning presented by Cropley (1979), Ball (1991) and others, it is clear that the concept is perceived as an activity for not just individuals, but also for whole communities and whole societies at national level and beyond. This is consistent with Wain's (1993) perspective that learning extends the concept into arenas of informal learning, that is those that occur in society in general, and not only in some specialised post-school sector. Furthermore, Tight (1998a) observes that lifelong learning has become part of a trinity - lifelong learning, learning organization and learning society.

In the endeavour to promote continuing learning amongst all, the concept of a learning society or an education-centred society formed the central theme of the Faure Report (Faure et al 1972). This term also forms part of the title of the Dearing Report (NCIHE 1997) although the report makes very little reference to lifelong learning itself. It's summary section notes that the title 'reflects the vision that over the next 20 years, the United Kingdom must create a society committed to learning throughout life' (p. 8).

Faure et al (1972) observed that although still probably idealistic, the learning society concept is seen as the cornerstone of the consistent evolution of lifelong learning. It was expected to be democratic and consist of educational policies and strategies that would strive to ensure that education is not the privilege of an elite, or the concomitant of a particular age. Nor would it be seen as a social service, but as the right of citizenship, available to every individual at all times.

Learning society

Jarvis (1995 p. 40) indicates that the Royal Society for the Encouragement of Arts, Manufacturers and Commerce (RSA) defines the learning society as 'one in which everyone participates in education and training throughout their life. It would support them as citizens, in their employment and leisure'. Jarvis (1995) notes that the learning society is one in which everyone begins with liberal education in educational institutions and continues liberal learning either in such institutions or outside them in centres that enable independent and critical thinking.

Faure et al (1972) envisaged that such a society will organise itself deliberately so that 'formal' institutional arrangements promote the greatest number and variety of opportunities for 'non-formal' learning in an environment and manner that is 'informally' enriching and stimulates continuing learning. Thus the learning society provides both the resources and the context for effective self-realisation through active learning of its members. Thereby,

... each person should be able to choose his path more freely, in a more flexible framework, without being compelled to give up using educational services for life if he leaves the system (Faure et al 1972 p. 186).

Ball's (1991) vision of a learning society is one in which all citizens participate in education and training throughout their lives, with their learning structured primarily to help them do things for themselves. However the translation of the vision of a learning society into reality is not seen as the responsibility of government alone, but also requires the co-operation, effort and enterprise of many agencies and all

parts of society (Ball 1991). Jarvis (1995) explains that while a learning society is emerging, a number of major constraints may exist to inhibit its progress, including:

- the idea that education should have an aim other than learning for its own sake;
- the prevalence of the idea that education is only initial education; and
- the understanding of leisure as being something which is uncreative and of little value, so that it is only malingeringers who have it.

Hughes and Tight (1995) also observe that UK society cannot currently be considered to be a learning society as the concept itself is a myth along with the related myths of productivity, change, lifelong education and the learning organization. However, they indicate that even as a myth, it has an important role to play in channelling energies 'in directions sought by policy-makers' (p. 290). Field (1998) also observes that the UK hasn't quite evolved into a learning society as yet, as there are problematic issues related to it in that some learning through the Internet for instance can be harmful to society, such as learning how to abuse children or to defraud others. Field (1998 p. 7) also notes that this has been identified in a 1996 European Commission report which warns of a 'growing gulf between the 'knowledge rich' and the 'knowledge poor'. This observation seems to confirm a problem identified several decades ago that one of the reasons for proposing lifelong learning in the first place was to combat continuing inequalities in access to higher education (Knapper and Cropley 1991) which was referred to earlier in this chapter.

Learning organizations

Extending from the concept of learning society, the second NAGCELL report issued in 1999, *Creating Learning Cultures*, indicates that the United Kingdom society is currently going through a period of profound change, which is referred to as 'risk society'. There are several characteristics to this, which include 'increasing fragmentation of experiences and institutions' (p. 7) within which lifelong learning must occur. The ENB (1994 p. 11) also focuses on learning cultures, and in the context of healthcare and educational organizations, notes that:

Because lifelong learning is not merely 'keeping up to date' but is concerned with a flexible and enquiring approach to everyday events, the development of a culture of a learning organization is an important part of the work of the collaborative partnership between various stakeholders in the NHS.

There is extensive literature on organizational theory analysing how several aspects of organizations function. Much is written about big national and international organizations becoming learning organizations (e.g. Pedler et al 1997, ENB 1994, Dixon and Haldane 1994). The latter authors indicate that fewer levels of authority are replacing hierarchical authoritarian organizational structures in industry. A consequence of this trend is that employees at several levels will be required to take on more personal and shared responsibility within teams rather than merely receive and execute orders.

Dixon and Haldane (1994) also suggest that organizations where employers see employee development as the key to business success are organizations that are likely to give this perspective priority in corporate planning, and therefore more likely to see themselves as learning organizations. Their strategy and structure provide an

environment in which innovation can flourish through the growth of the organization's knowledge and skills in a variety of ways. In addition to possessing relevant competences, workforce members must also possess (from initial education) or develop skills (from continuing education) in learning, and employers are increasingly expecting individuals to take more responsibility for their own learning.

Watkins and Marsick (1992 p. 118) note that 'Learning organizations are characterised by total employee involvement in a process of collaboratively initiated, collaboratively conducted, collectively accountable change directed towards shared values and principles.' The authors argue that this constitutes a conceptual shift by human resource developers from predominantly training to 'facilitation of learning', and from behavioural to broader more transformatory conceptions of learning. They recommend that the concept 'learning organization' be considered in terms of its outcomes as well as the process by which organizations must change to embed learning.

The ENB (1994) suggests that practitioners, students, managers and educators all have a vital part to play in contributing to the ability of the organization to become a learning organization. It is only if the individuals within an organization have the confidence to develop their own learning that the organization itself will move forward.

For healthcare, the ENB views the development of an organization that contributes to lifelong learning, as involving eight key features (table 2.2). Several clinical units seem to be endeavouring to achieve many of these features, both as intentions and as aims identified in their mission statements. In nursing the creation of practice development managers can be seen as a measure for promoting the NHS trust as a learning organization. The development of clinical supervision contributes to this culture by enabling practitioners to access professional peer support and development (Faugier and Butterworth 1994).

The culture of a learning organization is characterised by a willingness to gain insight from experiments and experiences (Argyris and Schon 1974). As Handy (1984) stated, the organization should positively encourage people to ask questions, to search for answers and to test out these answers; it must encourage curiosity, discovery and experiment because that is how people learn. How far clinical areas perceive themselves as learning organizations is uncertain, as the term is still relatively new and little known in nursing circles. The term clinical learning environment is relatively well known but there is no literature that indicates that this is currently explicitly linked to lifelong learning. If the clinical setting did see itself as a learning organization or a learning society, then what are the formal mechanisms and non-formal ethos that would facilitate it? This is one of the questions that this study aimed to explore.

Table 2.2: Eight key features of a learning organization (ENB 1994).

1. The existence of a clearly articulated health policy that puts patients and clients at the centre.
2. Effective communications throughout the organization.
3. Key stakeholders and practitioners at all levels of the organization are involved in its development.
4. Staff development and performance review is in place for all practitioners.
5. Clinical supervision is accessible for practitioners.
6. Recognition is provided that learning takes place in the workplace.
7. Determination guaranteed to translate rhetoric into action.
8. Commitment is given to encourage reflective practice.

Educational theories underpinning lifelong education

This section builds on the preceding ones, but in particular extends the analysis on the philosophy underlying lifelong education to educational theories that underpin it. Knapper and Cropley (1991 p. 17) note that lifelong education itself comprises an educational theory in that the term refers to 'a set of goals, a set of procedures for realising these goals, and a set of values'. These are based on the liberal-humanistic approach to education, and therefore it addresses the potential for promoting equality of educational opportunity through its role in the democratisation of education and for enabling individuals to achieve higher levels of self-actualisation.

Knapper and Cropley (1991) distinguish between two other modes of learning: simple exposure and planned intentional preparation. They suggest that whilst the former refers to general learning that the individual undergoes in reacting and adapting to circumstances, the latter is 'a way of short-circuiting personal experience by drawing upon the accumulated experience of others' (p. 41). It is the latter that belongs to the field of lifelong education, which nevertheless can capitalise on the former in formal settings. Previously, Tough (1971) had suggested that lifelong education needs to be underpinned by 'deliberate' learning, which means that it is intentional and is not undertaken simply because of factors such as boredom, for instance.

Another perspective is provided by Wain (1993) who reviewed the existing literature on lifelong education and examined the 'minimalist' and the 'maximalist' principles

underlying the implementation of the concept. He noted that the minimalist approach equates with in-service training, recurrent education and the whole domain of adult education. The maximalist approach on the other hand sees lifelong education as involving a fundamental transformation of society so that the whole society becomes a learning resource for each individual, and is aware of its educational responsibility. Minimalists share the view of adult education as a 'stop-start' provision of educational opportunities, or as topping up of professional or academic education. The maximalist 'totalising thrust', Cropley (1979) points out, leads towards a 'learning society', or Suchodolski's (1979) 'educative society'. The writers indicate that this approach entails a co-ordinated mobilisation of institutional and personal resources for learning, and a particular mentality. This may be extended to reformist or even missionary levels, translating into educational philosophy, structures and policies.

Although several authors, such as Gelpi, Dave and Lengrand accept the maximalist approach, Wain (1993) argues that the maximalist view has largely disappeared through using lifelong education interchangeably with adult education. This is despite constant warning by these authors against confusing it with adult education as this would unduly limit the concept and distort the educational philosophy it represented. This is because the term 'adult' distinguishes a particular and restricted phase of life rather than life in its totality.

Currently, it seems therefore that the minimalist view is triumphing even if it only 'makes a stronger case for adult education through the pragmatist case for lifelong

education, and revitalise adult education by using a new and trendy term' (Wain 1993 p. 94). To some extent this is supported by the fact that few articles published in *'The International Journal of Lifelong Education'* are on lifelong education itself as a concept, but it has quite a few on adult education.

As Knowles (1990) indicates, the approach to education of adult learners needs to be different from that of non-adults. Educators should for instance take into account that adults have different competing demands on their time and that they come to learning with fairly specific expectations. However, both Lawson (1992) and Usher (1991) observe that even adult education is either under-theorised or has yet to theorise itself in its own right. Blaxter and Tight (1995) considered the idea of life transitional events as a possible explanatory theory of adult participation on learning. Based on a study entailing interviews with thirty-six undergraduate students, they concluded that this idea does not constitute a suitable basis upon which to build a satisfying explanatory theory of adult participation.

Wain contends that, if the minimalist view continues and the maximalist view was to disappear, then one big danger is that the implications for the earlier phases of education in childhood and youth, which is for education to become a lifelong process, could be lost. These phases should cultivate 'educability' and not work towards some finished product of 'the educated person'.

Finger (1995) identifies three major paradigmatic orientations - or models, theories, or frames of reference (Covey 1989) - in adult education, namely lifelong education as promoted by UNESCO (e.g. Lengrand 1975); radical adult education and the

pedagogy of liberation (e.g. Freire 1972); and andragogy (e.g. Knowles 1990). Thus lifelong education is seen as a major development in the field of adult education. The concept of radical adult education and the pedagogy of liberation are seen as having their origins in the work of Freire (1972), who Mayo (1994 p. 125) notes viewed education from 'unmistakably left-wing politics of social transformation'. Freire (1972) suggested that there are two approaches to education, which are the 'banking' concept of education versus 'problem-posing'. The banking concept, as the traditional one, involves the teacher helping to fill the student with knowledge, which is later 'cashed out' relatively unchanged, in examinations. The problem-posing approach to education is education through dialogue. The facilitator and student meet and exchange ideas and experiences through critical argument and debate. Neither facilitator nor student has the 'right' answer, as there is room for 'multiple realities'. It is based on these perspectives forwarded by Freire (1972) that Mayo (1994) later forwarded the theory of 'radical adult education'.

This theory is based on the following argument. Mayo (1994) notes that both Freire and Gramsci (1891-1937) separately were involved in similar movements of social reform and were also campaigning for similar results in the field of adult education. Consequently Mayo proposes a synthesis of the combined insights of Freire and Gramsci for the theory of radical adult education, which would consist of:

- a commitment to confronting oppression in its different forms;
- awareness of power relations in a given society, and promulgating democratic and dialogic social relations;

- movements that recognise non-formal learning and education delivery on a multiplicity of sites;
- adult educators promulgating social relations and dialogic style of teaching that appreciates the learner's culture; and
- engaging in language codes that the student can understand and develop from.

Mayo (1994) adds that radical adult education also needs to address issues of race, gender, sexuality, etc, to ensure that the dialogue between educator and educatee is on the same wavelength so that the latter is not disadvantaged. The theory of radical adult education can in turn be seen as a theory underpinning lifelong education. However, educators in nursing tend to be appreciative of other theories of education such as the humanist (e.g. Rogers 1983), behaviourist (e.g. Bandura 1977) and cognitive (e.g. Ausubel et al 1980) approaches.

Deterrents, obstacles and reservations about lifelong education

So far this chapter has defined and explained the terms lifelong learning and lifelong education, and reviewed some of the philosophical beliefs that underlie these concepts. It has explored the related concepts learning society and learning organization, and then the educational theories that underpin lifelong learning. As lifelong learning needs to occur in a very complex and ever-changing world, in which the nurse as an individual lives and works, this section explores aspects that can present as obstacles and potentially deter RNs from engaging in lifelong learning. Several deterrents and obstacles to lifelong learning in the wider educational arena

have already been identified by Knapper and Cropley (1991) for instance, and in the context of widening participation, by McGivney (1990).

According to Knapper and Cropley (1991) there are various problems with the implementation of lifelong learning and lifelong education in the higher education sector. They include:

- i) universities not changing at a fast enough rate to facilitate the development of lifelong learning in individuals;
- ii) the scarcity of studies on participation in learning, that is the research or scientific basis for lifelong learning and lifelong education; and
- iii) practical difficulties of access to education by individuals in different socio-economic groups.

Titmus (1999) explored the feasibility of implementing lifelong education and lifelong learning, and concluded that little has been achieved. He found that among the more highly resistant obstacles with regards to the current concepts, institutions and practices of education is the absence of '...the political will and the sense of urgency that will apparently be required' (p. 343).

McGivney (1990) studied the extent of participation in education in the UK, and recorded the most frequently mentioned deterrents to participation in liberal adult education. These are the:

- 1 lack of time - cited most frequently by unskilled workers and young mothers

- 2 negative effects of school experience - for both the unemployed and the unskilled
- 3 lack of money - cited by unemployed and by women and older people
- 4 lack of confidence - cited by black groups
- 5 distances from classes - elderly, women with dependent children and ethnic minority groups all mentioned this
- 6 lack of childcare - mentioned by mothers with dependent children
- 7 lack of daytime opportunities - mentioned by women and older adults
- 8 education regarded as irrelevant by unskilled people
- 9 lack of transport - cited by mothers with dependent children, older adults and ethnic minority groups
- 10 reluctance to go out at night - mentioned by women and elderly adults

It seems that many of these deterrents might apply to nurses as well because 90% of the nursing workforce consists of women. In the endeavour to understand the extent to which different learners' experiences act as deterrents or barriers to learning, Valentine and Darkenwald (1990) compiled a typology of adults, which is reproduced in table 2.3. Of the five types of potential adult learners, the first four may clearly reflect sections of the RN population, as some individuals could be deterred from learning due to personal problems, lack of confidence to take up university education, costs, or they may not see the value and rationale for university based nurse education. That is, these deterrents and obstacles might apply equally to those real-life problem areas that RNs might encounter in their pursuit of lifelong education. For instance, some individuals could be deterred from

Table 2.3: A typology of adults (Valentine and Darkenwald 1990).

Type 1	People deterred by personal problems (the single largest sub-group 29.5% of the sample) expressed in the form of family or childcare responsibilities, difficulties with location, health problems and problems of handicap.
Type 2	People deterred by lack of confidence (27.2%). The dominant profile here was that of a mature person who lacks the confidence to participate in adult education but who is otherwise in a position to attend.
Type 3	People deterred by educational costs (the smallest cluster of 12.9% of the sample). Characterised by part-time, predominantly female, employees of 'moderate education and moderate means' who have the confidence to participate but who are unable to afford the direct and indirect costs of learning.
Type 4	People not interested in organised education (14.3%). Characterised by well-educated, affluent, working individuals, more likely to be male than female, and who places relatively low value on participation in adult education.
Type 5	People not interested in available courses (16.2%). Disproportionately male group, 83% of whom had college or graduate degrees, classified by the authors as 'highly educated, middle income, working individuals who place considerable value on continuing education but find exist programming irrelevant to their needs.

learning due to personal problems, others not wanting to travel long distances to universities that are usually city-based. Previously, such education was available in the many more local hospital-based schools of nursing, but they unfortunately lacked academic recognition. Jarvis (1987) notes that one of the criticisms of lifelong education that was postulated by Illich and Verne (1976), which is that it is a unified system that provides for education from the cradle to the grave, may not be desirable because it might 'imprison learners in a global classroom'. Moreover, in his exploration of the concept, Duke (1976) expressed a number of criticisms and reservations directed at 'the grand ideal of lifelong education'. These included:

- Lifelong education as a guarantee of permanent inadequacy;
- Lifelong education enhancing rather than reducing inequality; and
- Lifelong (or recurrent) education being too costly.

Duke went on to explain other psychological and emotional (rather than rational) factors that might cause resistance to lifelong education. Instances of these might be:

- that it is merely seen as the most recent fashion, a novelty that will not endure;
- adopting the concept on a short-term basis by making a few changes, while leaving the system itself essentially unchanged;
- and the professional interests of the teacher not being adequately considered and thus the teacher being prevented from acting as a living model of lifelong learning.

The main point for nursing in relation to obstacles and deterrents to lifelong learning is that many of those identified above might also apply to qualified nurses. They represent deficits in formal and non-formal mechanisms, but have not been investigated formally. However, on a positive note, Gelpi (1985) had previously indicated that examples of the intellectual and practical development of lifelong education are increasingly to be found in educational policy and practice, such as in the integration of general and vocational education.

CPD and CPE as components of lifelong learning

The DH (1998 p. 42) sees continuing professional development (CPD) as a component of lifelong learning, and defines it as:

... learning for all individuals and teams which meets the needs of patients and delivers the health outcomes and health care priorities of the NHS and which enables professionals to expand and fulfil their potential.

At the practical level, Wallace (1999 p. 28) indicates that CPD 'is the term given to the learning which takes place in a professional's career after the point of qualification and/or registration'. Wallace prefers to see CPD as identified and intentional learning rather than unplanned casual learning. Madden and Mitchell (1993) see CPD along similar lines as activities undertaken to maintain and enhance knowledge, expertise and competence by professionals throughout their careers according to a plan formulated to the needs of the professional, the employer, the profession and society. Thus becoming a lifelong learner includes participation in CPD or continuing professional education (CPE) (the difference being in the meanings of the words education and development).

Another definition of CPD is presented by Maggs (1996 p. 98) as a term '.. used to encompass those teaching and learning activities, including open and experimental learning, which follow registration and are directed towards improving the quality of care provided to the public'. Todd (1987) also believes that professional development is something that occurs where a professional sees his task in a new light. Thus, with CPD, the individual aims to maintain or improve the quality of professional performance. Nevertheless, many individual nurses who are conscientious about the art and science of nursing have always recognised the importance of CPD for the maintenance of up-to-date practice, while others seem less enthusiastic. This is succinctly summarised in context by Lowenthal (1981 p. 519) as 'some professionals catch up, others keep up, and some get ahead'.

Madden and Mitchell (1993) suggest that there are two models of CPD, namely the 'sanction model' and the 'benefits model'. In the former model, it is implied that if the professional fails to undertake CPD then sanctions might be applied. In the latter model, the stance is that practitioners are rewarded for voluntarily maintaining and enhancing their competence. However, although participation in CPD is often compulsory for continued professional registration in the United States, it has been a mandatory requirement for nurses in the UK since April 1995 (UKCC 1995a). While the former approach seems to be the stance taken by the UKCC and the latter by the ENB, Cervero (1988) indicates that for CPD to be effective, the work setting should have the appropriate CPD culture. According to Cervero (1988), such a culture entails:

- a) the existence of a positive attitude within the professional group towards lifelong learning;

- b) envisaging the need for CPD, and its relevance, right from the stage of initial professional education;
- c) an emphasis on helping practitioners to learn effectively; and
- d) the provision of support and guidance for people undertaking CPD.

Such culture is consistent with the concept of the learning organisation, and exists to varying degrees in clinical settings. The UKCC (1994) has already acknowledged that the required minimum 35 hours of study every three years is not likely to be sufficient, and therefore practitioners should be encouraged to undertake additional professional development. Hinchliff (1994) argues that CPD leads to increased job satisfaction as well as personal and professional competence.

CPD became a major issue in nursing at the beginning of the 1990s, and as Hewitt (1991) indicates, it is increasingly viewed as a right of the individual rather than a luxury for nursing to develop as a profession. It enables the RN to meet the needs of society and keep up with the rapid growth in professional knowledge. The view that CPD is essential for the professionalisation of nursing has been confirmed by some recent studies (e.g. Nolan et al 1995, Hogston 1995), by reports (e.g. Price Waterhouse 1988, Audit Commission 1991), and by nursing commentators such as Maggs (1996).

Bariball et al (1992 p. 1131) cite the generally accepted American Nurses' Association's definition of CPE, which is:

... planned educational activities intended to build upon the educational and experiential bases of the professional nurse for the enhancement of practice ... and improving the health of the public.

Thus, a distinction can be made between CPE and CPD, in that the former refers to professional education provided for RNs and RMs in universities, while the latter encompasses a wide range of professional learning provision and activities. The above definitions clearly indicate that enhancement in patient care needs to be at the centre of the purpose of engaging in CPE by the practitioner.

Nolan et al (1995) studied the advantages of CPE as perceived by managers, students and educators, and found that the views of the managers and the students were fairly similar, but were to some extent different from those of educators. This can be a point for further research, as educators are the planners and deliverers of CPE. However, the advantages of CPE (Nolan et al 1995), as perceived by managers and students are as follows (presented hierarchically most cited to least):

- up to date knowledge;
- delivery of better patient care;
- ability to question and change practice;
- raised professional status and academic credibility; and
- practitioners demonstrate greater assertiveness.

Based on a study of 'investment in post-qualifying education', Calpin-Davies (1999) reports that, in comparison to funding for other health care professions e.g. physiotherapy and medicine, nursing remains underfunded. She found that managers have been effective at forecasting the NHS workforce's educational needs, and additional funds for non-medical post-qualifying professional education should be treated as a priority. However, funding for CPD for nurses has remained

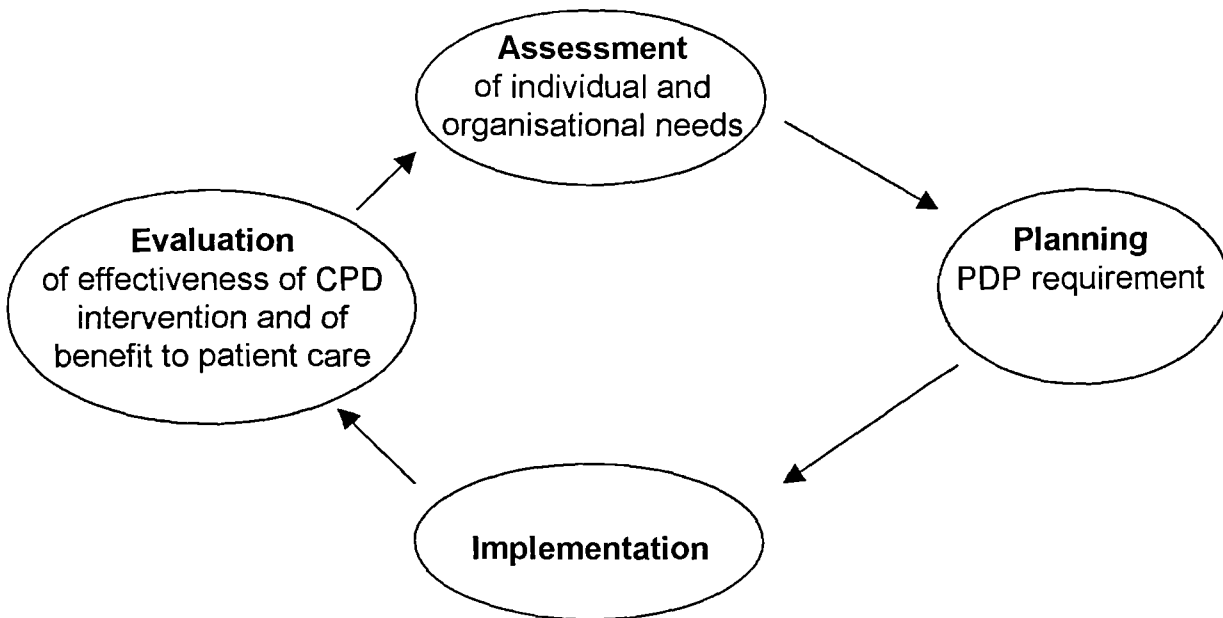


Figure 2.2: A model of a CPD cycle (Department of Health 1998).

on the agenda, as in the government's *A First Class Service* (DH 1998), *Making a Difference* (DH 1999b), and *Continuing Professional Development: Quality in the New NHS* (DH 1999c).

The former document discusses the issue and provides a model for CPD (figure 2.2), which is clearly seen in the context of 'setting, delivering and monitoring standards' in the NHS. The model directly links the needs of the organisation with that of the individual employee. It includes utilisation of Personal Development Plans (PDPs) and evaluation of CPD. The third document mentioned above indicates (DH 1999c p. 1) that 'CPD has an important contribution to make to the government's agenda for lifelong learning'. It also indicates that CPD relies on partnerships between the government, NHS employers, regulatory bodies and Higher Education with the ultimate aim of promoting lifelong learning and supporting excellence in clinical care. It provides a 'long-term vision' and identifies what the government sees as core principles of CPD. These are that CPD should be:

- purposeful and patient centred;
- participative i.e. fully involving the individual and other relevant stakeholders; targeted at identified educational need;
- educationally effective;
- part of a wider organisational development plan in support of local and national service objectives;
- focused on the development needs of clinical teams, across traditional profession and service boundaries;
- designed to build on previous knowledge, skills and experience; and

- designed to enhance the skills of interpreting and applying knowledge based on research and development.

This 20-page document also delineates a comprehensive plan that details the roles of all parties in the operationalisation of CPD.

Waddell (1991) conducted a meta-analysis of the impact of CPE on clinical practice because she noted that nursing, like other social sciences, has difficulty implementing randomised controlled trials. She sees a meta-analysis as a 'quantitative, systematic, and objective approach to combining the findings from a group of studies, offered the opportunity to obtain reliable and valid conclusions' (p. 113). To conduct the analysis, she used Cervero's (1988) model of four independent variables, which consists of:

- characteristics of the learner;
- the environment;
- the nature of the change; and
- the 'continuing nurse education' offering it.

Ninety-five studies were located through a comprehensive multi-mode search, but only 34 were appropriate for the purposes of the meta-analysis. She concluded that continuing education positively affects nursing practice. Therefore the issues related to CPD and CPE for nursing are that these are seen as part of the lifelong learning framework for nurses, and studies show that they do benefit nursing practice. However, they also show that more funding is required to convert the findings from rhetoric to reality.

Lifelong learning in nursing

Lifelong learning as a concept and practical activity in nursing is addressed by the ENB (1995a) in *Creating Lifelong Learners*, wherein it declares its commitment to the notion as it sees nursing as a vocation that requires career-long professional education. However, Hinchliff (1994) points out that to become lifelong learners in healthcare, particular skills or competencies are essential. These include:

- an ability to set and work towards realistic goals that are achievable within the constraints of the individual's personal and professional life;
- maintaining motivation to learn continuously and evaluating the effectiveness of the learning; and
- an ability to locate relevant information and resources, and using appropriate media.

The ENB (1994 p. 10), which was the nursing statutory body that approved professional courses, maintained that diploma and degree programmes should be planned to develop nurses and midwives who have the skills to become lifelong learners and who are eager to continue to learn, and to contribute to meeting health service targets. It asserts that consequently, the lifelong learning nurse can, for instance:

- practise in a safe, accurate, efficient effective and caring manner;
- question practise, explore and develop strategies to evaluate and develop effective care;

- analyse and respond to the impact of research findings, social policy and politics on the provision and implementation of health care in their area of practice; and
- underpin their practice with a thorough theoretical grounding and the application of research.

In addition to competencies, the ENB (1995a) also lists the characteristics of nurses as lifelong learners (table 2.4), and different components of nursing wherein learning can be undertaken. The components of nursing comprise:

- ◆ Accountability
- ◆ Clinical skills
- ◆ Use of research
- ◆ Team work
- ◆ Innovation
- ◆ Health promotion
- ◆ Staff development
- ◆ Resource management
- ◆ Quality of care
- ◆ Management of change

The content of table 2.4 is conceptually distinct from Dave's approach to the subject area, in that while the ENB identifies the characteristics of individuals as lifelong learners, Dave provides 'characteristics of the concept' of lifelong learning. As seen in earlier sections of this chapter, the document also identifies the key features of a clinical setting as a learning organisation (table 2.2). However, the latter also

Table 2.4: Characteristics of lifelong learners (ENB 1995a)

Nurses, midwives and health visitors who have developed as lifelong learners as a result of their pre-registration education have characteristics that the health services need. Lifelong learners are:

- 1 **innovative** in their practice
- 2 **flexible** to changing demand
- 3 **resourceful** in their methods of working
- 4 able to work as **change agents**
- 5 able to **share good practice** and knowledge
- 6 **adaptable** to changing health care needs
- 7 **challenging** and creative in their practice
- 8 **self-reliant** in their way of working
- 9 **responsible** and **accountable** for their work

Generally, nurses seem to accept these perceptions, which are probably best seen as benchmarks that can be referred to whenever appropriate. The ENB (1995a) believes that by addressing lifelong learning as something that should be adopted by nurses, it has taken a long-term perspective of the needs of the health service, and how nurses, midwives and health visitors can more effectively be prepared for their challenging roles. Lifelong learning is very much apparent in nurse education, although it can be argued that currently it largely seems to take the form of CPD. The Department of Health (DH 1998 p. 42) *A First Class Service* document sees lifelong learning as 'an investment in quality' and indicates that 'Health professionals in all health care settings need the support of lifelong learning through (CPD) programmes'. Essentially, the possible sequence of education representing lifelong learning for the professional nurse may be:

Pre-primary education > Primary education > Secondary education > Tertiary + Vocational Education (for Registration) > Experiential Supervised Learning + Reflections as associate primary practitioner > primary nurse* > Specialist tertiary learning > Research/Advanced education > leisure learning

* includes role expansion

CPD is provided in the form of modules and courses at diploma, degree and higher degree level as well as half day to multiple study day programmes. Various other forms of informal learning go on all the time. It would seem that lifelong learning encompasses all forms of learning as identified in detail by Longworth and Davies (1996) for instance (figure 2.1), but CPD focuses on learning that is directly related to one's professional career or employment.

Research in lifelong learning in nursing and indications for further research

As detailed at the beginning of this chapter, the literature was thoroughly searched in order to identify existing research in the field of lifelong learning. Very little research on lifelong learning itself surfaced during the literature review. Those in related areas tend to cover mostly the notion of widening access to further and higher education, effectiveness of andragogy as a theory of adult education, self-directed learning (SDL) and CPE. Hart (1998) indicates that if very little or no research exists in the topic area being studied, then other studies of similar nature might be reviewed to ascertain the area that needs studying and the research method that might be most appropriate for the proposed study. Some of these have been discussed in this chapter already. For instance, studies conducted on the effectiveness of CPE and CPD (e.g. Waddell 1991) and that on widening participation by e.g. McGivney (1990) were discussed earlier.

In one study, Dowswell et al (1998) used qualitative methods to explore the motives and effects of nurses, midwives and allied professional staff's participation in CPE. The report, which was published halfway through the data collection period of this study, indicated that healthcare staff were receiving mixed messages about continuing education from policy makers and employers regarding funding for CPE. They concluded that if CPE depends on the individual healthcare staff's ability and willingness to pay for post-registration degree-level studies, then this is likely to present as an obstacle in the venture to establish lifelong learning in healthcare professions.

McGowan (1995) reports on a study of problem-based learning as a method of teaching that enables development of lifelong learning, but found no difference in perceptions of lifelong learning between graduates of PBL curricula and traditional curricula. The paper concludes that because of this, health sciences librarians have a key role to play in the process of developing lifelong learning in students.

Janhonen (1991) reports on a study of andragogy in Finland, which found that 'nurse instructors' have largely accepted the features of the concept as their didactic perspective, especially SDL, and that they constantly endeavour to develop themselves to fulfil this stance.

Wagner (1989) who conducted a study in America that aimed to identify factors that influence professional nurses' pursuance of lifelong learning reported the only research literature directly relevant to this study. Research questions posed for the study focused on the source of lifelong learning; role of the pre-service curriculum in developing and nurturing lifelong learning; professional role expectations; effects of mentoring/role modelling; presence or lack of support systems; and primary benefits derived from continuing learning. A grounded theory methodology was used with purposeful sampling of twenty-three professional nurses nominated by their peers. 'Socialization' emerged as the integrating concept, and the sources of lifelong learning included the self, parents, and family. Professional role expectations were identified as a major learning stimulus. Major restraining factors were self-limitations and the balancing of multiple social roles.

The absence of research in a particular concept generally lends itself to clarification of the concept through qualitative studies and tentative development of theoretical frameworks that can subsequently be further scientifically investigated or tested by quantitative methods (Morse and Field 1996 [p8]. This seems to be the case with lifelong learning in nursing.

Conclusion

The concept lifelong learning has prevailed for several decades, but gained prominence in nursing education mainly in the 1990s. The literature seems to indicate that lifelong learning as a concept is still evolving, and that it will continue to do so because the underlying philosophies are varied, and also because it is closely related to policy and provision, which in turn are determined by and determines levels of financial resourcing. This chapter has examined the main issues related to lifelong learning in nursing. This involved definitions and distinctions between lifelong learning and lifelong education; the philosophy underlying lifelong education; the concepts learning society and learning organisation; educational theories underpinning lifelong education; deterrents, obstacles and reservations about lifelong learning; continuing professional development and education as components of lifelong learning; lifelong learning in nursing; and research and indications for research in lifelong learning in nursing.

It emerges that there are several issues that are as yet unresolved in this topic area. For instance, it seems also that there is only general agreement on the philosophy underpinning lifelong education, but the possible educational theories underpinning

them, such as adult education, indicate that lifelong learning is a deliberate activity on the part of the individual with the aim of achieving higher levels of self-actualisation as well as for society to overcome inequalities in access to education. The main issues related to, or problems inherent in the philosophical and educational underpinnings for nursing are that, although there has been general expansion in the provision of CPE for RNs, some RNs might be experiencing difficulty accessing them due to a number of factors at personal or structural levels.

Titmus (1999 p. 353) points out that:

With the prospect of an even faster changing human society before us, it is impossible to foresee its lifelong educational needs with any certainty. Perhaps the best that we can hope for are the acquisition of learning skills for the immediate future, the ability to adapt such skills to meet the requirements of changing circumstances and, above all, the ability and will to apply learning to action.

As to the future direction that lifelong learning might take, Titmus (1999 p. 353) notes that the prospects of achieving at least some form of lifelong learning are increasing, but 'the weight of the past and the present, from which it cannot free itself, seem to ensure that it will be imperfect and incomplete'.

Such imperfection is constantly experienced by nurse educators in that for instance as new research-based pre-registration and other nurse education curricula are implemented, further research and evaluations soon show weaknesses in their effectiveness along with their strengths (e.g. Elkan and Robinson 1991, While et al 1995). Constant changes driven by novel technologies and new knowledge means that unforeseen effects are likely to emerge. Thus the perfection and completeness

Titmus alludes to, seems to be an ideal that is something to aspire to, but may not be reached every time.

Based on the issues found in the literature review on lifelong learning and lifelong education it is apparent that there is a lack of convincing evidence on how RNs' perceived this notion that was being exhorted for them as a professional activity. The structures necessary have not been categorically and comprehensively identified, other day-to-day factors that impinge on learning have not been explored, nor have the probable effects of lifelong learning on nursing been researched. These areas therefore constitute the scope for this study.

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Chapter Three

METHODOLOGY AND RESEARCH METHODS USED

Introduction

This chapter explains, justifies and evaluates the research methods utilised to endeavour to achieve the aims of the study. Chapter two concluded by identifying gaps in knowledge, and argued that qualitative methods were more appropriate for addressing them. The research design selected entailed three data collection methods: individual interviews, focus groups and documentary analysis. The purpose of using more than one method was to endeavour to achieve 'method triangulation' so as to increase the concurrent and external validity of the study.

- Twenty-six semi-structured individual interviews were conducted. Of these, the first three were designed to be pilot interviews with the intention of testing the practicability of the exercise, the clarity with which the questions were being asked and whether they would achieve the aims of the study. Very minor adjustments were required and therefore the data ensuing from these interviews are also included in the data analysis.
- Two focus group discussions were conducted, with five RNs in the first group, and six in the second.
- A comprehensive critical review of published literature and key reports on lifelong learning in the UK was undertaken.

The sample for the first two methods was RNs who were studying on or had recently successfully completed at least one diploma level module in healthcare within the higher education sector.

The discussion in this chapter focuses on:

- using qualitative methods in this study;
- sampling for the study;
- access;
- individual interviews;
- focus groups;
- documentary analysis;
- triangulation;
- validity and reliability issues; and
- how the data was analysed.

Using qualitative methods in this study

According to Phillips and Pugh (1994), there are three types of research, namely exploratory research, testing-out research and problem-solving research. Because of the relatively novel status of the concept, and of the absence of research on RNs' understanding of lifelong learning, it was decided that an exploratory research approach, within the qualitative paradigm, was the most appropriate for this study. This was to test out the assumption that the concept is fully understood and accepted within nursing circles, and to ascertain the nature of problem areas.

The qualitative (or subjectivist and idiographic) approach concerns itself with understanding the way in which the individual creates, modifies and interprets the world in which he or she finds himself or herself (Cohen and Manion 1994 [p8]). Consequently, the research methods selected in the design of the study comprised

individual interviews, focus groups and documentary analysis. These methods were chosen in the light of Morse and Field's (1996 p. 10) argument that the choice of method depends on a number of factors, including 'the nature of the phenomenon to be studied, the maturity of the concept, and the researcher's agenda'.

The publications on lifelong learning indicate that the nature of the concept in relation to nursing was not well known in the 1990s. As to the maturity of the concept, this was variable, but little empirical investigation had been carried out. As to the researcher's agenda, my perspective was to explore as open-mindedly as I could how RNs felt about the phenomenon of lifelong learning.

Dey (1993) has suggested that qualitative methods or approaches constitute three basic orientations, namely:

1. Language-oriented, that is being interested in the use of language and the meaning of words, i.e. how people communicate and make sense of interactions;
2. Descriptive/interpretative, that is being oriented to provide thorough descriptions and interpretations of social phenomena, including its meaning to those who experience it; and
3. Theory-building, which means being oriented to identifying connections between social phenomena, e.g. how events are structured or influenced by how actors define situations.

The orientation of this study verges predominantly towards Dey's second and third orientations. It endeavoured to describe and interpret the 'phenomenon' (or concept) of lifelong learning in nursing, identify how nurses make connections between lifelong learning and other components of nursing, and thereby define the situation. Dey argues that the distinctions between these orientations are not seen as watertight, and the classification is contestable. However, throughout data collection, I have tried to remain aware of the language being used by informants. For instance, I found that informants were using various metaphors in their explanation of the phenomenon, which led me to endeavour to fully understand their perceptions through further questioning.

By selecting the qualitative research approach, this study also took the 'emic' approach as advocated by Silverman (2000), which seeks to ascertain the 'personal' or 'insider' view, and aims to develop theory 'inductively' from data.

I also critically considered the context, that is, the concepts and activities that were having an impact on or directly interacted with lifelong learning. They include those explored in chapter one, as they also dominated nursing in the mid- to late 1990s. Lifelong learning began to have a major impact within nursing at the time of establishment of pre and post-registration nurse education within the higher education setting. As explained in chapter two, lifelong learning has gained new momentum within the nursing profession because of the increasing necessity for nurses to constantly update their knowledge, competence and attitudes.

Sampling for the study

Having decided that a qualitative approach was more appropriate than a quantitative one, the next step was to consider which nurses would be the most appropriate to provide the data. To do this, my initial thought was to identify a stratified sample of nurses on clinical grades D, E, F, G, H, and I from the national nursing population in different parts of the UK. Newly qualified RNs start working as a D grade and move up to E, F, etc grades as they progress through their careers. Therefore, an attempt was made to establish how many staff on these grades worked in the NHS, but it was found that the UKCC does not hold data with these details, because of the fluid nature of clinical grades due to career progressions and other factors. Despite persevering with attempts to acquire data at regional and local levels, I was unable to obtain them, as for various reasons the organizations did not wish to release them.

Figures were however available from the Royal College of Nursing (1992) for RNs working in the NHS at the time, and are reproduced in table 3.1. A further 18,000 work as practice nurses with family practitioners. It is interesting to note that with approximately 634, 000 practitioners on the effective register, and only around 380, 000 work in the NHS. The remaining quarter of a million RNs presumably are working in the private sector, abroad, or not in nursing.

In selecting the subjects or informants for this study, a choice was made to explore and gather the views of nurses who were most involved at the care delivery end of nursing within the NHS and the private sector. This is because these are the RNs

Table 3.1: Number of nurses working in the NHS by clinical grades (RCN 1992).

Grade	Number
C	28,154
D	103,622
E	115,047
F	36,489
G	70,011
H	11,273
I	5,826
Other qualified nurses	9,942
Total	380,364

whose clinical knowledge and competence most needs to be up to date to ensure the patient receives the most informed care. They were nurses on the D to H clinical grades, with those on higher clinical grades working in the capacity of clinical nurse specialists or managers. They also included some of the most recently qualified DipHE nurses, as well as pre-Project 2000 but very experienced nurses.

Thus the sample comprised nurses:

- who had completed or were at the time well into studying for at least one nursing module at level HE 2;
- whose pre-registration education was through the Project 2000 programmes, or the 'traditional' pre-registration course;
- who worked in the Coventry and Warwickshire area in primary care (community) or secondary care (hospitals);
- whose clinical grades ranged from D to H, but who were directly involved in 'hands-on' patient care.

It was decided that, for convenience and ease of access, informants drawn from the NHS trusts in the Coventry and Warwickshire areas only would be selected. It is debatable whether the perceptions of nurses in one geographical area could be seen as representative of nurses in UK in general. However, the Project 2000 pre-registration course is planned and approved according to national guidelines and rules. Similarly, pre-registration and post-registration programmes at the time were centrally guided by the UKCC and approved by the ENB and are therefore largely standard across England.

However, there may be some local cultural differences (a concept characteristic of lifelong learning identified by Dave (1976)), in that the catchment areas of some NHS trusts may experience more of particular illnesses. It might also be the case that a minority of NHS trusts that are attached to the local medical school may be more strongly research-oriented than those which are not, although there is no known research evidence for this. It is assumed, therefore, that the findings of this study can represent only the views of RNs in the Coventry and Warwickshire area.

When considering sampling for this study, one of the other choices made was between probability sampling and non-probability sampling. Cohen and Manion (1994) indicate that a 'probability sample' is one in which there is an equal probability that the perspective of every person in the population is included. A 'non-probability sample' is a sample in which there is no way of estimating the probability of each subject's perspective being represented. These methods have implications for the degree of generalisability of the findings in that probability sampling increases the generalisability of the findings, while non-probability sampling does not make such claims as emphatically. Qualitative methods tend to utilise non-probability sampling and do not claim that the view of every person in the population can be represented.

The non-probability sampling method ultimately seen as appropriate and selected for this study was purposive sampling, as used by Marsland (1998) in her study of career guidance for newly qualified nurses. Cohen and Manion (1994 p. 89) note that 'purposive sampling refers to hand-picked cases selected on the basis of

researchers' judgements of their typicality'. For focus group discussions, the samples were also purposive, but they could also be classified as convenience non-probability samples.

Critique of sampling method

Despite deciding on purposive sampling as the most appropriate method for achieving the aims of the study, the inclusion of other distinct groups of RNs was also considered. For instance, the sample could have been compared with a group of RNs who qualified through the Project 2000 pre-registration course, and were awarded a DipHE level HE 2 qualification. It is expected that these RNs would have been equipped with lifelong learning skills and motivation for CPE. One option, therefore, could have entailed selecting two groups of RNs - viz: (i) RNs with DipHE; (ii) RNs qualified through traditional course - and then comparing and contrasting their perceptions. However, this was not pursued as it was felt that because DipHE programmes were so radically different, comparability would be difficult.

Additionally, RNs in group (ii) could have contained non-practising nurses, or of those whose pre- and post-registration qualifications had been at certificate level, and were being guided into gaining diploma and degree level qualifications, either because of (mis-) perceived mandatory requirements or through persuasion by their clinical managers or colleagues. It was therefore felt that it would be unethical to identify the findings drawn from such a comparison. Cohen and Manion (1994) refer to this as one of the 'dilemmas of choice of sample'.

Other reasons for choosing the particular group of informants are as follows:

1. It is estimated that there are 100 000 qualified nurses who are not practising as nurses. It would need a separate study to find them to explore their perceptions, and the logistics of doing this seemed very problematic, as it would have been difficult to ascertain where they were, especially as some only take casual or temporary jobs.
2. It may be unethical, and in this context probably not worthwhile, to question people who may have left nursing out of disillusionment, and are happier in another vocation, possibly with lesser remuneration, or are out of work through choice or redundancy.
3. A number of modules and ENB courses have been run at certificate level, and are now at diploma level within the higher education sector. This may cause incongruence in that two members of staff may be practising in the same clinical setting with the same clinical functions, while one holds a certificate, and the other a diploma in the same clinical speciality.
4. Although there are some studies under way that aim to determine the credit value (and the academic level) of learning that occurs in the practice area (e.g. Walsh and Johnson 2000), some highly experienced nurses seem to feel that their clinical experiences are not valued academically

These complexities led to the decision to target informants who could provide more analytical and constructive views of the concept explored. The informants, albeit a sample, encompassed a good range of experience.

As I was keen to include Project 2000 qualified nurses in the sample, and I felt that there was always a possibility of a change of mind between an individual agreeing to an interview and the actual interview, I had to be opportunistic on occasion to obtain their commitment. For instance, one informant was interviewed after only 10 minutes of agreeing to participate, and therefore had no chance to think through possible questions or explore their self-knowledge of the concept of lifelong learning before the interview.

Access

Having identified the criteria for selecting informants, consideration was also given to how to persuade each informant to give their time, and to verbalise their perceptions of the concept honestly. In nursing, individuals who have completed their pre-registration courses often work on a rotational basis within one specialism, directorate or trust during the first few years, possibly under the guidance of a preceptor. Others, of course, work part-time and pursue further academic studies, move to other parts of the country, or even travel abroad for a while. For these reasons, at times they are difficult to locate for research purposes. Even if located, it can prove difficult to get a full commitment from them to engage in focus group discussions or interviews.

Because the vast majority of the nursing workforce consists of women, with various domestic commitments, special efforts might be required on their part to carve out time and be in the appropriate mind-set to act as interviewees. When considering access to informants, I had to take these factors into account, and give potential participants as much detail as appropriate when asking them to take part in the

study. I was also prepared to encounter refusals based on either shortage of time on their part or for some other reason. It is also the case that, even for those RNs who were currently on site on a course at the university where I work, their time may be limited as some tend to have to leave lectures early to collect their children from childminders, nurseries or schools.

Issues considered before seeking access included who and what I wanted to research; how much commitment I required from my subjects in terms of hours, and which days, weeks or months were most suitable; any potential problems I could identify with regards to access; and whether there were any key individuals or gatekeepers who I needed to get permission from. In fact, there were no gatekeepers, as every potential informant was approached as a professional individual in their own right.

The RNs who acted as informants in this study were either RNs I had known previously, or had been recommended for the study as potentially willing and suitable subjects by clinical or nurse lecturer colleagues. There is a possibility that this could bias the findings of the study, in that informants might wish to show that they see lifelong learning positively, especially because, as the researcher, I obviously seemed to value the concept. Furthermore, individuals are unlikely to state that they have stopped learning.

I planned a reserve strategy in case access was refused. This would have entailed asking other individuals in the same institution, or other institutions, trying again

later and even changing the research strategy. The changed strategy would have entailed targeting suitable informants through key people such as practice development managers and project leaders for instance. However, this strategy was not required as barring one, every individual approached consented to participation.

The individual interviews

Qualitative research methods are highly valued within nursing. This is because of the holistic and humanistic philosophies that form the foundation of nursing care, and because nursing finds itself in a slow evolving professionalisation process, as noted in chapter one. Thus, the semi-structured individual interviews as a means of developing theory or generating hypothesis on lifelong learning in nursing, was seen as appropriate. They were used for exploring the experience and perceptions of individual nurses becoming and being lifelong learners, and for finding out their views on the mechanisms necessary for the realisation and maintenance of lifelong learning.

The literature was explored for insights into how researchers perceived the nature and application of individual interviews. Oppenheim (1992) notes that the purpose of the depth interview is to ascertain perceptions and collect ideas. Cohen and Manion (1994 p. 271) note that the research interview is:

.. a two-person conversation initiated by the interviewer for the specific purpose of obtaining research-relevant information, and focused by him on content specified by research objectives of systematic description, prediction or explanation.

Cohen and Manion (1994) identify four different kinds of interview: the structured interview, the unstructured interview, the non-directive interview and the focused interview. However, Oppenheim (1992) points out that interviews are basically of two kinds: the exploratory (or depth) interview, and structured interviews. Using structured interviews has its own advantages, but it is the depth interview method that was seen as most appropriate for this study. The interviews were conducted in such a way that they were open enough for interviewees to voice their views, and for allowing further exploration through probing whenever that was felt appropriate.

Oppenheim (1992) explains that an exploratory or depth interview is 'essentially heuristic', and enables the researcher to develop ideas and research hypotheses rather than gather facts and statistics. Consequently, the purpose of depth interviews is seen not so much as 'data collection' but as 'ideas collection'. Furthermore, Oppenheim notes that the setting of the interview should be private, quiet, comfortable and not intimidating. The interviewer should maintain control of the interview, probe gently but incisively, and present a measure of authority and an assurance of confidentiality. The tone of voice, a pleasant polite manner, deportment, choice of attire, management of personal space, an accepting and non-judgmental attitude and a willingness to listen are important interpersonal skills for exploratory interviews.

Furthermore, the aims of the research were not to formulate fixed questions but to employ a list of general topics or areas of focus. It was also important to identify the number of topics that could be covered in one interview, which generally lasts

approximately one hour. Oppenheim (1992 p. 70) suggests that it is 'better to obtain some rich material on a handful of topics, rather than to press on at a relatively superficial level in order to cover every point'. An interview schedule is required, which Cohen and Manion (1994 p. 284) indicate involves translating the research aims 'into the questions that will make up the main body of the schedule'.

The interview schedule for this study

Based on the aims of the study, approximately 8 areas that were seen as appropriate interview items were identified, and included in the interview schedule (Table 3.2). The interviews were conducted in such a way that there was ample space and opportunity for informants to add other views on the concept explored. They were organised in broadly three sections. The initial 3 to 5 minutes were for general conversation and attempts to relax the interviewees, so that they would voice their perceptions in comfort and with a clear mind. This also included ensuring the informant was aware of the interview's confidentiality and exactly which destinations the data might reach. This was followed up by exploring the topic areas that form the focus of the study, and then the final scheduled question invited the informant to add any further perceptions. The interviews were mostly held in an empty classroom or at the informant's home. Every participant was asked questions on all areas in the interview schedule, but decisions about precise wording of questions and depth of exploration were dependent upon interviewees' responses, an approach also adopted by Marsland (1998).

Table 3.2: The interview schedule

Thank you for agreeing to help me with my research. I am interested in this idea of **nurses being or becoming lifelong learners**, and I'm trying to find out how people see this idea of lifelong learning. I'd just like to know **your thoughts** on this idea for nurses. It is **not a test**, and therefore there is **no wrong answer**. It is confidential.

- A1. The syllabuses for both pre-registration and post-registration courses are known as 'Creating Lifelong Learners'. Could you first tell me what you **understand by this term** lifelong learning?
- A2. Do you **see yourself** as a nurse who is a lifelong learner?
Yes/no - Why do you say that?
- A3. What would you say are the **characteristics that you have** that make you a lifelong learner?
If no, what characteristics do you feel **you don't have** that could make you a lifelong learner?
- A4. What do you feel are the **factors that led** you to **become** a lifelong learner?
or What are the factors that **prevent you** from becoming a lifelong learner?
- B1 We've talked about your thoughts of yourself as a lifelong learner so far. Do you think **other nurses see the term lifelong learning in the same way** as you do?

In **what ways** are their views of lifelong learning the **same as/different** from yours?
- B2 What are the **characteristics** that you think most nurses **would have to have** to make them lifelong learners?

- B3 How do you feel **other nurses** in general, i.e. other than yourself, **become** lifelong learners?
- B4 If you were **describing** the **ideal** lifelong learning nurse, what do you feel would be her or his characteristics?
- B5 Do you think lifelong learning for nurses is **a positive thing**? Why do you think so?
- C1 What sorts of **things or factors**, such as resources, motivation and so on, would you say are **currently available to enable** nurses to become lifelong learners?
- C2 What are the factors that we **don't have**, that you think could **help** nurses to **become** lifelong learners?
- C3 Other than **significant other nurses** who you have met or know of as lifelong learners, are there any **significant other people** who are not nurses who have **influenced you to become** a lifelong learner?
- D Is there **anything else** you can say or want to add to the idea of lifelong learning for nurses?

Brief professional details were also asked for, to see if these factors affected the informants' perceptions (Table 3.3).

Critique of individual interviews

The first three individual interviews were treated as pilot interviews, but only minor wording adjustment was required afterwards. Additionally, I learned to expect possible surprise questions in return as, for instance, one question asked about any

Table 3.3: Brief professional data.

- Current post:
- Current clinical grade:
- Place of work (please circle):
 - i) a hospital, or
 - ii) community care
- Years in nursing:
 - 0 - 3 years
 - 4 - 7 years
 - 8 - 10 years
 - more than 10 years
- Was your pre-registration course (please circle):
 - i) traditional pre-registration course?
 - ii) Project 2000/Diploma course?
- What is your:
 - i) highest academic qualification?
 - ii) latest post-registration professional course?

nurse who influenced the interviewee to become lifelong learner. One interviewee responded by asking 'Does this include a nurse who either is or isn't a lifelong learner?' This was a surprise response, but I had to reply yes, and in subsequent interviews allowed time and non-verbal space for such possibilities.

Miles and Huberman (1994) note that one of the '(recurring) features' in qualitative research is that certain themes and expressions can be taken back and reviewed with informants. In some studies the researcher chooses to send the full transcript to informants for verification. I could have sent interview transcripts to informants. However, due to uncertainty about whether informants would have been willing to review these, and about how long it might take them to do so, this action was not seen as necessarily beneficial.

Focus groups

In addition to individual interviews, two focus group discussions were also conducted. The intention was to conduct four to six audiotaped focus group discussions, but only two were conducted, owing to difficulty in assembling groups of RNs. Additionally, although the aim was that each focus group would consist of 6 to 10 members with the facilitator in attendance, only five were able to attend the first and six participated in the second, which are considered minimum numbers (Kitzinger 1995). They consisted of nurses from various specialities and seem to possess different levels of motivation for pursuing post-registration education, from the ambitious career-minded individual to the relatively unmotivated. Each session lasted approximately one hour.

The reasons for choosing this method are as follows. Kitzinger (1995) argues that a focus group discussion is a form of group interview that capitalises on communication between research participants in order to generate data. They provide one way of exploring issues and arriving at a consensus when there is some uncertainty or dispute about a topic area. The technique is used for discussion and debate on an issue that is either in the public domain or is part of the working lives of those closest to the issues under discussion. Both reasons are pertinent for exploring nurses' perceptions of lifelong learning in nursing. Yet another reason is that the concept is relatively novel in nursing.

Despite having its roots in market research (Millar et al 1996), the focus group method has been used successfully by researchers in nursing. Benner et al (1992), for instance, adopted this method in their study of nursing expertise, which they did by encouraging 'storytelling' to generate data.

Kitzinger (1995) notes that the technique enables the researcher to tap into many different forms of communication, with the aim of getting informants to tell us about what people know or experience, which may not be evidenced by responses to direct questions. Focus groups discussions can reveal dimensions of understanding that often remain untapped and, through the analysis of the humour, consensus, dissent and different types of narratives, the researcher can identify shared and common knowledge. It is, thus, also particularly useful in studying dominant cultural values, such as those within nursing settings.

In her discussion of focus groups, Kitzinger (1995) identifies seven main aims of using focus groups. The ones that appear most appropriate for achieving the aims of this study include:

- to highlight respondents' attitudes, priorities, language, and framework of understanding;
- to help to identify group norms and cultural values;
- to generally facilitate the expression of ideas and experiences that might be left underdeveloped in an interview as well as to illuminate research participants' perspectives through debate within the group.

Advantages and disadvantages of focus groups

Kreuger (1988) noted that some of the advantages of using this method are that:

- participants are able to explore and generate their own hypotheses as there is free exchange of ideas because of the social nature of the group;
- the dynamic nature of the interaction is achieved with little input from a facilitator; and
- the group has the opportunity to explore unanticipated areas.

According to Kitzinger (1995), another advantage is that any inhibition or intimidation that could be experienced by individuals in a one-to-one interview situation might be reduced in a focus group. It can provide an opportunity to explore problem areas and determine possible solutions. She notes that focus groups

- can encourage contributions from people who feel they have nothing to say - they may engage in discussion generated by other members; and

- do not discriminate against people who cannot read or write.

Additionally, focus groups provide a relatively low cost and rapid method for developing insights into sensitive issues (Lee, 1993; Morgan, 1993). They also use research participants as 'consultants' rather than respondents. Therefore, the two focus group discussions were held because:

- i) of the several advantages to focus groups as a method of data collection; and because
- ii) they were seen as appropriate to see if the type of data they would generate were similar to or different from individual interview data.

However, there are certain problem areas that could be associated with focus group methods. Some of those that were anticipated for this study, but did not occur markedly, were:

1. It could be difficult to achieve group consensus because the world of each individual is presumed to be different (Phillips and Erickson 1970). Consensus can only be achieved by a process of synthesising relevant portions of the world of each participant.
2. For the groups to function productively, members must feel able to talk to one another (Knodel 1993).
3. Active, vocal and high-status participants may dominate the quieter and more passive members (Morgan 1993).
4. There may be an issue of compliance or 'normative behaviour' where there is pressure for conformity (Delbecq et al 1975). This can constrain freedom and openness, which is opposite to the notion of group discussion.

One of the skills of the researcher is to avert these problems.

Focus group questions

Twelve questions reflecting the aims of the study were presented in each focus group session (table 3.4). After negotiating with members to be part of the group and providing them with some indication of the aims and content of the study, the following instructions were given just prior to the session.

- Members were thanked for agreeing to participate in the study. They were informed that I was interested in finding out how people see the idea of lifelong learning, and how nurses become lifelong learners; that I just wanted to know their thoughts; and that it was not a test and therefore there was no wrong answer.
- Members to briefly introduce themselves.
- The discussion would be tape-recorded, transcribed and analysed. It was confidential.
- The researcher will intervene minimally or not at all.
- All members should be allowed to have a fair say.

The groups were also informed that this is a completely informal discussion, self-led by the group, and recorded on camcorder because the microphone attached to the audio-recorder was not powerful enough to catch everyone's voice with adequate clarity.

Table 3.4: Focus group questions.

The ENB sees both pre-registration and post-registration nurse education as being about *Creating Lifelong Learners*.

- 1 As an idea and a word, what does lifelong learning mean to nurses, and in nursing?
- 2 Are nurses lifelong learners? What makes us think we are/aren't?
- 3 Assuming professional people are those who engage in continuing learning throughout their careers or lives, how do we nurses become lifelong learners? Who and what have influence?
- 4 What are the behaviours, attitudes, characteristics, and qualities of the nurse who is a lifelong learner?
- 5 What am I currently like as a lifelong learner, and how would I ideally like to be?
- 6 Should nurses be lifelong learners? Yes/no - why?
- 7 Should the idea be part of nursing, and if so, how can it be consolidated or advanced?
- 8 What are the positive aspects and possible problems with this notion?
- 9 What factors are important to enable the nurse to become and remain a lifelong learner?
- 10 Which of these factors are already currently available, and which are not?
What is the basis for your answer?
- 11 Who, nurses and non-nurses, have had significant influence on your perception of your continuing learning?
- 12 Any other points regarding lifelong learning for nurses, in nursing.

Brief professional data, the same as for the individual interviews, were also requested. The plan was to give the focus group questions to group members approximately a week prior to the discussion day. However, for the two group discussions held, the questions were given on the day, only a couple of hours beforehand. The prompts required during the discussions were minimal.

Documentary analysis

Blaxter et al (1996 p. 150) suggest that 'all research projects involve, to a greater or lesser extent, the use and analysis of documents'. Therefore, an essential component of this study was a critical review and analysis of reports and policy documents on lifelong learning. Consequently, the whole range of appropriate reports from authoritative bodies and the general literature were considered. They include documents:

- on projects commissioned by the government
- from the Department of Health
- from the ENB
- from the UKCC
- from the King's Fund Centre
- from NAGCELL.

The documents were selected on the basis that their primary focus was on adult, continuing or lifelong education within FE or HE sectors, and those that addressed nursing contexts and issues closely related to the aims of the study. They were discussed in detail in chapter two

Triangulation

The rationale for conducting focus group discussions was partly to generate more qualitative data and partly for triangulation purposes. Cohen and Manion (1994) specify that triangulation entails the use of two or more methods of data collection in the study of some aspect of human behaviour. Triangulation is defined as a 'research design that combines a range of methods, sources of data and theories in an attempt to examine the same problem (e.g. quality of nursing care) from the varying perspectives of those most closely involved' (Norman et al 1992 p. 43). Triangular techniques in social science therefore attempt to map out or explain more fully the richness and complexity of human behaviour by studying it from more than one standpoint.

Cohen and Manion (1994) point out that exclusive reliance on a single method may bias or distort the researcher's picture of a particular slice of reality. The researcher must be confident that data generation is not simply an artefact of one specific method. This confidence can only be achieved in 'nomothetic (or deductive) research' (Burrell and Morgan 1979) when different methods of data collection yield the same results. For example, if the outcomes of a questionnaire survey correspond to those of observational study of the same phenomenon, then the researcher will be more confident about the findings. If findings are artefacts of individual methods, then the use of contrasting methods considerably reduces the chances of this happening. Triangulation also avoids 'methodological parochialism or ethnocentrism' and overcomes 'method-boundedness' (Cohen and Manion 1994 p. 234).

Norman et al (1992) note that triangulation has been increasingly used in social sciences research when investigating a social issue by combining quantitative and qualitative methods. They see two main purposes of triangulation. The first is for confirmation, i.e. for confirmation of results and conclusions, triangulation utilises two or more independent methods whose strengths and weaknesses as data collection techniques are known. Comparing the results from each method serves to counterbalance the threats to validity that each contains. The second is for completeness, which involves using multiple strategies in an attempt to reveal the varied dimensions of a domain of interest; the areas outside the common ground are sought in an effort to describe the whole domain.

If the same conclusions can be reached by using different methods or sources, then it is felt that no peculiarity of method or source has produced the conclusions, and one's confidence in their validity increases (Open University 1979). This type of triangulation is known as *method triangulation* (or multiple methods); other types are:

- *investigator triangulation* (or multiple investigators);
- *data source triangulation* (or multiple data sets);
- *theory triangulation* (or multiple theories); and
- *unit of analysis triangulation* (or investigating multiple units).

Method triangulation, which was aimed for in this study, is seen by Cohen and Manion (1994) as the use of different research techniques to collect data in relation to the same topic of study, or the use of the same method on different occasions to reduce different threats to validity (e.g. source of bias, reactivity). However, although

the investigator initially sets out to see if different methods actually elicit the same results, Burgess (1993) argues that differences in results may help the researcher much more in understanding a social situation than if similar data are obtained. Furthermore, Burgess (1993) suggests that the researcher may consider seeing whether the data from different methods can be integrated or seeing whether they complement each other. In this study, they seem to complement the interview data.

Validity and reliability issues

In any research study, one of the primary concerns is whether the conclusions meet the criteria of validity and reliability. This relates to the rigour with which the study was conducted and the data analysed and interpreted. Morse and Field (1996 p. 118) indicate that 'Rigour in any research is required to prevent error of either a constant or intermittent nature'.

There are various definitions of validity but no real disagreement regarding its meaning. Morse and Field (1996 p. 200) indicate that in qualitative research, 'validity refers to the extent to which the research findings represent reality'. Blaxter et al (1996 p. 200) note that 'validity has to do with whether your methods, approaches and techniques actually relate to, or measure, the issues you have been exploring'. Morse and Field (1996) note that the strength of qualitative research is high validity, although they are wary of the possibility of the researcher being of 'low credibility' and either the interview or the data being mismanaged. However, the phenomenon itself may change over a period of time through maturation of the group (p. 119) (nurses in this instance) or various other factors.

According to Eby (1993), qualitative research has fair potential for external validity, high potential for content validity, but is low in internal validity.

Morse and Field (1996 p. 120) indicate that external validity is also 'enhanced by synthesising the results of studies that examine the same phenomena but in different contexts and then comparing and contrasting the results'. This has been addressed in this study by following up the findings through searching for comparable work with other groups within the lifelong learning literature (e.g. Blaxter and Tight 1995, Sargant et al 1997). However, it achieves only content validity, and although there is potential for external validity, this is difficult to achieve in qualitative research (Cohen and Manion 1994).

Bias and validity

Since the sample for this study was selected through purposive sampling and consisted of nurses with experience of study for professional development courses in higher education, the nurses in this sample are not likely to be representative of the UK nursing population at the time; nor would they be representative of the nursing population working in the Coventry and Warwickshire area. This is because many nurses working in the Coventry and Warwickshire area, as in many other areas in the country, haven't had experience of studying nursing in universities, as nurse education had only recently moved into this sector. Consequently, the findings of this study need to be seen as somewhat biased, as they largely reflect the views of only those nurses who have experienced studying in higher education.

Cohen and Manion (1994) note that despite the fact that face validity (that is, whether the questions asked look as if they are measuring what they claim to measure) may seem high in qualitative research, bias is often the cause of invalidity. That is because there can be a marked tendency to overstate or understate the true value of an attribute. Burns and Grove (1997) note that another reason why bias can threaten the validity of the study is that qualitative researchers tend to work alone. Sources of bias, which should be minimised to increase the study's validity include the interviewer, the characteristics of the respondents, and the substantive content of the questions asked (Cohen and Manion 1994).

Another strategy for examining the validity of qualitative measures is checking for researcher effects, ruling out spurious relations and looking for negative evidence (Burns and Grove 1997). These were heeded throughout the data collection and analysis exercises. I endeavoured to achieve validity in focus groups, for instance, by placing myself in the room as unobtrusively as possible, away from the group, and during both qualitative methods by explaining to informants that the study was being done as part of a course at another university, and not in my capacity as nurse lecturer at Coventry University.

Another perspective from which to consider the rigour of a qualitative study is to ascertain the 'trustworthiness' of the research (Morse and Field 1996), which includes the *applicability* and *neutrality* of the study. *Applicability* refers to whether the findings can be applied in other contexts or settings, which I would argue is the case here. *Neutrality* or *confirmability* is the criterion that questions the degree of

objectivity with which the reported findings were identified. Although there is a debate as to whether objectivity as a concept can exist in its pure form, as the notion of intersubjectivity may be preferred (e.g. Pierson 1999), the guidance presented by Morse and Field (1996), Cohen and Manion (1994), and Oppenheim (1992), on how to endeavour to be bias-free has been followed. With semi-structured interviews this was achieved by endeavouring to conduct interviews with reflexivity, and therefore exhaustively; and by ensuring a good number of individual interviews were conducted (26 in this study lasting on average one hour each).

How the data was analysed

Quite comprehensive guidelines have been detailed in the research literature on methods of analysis and interpretation of the data in qualitative research (e.g. Silverman 2000, Morse and Field 1996, Cohen and Manion 1994, Woolcott 1994, Dey 1993, Lincoln and Guba 1985). Miles and Huberman (1994) note that one of the 'recurring features' in qualitative research is that most of the analysis is done with words. The words can be assembled, sub-clustered and broken down into semiotic segments. They can then be organised to permit the researcher to contrast, compare, analyse, and bestow patterns upon them.

To enable analysis and interpretation of the data, all individual interview and focus group recordings were transcribed verbatim with a view to conducting a content analysis to identify emerging themes. This was influenced by the key areas addressed in the interview schedule, which were themselves initially guided by the nature of the problem and the aims of the study. The steps involved in data analysis

that are delineated by Dey (1993) (Table 3.5) were closely followed in the analysis and interpretation of the data. The transcriptions were read in conjunction with replaying the audiotapes to try to ensure that none of the data, nor the non-verbal tones, were missed. Then the data from all respondents were grouped under the questions asked or addressed in the interview schedule (Table 3.2) and in the focus group questions (Table 3.4). The next phase entailed re-reading the transcripts and annotating them with a view to subsequent assigning and creation of categories. A note was made of where the informant voiced a point with more or less emphasis. At the same time, transcript contents that were not appropriate to the concept of lifelong learning and the aims of the study were disregarded. These processes are regarded by Dey (1993 p. 43) as 'categorising as a method of funnelling data'.

These categories were thereafter linked to identify emerging themes. An example of these is illustrated in table 3.6. The transcripts were revisited several times to ensure that the notes, categories and themes did reflect informants' accounts, and thereby endeavour to minimise spurious interpretation of the data. Following this, the categories and themes were mapped in the context of the aims of the study to develop the findings and theory emerging from them.

Conclusion

The focus of this chapter has been on explaining the research design for this study, on the methods of data collections, and on issues related to both in the endeavour to achieve the aims of the study. The decision to utilise qualitative methods has been discussed and justified. This was followed by discussion of the sampling for

Table 3.5: The steps involved in data analysis (Dey 1993).

- Finding a focus
- Managing data
- Reading and annotating
- Categorising data - creating categories, assigning categories, splitting and splicing
- Linking data
- Connecting categories - associating and linking, using maps and matrices
- Corroborating evidence
- Producing an account

Table 3.6: An example of an instance of data analysis

Data- from child protection nurse	Notes / memos	Analysis/ categories	Possible themes
<ul style="list-style-type: none"> <i>The mechanism wasn't there, but as far as I know, from talking to the girls on this course, it is there now, and it is all wrapped up in IPRs, and their clinical supervision, what it is they get with their managers, identify their learning needs, and they try and match them. So that they are giving them opportunities always to build, for those that want to.</i> 	Factors that facilitate or obstruct continuing learning	Management support for CPD; learning organisation	Structures and processes that can enable lifelong learning
<ul style="list-style-type: none"> <i>I think a lot of that's fear. Fear of not being able to take on board further education. And also I think probably fear of not getting support from management to have time to do it.</i> 	Factors that facilitate or obstruct continuing learning	Management support for CPD	Structures and processes that can enable lifelong learning

the study, access to informants and their perceptions, a critique of individual interviews, focus groups and documentary analysis as methods of data collection, the attempt at triangulation, validity and reliability issues, and how the data was analysed and interpreted.

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Chapter Four

LIFELONG LEARNING IN NURSES' CAREERS AND LIVES

Introduction

The focus of aim 1 of the study was to explore the perceptions of lifelong learning held by those RNs who were directly involved in patient care, and their thoughts on the characteristics or attributes of nurses who are lifelong learners. Questions A1, A2 and A3 in the interview schedule were specifically designed to elicit information on these areas. During the semi-structured interviews and focus group discussions informants were asked what the term lifelong learning meant to them and what they thought it meant to other nurses. They were also asked if they thought of themselves and of other nurses as lifelong learners, and their reasons for thinking so. The purpose of this was to ascertain the perceived parameters of the concept within nursing.

As indicated in chapter 3, the transcribed data were analysed and interpreted using guidelines from the qualitative data analysis literature. To ensure coherence, Dey's (1993) framework (table 3.5) was closely followed. One example of how notes were made based on informants' responses, possible categories were identified and themes were captured was presented in table 3.6. The same processes were utilised to capture the themes that were emerging in relation to perceptions of lifelong learning and of the attributes of nurses who are lifelong learners. Examples of these are presented in table 4.1, except that the 'categories' column shown in table 3.6 has been omitted to avoid cluttering the table.

Table 4.1: How themes were captured in relation to perceptions of lifelong learning

Data	Notes	Themes
<p>i) ... learning goes on all the time, and you could argue that everybody is a lifelong learner in some way or another, because you learn from experience everyday (Respiratory CNS).</p> <p>ii) I think a lot of those skills ... they're learnt by your general experiences of life ... And that you learn by your mistakes, as well ... And by doing that, you reflect on it ... you learn not to make that same mistake ... so we're learning to adjust, as well at the same time (Child Protection Nurse).</p>	<p>Continual learning from day to day experience.</p> <p>Learning from daily experiences. Learning to adjust one's thinking.</p>	<p>Learning as a natural human activity.</p> <p>Learning as a natural human activity.</p>
<ul style="list-style-type: none"> This theme emerged from question A3, which asked informants directly what they felt were the attributes or characteristics on RNs who are lifelong learners. Several examples are cited on table 4.4 in this chapter. 		<p>Characteristics of nurses as lifelong learners.</p>
<p>i) The first one I did was the bereavement course. I did it because of PREP. It included counselling skills and I enjoyed it so much I thought I'd become a counsellor (ITU Nurse).</p> <p>ii) The introduction of PREP goes towards everyone learning something, because in the trust, there are some people who have through the years, not really done anything, taken any more knowledge than what they've got already from their training. They never felt they needed to. It wasn't encouraged to go and learn different things (Ophthalmology Nurse).</p>	<p>PREP leading RNs to do further courses.</p> <p>Without PREP some nurses may feel their pre-registration course have equipped them with competence for their whole career.</p>	<p>PREP as a trigger for professional lifelong learning.</p> <p>PREP as a trigger for professional lifelong learning.</p>

Data	Notes	Themes
<p>i) <i>But I think you need a certain amount of ambition, really. I think if you are starting as a D or E grade and you are quite happy sat there, and you are quite happy in a rut, ... if you are ambitious chances are you'll get promoted quite well (Coronary Care [Male] Nurse).</i></p> <p>ii) <i>Intrinsic and extrinsic factors, professional desire, and I fought for myself to develop my career, but also for the benefit of my dermatological patients (Dermatology Nurse).</i></p>	<p>A certain degree of ambition is needed.</p> <p>Steady career development.</p>	<p>Career opportunities, career development and ambitiousness.</p> <p>Career opportunities, career development and ambitiousness.</p>
<p>i) <i>When ... I got into the clinical area, I found that there was so much to learn to do with that, that the academic bit seemed less important I thought I've had placements in CCU, I'd be alright in CCU. When I actually got there I did not know a thing ... I couldn't read an ECG for example, and that is such an everyday occurrence (Coronary Care Unit Nurse).</i></p> <p>ii) <i>I am only competent now to work in the community, and again within a very very tight setting. I am not competent anywhere else ... I think specialisms is very important. Uhmm, proper trained specialist nurses, who have the acknowledged ENB courses behind them (Child Protection Nurse).</i></p>	<p>Skill deficit in the newly qualified P2000 RN.</p> <p>Nursing is increasingly becoming specialised and require specific further learning.</p>	<p>The newly qualified nurse, and learning generalist or specialist skills</p> <p>The newly qualified nurse, and learning generalist or specialist skills</p>

Two instances of informants' responses are reproduced in the table as examples of how the notes made on the data reflected impressions that were subsequently identified as themes. Themes related to the other aims of the study were similarly extracted. Further instances of informants' responses suggesting these five areas in relation to nurse' perceptions of lifelong learning in the context of their careers and lives are cited in the discussion under each theme in this chapter.

The five themes that emerged from the data in relation to RNs' perceptions of lifelong learning were:

- Learning as a natural human activity
- Characteristics of nurses as lifelong learners
- PREP as a trigger for professional lifelong learning
- Career development and seizing opportunities
- The newly qualified nurse, and learning generalist or specialist skills

Thus, the study informants perceived lifelong learning as a natural human activity; lifelong learning RNs as having particular characteristics; lifelong learning being triggered by having to study to be able to re-register as a RN; lifelong learning being related to the RN's career plans and opportunities; and lifelong learning having implications for the newly qualified nurse as well as for the more experienced specialist nurse.

Criteria for using quotations

Within the chapter and the rest of the thesis, the quotes included are selected according to guidelines suggested by Morse and Field (1996 p. 147). These are that:

- quotes are included to ‘supplement the text and provide human insight and dimension to the analysis’;
- the point the researcher is making is clearly described before inclusion of the quote; and
- quotes are included when the participant has made a point in a manner better than the researcher could have made himself.

Quotes from the data are presented in italics; those from related literature are in regular font. Furthermore, for some short phrase quotes within sentences, the professional capacity of the nurse (e.g. community nurse) is not identified when the absence of this does not affect the meaning of the argument being presented.

Learning as a natural human activity

Several perspectives were offered by informants to explain what the term lifelong learning meant to nurses. Many of these perspectives presented lifelong learning in a positive way, whilst other responses suggested reservations about the concept. As might have been expected, informants indicated that lifelong learning comprises learning throughout life, and which occurs during one’s normal day-to-day personal life experiences as well as through professional activities. Thus learning as comprising a natural human activity emerged as one of the themes within RNs’ perceptions of lifelong learning.

Positive perceptions of the concept

The following statement represents an example of learning as a natural human activity: *'... to me, the concept of lifelong learning is like a cradle to grave type thing ... These things go on, probably throughout life'*. Phrases such as *'a desire to learn and to succeed'*, and *'learning for pleasure'* were used by participants to illustrate positive perceptions of the concept. However an Accident and Emergency nurse indicated that such learning tend to occur when *'it is an integral part of yourself. It just needs something to maybe ignite that. There is a capacity in everybody to be a lifelong learner. It's the will to be one though, ... and the commitment'*. Examples of the more positive perceptions of the term offered by informants are presented in table 4.2.

One informant indicated that formal educational courses, even if they are not nursing focused, could themselves have a stimulating effect on one's motivation to learn. Just a few years after qualifying as a nurse, this informant started to study for a degree in Business Studies, which, being a part-time modular degree course, allowed her the freedom to stop and start whenever she felt she needed to. In her view, it is *'healthy to do something a bit different'*.

That we are naturally inclined to learn is also suggested by Courtney (1992 p. 15) who observes that *'all humans share the propensity to learn and to confront the world existentially as learning beings'*, and that learning is not just a component of human evolution. Furthermore, Courtney feels that learning is an essential aspect of humanity itself, and lies at the foundation of human progress. It also implies choice.

Table 4.2: Positive perceptions of the term lifelong learning

- *It's personal and professional. You never stop learning, everyday you learn something new.*
- *Every new experience whether it's personal, academic, is a form of learning.*
- *A lot of it is trying to be pro-active as well. Saying that this is a situation that I am probably going to come across in the future, so I need to create my knowledge about it.*
- *It's kind of habit, it gets you in the routine of essay writing, reading and all that.*
- *As adults, we're learning things in different areas, not just within nursing.*
- *Life is a lifelong learning process, you are learning all over life, which is constantly changing all around us; you develop from it.*
- *Survival as learning is a human instinct; it's something that used to be nurtured. It's not just nursing, it's your whole life.*
- *Specifically, in your career or role, you can learn something, ... but more specifically, it is career-based.*
- *It's not a chore, it should happen normally, be part of the professional to find out. And it's not scary, don't have to do a big thing, it could be a small thing that you do.*
- *It comes from within, but it gets promoted from outside as well.*
- *They're all skills that can be used in different ways, job or leisure-wise. They might start as leisure and become business.*

Sargant (1991 p. 9) also agreed that 'everybody is engaged in learning - all the time'. Additionally, Tight (1998b p. 260) comments:

How can we not learn, in some sense, as we continue living? ... When you probe individuals about their experiences, and take a broad view of what constitutes a learning activity (i.e. not confining it to formal education and training), it is actually quite difficult to find non-participants.

Furthermore, quite a few informants stated that becoming a lifelong learner might have its foundations in the earlier years of one's life, long before reaching adulthood. One informant who also has direct regular contact with secondary school children through her role as facilitator of career seminars, indicated that: *'small people have that desire, and it's knocked out of them, which is a real shame'* (NVQ Co-ordinator Nurse). This view seems consistent with those expressed by Titmus (1999) and by Wain (1987) that the habit of lifelong learning is usually developed during childhood and adolescence, as discussed in chapter two. However, the informant felt that the focus of primary and secondary school education might need to be adjusted to ensure that their role in the development of individuals as lifelong learners is taken into account. The above informant elaborated that in principle, lifelong learning should have been introduced within the school years as a normal course of action, and:

... if that is instilled into a small person, right at the very beginning of their learning career; that's something that schools have to take on board (NVQ Co-ordinator Nurse)

Courtney (1992 p. 123) explains that:

... the most enduring finding of participation in adult education (PAE) literature is the strong relationship between levels of formal schooling and later involvement in post-secondary education: those who avail of opportunities for adult education tend to be those who have already achieved significant levels of earlier schooling.

However, in their studies of learning, Jarvis and Gibson (1997) suggests that not all life experiences present themselves as learning opportunities, which implies that learning cannot be seen as a continuous and consistent non-stop activity.

Learning can be seen in yet another context in that people can choose what they wish to learn. One interviewee felt that she needed to continue to learn despite constraining life circumstances, because *'It's like freedom of choice, and if that's what people want to do'*. Another indicated that *'It's a sort of emancipation, that is even though there are other calls on you, you still can be independent as a person'*.

However, professionally, not all nurses necessarily see learning as a natural human activity, as informants felt that a good number of nurses are not interested in extra formal learning. Nonetheless, it seems that at times, RNs need to attend courses to review and validate their competences and also to further develop their professional roles e.g. through the ENB 998 course:

Because of the nature of being a nurse, sometimes you have to study certain courses in order to be recognised for the skills that you've got It's a good idea to have your 998 in order to assess, and to teach students, that's how you develop your roles (Emergency Assessments Nurse).

On stating that lifelong learning is not only related to one's vocation or profession, informants also indicated that learning after retirement is more of a personal nature, focusing on personal interests, and increasingly less formal, as also identified by Longworth and Davies (1996).

According to the data, lifelong learning is not necessarily seen as a new concept. Another positive aspect of it, is that it enables the individual to develop life skills,

which include for instance, interpersonal skills and literature searching skills. There were several examples of this, including:

It isn't just to do with professions; it's in everything you do. I am bringing up children, but I learn about things everyday. They say that the elderly are wise, it's true. They've continually learnt from their life experiences (Intensive Care Nurse).

Certain life skills such as interpersonal skills can be developed through socialisation and social experiences, and they could also be applied in clinical settings.

There's a lot of learning that goes on through socialisation, in our communication and interaction with others, ... and therefore our relationships with our clients and our colleagues develop and change through our own experiences (Respiratory CNS).

This type of learning can be seen in the context of social learning (or observational learning) theory, whereupon social situations play a vital role in learning (Bandura 1977), in that the individual learns through observing other people. Social learning theory potentially constitutes a very significant learning perspective, in that, particularly for individuals new to nursing, each nursing activity is first observed being practised by the skilled person before it is attempted and practised by the 'novice'. The notion of role models is an integral component (Darling 1984).

Literature searching skills can also be seen as a life skill and a key element that facilitates lifelong learning. One informant indicated that lifelong learning entails effective and efficient use of libraries on a fairly regular basis, the purpose for which would be to increase knowledge generally related to work issues. However, informants also indicated that they were interested in finding out new things anyway, that is learning for the sake of learning something new. Thus, learning that is related to work could be seen as 'a *small research*' related to a clinical activity e.g. a

dressings. Such learning would benefit patient care, but it would require the management of change, as collaboration and approval is required from team colleagues to be able to implement new practices.

Nurses increasingly have to become conversant with the use of the Internet and specialist databases for literature searching. This includes, for instance, the Cochrane library, which is a comprehensive database that is constituted through meta-analyses and critical reviews of research on selected topic areas. Quite a few informants reported owning home computers, which may enable access to the Internet, and learning how to use it is seen as one of the characteristics of a lifelong learning nurse.

A more positive approach for RNs to develop lifelong learning skills is suggested by Hull (2000), which is as follows:

- *Choose a professional development programme* that builds upon what they know and can do - and this then helps them to learn new and meaningful things, relevant to practice;
- *Share ideas* with other healthcare practitioners and listen to the ideas of others;
- *Draw on perspectives* from within and beyond their own professional boundaries and use these to inform their own practice; and
- *Critically reflect* on and evaluate their own personal, professional development and learning.

Hull therefore also indicates that lifelong learning is goal-directed, planned and active learning.

Reservations about the term lifelong learning

In contrast to the positive perceptions about lifelong learning noted in table 4.3, several informants also expressed reservations about the concept (see examples in table 4.3) and did not describe lifelong learning in an entirely positive vein. Reservations related to lifelong learning found in the general literature were also discussed in chapter two. The notion that everyone is a lifelong learner was also counter-argued by one informant, who as a clinical nurse specialist felt that she had added responsibility, because other staff in clinical settings weren't motivated to develop their clinical skills further.

However, it seems that other perceptions of lifelong learning are more balanced, and the concept is seen from different perspectives. One such perspective related to the personal gains from learning:

Learning carries different rewards, as far as I'm concerned. To be a lifelong learner, you're not in it for the reward. That I think you'll get them anyway if you keep up to date with your career and development, ... It's the sense of satisfaction as well. It's very much this inner belief, the desire to improve, to gain more skills and more competencies ... to be a better practitioner (Community Nurse).

It was also suggested that the term lifelong learning might not be the most appropriate term to convey the philosophy and the activities involved. However, the

Table 4.3: Reservations about the term lifelong learning

- *It's a strange concept; it's stating the obvious, because we're always learning.*
- *I wouldn't generally say all nurses see the term lifelong learning in the same way as I do, because other people have different priorities.*
- *Life's a very long time, but when I qualified I was quite keen to go on to do something else quite quickly, like the degree, 'coz you are still in that student mode.*
- *Impressions are that, that's really quite daunting. You've got to be learning all your life. The poor students who are coming out now will think I've got to keep learning, for ever more for the next, but this is with any job you think you've got to keep this job for 15 years or whatever, or 40 years till I retire.*
- *I do feel sorry for students. You've got to learn for life, and they think shock, horror, god, this isn't going to be the end of it.*
- *Can be interpreted as a very long period of time, and people can be put off by that term; may not like it, it's forever, it can be a bit off-putting, but it depends on the individual really.*
- *Lifelong learning it's sort of a bit airy-fairy.*
- *As a concept could be quite threatening to some people. For me, it's not, because I've evolved into it.*

enthusiasm of nurses who are keen on learning is seen as enduring. For instance, one informant indicated that *'I'll continue to learn till the day I die'*.

The tone of that informant's speech indicated that her enthusiasm for learning is connected to wanting to do more within her job role. The knowledge base for this can be acquired from several sources, and motives including a personal interest in the subject or topic area. Another informant saw lifelong learning as neither just another new concept nor a transitory one, but as a more enduring notion that needs to be accepted by all, because:

We've had to cope with a lot of that in the last few years and just it gets a bit of overload. So I hope that lifelong learning is not one of those terms that just comes and goes, coz it shouldn't be (Intensive Care Nurse).

Characteristics of nurses as lifelong learners

More than one of the interview questions directly enquired what might be the characteristics or qualities of nurses who are lifelong learners. The purpose was to explore the personal psychological constitution that drives the nurse as an individual to be a lifelong learner. Although this appears to be based on the assumption that there are certain personal characteristics that are either inherent or consciously developed, informants were questioned in such a way that they could refute the assumption if they wanted to.

Responses reflect several facets of lifelong learning, but one of the more common ways of responding to questions on characteristics of lifelong learners was:

... having done their initial training, ... continue to explore new knowledge to try to find out how you can improve on the topic ... you go on from there, it's the beginning (Private Sector Theatre Nurse).

Some of the words used by informants to identify the characteristics of the lifelong learning nurse (see table 4.4) were relatively similar to those identified by the ENB (1995a) presented in table 2.4 in chapter two. Each of the characteristics in table 4.4 can be analysed and interpreted in ample detail. However, only one of these will be examined here in some depth, predominantly because it was the one that was most frequently mentioned by respondents. The focus is on self-assessment and self-improvement.

Self-assessment and self-improvement

The majority of active learning that any one person undertakes seems to be based on self-assessment of knowledge and competence. Several informants identified this as a basis for all professional learning. For instance:

Sometimes it can be difficult once you qualified to say you've got your limitations. A lot of the attitude is that oh I am a professional in my own right, I should know everything. Self-assessment plays a lot in it (Accident and Emergency Nurse).

There are various components to the concept of self-assessment. They include how self-assessment skills can be developed, the benefits and drawbacks, and research findings on self-assessment. Self-assessment forms the foundation of CPD and for meeting PREP requirements (UKCC 1997). Additionally, current literature (e.g. Boud, 1991 & 1995) indicates that:

- self-assessment is an essential learning activity which is more pervasive than immediately apparent; and

Table 4.4: Characteristics of the lifelong learning nurse evidenced from the data

- > *Motivation to learn.*
- > *An eagerness to improve/ have a good standard of patient care/practice.*
- > *Curiosity for knowledge.*
- > *Prevent boredom.*
- > *Sharing learning.*
- > *Be able to instigate change and see it as a positive thing.*
- > *Look up things and try for yourself.*
- > *Be open-minded, and able to take on new ideas.*
- > *Flexible, Identify positive things and areas that could perhaps be improved.*
- > *Need energy, commitment.*
- > *Self-direction.*
- > *Enthusiastic.*
- > *They've got to enjoy it to get something out of it.*
- > *A lot of it though is personal determination.*
- > *Never too old to continue learning, never stop learning.*
- > *Humility to recognise that you don't know everything.*
- > *Patience, accept that it has to be done in piecemeal fashion.*
- > *A thirst for knowledge, you have to have a will to learn.*

- it is a skill that individuals engage in through a range of activities.

The NMC's (2002) *Code of Professional Conduct* indicates that nurses must 'maintain and improve your professional knowledge and competence' (clause 6), and must 'acknowledge the limits of your professional competence (clause 6.3).

One informant, for example, noted that the nurse must:

... have an ability to know where their limitations are; able to say I need to go on this course because I need to be able to do this. Probably 20% or less of nurses are prepared to actually say I have limitations (Accident and Emergency Nurse).

Purdy (1997 p. 136) observes that self-assessment plays a relatively minor role in pre-registration nursing courses, but 'assumes a role at the very heart of professional practice and development' for the RN. Jarvis and Gibson (1997) observe that self-assessment is important for nurses' continuing education, as the more skilled and autonomous the nurse becomes, the less likely she is to be assessed by others, or be assessed as frequently. They also suggest that professionalism itself is a fundamental reason why constant self-assessment of competence and knowledge is essential. Self-assessment therefore seems to be not only an essential feature of lifelong learning, but also a factor in creating and maintaining the culture of a learning organisation within the clinical area.

It seems that self-improvement is a prominent feature of lifelong learning, as one informant explained:

I've got on like a ladder; I've had to go through every one of them rungs of the ladder. And it's been long difficult road. When I think back, 10 years ago,

when I was in my comfortable role, if I thought of lifelong learning, I would have seen it as quite a threatening concept. Once I was in this process, once I got on board, for lifelong learning, that all fell away. And all my fears and anxieties went, because the positive things out-weighed the negatives (Community Nurse).

One RN, who had been qualified for only one year, explained that the reason for wanting to exercise the qualities of a lifelong learner would be, for instance, because she felt that there's substantial learning to be done because of gaps in her knowledge. Another reason is that she wanted to be as competent as her peers and colleagues. She would therefore regularly read on the subject area for fear that she may get asked a question on her clinical practice that she might not be able to answer, and there may not be any other knowledgeable staff around who she may turn to for an answer. The informant also felt that the nurse must have a wealth of knowledge about different things, probably not in depth, but a little about each area, and knowing how to find and retrieve further information when required.

Examples (in the data) of qualities of the RN who strives to self-improve include:

- * *Always being conscientious.*
- * *Mature, know how to manage time.*
- * *Ego, self-drive, their own recognition, their desire for knowledge.*
- * *Got to enjoy it to get something out of it.*
- * *Quite assertive in getting the opportunities to learn, and quite organised.*

Wanting self-improvement may or may not be related to seeking promotion, but could result in increased self-satisfaction, self-confidence and ability to challenge other health care professionals when necessary, which could comprise character development as well.

PREP as a trigger for professional lifelong learning

The data indicate that Post-Registration Education and Practice (PREP) has had a major impact on nurses' learning. Since 1995, the UKCC has required nurses to declare that they are professionally up to date to be able to remain a Registered Nurse. This amounts to mandatory continuing education (MCE), which is discussed in chapter five. Most nurses seem to accept MCE, but another informant indicated that she did not see mandatory learning as lifelong learning. It seems that there are certain negative impressions of PREP that differentiate it from lifelong learning. However, to ensure that nurses are keeping up to date with knowledge and competence, one informant advocated that it had to be made compulsory. Attending such courses may also instigate a desire for continuing learning, viz:

I think some of them go on a course, by being told to, and may be there is something within that course that sparks something that initiates this curiosity. I think then they start looking at something, they go to the library and look up the journal, and carry on with that. And then that re-programs their thinking process, and gets them to start thinking about things more deeply (Palliative care nurse).

However, informants indicated that individuals couldn't be forced to learn, as is also argued by writers on adult education such as Mezirow (1981), and Knowles (1989). Learning is more self-directed, as 'You can't make people become lifelong learners, can't force them into doing anything ... it's got to be self-directed' (Accident & Emergency Nurse). This is because the value and quality of learning that results from attending the course is doubtful when the nurse is compelled to go on it (Marton et al 1997).

Thus, although substantial knowledge and skill acquisition begins on qualifying (or becoming a RN), it was felt that the individual professional should determine the

necessary areas of learning themselves. This learning could be instigated by ward-based experiences, but this self-direction could become career-long. One study on self-directed learning (SDL) which was published some time after data collection for this study was that by Lunyk-Child et al (2001), who undertook a qualitative study of lecturers' and students' perceptions of SDL and factors that facilitate or impede it. They found that students who engage in SDL undergo a transformation that begins with negative feelings (i.e., confusion, frustration, and dissatisfaction), but ends with confidence and skills for lifelong learning.

However, Hughes (1999) provides another perspective on SDL by indicating that this approach is not necessarily emancipatory, in that it has become a 'repressive instrument' because it marginalises the significance of collective and co-operative learning.

Keeping knowledge and competence up to date, and accepting change

The data indicates that willingness to keep up to date and accepting of change are seen as essential characteristics of the lifelong learning nurse. This is because of ongoing changes in clinical practice. Hyde and Wright (1997) indicate that PREP is grounded in the rationale that RNs take responsibility for their own development. This engenders awareness and responsibility, and is of value to both the individual and the organisation. In addition to these, being up to date is also consistent with compliance with nurses' *Code of Professional Conduct* (NMC 2002). There are other reasons for keeping up to date, such as to be able to teach students in the clinical setting, as this is unlikely to be as efficacious if the individual practitioner is herself

not up to date with practice. Even from the patient's viewpoint, keeping up to date is important, as they are likely to expect competent, informed and evidence-based health care interventions, as:

... couldn't do the job effectively and efficiently if the nurse was not a lifelong learner (Child Protection Nurse).

Although most RNs seem to accept that they have to keep up to date with technological and professional changes, some may see it as just 'going through a period of change'. Despite these different perspectives on reasons for participating in study days and courses, whether or not learning is consciously undertaken, it seems that several people generally just accept the changing nature of the world and adapt to it as and when they feel inclined to do so, because '*... lifelong learning concept fits with change, neatly*' (Community Nurse); and,

I am no spring chicken; I'm coming up to 55. If I wasn't into lifelong learning, I would have perished as a professional long time ago (Practice Nurse).

It seems that attitudinal change to learning is a key factor for developing as a lifelong learner, and the impact of this is discussed in detail in chapter seven. The possible consequences of not keeping up to date with changes are pre-empted by some nurses, and actions taken, but changing attitude towards learning can take time, as:

(Previously, nursing) was very task orientated, very fixed and inflexible. But it took me possibly 10 years to get out of that mode, because suddenly there was a conceptual shift, and that was quite enlightening for me (Community Nurse).

According to Rogers and Shoemaker (1971) one of the factors that trigger change is the perceived advantage of the new activity over the status quo.

Attitude change and the need for a managed strategy for marketing lifelong learning

Davies (1996 p. 56) indicates that the qualification gained at the end of professional preparation on pre-registration courses is not a license to practise for life, and that 'continuing professional education is a form of a lifelong learning model that in part confronts the idea of complete and once-for-all mastery of knowledge that underpins the old model'. This might have been a previously held attitude by many, but is not a sustainable outlook any longer.

However, some informants indicated that the concept was not 'sold' or marketed to RNs very persuasively. Lifelong learning was introduced in nursing with certain aims by the statutory bodies, but it seems that there should have been some form of additional component to the strategy for implementing it. It is not just that nurses are continuously learning as they are affected by changes. It seems to be a matter of identifying this necessity and having a strategy so that the concept can be accepted and adopted. It is a matter of marketing and selling the idea to practitioners because it has:

... implications for how lifelong learning is marketed, in that it has to be marketed very subtly, to reach everybody, to meet people at grassroots levels that don't want to embark on that level of study, but want to progressively enhance their practice... If you've got to keep people within the service, stop people voting with their feet, leaving the NHS, then we've got to see them positively (Community Nurse).

The metaphor 'voting with their feet' was also used by subjects in Secombe and Smith's (1996) survey of nurses' attitude towards the vocation, which revealed that an increasing number of nurses would leave nursing if they could. Therefore, the data suggests that marketing and publicising educational opportunities may be an

issue, in that some nurses, particularly in the older age group, are more likely to participate in formal learning if university staff can reach them by taking information about opportunities to them rather than just relying on leaflets and prospectuses. This age group may just need prompting and encouragement for them to commence participation in formal learning because:

Everybody should be given the opportunity; the college people have to go out there to the nurses. I don't think the nurses will come to them, especially the older nurses, some will, but there are nurses out there that just need pushing a bit. The incentive, the information, and they'll do it. And they'll get a lot of enjoyment from it, but they won't probably volunteer to do it (Gynaecology Nurse).

However, it may be that the wish to learn must be supported in a more equitable way, as.

Lifelong learning is a positive thing for nursing as long as it is promoted, and everybody's given a chance to go on courses. It's got to be cost-effective and value for money (Gynaecology Nurse).

Career development and seizing opportunities

Another finding emerging from the data, in addition to keeping up to date with current professional knowledge and competence, is that lifelong learning is linked to career development. This seems to entail undertaking appropriate CPD courses as well as developing skills in areas appropriate to one's career plans. It requires open-mindedness [as noted by Goodman (1984) for instance] towards professional experiences that present as learning opportunities, so that:

Always making the most of your opportunities to learn. It's not necessarily formal courses, or get a certificate in this, a certificate in that. It's about promoting learning through all available opportunities that arise (Intensive care Nurse).

Such opportunities could have an effect on the RN's career aspirations and plans. One informant indicated that if the individual does not seize opportunities as they arise, then there are always other individuals who will take them, and *'you've lost the opportunity'*. The informant also suggested that the benefit of seizing opportunities when they arise is that they could act as important turning points in one's career and life.

The nurse interested in a healthy career in nursing seems to be *'... people who've always enjoyed learning, always will, and be drawn towards jobs that will give them scope'*. Lifelong learning is therefore related to *'broadening your horizons'* beyond one's immediate specialism and possibly beyond nursing. Thus there seems to be an attitudinal component in individuals who are career-minded and aim to achieve certain goals in their professions. For instance:

One of the Macmillan nurses, she was saying that she wanted to be a Macmillan nurse right from being a student. She knew the pathway she had to go. She had to have a degree, she had a goal, and which made her go through and do it (Gynaecology nurse).

However, the data also gives the impression that some Project 2000 qualified RNs tend to expect to be promoted to senior posts much more quickly than RNs qualified through traditional courses. Nonetheless, the notion of career planning and professional/personal development plans is supported by policy documents such as *Making a Difference* (DH 1999b), and the data indicates that being career-focused is therefore a factor that enables the nurse to be a lifelong learner, albeit that some nurses might see nursing as merely an employment that provides a salary. According to Thomson and Mabey (1994) a career implies advancement, as in

moving 'up' in one's career, and therefore relates to work-related experiences that span the course of the person's working life. This perception might suggest that a person's career can take the form of smooth progression over one's working life. Nurses who are keen to achieve high status and income more rapidly could therefore be seen as ambitious. However, one informant indicated that RNs who continually study merely to gain quick promotion and reach high status might be seen as generally dissatisfied because they miss out on other learning experiences such as those gained by undertaking different roles.

Nevertheless, Sargent et al (1997) found that participating in learning could be related to wanting promotion at work and therefore seen as a highly significant life change or event. Courtney (1992 pp. 153-4) asserts that

It ought not to surprise us if people arrive at stages of their lives when former goals can no longer sustain them. In their search for new goals, new dreams, they may encounter education, and that too becomes part of the grand search.

Thus, ambitiousness may be seen as another perspective for understanding lifelong learning in nursing. Attempts were made to check informants' reactions to the word ambition. One informant was clear-minded about this, and argued that being ambitious can be perceived in a positive or in a negative sense. This is because it can be seen as being either very keen and interested in one's profession and one's life, or as being self-centred.

However, one informant in this study also indicated that there are fewer opportunities for promotion as the nurse goes higher up the clinical grades. Alternatively, other individuals continue to learn, but they do not do so necessarily

with the aim of moving up the career ladder, suggesting that learning does not come to a halt because one is not seeking promotion. A number of nurses seem quite content on lower clinical grades, and some *'have never had the desire to become a sister'*. The reason for not being ambitious may be because the individual's time and attention is occupied with other higher priority activities in their life. However, other informants observed that unless RNs have aspirations for progression, the motivation to learn could become blunted.

Setting one's own career goals and acting to achieve them may involve holding other life activities temporarily in abeyance, such as *'stop going to evening aerobic classes'*. Other individuals with less commitment in other aspects of life may be able to progress on with their career fairly smoothly. At the same time, being career-minded and planning one's career does not have to imply strict discipline in every aspect of life. For instance one informant presented another perspective indicating that:

... you've got to be relaxed with your learning. You haven't got to worry about the house and you've got to be able to spread out a bit, and just take it as comes really. I think you will achieve more, I mean that you've just got to let it go, ... while you studying (Private Sector Nurse).

The newly qualified nurse, and learning generalist and specialist skills

It has been relatively well established that many nurses who qualified through the Project 2000 programmes have been experiencing a self-confidence deficit in a range of clinical skills, as well as in management or leadership within the nursing team (ENB 1995a, DH 1999b). This was also stated by one RN who qualified through the Project 2000 programme, and on starting employment as an intensive

care nurse realised that *'As a student, you felt like you were doing a lot of caring, that you had a lot of input. But you didn't'*. An example of self-confidence deficit in one's skill and knowledge is:

I couldn't read an ECG for example, I looked at them and just saw a load of lines, ... so I got a couple of books out. Now I just look at them and I know where there is something wrong (Intensive care Nurse).

Kramer's (1974) seminal work on the experiences of newly qualified RNs documents how they suddenly realise with awe the responsibilities and accountability they adopt in their new capacity. Later studies (e.g. Makepiece 1999, Bick 2000) still report similar findings. Such confidence deficit and apprehension could be compared with other new responsibilities experienced in personal life such as *'It's like driving a car. You only learn to be a staff nurse once you're qualified'* (Intensive Care Nurse).

The UKCC (2001c, 1997) recommends that newly qualified nurses should be supported by more experienced nurses under the preceptorship mechanism. However, this system does not seem to be fully functional in all clinical areas due to staff shortages and other problems. Bick (2000) reviewed related literature and reported on the operationalisation of the preceptorship concept at one hospital. She used a questionnaire survey to ascertain the exact 'skill deficits' being experienced by newly qualified nurses, and then identified standards for a preceptorship framework for in-house clinical education. A clinical facilitator was appointed specifically for implementation and audit of the framework.

Generalist or specialist nurse

With the support of preceptorship, the RN consistently develops her skills in the particular specialism, but at some point might start to sense uncertainty regarding her nursing skills in other specialisms. This notion is part of the debate on specialist and generalist skills. Two key issues seem to be related to the discussion of specialist and generalist skills. One is whether nurses should be generalists or specialists (Shepherd 2001), and the second is that, with the current consideration of multi-professional education and multi-skilling, the thinking has moved towards all health care professionals having certain common generalist competences, as well as the specialist ones that identify each as a separate occupational group (DH 1999b). However, as for nursing the generalist competences are those that are common to, and needed in all, nursing care delivery settings, and the specialist competences are those that are much more focused and developed for a particular clientele group needing specific clinical skills and knowledge.

Nursing has moved into specialisms because of the development of specialist knowledge and competence, and also due to the competences developed through expanding roles (UKCC 1992). The next quote illustrates the point that it has become difficult for a nurse working in one specialism to transfer to another. This constitutes the concept of 'glass walls' (DH 1999b), which is a barrier that the government sees as removable.

Although I'm registered as a general nurse, there's no way I can go back in, and nurse generally, without a tremendous amount of extra training. I almost would have to start all over again, in my view if I wanted to feel competent (Child Protection Nurse).

It is suggested therefore that there should be mechanisms in place to enable nurses to change specialisms if they so wished, because *'you get out of touch with other clinical areas'*. Bick (2000) reports on the option of 'rotational posts' for newly qualified staff that enable them to experience clinical care in different areas, although such opportunities for more experienced staff seems scarce.

The essence of this discussion on specialist and generalist skills is that there may be a need to identify core nursing skills, (or transferable skills) and specialist skills and knowledge. One informant did indicate that current pre-registration courses are deliberately designed so as to enable the individual to develop and to adapt to different clinical settings and situations. Besides, working in different specialisms presents its own benefits, as *'(I) .. learn more from going to other areas, it makes me a better nurse (E grade intensive care part-time night nurse).'*

Conclusion

This chapter focused on the first aim of the study, which was to explore nurses' perceptions of the concept of lifelong learning in nursing, and of themselves and other nurses as lifelong learners. The findings are discussed as five themes that emerged from the data, as detailed at the beginning of this chapter. Although individual quotes are utilised to illustrate facets of these themes in the text, the themes were identified because quite a few informants felt that these were important perspectives of lifelong learning in nursing.

One of the emerging themes relates to the notion that learning is seen as a natural human activity, while the concept of lifelong learning is generally perceived positively, a number of informants also expressed reservations and caution. It seems also that the foundation for lifelong learning should be laid during initial education years. The literature tends to agree with this suggestion. However it is argued that the learning undertaken as an adult is broadly based on self-assessment of one's knowledge and competence, be it professional or general.

The second theme relates to the characteristics of nurses who are lifelong learners. Informants specified several characteristics, each one of which could be discussed in substantial detail. Thirdly, PREP seems to have had a major role to play in instigating learning. As mandatory updating, the idea is accepted by a number of nurses as inevitable, whilst others resent the notion of having to attend courses, which could be something they do not want to do. Fourthly, perceptions of lifelong learning seem to be associated with career aspirations, development and progression. Finally, lifelong learning is seen as a necessary activity and feature of being a newly qualified RN and later as a specialist RN.

It is suggested that these perceptions and issues could be effectively explored in further detail, quantitatively if desired, to illuminate the extent to which each issue might be further developed or treated as a problem that needs resolving.

The following findings related to perceptions of lifelong learning (aim 1 of the study) amongst nurses can be identified as ensuing from the study.

- 4.1 Lifelong learning is related to natural human inclination to want to engage in personal and professional learning, it is perceived positively but there are also some reservations about the concept.
- 4.2 The foundation for becoming a lifelong learner is developed during childhood and school years, but it can be triggered by learning encounters later in life.
- 4.3 CPD also enables the development of personal skills in for instance CIT, teaching, communication, which are transferable to other areas of life.
- 4.4 Particular personal characteristics or qualities can be identified in nurses who are lifelong learners, and this is complemented by self-assessment and desire for self-improvement.
- 4.5 For some nurses, lifelong learning is triggered by having to undertake professional updating to meet PREP requirements, but subsequently can become self-directed.
- 4.6 Some nurses undertake studies to meet PREP requirements merely to be able to keep their jobs, i.e. an income.
- 4.7 There is a tension between the underlying philosophies of lifelong learning and mandatory CPD, because this and PREP tend to incorporate compulsory and protracted connotations.
- 4.8 PREP and lifelong learning were not marketed as effectively as they could have been to reach all RNs to enable attitude change towards learning for those RNs who are reluctant to recognise the need for ongoing learning.
- 4.9 Learning can be instigated by interest in seizing career opportunities, a certain degree of ambitiousness, and realising one's potential; but other nurses may be content in their current professional career positions.

4.10 The newly qualified nurse seems to experience a steep learning curve on starting employment as a RN.

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Chapter Five

STRUCTURES AND PROCESSES THAT FACILITATE LIFELONG LEARNING

Introduction

This chapter focuses on the structures and processes that the study informants felt were available to enable nurses to become lifelong learners and those that they felt were either unavailable or less readily available. This is related to aims 2 and 5 of the study. The literature review indicated that 'structures' and 'processes' are distinct concepts from the non-formal and more informal factors that lead nurses to become lifelong learners. The former refers to mechanisms and policies that have been deliberately installed at organisational level to enable continuing learning. The latter refers to other features, such as the informal aspects of the organisation and social factors that can instigate and support learning, and are discussed in the next chapter.

In particular, questions C1 and C2 in the interview schedule (table 3.1) directly asked informants about structures that are already available and those that could be made available to enable RNs to become and remain lifelong learners. However, other questions (e.g. questions A4, B3 and D) also implicitly explored these notions. The data ensuing from these questions were examined for evidence of structures and processes that interlink with lifelong learning in nursing. The same processes of data analysis and interpretation that are presented in table 3.6 in chapter three, and were utilised to capture the themes in the preceding chapter, were used. Two examples of data that led to determining each theme are presented in table 5.1. As in chapter four, the category column has been left out of table 5.1 to avoid

repetition. The table shows how the notes made on the data reflected the impressions that were identified as categories. The structures and processes that facilitate lifelong learning are:

- Funding for lifelong learning and continuing professional development
- Time and release from duty for continuing professional development
- Work-based learning and in-service training
- Changes in nurse education methods
- Professional regulation and mandatory continuing education
- Clinical supervision, reflective practice and peer review

Many of these themes are closely related and, therefore, some of the points made in this chapter could have been discussed under other themes. For instance, in relation to the first and second themes, RNs generally expect their managers to both fund the courses as well as release them from work to attend them.

Funding for lifelong learning and continuing professional development

Several informants in this study indicated that 'block contract' money has been available for funding CPD for qualified staff for some time. This money comprises government funding for CPD and was first established through *Working Paper 10* (DH 1989). This arrangement lasted until March 1998, after which it became the responsibility of Education and Training Consortia (ETC). These consortia comprised individuals from NHS trusts as well as universities, and their remit, according to Burke (2000), was to work in partnership rather than as purchasers and providers of CPD courses respectively. The main reason for establishing ETCs

Table 5.1: How themes were captured in relation to structures and processes that facilitate lifelong learning.

Data	Notes / Open codes	Categories
<p>i) <i>The medical directorate manager's been very supportive throughout my secondment. I mean I was working for her for a number of years; she signed the block contract to allow me to go (Pain Control Specialist Nurse).</i></p> <p>ii) <i>If opportunities were spread a little more evenly throughout the hospital, or trust, it would make it a little fairer, because you do hear stories of people who tell you 'well I had to fund the course myself' (Cardiothoracic ITU Nurse).</i></p>	<p>Block contract support enables RNs to attend courses.</p> <p>Some RNs have to fund their own CPD courses</p>	<p>Funding for lifelong learning and CPD.</p> <p>Funding for lifelong learning and CPD.</p>
<p>i) <i>The big problem is that there are people who want to go on courses, but they can't because people find it difficult to get on courses because of time. The first of my module, I did it in my own time (Ophthalmology nurse).</i></p> <p>ii) <i>Because you are told as we are, that study leave has to be in your own time, you know there's no funds to pay for this, that and the other, then it's going to be very negative, and we're going to think well sod that, I'm just not going to bother (Respiratory CNS).</i></p>	<p>Difficulties with release from work to attend courses</p> <p>Lack of support for CPD</p>	<p>Time and release from duty for CPD.</p> <p>Time and release from duty for CPD.</p>
<p>i) <i>There's got to be some support there. There's got to be some kind of cultural thing at work as well ...for the ward learning environment (Coronary Care Nurse).</i></p> <p>ii) <i>There's in-service department and whatever they contribute to people's learning, but if I might make a suggestion that they can be a bit prescriptive in what they expect or desire people to learn (NVQ Co-ordinator Nurse).</i></p>	<p>The ward as a learning environment</p> <p>Role of in-service training department</p>	<p>Ward-based learning and in-service training</p> <p>Ward-based learning and in-service training</p>

Data	Notes / Open Codes	Categories
<p>i) <i>Looking at what I have read about project 2000 training, and the way health visitors are trained, I think the training and the teaching is far more student centred, student-led than was (Child protection Nurse).</i></p> <p>ii) <i>Change in nurse education system as well as a shift in what you could do, because it opened doors and welcomed more learning, encouraged it ... (Community Nurse).</i></p>	<p>Changes in teaching methods.</p> <p>New education methods encourage learning</p>	<p>Changes in nurse education methods.</p> <p>Changes in nurse education methods.</p>
<p>i) <i>To comply really also with PREP. You know you have to do it, you have to have done your minimum days study every three years to re-register with the UKCC, so in a way that's where you are compelled to study (Private sector nurse).</i></p> <p>ii) <i>... that's what I said about 998, there were quite a few people there who were forced to do the course, they were told by their managers that they've got to do it (Practice Nurse).</i></p>	<p>PREP as mechanism that instigates learning.</p> <p>PREP as compulsory learning</p>	<p>Professional regulation and mandatory continuing education.</p> <p>Professional regulation and mandatory continuing education.</p>
<p>i) <i>Clinical debriefing sessions, after different incidents, so you can actually sit down, and do an informed reflective process on how you think it went, and what can be improved. This happens informally if there is a nasty case of resus or something horrible goes on. And people do often after a shift, they go out for a drink ... let's chill out ... see how everybody feels about it (Accident & Emergency Nurse).</i></p> <p>ii) <i>... the reflective sessions can be used for trained nurses, not just for student nurse, and it's certainly something that I'd like to develop where I work (Community Nurse).</i></p>	<p>Informal peer support</p> <p>Reflective practice in nursing life</p>	<p>Clinical supervision, reflective practice and peer review</p> <p>Clinical supervision, reflective practice and peer review</p>

was the belief that such work required collective and collaborative planning that the internal market principles and practices instituted by the previous government did not facilitate.

More specifically, the ETCs' function has entailed planning and commissioning of non-medical education and training (NMET), non-medical education signifying nurses and Professions Supplementary to Medicine (PSM). Burke (2000) notes that the greater share of NMET money is spent on nurse education, but this is planned on a short-term basis. Consequently, universities have been experiencing several problems with such short-term contracts for nurse education, including difficulty in attracting and retaining staff. Burke's (2000) study suggests that, because of this short-termism, universities have also been reluctant to make investments in adequate staffing. The role of ETCs, primary care groups (PCGs) and health authorities (HA) were being reviewed at this time.

Since April 2001, allocation of funds for CPD for nurses and PSMs has come under the remit of Workforce Development Confederations (WDC). This represents a radical change in funding, in that the WDCs, when they become fully operational, would also manage funding for medical courses (DH 2001a). One of the principal aims of WDCs is also to co-ordinate the various sources of funding for all health care professions, and their operations are guided by Department of Health publications such as *Workforce Development Confederations: Functions, Accountabilities and Working Relationships* (DH 2002).

In addition to 'block contract' or NMET funding for CPD courses held in universities, informants indicated that RNs could have access to finance available from training budgets in NHS trusts, as well as money from charity organisations, or they could pay for the course themselves. Furthermore, sales representatives from pharmaceutical companies also at times meet the cost of certain study days and courses on behalf of their organisations.

There are also other '*pockets of money*' for CPD for nurses, that include the '*The Nurses' Fund*', and '*... very often relatives, they've had people die there, rather than having a lot of flowers sent to a funeral, they collect and give a donation*'. These funds may even include staff replacement costs, in part or in full, to cover for permanent staff on study leave.

To access some of these monies, some informants indicated that the nurse might have to develop political awareness, and have an appropriate strategy for negotiation. However, although block contract money is available for CPD for all RNs, funds from donations may not be available for staff in certain areas as an Emergency Assessments Unit (EAU) nurse explained. This is because the patient who arrives in EAU is either critically ill and is quickly transferred to critical care areas, or is brought in as an emergency but found to be not seriously injured or ill, and is therefore discharged. It is not a ward where patients stay over several nights until they recover, and some patients die soon after arrival.

Adequacy of block contracts

Because funding through block contracts have been available to many nurses, albeit only to varying extents, generally staff seem satisfied with this. However, the experiences of some nurses are that: *'...the block contract, it always seems so tight. In other career or profession, it isn't such a big deal'*.

Some informants felt that block contract funds may not be fairly subdivided between the clinical directorates within the trust. In some directorates there is more motivation to use this fund and managers actively encourage their staff to undertake CPD. In other areas, this is less so, and the former therefore leads to competition for a share of the fund. This also raises the question of equity of financial support as: *'... not saying resources are evenly spread throughout the trust or the hospital'*, and *'... there should be a fair way of issuing the study time while other people can't get on anything'*.

Furthermore, in some clinical areas budget-holding managers are much more scrupulous with their finances, which they consider to be the topmost priority. This can have adverse effects on the staff's motivation to undertake CPD and to work in the particular clinical area, as indicated by the following.

It's the way the manager manages her service, and her remit was to save money. She brought the medical budget in line this year, but at what cost to the service, because nurses are leaving left, right and centre (Dermatology Nurse).

As a lifelong learner, the individual may look to be funded by the employing organisation, but he or she might want to persevere even if this is not forthcoming, and therefore some may have to meet the course costs themselves, which includes

the course fee, the costs of buying books, travelling, and buying and learning to use a computer. At times the manager is able to meet part of the course fee and the nurse makes up the remainder. This is because funds for such specific purposes usually have an upper limit. However,

If your employer is not very motivated towards it, then you're gonna struggle anyway. If you want to be a lifelong learner, to promote yourself, and to promote the profession, you have to pay to do it (Intensive Care Nurse).

The availability of money for CPD as a structure that facilitates lifelong learning therefore seems to be fairly good but can be improved. One CNS explained that if sufficient money was available, then clinical areas could avail themselves of ample educational facilities on site, as well as be able to employ extra or even agency staff so that the permanent staff [those who Handy (1989) refers to as core staff] can be freed for their CPD.

More than one informant felt however that even CPD for PREP should be funded by the organisation.

So, even though it's only 5 days over 3 years, they may have to fund that themselves in order to maintain their registration, which I think is a misnomer really, because their registration is for them to continue in employment, and yet their employers are refusing to fund it (NVQ Co-ordinator Nurse).

In the context of the current quality ethos and culture, many organisations are keen to demonstrate that to raise the quality of the service provided, they invest in staff development in systematic ways, that is they have a staff development strategy and/or policy. Consequently:

New staff know from the beginning which staff development programme, exactly when she will access which course (Renal Nurse Manager).

The above informant indicated that in her clinical area, the staff CPD strategy is well defined and consists of the following. Newly qualified RNs spend approximately six months in preceptored learning under the supervision of more experienced staff, and then embark on the research module followed by the double clinical open learning module. Ultimately, they study on the management module to complete the 4-module long specialist ENB renal nursing course. Beyond this, CPD is based on IPRs. This is in addition to the day or 2-day long seminars, conferences and in-house or in-service short courses. The development of such structured strategies in the 1990s is a reflection of the value nursing management places on CPD for nurses, although other reasons may be related to staff recruitment and motivation.

From this discussion it is clear that there are a number of perspectives to the concept of funding for CPD. However, informants also indicated that in addition to funding, release from duty to attend CPD events also seems to be an issue.

Time, and release from duty, for continuing professional development

Getting time off the wards, that is release from normal duties to attend CPD courses, appears to be the main problem noted by the majority of informants. Time is one prominent factor that constitutes a structure that can foster lifelong learning, but that clinical managers are experiencing increasing difficulty in allowing their staff to have. This is despite the availability of money to fund CPD programmes. This difficulty is related to the shortage of qualified nurses, difficulties with recruitment, as well as with hospitals becoming places for more acutely ill patients, and experiencing increasing demand for hospital beds. However, the data indicate that

staff usually expect to be released from their duties to attend these courses, even if they are one-day workshops, 3-day conferences, one day per week study over one or more terms, or full secondment for a year on to a master's course.

It is possible to get qualified staff from nursing agencies to replace staff attending CPD courses, but often these staff lack the specific skills necessary for the particular specialism, and are therefore often not suitable. However, in some areas, nurses get neither time off the clinical area, nor funding. This is much less of a problem in private sector nursing because the staff do not seem to expect it anyway, and because, as one informant reported, the private sector is less able to give staff time off to attend courses. Yet another perspective is that there could be a difference in motivation and approach to learning between private sector and NHS employed nurses as another informant indicated that *'those who work in the NHS tend to be a bit more motivated, into lifelong learning'*.

Thus, increasingly, clinicians have to attend courses in their own time, but there is also an issue of being able to find time from personal life because the nurse might feel quite overwhelmed by demands made on her time from different directions. That shortage of time could lead to cessation of professional learning was clearly linked by one respondent to the time that she dedicated to having and raising a family.

When I had my children, my time had to be directed elsewhere. I did not stop learning. I learned about children, having babies, but professionally, I stopped learning (Intensive Care Night Nurse).

Another informant indicated that:

I haven't got the means to get me to the college ... you have to consider your personal life. You've got to have time to do it. And there must not be too much other pressures that can prevent you achieving it (Gynaecology Nurse).

However, even if there was a strong expectation of release from work to attend a course, this could be unexpectedly curtailed at the end of the financial year, leaving the nurse with the dilemma of whether to continue with the course or to abandon it. Release is also problematic if a particular team has vacancies and the same workload has to be carried with reduced number of nurses.

It's an old chestnut, not having enough staff in the NHS, staffing level do sometimes let people down, and managers aren't happy to let staff go (Community Nurse).

The attitude of colleagues within one's work area who occasionally make remarks such as 'they are always off on courses', or 'they're not interested in the day-to-day patient care' can have detrimental effects as well. Some wards seem to have a sufficient number of qualified staff to cover for individuals who are given time off to attend CPD events. However, the clinical areas can encounter phases when there is longer-term sickness or where there is 'a bit of a recruitment problem', or have 'the reputation of being very heavy and very busy ...'.

According to one informant, one of the reasons why release from work for CPD is an issue is that nurses have been conditioned to expect time off work, as:

We're used to being spoon fed, sent on courses and given the time, whereas if you look at other professions that may be comparative to us in status, they would have to spend more of their own time, their own money, in their education. So I think we're gonna have to get used to that as a profession (Intensive Care Nurse).

It also seems that if full support is given to some individuals, then fewer staff might be able to attend courses than if the support was partial. From the clinical manager's perspective, naturally having adequate staffing levels to care for patients or clients is always the highest priority, and when one of her staff approaches the manager for support for attending CPD courses, the spontaneous counter question may be: *'Do we need any cover?'*. However, one informant explained that nurses recognise the fact that when a clinical setting is short of staff, CPD has to take second priority, but, *'If you're short of staff, it's demoralising actually ...'*

Alternatively, another informant felt that release from duties could be staggered so that different staff are released on different days. However, because of this difficulty, some RNs are deterred from applying for support to attend CPD courses because they fear leaving the clinical setting depleted of staff. This can be even more difficult in some settings such as Practice Nursing where the team is very small or even single-handed. One very highly motivated practice nurse informant indicated that she declined the offer and opportunity to do a master's course with the fees paid, as time release from the clinical area was a problem.

However, one nurse manager indicated that she would like to release staff for attending courses, including the 'returners', but finds it very difficult. In Schuller's (2000 p. 231) study 'difficulty in securing time off for study' was an issue identified by a number of employers and employees. However, in this study, two respondents explained that not only should staff be released from work for CPD, but the norm should be that time is allocated within one's paid working hours (referred to as 'time

out' by one respondent) to every staff member specifically for the purpose of self-directed or peer-related professional development. Funding for a provision akin to this is already available for medical staff in the form of post-graduate education allowance (PGEA) (Challis et al 1997). Therefore:

Our hours should be changed, so that if you do a 30-hour week, that 3 hours at the end, should be paid for and you should be able to go off and fill in your portfolios, and do your reflections, and do all this (i.e. research) (Intensive Care Night Nurse).

This is particularly so because nurses are so busy at work, but some informants also felt that there should be structured mechanisms for people to be able to engage in enough CPD within work time rather than in their own time to be able to meet PREP requirements. However, this is counter to one informant's (a nurse educator) perception in Nolan et al's (1995) study, who felt that the notion of expecting mandatory CPD to occur within working hours 'is untenable'. But it is consistent with the finding that staff nurses objected to having to pay for own CPD as the learning was related to the job, which in turn is 'always expecting more for less' (Nolan et al 1995 p. 55). Where these conditions prevail, some staff may react by leaving the service as, *'If they haven't had the study time, the grass is greener, and people leave'*.

While some managers believe that CPD courses should be done in work time in principle, others believe the opposite to this, that is that staff should attend courses in their own time. Staff generally feel demotivated towards learning in the latter way, because *'people who work full time in a very stressful environment, haven't got the time or energy once they finish to go away and learn'*.

One informant observed that the effects of staff shortages could also mean that the nurse has to engage in on-the-job learning. Her clinical manager has attempted to resolve the problem of inability to release staff by exploring the provision of in-house courses, although these may often only be the expanded role type courses. Expanded roles refer to those specific competences that the RN learns after qualifying as a nurse (UKCC 1992). Most of these competences were previously part of doctors' roles, and RNs only undertake them after appropriate training and assessment (Rushforth and Glasper 1999).

Work-based learning and in-service training

As noted earlier, substantial learning tends to occur through observing and then participating or engaging in patient care delivery. For the clinical area to be conducive to learning, several factors come into play such as staff attitudes and resources. Therefore it has long been recognised that the degree to which clinical areas are learning environments varies (Orton 1981, Spouse 1990). More than one informant suggested that '*an open environment*' on the ward, and more learning-orientation could facilitate effective learning where '*People will discuss things that they've done, like courses*'. The effect of such an environment is that:

... they are a big influence, ... and it can be like a domino effect on your own educational needs. It's a bit of an eye-opener, coz you can question them (about a course), and if that suits your needs then you might go and do it (yourself) (Cardiothoracic Intensive Care Nurse).

As discussed in the preceding section, it seems that one concern for the clinical environment is that of ensuring time is identified specifically for this, but also that staff are competent at imparting knowledge and competence i.e. at teaching. The Practice Development Manager role has been created and designed to act as a

structure to co-ordinate and facilitate this. In addition to the ongoing development of clinical skills, another example of ward-based learning is the opportunity of 'office days' for instance, for qualified nurses to develop management skills. However, one informant suggested that not all learning should be ward based, and it is important to have formal education mechanisms, i.e. in the higher education sector.

However, as for university-based CPD, part of the *Dearing Report* (NCIHE 1997) includes the findings of a questionnaire survey, which revealed that of the 119 employers who replied, 90 per cent already used HEIs for CPD, and over a third felt that demand for CPD will increase in the following few years. In relation to one university-based management module one informant stated:

Before the management module, you learned from other people or your own personal experience, because there're certain people who you respect, and you admire their management skills (Emergency Assessments Nurse).

Work-based learning

Clinically-based learning seems akin to the concept work-based learning (WBL), which, according to Flannagan et al (2000), entails the bringing together of self-knowledge, expertise at work and formal knowledge. They suggest that it takes a 'structured and learner-managed approach to maximising opportunities for learning and professional development in the workplace' (p. 363). Examples of such learning include *'Like taking blood out of arterial lines, if you've got someone to show you, step by step instructions, but it's really useful'*. These skills are identified and acquired often as part of 'Induction' or 'staff development programmes':

There are competencies for staff to achieve; some are trust-wide, and some specific to nephrology. There are in-house training packages (Renal Nurse Manager).

Dewar and Walker (1999) note that WBL is primarily concerned with the process of learning and with encouraging the individual to be explicit about what and how they learn so that their experiential learning may be assessed and accredited. Based on project findings, Foster (1996 pp. 20-21) identifies the following features of WBL:

- It is performance-related, focusing on tasks arising in the workplace;
- It is problem-based, focused on tackling complex work-based problems in management or care;
- It is autonomously managed, with learners taking a large measure of responsibility for ensuring that they learn from their work activities; and
- It is team-based, tackling problems requiring effective co-operation between people with different roles and expertise.

WBL as a teaching and learning method is seen as innovative in that it places firm emphasis on the importance of workplace as a site of learning (Guile and Young, 1996 p. 167), as well as for the integration of theory and practice.

All practitioners seem to value work-based learning, as some question why their years of experience as a RN are not valued and credited. To them, credit points should not be awarded exclusively for university-based education: *'Should we not get some brownie points for the amount of time that we've been in nursing, by being on the shop floor as it were, because that's how you learn (Dermatology Nurse).*

In some areas, there is also the mechanism of the 'link nurse', whose role entails teaching and learning clinical skills such as moving and handling patients and CPR

in the work setting itself, and is seen as in-house learning. The in-house learning mechanism is structured for qualified staff currently working in the particular clinical area, as well as for those hospital-wide staff who are involved in caring for patients requiring those particular interventions.

However, according to Guile and Young (1996 p. 166), currently there are issues related to WBL. For instance, there are the limitations of the concept of competence, in that it might incorporate behaviourist assumptions, and the consequent tendency towards reductionist descriptions of work performance. It should, therefore, not be limited to 'know-how', but should include understanding of the underpinning knowledge. Another issue relates to comparability and equivalence between academic and work-based learning.

A resource room

Informants indicated that the availability of a resource room on the ward or Unit that stocks specialist journals and publications is a key component of structures that can be instituted to facilitate continuing learning. This may be the staff room or a dedicated room, but at other times this may be the ward sister's office. Informants noted that the resource room may contain textbooks, students'/staffs' course projects, documented reporting on other projects, video-viewing facilities, research materials, and, latterly, computers and Internet access. Individual staff themselves who subscribe to journals sometimes bring them in for colleagues to browse or read, especially if they contain articles that point the way to improvement in patient care.

Furthermore, the journals should be those that are specialism-focused as well as those that are more generic. The use of specialist journals that are available in the clinical area can be extended to:

Things like journal clubs, and discussion groups, to be able to critique it, you find an article, you bring it in, and you know you discuss it with your colleagues (Neonatal Nurse).

The purpose of this is to create an effective learning environment where appropriate learning resources are readily available, including resource packs and in-house training packages. These tend to contain step-by-step instructions on, for instance, IV drug administration, or the use of the TENS machine. However, such facilities may be very under-developed in certain clinical areas, as in the provision of books on the ward for instance, where management is unwilling to purchase them and/or because the borrowing system is not effective.

In-service training

The in-service training Department seems to be a feature of several organisations including manufacturing, the teaching profession and others. This provision for nurses has latterly been known by other names such as the Professional Development Unit, Lifelong Learning Department or Post-Graduate Centre. Informants reported that courses provided by these sectors are pretty well publicised through Staff Notice Boards, Staff Development booklets and prospectuses. They supplement and extend work-based learning and provide short courses on topics such as: portfolio development; preceptoring and mentoring; and talks by CNSs or by Pharmaceutical Representatives. One informant indicated that 'cascade training days' are also a form of training, in which link nurses are involved

who teach a particular skill to a number of RNs, and who in turn impart those skills to other RNs in structured ways in patient care settings. These mechanisms seem to reflect a good range of learning opportunities provided by NHS trusts in several areas, and include:

... courses on record keeping, diabetes, national study days ... lots of other extended role (courses) ... like care of the Hickman line, care of the central line, chemotherapy, through in-house courses that are ratified by the university. And, we're actually encouraged and given choices if they want to do (Haematology Nurse).

Another instance of in-service training would be when speakers such as the Macmillan nurse are invited 'to enlighten about pain control methods'. This can be a weekend course when specific areas and issues are addressed, and which also provides an opportunity for networking.

The weekend courses for Macmillan nurses are for generally updating people. They have different topics each year ... So it's an update on current issues, how they apply to oncology, ... so networking is a different way of learning (Palliative Care Nurse).

Problematic aspects of ward-based learning and in-service training

Informants reported that there are certain discrepancies in ward-based and in-service learning that clinical areas and trusts could redress. These include the lack of space in the clinical setting, the nature of courses on offer, and the unavailability or inaccessibility of post-graduate centres. But:

The in-service training department ... can be a bit prescriptive (NVQ Co-ordinator Nurse).

The above informant reported that some courses can be very basic and the annual updates are repetitive instead of being directed at individual learning needs and clinical specialisms. However, other informants noted that some clinical areas have

great difficulty in identifying a room for these learning activities. When one is identified, it may be located in an unsuitable area, as it may lack even the most basic of facilities for teaching and learning, as asserted by an Emergency Assessments Nurse. In such areas, even conducting practise-based assessment for RNs on post-registration courses can prove extremely difficult. One of the informants identified teaching hospitals, that is hospitals that are part of medical schools, as being more geared to learning than non-teaching ones.

Changes in nurse education methods

The development of lifelong learning in nursing coincided with the arrival of Project 2000 type pre-registration courses. This radically restructured programme included the use of andragogical approaches in nurse education, and the development of nurses as more effective critical thinkers. This is corroborated by one ENB (1995a) research report, which indicated that nurses qualifying through Project 2000 type courses were more likely to be critical thinkers, problem solvers, and able to adapt to new situations.

Despite the progress made by the introduction of Project 2000, changes in nurse education are ongoing because *'nobody will ever get it right, it's something that constantly has to be amended to move with the changes'*. However, as a result of the publication of DH's (1999b) *Making a Difference* and the UKCC's (1999) *Fitness for Practice* documents, a novel pre-registration nursing programme has been implemented in UK universities since September 2000 partly to rectify the skills deficit noted in chapter four.

One informant in this study emphasised that current and recent changes in nurse education have increased the opportunities and the range of methods of studying for a course. Novel approaches include flexible or open/distance learning (ODL) methods of accessing courses, including open studies courses, the establishment of AP(E)L systems to accredit prior learning, and mixing with non-nurses through shared learning.

Access to these courses and mixing with students from different occupations also have influence. While studying on the City and Guilds 7307 course, one informant asserted that the student group consisted of students who were non-nurses namely policemen, glaziers, computer operators and beauticians, which:

... gives a healthy perspective, ... and it's healthy to understand how other people view your organisation, and your management issues (Intensive Care Nurse).

It seems therefore that the andragogical approaches adopted in nurse education further facilitates learning as *'They are all positive things, like a breath of fresh air (Community Nurse).*

It seems that a fair few nurses see that the open learning materials presented in professional journals such as *Professional Nurse* and *Nursing Standard* are also a way of developing and updating knowledge. One practice nurse spoke very highly of the quality of education received through doing Open University courses.

What I found with the Open University, it was like suddenly I had come home. Suddenly there were books talking to me in the language that I want. I always felt I was fighting against the system, ... good research based, but also loose enough to be innovative (Practice Nurse).

The Open University has been a key player in widening participation by providing courses for anyone over 18 years of age, without specifying any academic entry criteria (except for some courses beyond foundation level). One of the first courses offered for nurses since 1984 was *Systematic Approaches to Nursing Care*. Current courses most appropriate for health care staff are offered by the School of Health and Social Welfare, although nurses can access standard BA courses or BSc (Hons) in Health and Social Care or in Health Studies, or shorter programmes with courses and modules from other faculties such as Social Sciences and Humanities.

These courses can also benefit patient care:

The Open University, the health promotion certificate gave me the inspiration to do a lot of the things (with General Practice patients) last year (Practice Nurse).

Even Open Studies Courses at more conventional universities such as those offered at the University of Warwick are regarded highly:

... at Warwick University, they open up your mind, and that in fact encouraged me to do a part-time degree. That had a huge influence in showing me what you can do ... in an enquiring sort of way ... A new world opens itself if you are prepared to put that effort into it (Private Sector Theatre Nurse).

Thus both the distance learning centres and conventional universities have a major role to play in widening participation in learning for nurses. Other benefits from courses are that learning occurs through mixing with nurses from other areas, which also gets disseminated to colleagues at one's workplace:

... and you're getting a lot of ideas which can actually work in your workplace ... and you reflect on it, and we're building up good practice by doing that as well (Community Nurse).

Furthermore, the availability of master's courses in nursing practice also seems an attractive offer. The master's course that one informant attended was clinically focused, in that each course participant had structured opportunities for exploring their own specialisms. There were, however, also reservations expressed about the sustainability of the clinical role for specialist nurses prepared at master's level, as there is a danger that they will be channelled into non-clinical, i.e. management type, responsibilities, and thus removed from the patient care delivery role. Others expressed concern about the focus or style of the advanced practitioner level master's course in that the student/practitioner is *'being pushed back into the medical model'*. This is a perceived weakness of the course. However, there may be other reasons for the reluctance to participate in master's level courses:

... they are supposed to get degrees within their specialism, which people don't necessarily want to do. They don't want to be tied within certain area. They want to move across (Intensive Care Nurse).

This seems to make the point that studying for a degree can imply further specialisation in one's own field of practice, and not being able to move to another area if desired. It was also indicated that opportunities to report back to colleagues after attending courses motivates RNs to undertake further studies. This is further enhanced, to a certain extent, by local provision of such resources as post-graduate libraries. Thus *'motivation is infectious'*, and *'Once you get somebody who is on the roll, then they're likely to take others with them'*.

However, as to the implementation of learning into clinical practice, the ENB (1998a) conducted an evaluation of the implementation of the framework for CPE and found that there was recognition across all components of CPE in terms of:

- maintaining a suitably knowledgeable and skilled workforce;
- maintaining standards of patient care; and
- assisting in the recruitment and retention of staff.

The concerns or tensions that emerged were related to responsibilities for researching CPE and barriers to equitable provision. Nurses viewed such barriers as being significantly greater than did nurse manager respondents. The latter group are also more likely to see it as reasonable that practitioners either pay for their CPE or attend in their own time. A SWOT analysis done as part of the same study revealed poorly developed support structures (for CPE), especially in the clinical environment (ENB 1998a).

Professional regulation and mandatory continuing education

Professional regulation and self-regulation

Nursing has a relatively well-established and successful professional (self) regulation mechanism in PREP (UKCC 2000d), which also constitutes a structure for continuing learning. All informants in this study saw PREP as a structure that interfaces with lifelong learning. The Department of Health's (1998) quality and standards document *A First Class Service*, and other health care literature, tend to see professional regulation as a problematic area for other health care professional groups. Subsequent government documents have recommended 'modernisation' of

professional regulation with the main focus being on making accountability transparent (e.g. DH 2000).

Nurses seem to have largely accepted the mandatory updating requirements of PREP, which has been implemented since 1995, although it seems that there are certain groups of nurses who resent such imposition. The ultimate purpose of all UKCC activities is public protection, and this is done through standards for entry on, remaining on and removal from the register (Wallace 1999). The UKCC (1995a) has stipulated four requirements for ensuring that professionals keep their knowledge and competence up to date. These are:

- To complete a *Notification of Practice* form every three years
- Undertake a minimum of five study days, or equivalent, of relevant study every three years
- Maintain a *Personal Professional Profile* with details of professional development
- To undertake a *Return to Practice* programme if the nurse has had a break from practice of five years or more.

There might be some nurses who are against PREP in principle, those who are apprehensive about formal academic studies, and those who feel they already deliver the highest quality of care and have no need to justify their professionalism to anyone else. Nevertheless, nurses see professional regulations as important:

... because there are a lot of us, and we're looking after the public, and we've got to be regulated to an extent, and we are (Private sector Nurse).

On the other hand, some staff feel pressured to attend particular courses such as 'Mentoring and assessing in the clinical setting'. One of the reasons for this is to ensure adequate numbers of qualified mentors for students in the clinical area. Another is to ensure utilisation of already allocated yearly CPD funds. This encouragement or pressure however may occur quite subtly, through IPRs for instance. This particularly applies to staff who are not themselves forthcoming in taking up CPD certificated courses.

This study revealed that another issue related to professional self-regulation requirements in that staff who meet these requirements under duress, and merely do so to maintain their registration, may fail to take account of the philosophical basis of professional updating, and therefore may remain out of date. There is also an issue about the quality of the learning undertaken. Ramsden (1988) reports that if someone treated learning as an external imposition and concentrated on memorising facts, then that person was taking a surface approach to learning, and this resulted in poor knowledge and understanding of the subject. Alternatively,

... if they intended to understand and interacted vigorously with the content of the article (a deep approach), they stood a better chance of getting the author's message and being able to remember the supporting facts (Ramsden 1988 p. 19).

This is an appropriate context for nurse education to be aware of, as, particularly in the age of EBHC, the nurse has to be able to substantiate or provide rationales for every patient intervention action taken. It also interfaces with the issue of accountability.

Although some informants spoke persuasively about the rationales and need for PREP, those who are seen as doing the minimum just to meet PREP requirements

may have practical reasons for doing so, such as: *'Some of them (who) find it quite difficult ... those with younger families.* Furthermore, the UKCC's recent audit found that 90 per cent of nurses had complied with PREP requirements, but 10% of nurses had not renewed their registrations - which is a major cause for concern (UKCC 2000b), particularly if it recurs.

PREP and mandatory continuing education

Wallace (1999 p. 155), who was Director of Standards Promotion at the UKCC and fully involved in the implementation of PREP and other major initiatives in the 1980s and 1990s, explains that:

... however much the details of it may change in the future (which, of course they are bound to, as the policies are evaluated in practice) - the idea of continually updating your knowledge and competence is here to stay. Indeed, even if PREP had not come when it did, the UKCC would be working on such a project right now - but it would be chasing behind the leaders, instead of having been in the vanguard for change. ... some people may think that PREP is just another straw designed to break the proverbial camel's back. But it is there, and will not go away.

PREP is treated as a formal organisational structure as it is instituted to ensure continuing learning. However, the UKCC has made the point clearly that attending courses is only one way of achieving and obtaining evidence of updating (UKCC 1997, UKCC 2001c). However, the UKCC (2001a p. 4) specifies the drastic consequences if the standards not being met, in that 'If you are not registered with the UKCC, you cannot be employed to practice as a registered nurse, midwife or health visitor'.

For the above reasons, PREP is seen as 'a mechanism with power' as it makes the difference between having a job and earning a living as a qualified nurse, or having the title RN taken away. This is perceived as a threat:

It's only when you start to look at what you are doing that you realise that you are on a dodgy wicket half the time ... Only when you see what can actually go wrong that you start to think I better do something about it (Neonatal Nurse).

The perception that lifelong learning has become compulsory learning, and is focused on vocational and economic needs, has been identified by Tight (1998b p. 262):

While learning in adult life can rarely be full-time, because of the requirement to work, it is nevertheless becoming compulsory, and the simplest way of making it compulsory is to embed it within work.

This seems to be true for nursing as well, as briefly noted in chapter four, and as one informant indicated:

To comply with PREP, you're compelled to study, but I wouldn't put that in the lifelong learning vein ..., and I can re-register now, and that's it (Private Sector Nurse).

This quote also implies that PREP may therefore not even be seen as a prime instigator of learning. Furthermore, Field (1999) observes that although participation in learning tends to have connotations that it is a voluntary activity, individuals carry out a great deal of professional development and skills updating because they are required to do so. He continues: 'Contract compliance, regulatory frameworks and statutory requirements are three of the main culprits' (p. 11).

Resistance to mandatory lifelong education and formal academic learning

The data indicate that there may be a particular group of nurses who resist going on academic courses, as also found by Hewison (1999). It seems that some - in particular some of those who are approaching retirement, or nurses who qualified a

while ago - on the surface at least, resist and do not value mandatory professional lifelong learning. They undertake such learning only because they are required to do so to keep their license to practise as a registered nurse. There could be numerous reasons for this resistance. It may not necessarily simply be a resistance to change. 'Intimidated', 'off-putting', 'frustrated', were words used to describe the compulsion to show evidence of updating, especially if this has to be done at university level. For instance:

... sounds prejudiced but a lot of nurses who qualified a while ago ... are quite intimidated by having to do some form of formal learning, study sessions, reflective practice, those sorts of things (Accident and Emergency Nurse).

Those RNs also seem to perceive university-based CPD as:

Brings academic connotations down with it; and feeling coerced to do courses. They don't feel they want to embark on that (Community Nurse).

Even one highly motivated Project 2000 qualified RN asserted that

The whole thing (PREP) needs looking at, and some of it doing away with really, allow people to collect points but don't make it so specialised as in only one area. If you want to collect credit points towards a degree, and you can do it in wider issues, rather than and just ticking boxes so they can show a certificate saying I am competent as an ITU nurse (Intensive Care Nurse).

It seems that one of the reasons why some RNs are very apprehensive about taking up university education is that nurse education was not located in universities when they entered nursing. Mandatory continuing education (MCE) tends to be associated with university-based learning. This is a conceptual leap for them and, if they are approaching retirement, then they may not see this as worth the effort, with the risk of experiencing failure. Other reasons given in the data include:

- *Damaged self-confidence from poor previous classroom/course experience.*
- *Graduate nurses going on diploma level modules.*

- *Complexity of courses e.g. pathways, PREP categories; diplomas/degrees/ levels.*

Referring to nurses who exhibit resistance to learning, particularly if they are approaching retirement, one informant asserted that they are '*a generation of nurses who are about to be taken over by the new*'.

Buchan (1999) and UKCC (2001e) note that overall one in five nurses in the UK are aged 50 years or older. Among these nurses, those who joined the NHS pension scheme 'before March 1995' have the right to retire with full benefits at 55. Furthermore, Secombe and Patch (1995) found that nurses aged 50 or older are less likely to participate in CPD than younger nurses are. However, as noted in chapter four, there are positive outcomes in attending academic courses, even if they are only undertaken as part of PREP requirement, in that it can induce lifelong learning, as:

PREP - has changed, it's not you're now qualified and you know everything, there's a lot of scope of things you can learn. I think there's a lot of willingness to people to learn, partly because they have to do it for PREP. And partly, once you start learning you realise there's a lot you don't know, and then you progress on from there (Intensive Care Night Nurse).

Professional personnel who claim to believe that their initial education equips them with knowledge and competence for work for a lifetime of service were also reported in Schuller's (2000) study of a learning society in health care. One informant in this study indicated that prior to PREP, continuing learning did occur, except perceptions towards continuing learning by individual nurses varied, as '*you didn't challenge, well you might challenge it, but you can be viewed as a bit of an upstart (Cardiothoracic Intensive Care Nurse)*

Monitoring competence

However, the question seems to arise from the data as to whose responsibility it is to ensure that the RN remains clinically competent. It seems that it can be seen as a dual responsibility of both the individual nurse and the employing organisation, because:

... if you don't send your nurses on courses, then they will not re-register, and you're gonna end up losing them. This has given people a lot more push to open the ideas to organise study days, courses are going to be a lot more available (Accident & Emergency Nurse).

Although such mechanisms as PREP are instituted for encouraging continuing learning and development, keeping knowledge and competence up to date is also a responsibility of the individual nurse. Even if the RN does not want to be involved in academic learning, she could continue her learning via various other means. However, the measure of the effectiveness of PREP is difficult to gauge at the service delivery end, as *'how can you police it, properly and effectively'*. That is, the effectiveness with which PREP requirements monitor knowledge and competence related to clinical practice seems questionable. However, another probable means of ascertaining that each individual nurse's knowledge and competence is up to date is:

... possibly (by) managers themselves by their interactions, and through IPRs, have some idea of how competent that practitioner is, but then that may be down to how good the IPR is (Child Protection Nurse).

Informants explained that IPR is an important factor in instigating learning. However, although it is becoming available to an increasing number of staff, this is not yet universal. Not having the opportunity to avail oneself of IPRs is seen as a factor that can cause deficiency in learning.

IPRs help, the absence of them can act as blocks to learning, because you need feedback on where you are, what you need to go on to develop, how people think you are doing, good or bad; what's your interests, what you're hoping to move into, what you want to achieve, and what your short and long-term goals are (Accident & Emergency Nurse).

One of the recommended means of demonstrating updating of clinical competence is through personal and professional portfolio recordings. However, one informant indicated that even the professional and personal portfolio is not a sound mechanism for demonstrating up to date knowledge and competence, as the individual might be very good at recording study events, but still not actually learn from the event or apply this learning to clinical practice. Such concerns have previously been voiced in nursing journals, long before the implementation of PREP (e.g. Carpenito 1991, Naish 1992).

Portfolios and profiles are not wholly popular, possibly because they constitute a UKCC (1995a) requirement, as *'I get a bit cheesed off with these profiles, personal profiles'*. Additionally, the use of portfolios appears to have generated a side issue that probably can only tentatively be explained or regulated, in that staff attending even a one hour clinical update - e.g. on how to use a new glucometer, or a new Patient-controlled analgesia (PCA) equipment - are issued with *'the silly little certificate'* of competence.

Schuller (2000) indicates that there are variations in the substantiality of training or education that can be seen as deserving of being awarded a certificate. For instance, 'Scots appear to have a higher threshold below which events are not

considered worth recording as training events' (Schuller 2000 p. 231). Taking as an example a recently qualified nurse who has a 40-year career ahead of her, if she is awarded even only five such certificates a year, she will have an awkwardly wide collection of such certificates to include in her Personal Professional Portfolio through her career. It is likely to be the case that a few of these will become out of date at some point, but also likely is that most of these have to be kept as a record of their career trajectories.

Despite the flexibility in the range of ways professional updating can be demonstrated, one informant noted that

... there is a group of people out there who will never become lifelong learners. ... it's their lack of motivation, lack of ambition (Intensive Care Nurse).

Davies (1996 p. 55) argues that 'Each professional must be self-regulating and peer review [a notion discussed later in this chapter] is the only appropriate form of monitoring'. It is clear from the discussion on PREP, accountability and professional regulation that developmental work is required and this has already begun (Whitfield 2000).

Clinical supervision, reflective practice and peer review

Clinical supervision and peer support are mechanisms or structures that facilitate learning, and the literature indicates that they should be instituted and made available to all nurses. Availability of clinical supervision is already an essential component of the clinical governance quality mechanism advocated by the Department of Health (1998). It often includes reflective practice, even though the two concepts are distinct. However,

even reflective practice is seen as new to many RNs, and it is resisted by some but valued by those who are cognisant of it.

Whereas clinical supervision is generally peer-facilitated, one informant reported that in their work setting, this is done by the use of an outside counsellor. This makes the literature on counselling pertinent to clinical supervision. In some areas, clinical supervision takes the form of 'clinical debriefing', as an Accident and Emergency Nurse indicated:

(We have) clinical debriefing sessions, after different incidents, so you can actually sit down, and do an informal reflective process on how do you think it went, and what can be improved.

Clinical debriefing relates to discussions on outstanding and more unusual incidents, which occur during day-to-day work. The Accident and Emergency Nurse explained that it tends to be fashioned in the following way.

This happen, if there's a nasty resus case or something horrible goes on. And people do often after a shift, go out for a drink ... let's just chill out, see how everybody feels about it, check that they are OK, is there any questions about that. Where I worked previously, they were trying to do this as a formal debriefing session for 15 or 20 minutes. But a lot of people found that at the end of the shift, you just want to go home.

As the above informant indicated, reflective practice or learning needs structured mechanisms for it to be firmly established in nursing. That is although personal reflection is an individual exercise, peer and group facilitated reflective practice based on professional incidents requires dedicated time. Therefore, even if reflective practice or learning are undertaken in one's own time:

It is hard, it's not easy, because you've not done it for a while, and then it's hard to get into it. I still find it hard to reflect, you know because you are busy at work, and you don't have time, so you've got to do it in your own time (Gynaecology Nurse).

It seems however that structured support through clinical supervision and reflective practice, which are mechanisms contributory to lifelong learning, are becoming increasingly available. The process of such mechanisms includes the willingness of staff to share their learning from courses with colleagues. Additionally, preceptorship and mentorship are formal mechanisms instituted for facilitation of learning. They can benefit the nurse as they can *'heighten people's awareness of their strengths and weaknesses, in a one-to-one, confidential environment ...'*. Motivated staff, who are career-orientated, are said to have an influential effect on generating enthusiasm for learning.

This can be operationalised by provision of time to consolidate what has been learned on formal courses, and opportunity for formal reflection within clinical debriefing sessions for instance.

Peer review to facilitate lifelong learning

Informants explained that to participate in learning, it is also important and useful to have encouragement from other health care professionals such as peers as well as nurse lecturers and clinical managers. Peer review and self-appraisal are seen as supportive mechanisms designed to appraise one's current state of knowledge, competence and insight, so that they can be appropriately further developed. For instance:

And I had the support from the group, meaning much like peer and self-appraisal; and review and evaluation, if you've got peer review, it shows you, it makes more self-aware, and therefore makes you realise perhaps where you were lacking (Intensive Care Night Nurse).

The study data indicates that peer review is an essential mechanism for facilitating lifelong learning in healthcare, as *'(lifelong learning) has a knock-on effect on your student, peers, and your organisation'* (Community Nurse). Peer review seems to have increased as part of the evolving quality culture within the NHS, with the implementation of clinical governance and professional self-regulation (DH 1998, GMC 1999), with substantial responsibility for clinical care being devolved on to clinical nurses. Central to the concept is accountability for practice. As nurses, we are accountable for our professional competence and knowledge to various parties such as the professional statutory body, the employer and society, as well as to ourselves. The role of self-assessment in lifelong learning was discussed in chapter four as a means that provides each individual with a medium for ascertaining their own level of performance, and consequently helps to identify their own learning needs. Peer review provides a healthy means for obtaining feedback and external perceptions from professional equals. It also brings with it several other benefits and meets other recommended professional requirements. It can be initiated and implemented at one-to-one, departmental or organisational level.

Other terms with similar meaning are peer mentorship (McAllister and Osborne 1997), peer learning and peer appraisal (Boud et al 1999), and peer consultation (Hart 1990). However, it seems that 'peer' itself can mean different things to different parties. A peer might be:

- a colleague of equal status in the same ward
- a colleague of equal status from another ward in the same specialism or department

- someone of higher status on the same ward or another ward in the same specialism
- someone of equal or higher status from another hospital

An advantage of such a broad perspective on the definition of this term is that the individual has a choice as to who he or she considers to be an effective peer. An example of peer support in action is:

I have one marvellous colleague who works down in South Warwickshire. I use her a lot. I sometimes ring her and say I'm ever so sorry, have you got 5 minutes? And run things past her (Child Protection Nurse).

The Royal College of Nursing's national forums constitute another peer learning mechanism, which seem to have been instituted for learning through peers and for support. These forums are nationwide networks of members sharing the same areas of interest (RCN 1999). They provide mechanisms for benchmarking and disseminating information within specialisms and professional interest groups. The RCN encourages all its members to belong to one or more of these national forums.

Conclusion

Having discussed RNs perceptions of lifelong learning in chapter four, this chapter focused on the structures and processes that facilitate this activity. It identified funding and release from work for attending courses; work-based learning and in-service training; changes in nurse education with consequent positive impact; the effect of PREP; and clinical supervision. It seems that, although fair progress has been made, there are a number of issues that need addressing and developing. This is complemented by the influential nursing commentator Wallace's (1999 p. 159) suggestion that a number of circumstances need to be considered in the

endeavour to enable practitioners to meet PREP requirements and become lifelong learners. These include:

- Time, including family commitments, friends, social events, voluntary work, travel, rest, personal space, the unexpected and other things
- Time management, including the support needed for this
- Finances, investments made by employers, the range of course fees, and whether costs and quality are linked
- Personal preferences
- One's own abilities
- Other issues, such as family members' activities, lifestyle changes, work requirements and physical/mental health

To a large extent, the study data supports this analysis. Wallace advises that lifelong learning should be seen as a privilege, a positive activity, and not a chore as it widens the individual's horizons and improves the care given to patients and clients. She also asserts that PREP (p. 154) is about 'freedom of choice, not imposed routes and explicit requirements' to achieve this. Data from this study indicates that nurses' experiences are not fully in accordance with this view.

The data revealed a wide range of findings related to structures and processes for lifelong learning. The key ones are:

- 5.1 Funding for CPD is fairly widely available through block contract, Workforce Development Confederations, as well as from charity organisations, but some RNs feel that overall this is not adequate.

- 5.2 Release from work to attend CPD events has become increasingly difficult and as a result more staff are having to engage in this, albeit reluctantly, in their own time.
- 5.3 Clinically or work-based learning is recognised and valued by RNs generally and a resource room in the clinical area is seen as essential for enabling this.
- 5.4 In-service training also remains a key provider of non-academic CPD programmes, and although there is a fair range of courses on offer, some of them may be seen as repetitive and irrelevant.
- 5.5 Recent changes in nurse education include an increase in ODL/flexible learning programmes that lead to wider participation in CPD, and this seems set to increase further.
- 5.6 Mandatory updating is a structure that aims to trigger learning but it is resented by some in principle because it implies compulsory lifelong learning. It also confines the individual to one specialism making changing specialism more difficult. Additionally, some RNs are unsure of their ability to undertake academic courses.
- 5.7 PREP may not be the most effective means for monitoring clinical competence.
- 5.8 Individual Performance Reviews are key factors in instigating and enabling learning and support, and although provision of these are patchy, their availability is valued by RNs.
- 5.9 The availability and practice of clinical supervision and reflective practice is erratic, but where they are available, they support learning.
- 5.10 The practice of peer review is expanding at individual, specialism and trust level, and this facilitates learning.

Having identified the structures and processes that can facilitate lifelong learning, the next chapter addresses other themes that emerged from the data, relating to more informal or day-to-day factors that nevertheless have a marked impact on the individual's motivation, accessibility and level of engagement in continuing learning.

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Chapter Six

DAY-TO-DAY FACTORS THAT MAY INSTIGATE OR OBSTRUCT LIFELONG LEARNING

Introduction

The purpose of this chapter is to discuss aims 3 and 5 of the study, which relate to the non-organisational factors that either enable or restrict nurses from engaging in lifelong learning. This relates to a gap in the literature in documenting factors other than formal structures and processes that affect RNs engaging in lifelong learning. Informants were also asked whether any particular individual directly influenced him or her becoming a lifelong learner.

The data were examined for key areas in non-organisational factors. Two examples of the process of data analysis are presented in table 6.1. The categories that emerged from the data as day-to-day factors that facilitate or inhibit lifelong learning are as follows:

- Nursing seen as just a job or as a career.
- Undertaking learning to redress earlier missed education opportunities.
- Clinical developments and new thinking.
- The clinical setting as the learning environment.
- Social and governmental factors influencing learning.

These themes are not discussed in any order of priority, but in the sequence that they emerged from the data.

Table 6.1: How themes related to day-to-day factors that may instigate or obstruct lifelong learning were captured

Data	Notes / Open codes	Categories
<p>i) <i>If you want to stay in it, you haven't got much choice. If you want to do the job well, then you've got to, in whatever capacity (Oncology Nurse).</i></p> <p>ii) <i>Career development is the main one for me, the main spur. Up to a point in my life, when my children were very small, your career and your lifelong learning is sort of on the backburner, to a certain extent. There are other things, you're learning to be a mother, and you haven't got time to worry about studying (Private Sector Nurse).</i></p>	<p>Nursing is only a job that gives an income.</p> <p>Career aspirations lead to continuing learning but it can be interrupted when raising a family.</p>	<p>Nursing seen as just a job, or as a career.</p> <p>Nursing seen as a job or as a career.</p>
<p>i) <i>The support that we had parentally was negligible, I think it pushed us even more, because we had no encouragement, and I think we both had this desire to develop and be as good as we could be, to reach that self-actualisation if you like .. (NVQ Co-ordinator Nurse).</i></p> <p>ii) <i>I left school with absolutely no qualification at all. I was never really nurtured into feeling that they were a particularly important feature in life, but I was an SEN because you didn't need qualifications at the time to access SEN courses. For some reason I started to feel unfulfilled (Respiratory CNS).</i></p>	<p>Insufficient learning support during childhood.</p> <p>Gaps in education.</p>	<p>Undertaking learning to redress earlier missed opportunities.</p> <p>Undertaking learning to redress earlier missed opportunities.</p>

Data	Notes / Open codes	Categories
<p>i) <i>You can't be doing your job if you are not lifelong learners. The job is forever changing, and roles are changing in the job, the environment of our job is changing. So much new skills come in, new technical equipment everything, you've continually got to learn (ITU Nurse).</i></p> <p>ii) <i>Ages ago, use pressure care as an example, how things were done then, the use of ice or oxygen, all these things, was it the action of turning the patient that contributed to the pressure care, building on that knowledge, and although that's what we did at the time, you think about it more now, and all these up to date research. Now I've learnt that that is not the way (Respiratory CNS).</i></p>	<p>Clinical developments influencing learning.</p> <p>Changes in clinical practice.</p>	<p>Clinical developments and new thinking.</p> <p>Clinical developments and new thinking.</p>
<p>i) <i>The area that you work in, if other nurses on the ward and the management is motivated, then you're going to be motivated, you're going to be caught up in that wave, don't you? (Cardiothoracic ITU Nurse)</i></p> <p>ii) <i>And they won't pay for the books. When I did the 998 everybody was asked to get a book, and I went to my manager and said look there's lots of people going on this course, would it not be useful for the ward to buy the book as a resource. And I was told no, you have to buy it yourself, it's only a book (Palliative Care Nurse).</i></p>	<p>A learning ethos.</p> <p>Not valuing suggestions for particular learning resources.</p>	<p>The clinical setting as the learning environment.</p> <p>The clinical setting as the learning environment.</p>

<p>i) ... person ... a long time ago, a nurse I used to work with, she's a personal friend of mine, .. when PREP first came out, and she is a lifelong learner herself, she told me all about PREP. I got interested ... and that had an effect on me (Private sector theatre nurse).</p>	<p>Learning instigated by social contacts.</p>	<p>Social and governmental factors influencing learning.</p>
<p>ii) I think the general public as a whole value nurses, I think sometimes they haven't gone past the short skirts, cut stockings and bottom wiping attitude of nurses (Accident & Emergency Nurse).</p>	<p>Society's attitude towards nurses.</p>	<p>Social and governmental factors influencing learning.</p>

Nursing seen as just a job or as a career

One of the themes emerging from the data is the notion that for many RNs nursing is essentially a job, and therefore the main, substantial or only means of gaining an income. In particular, if the nurse is a single parent or the breadwinner in the family, then she may feel that she needs to continue to develop her knowledge and competence so that she remains a skilled and valued employee, e.g.:

One of the things is that I am the breadwinner, and the only way I'm going to get on is if I actually put work in to keep myself updated, I make myself a desirable employee. So somebody is going to look at me and think, she already hasn't let the grass grow under her feet (Practice nurse).

Using metaphors such as 'breadwinner' and 'not let the grass grow under her feet', this informant argued the point that as a single parent, she needed an income for meeting her own and her son's basic needs, and to do so she has needed to make herself suitable for continuing employment in her current job. She does this by keeping her professional knowledge and competence up to date and further developing them.

The *Dearing Report* (NCIHE 1997 p. 115) noted this in the context of human capital theory, in that even later in life 'education makes an individual more productive at certain tasks and hence more desirable by employers'. This feature is also consistent with one of the key components of the government's Green Paper *The Learning Age* (DfEE 1998), which indicates that everyone must constantly acquire new skills and knowledge, in order to innovate and adapt in their present job, or to enhance their employability should they need a new job. Both Field (1999) and the second NAGCELL (1999) report *Creating Learning Cultures* also agree with this line of thinking.

At least one informant was specific about explaining that with the nursing workforce consisting of predominantly females, individuals have to find time and also negotiate support at home for studying. This was explained particularly in the light of perceived diminishing tutorial support when doing a course, which informants indicated is required quite substantially by those who have not studied at a university recently. Staff who qualified in recent years do not appear to require the same level of tutorial support, probably because they qualified through university education at diploma or degree level anyway.

One informant indicated that at times individuals go for job interviews predominantly for the interview experience. Tight (1998b p. 252) reports on situations where jobs are being re-designated 'so that existing employees are placed in a position of having to re-apply for their posts. Additionally, new minimum qualification requirements are being imposed with staff being given a period of time to meet

these if they wished to continue in employment'. To some extent, similar things have occurred in nursing, as employers have tended to designate the minimum qualification requirements for application for particular clinical grades. Some RNs who are already in the middle or higher grades do not necessarily possess those minimum qualifications. Thus, at times when job vacancies occur, the nurse finds that the qualifications required by the employer for the new recruit to do the same job as hers is higher than that which the exiting post-holder currently holds. Therefore,

.. most employers now, when (they) put advertisements in the paper or in the local press, they are asking for certain, like the 998 as part of the job. And people have to keep on learning to keep their job status (Haematology nurse).

However, one informant indicated that although the current emphasis on paper qualifications being required when applying for jobs is appropriate, this does seem to devalue learning undertaken through years of experience, as:

(it) ignores people's experience probably in some instances they just look at the paper qualification, which is a pity (Private Sector Nurse).

Another reason why nurses feel pressured to do courses and gain further qualifications is the advent of diploma and degree level pre-registration courses, particularly in the 1990s. It seems logical that qualified nurses, who act as mentors or supervisors for the students, themselves should be diplomates or graduates in the first place. Doing further studies tends to update the nurse on current nursing trends.

But then ... when they're (pre-registration students) coming on to the wards they question practice and things like that. So I think that's why it's important for the nurses actually in post to do this further study so they are more aware of what's going on, because I think you can become confined to one area, and you just lose tract (Pain Control Specialist Nurse).

These are examples of a sense in which lifelong learning is being perceived as having become compulsory. On a broader plane, Tight (1997 p. 22) delineates a current trend in that 'whether willing or not, greater responsibility is now placed upon the individual for maintaining and developing their skills and hence employment position'.

One informant observed that job threats might exist in other ways as well. An example of this is the issue of whether in operating theatres the surgeon or anaesthetist should be supported by theatre nurses or by operating department assistants and practitioners (ODAs and ODPs).

Retaining employability also interfaces with Enrolled Nurse status and the conversion course. With the advent of Project 2000 courses, the vast majority of Enrolled Nurses (EN) had to undertake the conversion course to become RGNs, RMNs, RNMHs or RSCNs. Besides, ENs did not always feel valued by clinicians.

... about 3 or 4 years ago, when I was working in EAU [Emergency Assessments Unit] with my green dress on the bank shift, one of the doctors said to me, is there any trained nurse around, and I just said to him no, because ... he wanted a trained nurse, as in staff nurse (Emergency Assessments Nurse).

Gaining the qualifications required for entry to the conversion course has tended to provide a pathway into formal learning. The EN Conversion course itself seems to have acted as a trigger and motivator for lifelong learning:

...I saw the conversion course as an opportunity, a window for me (Community Nurse).

In nursing there have been transitory phases when newly qualified nurses have had difficulty obtaining employment as RNs. However, for most of the 1990s as well as in the

new millennium, there have been widespread vacancies and a preoccupation with attracting nurses who had left nursing back to the profession. For nurses who have remained continuously in the profession, the idea of a progressive career remains a reality. However, the data reveals that, as mooted before, not all nurses are career-minded, for whatever reason, but could be taking up learning merely to safeguard their jobs.

Thus, there are a number of issues related to the fact that many nurses feel they have to take action to keep their employment. Wallace (1999) recognises that, in the mid-1990s, existing registered nurses were feeling threatened by the new RNs emerging with diplomas from Project 2000 programmes. As a result of this, the more experienced staff without this level of qualification have felt compelled to take up academic courses so that these new and inexperienced RNs are not perceived as better qualified and therefore more suitable for the post than they were.

Nursing as a career

The idea of nursing as a career was discussed in some detail in chapter four in the context of career development during one's professional life, and in chapter one. For RNs who see nursing as a career rather than just a job, career advancement can involve seeking promotion and addressing requirements that determine promotion up the clinical grades. Clinical grading was introduced in the 1970s to provide a well-developed career structure for nurses with increased opportunities for promotion (RCN 1992). However, promotion to a new clinical grade brings new job requirements with it. It

is also accompanied by an expectation and the responsibility for remaining competent and knowledgeable at those activities. For instance:

... at the lower grades it's easier to say you don't know different things, your skill is limited. But when up into management, people possibly lose respect and confidence if you say I don't know (Accident & Emergency Nurse).

Other RNs seem to do courses specifically as a lever for gaining promotion, although as indicated in both this study and the one conducted by Sargant et al (1997), gaining promotion triggers even more learning. This is not only due to new responsibilities, but also because of role model functions towards an increased number of subordinates or juniors. The individual should be able to perceive this as an integral part of his or her new responsibility.

An alternative insight into career developments is provided by Tight (1997), who explored careers as a concept, and observes that they are no longer uni-directional with the idea of progression replaced by that of trajectory. This implies that with the changing nature of employing organisations, individuals need to be prepared to learn new skills continually merely to remain in employment. In the study conducted by Tight (1997) on the learning experiences of employees, several related concepts were encountered, such as downsizing, delayering, re-engineering, as well as accounts of redundancy, unemployment and retraining. All these indicate the unstable nature of employment, and the need for continually learning novel skills.

A different perspective to career development is provided by Handy's (1984) notion of 'upside down thinking', which entails a shift in the employer's perspective to that of treating their employees as assets, and not costs, and hence investing in them.

Investing in employees constitutes ongoing learning, and while Handy's (1984 p. 153) vision applies to wider educational activity, he foresees that:

- More people will need and want more education at more points in their lives, and therefore education is an investment, not a cost.
- Individuals should have more scope to arrange their own network by choosing from a greater variety of schools or universities through systems of transferable credits or within consortia of schools.
- The work organisation must recognise its role as the principal school for work, both during employment and after it.

Thus Handy sees ongoing education as a necessity for either advancing careers or changing to other employment. Endeavouring to retain one's employment as a nurse and seeing nursing as a career are both examples of informal factors that trigger learning.

Undertaking learning to redress earlier missed education opportunities

Another significant point that emerged from the data in relation to day-to-day factors that influence continuing learning is the notion of missed education opportunities earlier in life. Thus, individuals who missed the opportunity to gain the usual qualifications by the end of school leaving age may seek and seize opportunities for formal education at a convenient stage later. Some informants reported that they had always wanted to obtain certain academic qualifications, ranging from basic GCSEs to higher degrees and/or further professional qualifications, and undertook them later when it was convenient.

Professionally, the qualified nurse may have started pre-registration education when the entrance requirements were not those of higher education. However, opportunities for formal learning may not have been available, or personal or domestic circumstances may not have been conducive for this. The notion of missed opportunities seems to relate to such factors as:

- * Insufficient early schooling, and maturing;
- * Gaps in learning and life transitions;
- * Resuming formal education; and
- * Studying for a degree.

Insufficient early schooling, and maturing

One informant explained that one of the reasons for uptake of education well into her adulthood was that when she was a primary school pupil, the school was heated by a coal-fired boiler, but because of repeated coal-miners strikes at the time, the school was often closed. This, and the then disinterested culture in the school, resulted in her early education being deficient. Other informants reported that insufficient initial academic education and achievement act as a motivator for uptake of academic study after gaining professional nursing qualifications. Some informants referred to not having done GCE 'A' level as a deficiency in their education, while one made the comment that: *'I left school with absolutely no qualification at all'*, but subsequently endeavoured to rectify this. In her experience:

Education is power almost. It perhaps opens up a whole new way you could be, and then it gives you confidence as well. From 1991 to now, I've gone from nothing to a master's degree (Respiratory CNS).

Schuller (2000) reports on a study that focused on continuing education and training (CET) in Scotland in four sectors, one of which was health care. One of the recommendations emanating from the study is a comprehensive review of advantages and disadvantages of prolonged initial education, 'especially where initial academic education is directly followed by extensive professional training' (Schuller 2000 p. 232). This is because the longer people spend on initial education, the stronger the basis for a lifetime of learning. However, this is so only to a certain extent, and perceptions of what constitutes initial education vary in that it can imply gaining GCSE, or A levels, a degree or a doctorate. Therefore, because initial education is a personal perception, and because it can be strongly connected to the notion of passing or failing, Schuller (2000 p. 228) reports that it can almost 'immunise' individuals 'against being aware of the value of CET'.

In this study, one informant cited '*a thirst for knowledge*' as a factor that leads the individual nurse to continuing learning. However, an earlier unfavourable experience within the foundation learning years or any learning setting can present as a deterrent.

For example, my daughter asked a question once about going on a school trip, and she was made to look stupid in front of the rest of the class. The teacher said well for goodness sake what a stupid question, ... everybody laughed. Now I believe, that something like that stays with you for life, and it's so difficult for them to ask the next question (Respiratory CNS).

Knapper and Cropley (2000) also discuss the influence of schools on lifelong learning, in that unhappy experiences there may have an inhibiting effect on lifelong learning. In post-compulsory education, on occasion, until the answer to a particular

question is found, subsequent learning in the particular topic area may be blocked.

For example:

... it's like me with my not quite understanding how they managed to get that lady's carbon dioxide level down, until I go and see that man and find out ... (Respiratory CNS).

However, it is also suggested that engaging in learning to make up for earlier missed opportunities may be propelled by personal maturity, as the value of learning is then more fully appreciated by some. This may be assisted by increasing use of home computers and access to professional and personal interest knowledge through the Internet, for instance.

Gaps in learning and life transitions

In addition to deficient initial education, informants drew attention to the notion of gaps in learning, which are periods in one's life when little or no learning occurs as when a woman takes a career break to have children. One informant observed that such gaps could be natural, and realised that, even at the time when the RN is engaged in these other events, and her profession-related learning comes to a halt, other types of learning - e.g. learning to nurture a family - continue.

When you are younger there are other things, because then you have family, you have commitments and everything else (Pain Control Specialist Nurse).

Although these gaps may be due to transient life circumstances, or during life transitions when professional learning seems to come to a halt and when the RN is unable to work full-time, she might still use any spare time she has to undertake professional studies through distance learning:

when I've been tied to the home to do 9 to 5, because I can't afford baby-sitters. I've used that time to do open learning packages, the asthma diploma, the

chronic obstructive airways disease diploma, then I did the asthma trainers course ... (Practice nurse).

The concept of stopping education due to life circumstances, and restarting can also be explained in the context of life cycle theories. A new life cycle begins when the individual's children become less dependent on them, or painful experiences have healed, then more formal learning within Higher or Further Education can be resumed. In a major survey of participation in adult education in which 4 673 adults aged 17 and over were interviewed, Sargant et al (1997) found that patterns of learning change across life cycles. They found that events such as getting married or a relationship break-up, or losing a job, related to higher proportions of learning than in the general population.

The data from this study indicates that formal learning after life events can be self-motivated and at a pace chosen by the individual:

... when I started studying proper if you like, that would have been about 1991, it was more difficult financially, getting people to look after children, the way society perceived working mothers and that. But I think now that's 9 years ago, and I think things have moved forward (Respiratory CNS).

Nevertheless, informants pointed out that where these 'gaps' occur, they should not be too prolonged as it can make re-starting to learn quite difficult, although such gaps can be used for travel and to gain broader perspectives in life. A study by Blaxter and Tight (1995) revealed that life transition events in themselves are not distinct determinants of educational participation by adults.

Resuming formal education

Life cycle events leading to eventual formal learning could also make the RN realise that they need to be eased back gently into studying. This is because on resuming learning individuals may find that to undertake learning as efficiently as before requires mental adjustment. One nurse who restarted professional education after a break stated:

I had a bit of a break, and then I did something very gentle, some IT skills, just one module at a time, slow and steady, just keep my brain ticking over (Pain Control Specialist Nurse).

To enable nurses to resume learning, especially because CPD courses are now undertaken in the university setting, study skills courses or modules that focus on acquiring or regaining academic writing skills may be offered. On the other hand, even when attending lectures, students may feel they need to be selective in the focus of their learning, and this in itself constitutes a skill. For instance:

How to write the essay, use the skills, and that's almost more important than what's the content of the actual curriculum. So when you're listening in lectures, or participating, you have to be selective (Child Protection Nurse).

However, informants felt that current modular courses may present a dilemma to students in that these may whet the individual's appetite for the subject area, but because modules are time and content constrained, they may limit how extensively the individual can engage with the topic area. One interviewee explained that it provides merely an inkling and not sufficient depth. One senior nurse whose role includes substantial teaching felt that the ENB 998 [Teaching and Assessing in Clinical Practice] course did not equip her adequately with teaching expertise and therefore proceeded to do the longer City and Guilds 7307 teaching course.

Continuing learning can be undertaken over a longer time span with short breaks based on the availability of appropriate courses. The benefit therein is that the individual develops an appreciation that theory is required to support clinical practice. For instance:

I believe we've got to get academic qualifications that will support our clinical practice. And we need to underpin that with theoretical concepts as well (Dermatology CNS).

Studying for a degree

After resuming formal professional education, an increasing number of nurses tend to progress onto study for a degree. This is partly triggered by the current debate within nurse education as to whether nursing should be a graduate profession (e.g. Greenwood 2000, Dinsdale 2002). A few undergraduate pre-registration nursing courses have been available since the 1970s, but this debate has gathered momentum and seems to put pressure on non-graduate RNs to study for a degree.

In contrast, some nurses seem to have clear personal perceptions of the level of university education they would aspire to:

In my position the diploma is the goal. Not a degree. The diploma is achievable, it's about practice, it's connected and the degree is a bit more mundane. Frightening. Me, I went to a secondary modern school, failed my 11 plus ... (Gynaecology Nurse).

However, there are benefits to be derived from studying at degree level, as was explained by one informant: '*... having done a degree, something quite formal helps, because it gives you confidence, you've got the academic ability ... making sure that whatever practice you do is research based, keeping up to date*' (Accident and Emergency Nurse). There are other motives for studying for a degree. For instance,

it may not always be focused on improvement of clinical practice, but more related to the individual's social context, as one informant observed: *'I think there's a little bit of snobbery'* and *'there does not seem to be any measurable effect to having gone on a year or 3 year university course'* (Child Protection Nurse). Other RNs continue their education towards a degree in non-nursing-related subject areas such as Arts, Theology or Business Studies.

As can be noted from the quote from the Child Protection Nurse, the professional benefits of studying for a degree may not be immediately noticeable. That is, the new graduate may not show any difference in professional competence at the end of a degree programme, which were seen as worrying to some informants.

Clinical developments and new thinking

Another area emerging from the data as a day-to-day factor that influences learning comprises developments in clinical practice and new thinking in nursing and healthcare. One change in thinking, for instance, is the shift from the previous internal market mechanism to the more clinically led integrated care and quality conscious government policy. Clinical practice developments include nurses performing invasive procedures such as minor surgeries. Further training and assessment are required for these, but they can also lead to more professional autonomy and self-directed continuing updating of knowledge and competence.

The advent of new government structures necessitate the acquisition of new skills and knowledge (NHS Executive 1997) that might directly affect the daily work of some

sections of staff. For instance, one informant spoke of Primary Care Groups (PCG), being implemented as a result of the Labour Party's new structure for the NHS (NHS Executive 1997):

Thinking of PCGs, they aren't going to look at the traditional role of the nurse and practices, they will want you to learn new skills, be open, be flexible to changes in practice as consequences of new knowledge ... May need much more knowledge of epidemiological data; playing important roles in, trying to help people, within failing marriages, I have no skills in this at this moment in time (Community Nurse).

Another development involves different health care professionals learning from each other and the concept of multi-professional education. It seems from the data that healthcare colleagues learning from each other is increasingly valued. The government's push for multi-professional learning encourages this, and the mechanisms to enable this are being explored (e.g. CVCP 2000).

Technological changes, role expansion and other ongoing developments, which are factors that instigate further learning, were discussed in chapter one. Already nurses have developed skills in a number of aspects of healthcare intervention, and a major advantage of this is that the patient benefits by receiving more holistic care. One informant for instance noted:

Oncology area cancer treatments are changing each day. They have to learn of the changes, and new treatments. So, it's all snowballs from there. The vast majority of nurses in the Unit where I work are happy to do this to enhance patient care. They are going to benefit from new research and new knowledge coming in (Haematology Nurse).

Although there are other developments that lead to new learning not all nurses are instant innovators, which is probably the case in any profession. There may be a wide range of new ideas and potential for improvement, but the time and conditions may not be 'ripe' for particular innovations (ENB 1987). It is also useful to appreciate that good

practice already exists, based on established policies, procedures, clinical guidelines and protocols. For example:

Some people are quite happy to come along and follow policies and procedures, which in fact, is less likely to get you in trouble, than you are by trying something different, which you've read about. But you need to be able to give yourself a bit of slack sometimes. Realise that you are doing some things right (Neonatal Nurse).

Another example of new thinking is neonatal nursing, wherein while previously patients who were transferred to say intensive care areas are now cared for on the neonatal unit itself. Consequently the neonatal nurses were required to acquire new skills and knowledge. However, for this to happen effectively, the clinical area requires the appropriate learning ethos.

The clinical setting as a learning environment

Handy (1984) notes that perceiving the workplace as a principal setting for learning requires the appropriate learning ethos, and means treating the setting as a learning organisation. The benefits of clinically based (informal) learning have to be highly valued with nursing being a skill-based profession, and as:

The skills you could pick up and improve on them. I work in casualty department, it's a wide client base so, and there is a lot you can learn through it (Accident & Emergency Nurse).

The extent to which the clinical area where the RN works constitutes a learning environment has been empirically studied for at least two decades (Orton, 1981; Hart and Rotem 1995). This has culminated in documents that provide criteria for auditing the clinical setting for its suitability for student placements (Spouse 1990, Orton et al 1993). Orton (1981) identified the characteristics of wards that are high-

student-oriented and those that are low-student-oriented. The local characteristics or culture in the clinical area is a factor that encourages informal learning, as:

There's got to be some support there. There's got to be some kind of cultural thing at work, it's seen that you keep your skills up to date (Coronary Care Nurse).

Organisational culture as a concept in healthcare delivery is widely discussed in the management literature. Mullins (1999 p. 31) defines culture as 'a distinctive pattern of values and beliefs which are characteristic of a particular society or sub-group within that society'. Mullins suggests that in the context of organisational culture, culture is seen as a multi-faceted concept involving various factors including attitudes, social organisation, language and education. The literature also addresses related issues such as the organisational climate, staff morale and conflict (e.g. Mullins 1999; ENB 1994).

Having a student on placement can itself instigate interest and enthusiasm for further and university based education in qualified nurses

People that haven't done very much in the way of university courses, they don't really grasp what it is, why they are doing it. Having students help people to realise what they are meant to be doing. Students open people's eyes make them look at things they do (Ophthalmic Nurse).

Informants' responses in this study indicate that this shift in outlook can be supported by a range of essential factors such as:

- professional leadership and the clinical environment;
- the clinical manager's apparent attitude to CPD;
- the availability of specialist journals;
- encouragement from the right people;
- being asked what course the nurse is interested in;

- reporting to colleagues from study days and disseminating learning;
- practice that is responsive to new evidence; and
- new skills, and new management mechanisms.

The data indicates that the first two factors are more critical, and these are now discussed in some detail.

Professional leadership and the clinical environment

Both the study data and the relevant literature (e.g. Fretwell 1982) suggest that sound leadership is an important aspect of the manager's role in creating and maintaining a clinical learning environment. For instance one informant indicated that:

The ethos in the workplace depends on the person who is directing that team ... part of being a good manager; you bring the best out of people who are working for you (Private Sector Theatre Nurse).

Transformational and transactional leadership theories are seen as the two most effective ones for managing healthcare staff (e.g. Shuldham 1997). In the late 1990s, the RCN produced a nursing leadership training package, which was supported by the government, who declared that it wanted all ward sisters to attend the associated leadership course (Parish 2000). Evaluation of this programme showed that on 'a number of leadership dimensions, ward sisters' and senior nurses' performance (as leaders) had significantly improved' (Cunningham and Kitson 2000 p. 34).

Informants in this study indicated that professional leadership is reflected by, for instance, managers subscribing to specialist journals for the clinical area, which can be

made freely available to staff in the clinical setting. Informants reported that these could be seen as a manifestation of the manager's commitment to learning.

On the other hand, the function of professional leadership in promoting learning is also apparent as informants' suggestions that being a senior nurse is itself a factor that leads nurses to continually learn. This could comprise a role model function, and:

The majority of my colleagues are all Gs, people who are at quite a high competency level. They would see that part of their remit is to continue to be learning. And disseminating that learning ... (Child Protection Nurse).

From the role model point of view, senior nurses who are lifelong learners themselves ... certainly have an influence on the educational aspect. Not in terms of peer pressure, but in terms of the knowledge that they have (Cardiothoracic Intensive Care Nurse).

The opportunity, mechanism and willingness to report to colleagues from study days and other learning activities are other day-to-day influential factors leading to continuing learning. The knowledge brought back can be made available on the ward as learning resources. Informants indicated that learning can also be facilitated by link nurses, who are key personnel in the clinical area with particular responsibility for exploring and disseminating components of better care, and assisting with the implementation of policies.

Thus the local organisational culture, management attitudes and other factors in the clinical setting can have positive effects on learning. However, it seems that they could also have negative effects on willingness to learn and therefore deter learning. A range of such factors is presented in table 6.2. Some managers' attitude may be that *'they may see it as a waste of time and that's why*

Table 6.2: Factors that have negative effects on, or deter willingness to learn

- * *Managers not appreciating the benefit and practical applications of knowledge and competence acquired from course.;*
- * *Nurses who do not bring back anything from courses.*
- * *Managers seeing staff going on courses as a threat.*
- * *Managers not facilitating learning and not helping to meet PREP requirements.*
- * *Lack of staff.*
- * *Staff leaving and difficulty recruiting.*
- * *Not being supported financially or other way if employed outside mainstream NHS organisations.*

they are not very keen for people to go on courses' (Gynaecology Nurse).

Some informants felt that the learning or knowledge acquired from CPD courses, particularly university-based courses, are not always appreciated or valued by colleagues or clinical managers. Where they are valued, their implementation can be quite protracted. It is a feature of continuing learning that further awareness and sensitivity is developed among some of the senior staff in relation to broader issues and concepts in nursing. It seems that they need to appreciate that learning from courses has direct relevance for nursing practice, as they were designed and approved in accordance with published ENB (1995b) regulations and guidelines.

Despite the negative attitudes of some staff and the discouraging culture in some clinical areas, it needs to be appreciated that as individuals, everyone has a desire for personal growth, and as noted in chapter five, there are staff who will go on and self-develop even if their managers are unable or unwilling to support them for this.

On the other hand, there can be nurses who are reluctant to attend courses, and who then also make vilifying comments to individuals who express a wish to do so. One informant noted that such attitudes could be a reflection of general unhappiness related to issues in their personal life. However, this can be more problematic if those staff go further and endeavour to dissuade or block colleagues from undertaking such activities.

There are also colleagues who actually do not appear to see any point in doing courses, especially as they are confident that their knowledge and competence are of very good standard. There are those '*who disagree with lifelong learning*'. It is reported that '*they'll always be unmotivated to do courses*', and were unlikely to be supportive of colleagues who engage in CPD courses. This includes nurses who haven't studied for a while, and also those who are '*forced*' to go on courses.

There are a number of people who disagree with lifelong learning, as opposed to doing courses, nurses who think this is a waste of time, they shut their mind to it. Because there are some people who will never be motivated, ... A lot of people see courses as totally inappropriate (Intensive Care Nurse).

This could be because of low self-esteem, which may be self-generated or suggested by others. In exploring the literature on widening participation in adult education, McGivney (1990) noted earlier findings that the major dispositional factors that impede participation are characterised by the absence of something, such as:

- confidence and self-esteem
- trusts in the system
- perspectives on the future
- awareness of opportunities
- educational preparedness (communication skills, basic education skills, etc)

That is they may not have participated in courses for some time, and lack the self-confidence to embark on this. McGivney (1990) concludes that education providers need to concentrate on supplying the missing elements in addition to addressing practical obstacles to access. This is because, despite this perceived reluctance by

some RNs to attend academic courses, informants felt that the majority of staff do learn by attending various courses in the expanded role category. For instance:

Some of the nurses who I work with ... they go on the practise course more than the academic course, so that is learning as well, you know when you do your cannulation, defib course, your CPR. But if they are in nursing, and it's ongoing, you're nursing lifelong (Macmillan Nurse).

Courtney (1992) also indicates that indeed all individuals are involved in informal learning all the time. The data from this study indicates that this involvement may also be personality based. For instance:

I think a lot of it boils down to personality. If people aren't motivated themselves, you can put them on the best course in the world, and they still won't do it. So, it's an individual's own decision if they are going to be lifelong learners (Accident & Emergency Nurse).

Management's attitude to continuing professional development

Other than professional leadership, another factor that was seen by informants as important is the nurse's clinical manager's attitude to CPD. This is usually positive as indicated by: '*... they do try to push you professionally to do courses, to develop yourself*'. One interviewee pointed out that continuing education is better achieved by doing CPD courses, than merely by ad hoc reading and browsing, etc. However, the attitude of clinical managers can be a factor, in that they may be seen as obstructive in that they are not able to support every member of staff's request for CPD at a time convenient to them. The manager is likely to perceive staff release from a different angle, that is the manpower aspect of resource management, as explained by Mullins (1999) for instance. Consequently, some staff have to wait for several years before their request for attending a course is granted:

... others were quite resentful, because they'd been asking for a long time, and had applied several times, but ... the management said no (Dermatology CNS).

I've been wanting to do this ENB course since I first came into post, 3 years ago, and I was refused it by management. ... But I needed to do this to see what I still need to do (Child Protection Nurse)

Such long waits can at times hinder learning, in that some courses are pre-requisites for other courses. This is because the CPD budget itself is allocated yearly, and if a conference or workshop is advertised later in the trust's financial year, even if it is particularly relevant, the manager may decide that she is unable to financially support the request because of the risk of overspending on the allocated budget. Informants reported that this happens despite the fact that, depending on demand, short courses and modules may not be offered for some time afterwards, and cause an even longer wait.

Even when release from work to attend a particular course has been agreed, it does not follow that for longer courses the release will be also available in subsequent years. This is because yearly budget review may not allow the same amount of money to be allocated for staff development, or because there are likely to be other staff who also need release from work for CPD opportunities. Sargant et al (1997) found that employment status affects people's opportunities for learning, with almost half (49%) of full time workers engaging in learning, compared to 42 per cent of part time employees.

The data indicates that staff shortages can also have adverse effects on participation in learning: for example, when the individual is asked to work extra shifts, as a bank nurse for instance, so that the clinical area is adequately staffed.

This does not leave the individual with sufficient time and space to undertake CPD type activities.

How does a nurse approach and ask the manager to be allowed to go on a course?

The opportunity to ask and the strategy employed to persuade the manager might itself prove to be a major factor that might therefore require some homework.

Alternative strategies include:

Approach the manager informally or speak to other senior member of staff on the ward who can go on your behalf (Cardiothoracic Intensive Care Nurse).

You can say whether you feel you need to develop your practice. Supervisor can suggest to management what you need to do, and what you'd like to do (Respiratory CNS)

Social and governmental factors influencing learning

Social factors include the probable influence by individuals who are not nurses, though the data reveals that a number of RNs felt that it was other nurses such as colleagues at work and course peers who had a more marked influence on their learning. They also included tutors and doctors, as well as friends, spouses or partners, family, and parents, although a few informants did not identify any such people and reported being self-directed.

An example of social influences is when a friend of one informant in this study stated that she felt proud of her for doing a professional course, even without the expectation of an increase in pay. Another example is provided by an informant who explained that all her friends are either graduates or studying for a degree, with the Open University for instance.

Social factors that prevent learning

Social factors that inhibit nurses becoming lifelong learners emerged as a separate issue, in that levels of learning are also influenced by people who the individual comes in contact with in the course of normal day-to-day personal and professional life. It seems for instance that for a predominantly female workforce, family demands have a significant effect on the level of CPD the nurse can undertake. The data in this study included statements such as:

- * *commitments, such as being a single parent family;*
- * *time shortage due to family instability e.g. illness;*
- * *maintaining motivation to study after a hard day at work;*
- * *having a 'problematic home life';*
- * *having to move around because of their husbands' jobs.*

One informant reported that her career had to be held in abeyance while her husband who was in the army was being posted to different parts of the world, as:

You're not just a nurse, you're a mum, a wife, and everything else. If you've got some time left at the end of the day, then you can do some studying, which I think limits people, because they've got so many outside pressures that it is difficult to go on and be a lifelong learner (Accident & Emergency Nurse).

Thus it seems at times that circumstances might not permit the individual to engage in education. One informant in this study explained that even student nurses on pre-registration courses may experience domestic risks because of their coursework for instance, as *'their families got neglected while doing the pre-reg course'*.

In addition to social factors, it seems that governmental attitudes also have an impact on how much nurses get motivated to attend CPD courses. There seems to

be an impression that the lower pay for nurses compared to those for similar professions reflects a lower esteem for nursing by the government. This in turn may lead to demoralisation, and not wishing to put extra effort into doing courses. For instance:

Sometimes the attitudes of the general public and the government does not help ... we are responsible for people's lives ... I think the general public as a whole value nurses, I think sometimes they haven't gone past the short skirts, cut stockings and bottom wiping attitude towards nurses (Accident & Emergency Nurse).

However, it is likely that, as pre-registration courses are increasingly at degree level, RNs qualifying from these courses would expect salaries on the same levels as other graduates do.

The government need to change their attitudes and see what nurses actually do ... and pay them in proportion ... You think if we screw up we are going to lose our professional status, and people who work in computers, ya it's a bit of a problem if they screw up, but it's not life and deaths at the end of the day (Accident & Emergency Nurse).

Nevertheless, despite prevailing constraining circumstances, nurses endeavour to deliver the highest level of care they possibly can, as:

A lot of our patients, when they come in and we're busy, and we're dashing around doing 425 different things, and they still get a good quality of care (Accident & Emergency Nurse).

Another deterring social factor is the lack of crèche facilities for nurses with small children, as noted in the government's nursing strategy document *Making a Difference* (DH 1999b), and by McGivney (1990). Yet another is that medical staff do not seem to have high regard for nursing research, as this is predominantly qualitative rather than quantitative. Even the post-graduate centre at one NHS trust being only accessible to doctors is an issue that can have a negative effect.

Meadows et al (2000) and Davies (1996) present documentary data that nursing as a profession suffers from a social image problem.

Conclusion

In this chapter I have examined nurses' perceptions of non-formal day-to-day factors that either facilitate or have a prohibitive effect on lifelong learning. They include personal, professional, and social as well as governmental factors. In particular, it was a revelation to me that to quite a few nurses, nursing is merely an income-providing occupation, which is likely to be the case with some individuals in other professions. They perform their daily work with care and probably dedication, but are not interested in attending formal courses away from the clinical area for a variety of reasons. However, many nurses see nursing as a career in which they endeavour to do as well as they can within the constraints of other commitments, such as raising a family or caring for older frail parents, or moving jobs if their spouses have to move area.

For other nurses, nursing provides a medium for engaging in academic pursuits that they feel they missed out on in their earlier years. However, it seems that there is an issue about the actual benefit of doing a degree course, if, on completion, there is no noticeable practical benefit to patient or client care. Thus, whether there is a difference in clinical practice between those who do their professional studies at degree level, and those who don't, remains to be researched. Additionally, it is argued that management's' attitudes to CPD in some areas could be more encouraging and professional leadership plays a key role in this.

In summary, the findings related to aim 3 and 5 are:

- 6.1 For some nurses, particularly those with very young families, nursing is merely an income-providing occupation, and professional updating is primarily employer-driven; for others it represents a career opportunity.
- 6.2 Missed opportunities during initial and professional education may instigate participation in formal learning at a convenient stage during one's lifetime.
- 6.3 Life transitions and life cycle events might also trigger engaging in education and learning.
- 6.4 Clinical developments and new thinking can instigate, encourage and guide the individual towards continuing learning.
- 6.5 The clinical setting can be viewed as a learning environment as long as the local organisational culture, management attitudes and other factors do not deter learning.
- 6.6 Teams of RNs in the clinical area consist of a mixture of individuals who are highly motivated to learn and innovate, and those who are much less enthusiastic. The balance between the two groups varies, depending on the local culture and probably specialism.
- 6.7 Nursing colleagues and friends, doctors, spouses or partners, family and parents, and tutors can constitute social instigators and supportive mechanisms for learning.
- 6.8 Family demands take priority and can affect participation in CPD negatively.
- 6.9 Social and governmental attitudes towards nursing may discourage further professional learning and still needs improving.

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Chapter Seven

EFFECTS OF LIFELONG LEARNING ON NURSES AND NURSING

Introduction

Having explored RNs' perceptions of lifelong learning as a concept in nursing (chapter four), the formal structures and processes that facilitate lifelong learning (chapter five) and other day-to-day factors that do so (chapter six), this chapter examines the likely effects of lifelong learning on nursing and on the nurse as a professional and a person. It seems that lifelong learning acts as a stimulus for RNs to engage in continuing learning, although it is unlikely to be solely responsible for instigating learning either in the nurse or in those towards whom she has a teaching role. However, this study indicates that the concept does have impact on nursing as a profession and on nurses as healthcare professionals, and it is likely to play a major role as it is set to do in society in general.

This chapter addresses aim four of this study, which was identified because of the lack of empirical literature on the effects that the concept might have on nurses and nursing. This void might be because of the relatively novel status of the concept during the mid-1990s in nursing. The data was analysed with the purpose of identifying aspects of this feature, and they were interpreted using the same processes presented in chapters three, four, five and six. Examples of how the data was analysed are presented in table 7.1. As in the three preceding chapters, two instances of informants' responses are reproduced here as examples of how the notes made on the data reflected the impressions that were emerging, which were categorised and subsequently identified as three themes. They are based on the

Table 7.1: How themes related to effects of lifelong learning on nurses and nursing were captured from the data.

Data	Notes / Open codes	Categories
<p>(i) <i>An attitude change, sharing knowledge, it's about individual growth, building the self-confidence, the self-efficacy up, from grassroots level. You need to instil that into the people. They've got to feel valued, they've got to feel they are doing a good job before they enrol, take this on board, and move forward themselves (Community Nurse).</i></p> <p>(ii) <i>It has to do with ... the environment and the attitudes of your colleagues, but I think a lot of it boils down to personality as well (Accident & Emergency Nurse).</i></p>	<p>Some RNs need support and advice to change their attitude towards continuing learning.</p> <p>Some RN colleagues may need to change personal outlook towards learning.</p>	<p>Impact of attitudinal change towards learning</p> <p>Impact of attitudinal change towards learning</p>
<p>i) <i>It's not just a job. It's a much bigger thing, it's an enriching thing ... And also it makes you want to impart that knowledge to other people, because if you understand something, someone else doesn't, you would say look I've got this. You want to share it with somebody. So you are disseminating (Private Sector Theatre Nurse).</i></p> <p>ii) <i>It keeps you up to date ... the student just out of college (need) practical knowledge, but you know they're looking to you as a role model, ... (Emergency Assessments Nurse).</i></p>	<p>Sharing knowledge and teaching colleagues.</p> <p>Being a role model to newly qualified RNs.</p>	<p>The nurse as facilitator of lifelong learning.</p> <p>The nurse as facilitator of lifelong learning.</p>

Data	Notes / Open codes	Categories
<p>i) <i>At the end of the day, my children benefit from my lifelong learning. And they benefit in many ways. I think they are influenced by it. When I got my masters degree, my kids were absolutely over the moon, they were so proud. And I thought that must have a positive impact on them, and the way they perceive education ... (Respiratory CNS).</i></p> <p>ii) <i>I was a good swimmer; I eventually swam for England. Now I've got back into swimming again, I'm classed as Master's, which is over 25. I've also become a swimming teacher, ... but maybe I wouldn't have had the confidence to do it, so maybe doing the ENB 998 has helped me become a swimming teacher (Gynaecology Nurse).</i></p>	<p>Effect of adult learning on their children.</p> <p>Professional courses positively impacting on personal life.</p>	<p>Effect of lifelong learning on personal life.</p> <p>Effect of lifelong learning on personal life.</p>

information provided by informants in response to the interview schedule questions (table 3.2). These categories are:

- The impact of attitudinal change towards learning
- The nurse as facilitator of lifelong learning
- The effect of lifelong learning on personal life

Impact of attitudinal change on learning

While the following discussion is based predominantly on the data from the study, it is noted that various documents also provide guidelines on how individuals can be guided in the direction of a positive outlook towards lifelong learning (e.g. Sargant et al 1997, ENB 1998b, NAGCELL 1999). In NAGCELL's publication entitled *Creating Learning Cultures*, the focus is deliberately on changing cultures so as to forge and facilitate lifelong learning. This recommendation is primarily based on the concept of

'risk society', described by Beck (1992), which signifies the perceived profound social change that the UK society is currently going through.

The data gave a strong impression that for lifelong learning to be successfully espoused within nursing, a relatively radical change of attitude towards learning would be required by some sections of nurses, both practitioners and managers. This emerged in the exploration of RNs' perceptions of lifelong learning in nursing in chapter four (p. 152), which revealed that certain groups of nurses were reluctant to engage in formal learning. Furthermore, in chapter five (p. 188), in the context of structures that facilitate learning, it emerged that the compulsory nature of PREP evoked similar resistance, in particular towards university-based learning.

So although many RNs might claim to be lifelong learners, a useful point made by one of the informants is that some RNs may just be *'going through the motions of becoming lifelong learners'*. The lack of motivation to learn seems to be because:

Some aren't motivated at all, and they just go there, and it's money (i.e. their salaries) at the end of the day (Emergency Assessments Nurse).

However, one informant indicated that:

Going into higher education, not everybody wants to continue, but once you start on the road of higher education, eventually most people will want to continue to better themselves, not just educationally, but professionally as well (Neurology Intensive Care Nurse).

Other deterrents or reasons for disinterest or rejection of university-based CPD courses may be the proliferation of new terminologies and the complexities they appear to present. The post-registration framework is seen as rigid and stifling autonomous practice.

All these key characteristics and practice outcomes, it's just overloading people with information. Other professions don't have such a rigid framework to work by. So it's a bit prescriptive. Pathways and things like that (Intensive Care Nurse).

In chapter six, significant issues in relation to personal, management, organisational and social attitudes toward learning were highlighted. It seems that lifelong learning keeps the individual interested and enthusiastic about normal life activities. Otherwise, life can become routine, complacency can set in, and may result in psychological stagnation. What might be the outcomes if attitudes towards learning do not change?

... if you are a closed book, you wouldn't be doing what you are doing, you wouldn't be able to do your job (Private Sector Nurse)

Consequently:

Lifelong learning for nurses it's positive, because I think it keeps your enthusiasm up, otherwise if it becomes an attitude of "I know what I am doing, and I'll always do the same thing", it becomes very mundane, very routine. And I am going to do the same for the next 20 years does not really fill me with enthusiasm (Accident and Emergency Nurse).

On the other hand, when attitudes do change, lifelong learning could enable self-fulfilment and achievement of self-actualisation as:

.. it makes you into a more fulfilled person, it has spin-offs in all sorts of directions (Private Sector Theatre Nurse).

I'm a little bit like a caterpillar, in that, I sort of become a butterfly, and be able to spread my wings. I mean so much has happened to me, in terms of opportunities, some wonderful opportunities have come my way (Community Nurse).

In spite of the negative and positive attitudes cited above, informants indicated that the change in attitude towards learning is related to various professional and personal factors, and its effects on nursing seem to fall in the areas of nursing professionalism (including role expansion in nursing), quality of care, and evidence based healthcare.

Nursing professionalism.

One effect of lifelong learning on nursing seems to be in the area of nursing professionalism, in that lifelong learning appears to foster professionalism and self-development in the nurse, and informants indicated that it should be adopted wholeheartedly.

Lifelong learning in nursing is part of the dynamics of the profession, and also part of self-development. It helps you to develop your clinical expertise, and also helps you to reflect upon the service and care that you provide, so you can take it further (Dermatology CNS).

Got to embrace this concept, to foster it as a profession, and help and support people in doing that (Community Nurse).

There is an abundance of literature on attitude change in organisations. Mullins (1999 p. 324) for instance argues that attitudes are learned throughout life through our socialisation process, and they can be core attitudes or peripheral ones. While the former is highly resistant to any change, the latter may change with new information or personal experiences. Mullins notes that, while formal organizations may initiate particular attitudes through policies and guidelines, and the general work structure and infrastructure, it seems that this can either embed learning and professionalism or could foster indifference. Although attitudes can become permanent and unchallengeable, peripheral attitudes can change, and managers may have a major influence on this. The process of attitude change depends on analysis of key factors such as why an attitude is held in the first place, what are the benefits of change and to whom, and what are the outcomes if it does not change (Mullins 1999 p. 327). Attitude towards learning seems to belong in the peripheral

attitude category, as generally informants suggested that they can change, albeit with the appropriate advice and support.

Other informants in this study indicated, however, that a change to a more positive attitude towards lifelong learning into nursing must not be rushed. This is because attitude change and learning can take time, and, in addition to the acquisition of skills, knowledge and attitudes, learning is also seen as a medium for generating knowledge, ideas and theories, which in essence boosts the professional standing of nursing.

You're constantly trying to promote yourself as professionals, and this is an important aspect of it. Coz through your own learning you generate a body of knowledge as well. You need to be able to demonstrate that we have explored these different areas, whatever they might be, and have tested them and done work on it, to justify what we do as professionals (Intensive Care Nurse).

The professionalisation of nursing and professionalism as a concept were discussed in some detail in chapter one as a factor that seems to be a determinant of lifelong learning.

Contrary to the above, Hewison (1999 p. 18) reports on a survey that indicated that the infrastructure for lifelong learning needs some attention, as 'lifelong learning is making nurses leave nursing'. The survey found that nurses were under great pressure to continue training 'without the resources to help them do it'. They were doing a stressful job, were themselves stressed, and beside being a nurse, a spouse, and a parent, they were also having to be a student and do coursework and attend classes in their own time. It was suggested that 'All the big stakeholders get what they want out of the system, the nursing royal colleges, the employers, the

trainers in universities - it works for them. But the people coming through the system are carrying the human, social and financial costs, and we have to reduce the burden' (Hewison 1999 p. 18). However, Moloney (1992) argues that, as more nurses are prepared at doctoral level, this will enable improvement in the quality of studies and increase the possibility of further theory development as nursing research reveals new insights about nursing's body of knowledge.

Attitudes towards learning thus may determine the willingness and the level of participation in education. Informants also indicated that lifelong learning keeps the nurse open to learning about developments in areas other than the nurse's own specialism. This is useful in the light of the nursing strategy document *Making a Difference* (DH 1999b), in that if the nurse feels that working in one specialism is not as challenging any longer then she can endeavour to move to another.

Effects of expanding nursing roles

Another way of seeing the benefit of lifelong learning and CPD is that as further knowledge and skills are developed, this also means acquiring further responsibilities through expanded roles. One of the key directives that instigated the marked increase in nurses expanded roles was the UKCC's (1992) *Scope of Professional Practice* document. Eight years later, an investigation on the effects and impact of this document was conducted by the UKCC (2000a). The findings indicated that although more than half of the 10 000 practitioners surveyed felt that it had given them the confidence to develop their roles, there were also concerns, related to, for instance:

- a) a lack of resources as a 'significant barrier' to implementing its principles;
- b) the *Scope of Professional Practice* having created increased workloads rather than practice development and those safeguards for patients are insufficiently robust.

Expanded roles are accompanied by increased accountability, but without necessarily extra reward to go with it (e.g. extra pay or promotion). In relation to role expansion, one informant explained:

They don't want to (do courses), that causes them cognitive dissonance; think about making a change or doing lifelong learning, it upsets their equilibrium, if they embark on further learning, it is going to have an impact on what they are, how they are now? It will bring more accountability, which they do not want (Community Nurse)

Thus, some informants deliberately do not undertake expanded role related learning so as to keep their accountabilities lower, e.g.

I've actually heard people telling me that they have a nice job, accountability needs are minimum, and they are earning a nice wage, they've got plenty of time in their hands, they are competent, they are content in that role, and yes they could do it, but probably means too many changes for them (Community Nurse).

A study conducted by Rushforth and Glasper (1999) indicated that, although there was widespread favour for nursing role expansion, there are also general concerns in that they could be detrimental to holistic care, that 'caring', which is a fundamental nursing activity, could be eroded in favour of more 'techno-medical' activities.

Nursing needs to maintain its unique holistic approach to care delivery as:

I think we're very good at being very caring, but not for being prepared to stand up for what we believe ... I think the whole attitude of Florence Nightingale maid-servant-nurse is well out of the window. With the advent of ENPs, Emergency Nurse Practitioners, and things like that, nurses are gaining a lot of power and responsibility (Accident & Emergency Nurse).

Impact on quality of care

Another benefit of attitudinal change towards learning relates to the quality of healthcare delivery. Current interest in quality assurance in healthcare (DH 1998) is endorsed by, incorporated in and operationalised through the concept of clinical governance.

One informant in this study pointed out that:

Lifelong learning is a positive thing for nurses, because in the long run it should enhance good patient care, by keeping up to date (Community Nurse).

Additionally, to improve patient care, the nurse would need to:

... review (your) practices, re-examine new research and new studies, and possibly identify gaps. With that improvement, comes job satisfaction and patient satisfaction (Community Nurse).

Clinical governance constitutes a complete change in philosophy from the former government's market oriented philosophy to a focus on the enhancement of quality of healthcare in the NHS. Lifelong learning is central to ensuring high standards of healthcare, and clinical governance entails several components, including clinical supervision, CPD, peer review and clinical audits.

The beneficial effects of post-registration nurse education on the quality of patient care were highlighted by Nolan et al (1995), as noted in chapter two. The effects on patients with skin disorders or problems for instance, were commented on by one informant.

The consultants would say we'll try this, that did not respond well, we'll try something else. Whereas if somebody had (done) the ENB course or something, then they would ... have interacted with the consultants, and developed a better service for these patients (Dermatology CNS).

Concern with quality of care provided to patients or clients is not a new phenomenon. One informant indicated that it is explored in case-based multiprofessional meetings held at lunchtime, for instance. Although good quality care is now directed by mechanisms such as clinical governance, it has always been a component of the professionalism of nurses as we have a duty of care to provide 'best practice' (Clarke 1999). For instance, improving or enhancing the quality of care for the dying patient was explained as follows:

Like how can we make things better for people who are dying? We haven't got a hospice in Coventry. So I was wondering, is it possible that we could create like a hospice environment but within the hospital setting? Dying people to have somebody with them ... (Palliative care nurse).

The role of benchmarking and sharing

One mechanism for continual improvement in clinical care is through benchmarking. Ellis (1995 p. 25) reports that this concept was defined by the International Benchmarking Clearing House, as: 'The practice of being humble enough to admit that someone else is better at something and being wise enough to try to learn how to match and even surpass them at it'. It relates to:

Courses that you attend and you can sort of exchange information, and you can change your own practice, ... because there might be different ideas, better ideas, ... it's networking with other people from all over, from other hospitals, to know how they operate, and that sort of makes you think, oh that sounds good, that's the way perhaps we should be doing it, or that the way we are doing it is the correct way (Pain Control Specialist Nurse).

Benchmarking encourages searching for examples of best practice from RN groups engaged in similar specialisms. Whoever achieves best practice shares their methods with others. Numerous advantages of benchmarking over other quality initiatives are identified by Ellis (1995), such as:

- effectiveness is evaluated by outcomes which are measurable and client-focused;
- it is able to prevent the waste of resources; and
- it is able to develop practice - not just monitor and sustain.

However, there seem to be possible problems with benchmarking. For instance, in some areas competition and mistrust can have adverse effects, and the good relationship required for successful implementation of the new practice may suffer. The commitment to improve the service may also suffer. Networking, good relations and trust are essential.

Ellis et al (2000) considered a range of areas for benchmarking within a trust through ensuring that practice is based on the highest level of evidence. Some of these areas are:

- intravenous care
- cannulation and venepuncture
- nutrition
- discharge planning
- visiting
- safely transferring the critically ill patient

An effective example of benchmarking is documented by Ellis et al (2000), who report on collaboration between paediatric units in 27 NHS trusts to share 'best practice'. Implementation of best practice is thereby seen as practitioner-led or user-led, and therefore should have a better chance to succeed than if it is top-down.

Benchmarking implies learning through the continuous search for better methods of delivering nursing or health care. Searching for the highest level of evidence on which to base practice is one of the more recent and important mechanisms in the quest for good quality patient care. This is known as evidence-based health care (EBHC).

Evidence based health care and changing practice

EBHC is another area in which the impact of attitude change towards learning is noticeable. This is because one of the effects of lifelong learning in nursing is that it enables the RN to engage in searching for evidence to support decisions made and actions taken. EBHC requires the RN to have the capability and the motivation to challenge and change current clinical practices where and when appropriate. The concept and theory associated with EBHC was briefly discussed in chapter four as one facet of nurses' perceptions of lifelong learning. The nurse suggesting change in care delivery needs to be armed with strongly supportive information, and this can be obtained through EBHC resources. These resources, e.g. those managed by the Cochrane library, constitute stores of critically reviewed (or critically appraised) research literature on the subject area in question. Current *'practice is much more evidence-based'*; and:

Senior nurses who'd carry out practices because that's the way it's always been done ... Now nurses challenge aspects of practice coz you're encouraged to do that, ... or you prove it (Cardiothoracic Intensive Care Nurse).

In this study, another informant indicated that:

You're striving to get that knowledge and education, and then to a certain degree you're gonna be analysing, and rationalising, and reflecting. If at the end of the day you challenge care, prove and disprove things, you can go and get the latest research findings, utilise them appropriately. Knowledge gives

you a sound basis to back up your argument (Cardiothoracic Intensive Care Nurse).

EBHC is an approach to clinical decision making in which the clinician uses the 'best evidence' available (Gray 1997) on which to base their practice. McInnes et al (1998) discuss grading of evidence, that is the strength of the evidence that supports each clinical guideline.

The evidence should also include intuition and tacit knowledge (when we know more than we can evidence or tell) (Benner 1984). Clarke (1999) notes that randomised controlled trials (RCT) should not be seen as the 'gold standard' for all evidence. Best evidence should be judged as that which helps the patient or client, not just on scientific evidence. Greene (1995) indicates that to think 'monologically' is to overlook the plurality of logics that exist, a feature which is consistent with post-modern thinking. Greene (1995) recommends that:

- a wide range of evidence to good practice is vital and nurses should contribute to this by research and dissemination;
- practitioners should not automatically respond to the next piece of evidence generated, but should balance such evidence with their own experience and judgement; and
- we should be aware of our own prejudice and value systems in relation to evidence, but adopt a critical stance towards evidence gained.

By encouraging all decisions to be based on evidence of their effectiveness, the concept and practice of EBHC is an endeavour to make nursing more scientific:

If you took just one small decision, then break down all those bits in-between from the decision, to the answer. You can break it down so finely, that there's justification there all the time for the decisions that we're making, and we're encouraged to grow and learn, then we've actually got something to base the decisions that we're making on. And I think that addresses accountability. And professionalism, ... and we're more scientific (Respiratory CNS).

Some informants explained that care was delivered in certain ways in the past, but those ways changed in the light of new thinking in the interest of better patient care.

Some informants suggested that change and keeping up to date are mentally stimulating. The changes from two decades ago to now are illustrated by the following example.

Probably 15 or 20 years, when we had myocardial infarction patients on wards, and I was a nursing student, you nursed them in bed for days on end .. they were then allowed into a chair for another few days. I'm surprised they didn't all die of boredom, I don't know about heart attacks. But nowadays they are in and out of bed in a few days (Child Protection Nurse).

It can be argued that, as new evidence and new empirical knowledge emerge, practice in particular areas of care will possibly change again and again, evolving like a spiral into the future. Although lifelong learning as a concept has surfaced with impact only in the last few decades in nursing, there have always been RNs who are continual learners and more motivated to be change agents than others, individuals who can be regarded as continual learners. For instance:

You try running the renal unit in 1970s where patients could wear what they like, behave like they like, and call you Pat. I was trying to get rid of the uniform, get them in trousers and that. It's like square peg in a round hole (Practice Nurse).

Thus EBHC is instituted for improving and innovating nursing practice. Introducing change and innovating are two different concepts, and some staff are naturally inclined to implement new ideas and innovate while others are less so. For instance:

Sometimes some people have bright ideas themselves, it's not gleaned from magazine articles or the books. Nurses are quite good at innovation themselves (Community Nurse).

The effect of new learning is in the quest for or implementation of the learning to clinical practice.

However, it was felt that some staff see it as a natural thing to want to experience stability and see the current mode of practice as more enduring. Nevertheless, one informant explained that managers are aware of staff who are innovators and put them in posts appropriate for them. They can be seen as developmental while others were more static.

There are those that have, like me an ongoing desire to learn, and to be at the forefront of every change that's going on, and there are those that really have to be pushed, and interestingly when I was at the George Eliot, they were looking at writing job descriptions for posts or jobs, of those that were developmental and those were static (NVQ co-ordinator).

For the results of lifelong learning to be effective certain personal characteristics are required. These include willingness to change and adaptability:

... got that enquiring mind, who has that desire for knowledge, who wants to see their practice develop and change and move on (NVQ co-ordinator).

Being able to challenge current practice is also important, which some nurses are more prepared to do than others. Continuing her argument regarding static and developmental posts, the previous informant asserted:

So they identified that there were 2 different types of nurses. And I am sure that, that's always going to be the case ... and therefore there are those who are going to develop, and change practice and change policy (NVQ co-ordinator).

In this context, Rogers and Shoemaker (1971) refer to individuals who are reluctant to change as laggards. The concept of change in nursing is extensively discussed by Wright (1998), who focuses on applying several general strategies and models of change management to changing nursing practice. Increasingly nurses realise that innovation is not always top-down, as practitioners can initiate and implement innovations as well. Earlier, the ENB (1987) had identified three strategies that can be applied either singularly or in combination.

The empirical-rational strategy refers to using empirical information and appealing to rational thinking by the users of the change. The power-coercive strategy denotes the implementation of change by a person who is in a power position to do so; and if the users do not accept the change, then sanctions can be imposed. The normative-educative approach refers to enabling users to see change as normal and evolutionary, and includes the learning that may be necessary for the change to be effective. How these three theories can be utilised in combination is implicitly encapsulated by the following quote.

Innovation was all about management top-down, and now I (as a practitioner) realise, I can be instrumental in implementing innovation into practice. And that's quite exciting, and quite challenging as well (Community Nurse).

In describing herself in that way, one informant saw herself as different as a lifelong learning nurse, in that:

I've always been ahead of my times, but I don't mind, even here I'm very much ahead of the pack. And you know I find that exciting and interesting, and it gives me a lot of opportunities to be innovative (Practice Nurse).

The practice nurse also explained how she endeavours to implement new ideas in her clinical practice by:

... often badgering them, and saying look I have this idea, can we try this, and we'll work it through. We have a very good and very adaptable team, but we're small, so we don't need to go through committees. If we think of something we do it. And if it works, we like it we do it, and if it doesn't, we think of something else (Practice Nurse).

This discussion on the impact of attitude change towards learning indicates that it has direct effect on the quality of healthcare delivered to patient or clients. Another impact is on the role of the nurse as facilitator of learning.

The role of the nurse as facilitator of lifelong learning

Even at the very early stages of data collection, it was becoming increasingly apparent that clinical staff do have either an explicit or silent role in facilitating lifelong learning. It is already established that teaching junior colleagues, patients and others comprise a key component of the RN's professional role (Wright 1990). This is in addition to clinical practice, management of care and research, that make up 'the four pillars' of nursing. The data shows that the teaching component of the role identified in table 7.2 involves enabling the various recipients of learning to take responsibility for the learning they each need.

This part of the chapter examines the role of the nurse from the perspective of becoming or acting as a teacher in the clinical area, which is the result of continuing learning throughout her career. This analysis is based on the study data, which indicated that lifelong learning does not only direct the nurse to be a lifelong learner, but also to facilitate lifelong learning.

Table 7.2: Dimensions of the RN's teaching role.

- > Mentoring pre-registration students and unqualified staff
- > Teaching colleagues and post-registration students
- > Acting as a resource and role model
- > Teaching junior medical staff
- > The concept of multiprofessional education
- > Educating patients, clients and their relatives
- > Promoting health and preventing illness in society

RNs working in the clinical area find that their roles begin to include some degree of teaching quite soon after qualifying as a nurse. Formal preparation for this role has so far generally been undertaken through some pre-registration input, as well as post-registration courses such as:

- *Mentors and Assessors* short courses – 2 to 5 days long;
- The *ENB 998 Teaching and Assessing in Clinical Practice* course – approximately 300 hours long university based course;
- The *City and Guilds 7307 Teaching* course - approximately 2 years part-time course at a college of further education;
- *Community Practice Teacher's* course;
- *Certificate in Education or Bachelor in Education*.

Since 2001, the most useful course appears to be a mentoring course using guidelines published jointly by the DH/ENB (2001). All the above courses seem to be effective, but informal teaching occurs in the context of work-based learning, in that, for instance when a student or a colleague asks a question, then the nurse has to present the answer as systematically as possible within the constraints of the circumstances in which it was asked. This can be followed up more comprehensively at a more appropriate time. Several clinical areas also have resource packs, information videos, and leaflets, and at times a mini library, which the questioner can be directed to at an appropriate stage of their learning. Generally, these should be easily accessible or available to appropriate personnel in the clinical setting so that the learning ethos can be enhanced.

Some informants indicated that attending courses such as the ENB 998 to become a teacher in the clinical area is gratifying for some nurses with many years experience, through utilising and making her teaching more systematic by basing them on teaching and learning theories. The data indicates that the course has significant effect in that the student subsequently adjusts the way she teaches as part of her normal duties, and thereby progressively improves her teaching skills. For instance, one informant explained the effect of ENB 998 on her teaching role in that she has a better understanding of principles of teaching and was now in a position to '*challenge the psychologist who designed the training packages*' that she uses for teaching some aspects of her role,

I look now at say perhaps a teaching plan, of the talks that I have done, I would probably re-write it, and approach it in a completely different way (Child Protection Nurse).

On the other hand, one ex-student from the course asserted that she had to follow up the ENB 998 course with the City and Guilds 7307 teaching course because the latter is a much longer course with a relatively extensive teaching component, albeit with very little on assessment of clinical practice. The value of this course is reflected in the interview data:

... with the 730, I'm needing to learn how to manage a classroom of people, how to respond to questions, and brainstorming groupwork, and how to make lessons interesting (Macmillan Nurse).

Mentoring pre-registration students and qualified colleagues

One of the most significant teaching roles of RNs is towards pre-registration students, and the structural mechanism that enables the more experienced RN to teach newly qualified staff is generally known as preceptorship. The RN takes the

role of a mentor or clinical supervisor [the terms are used interchangeably by Spouse, 1996, for instance] for a particular student for the duration of the latter's clinical placement, as required by the ENB (1987). A mentor is defined by Morton-Cooper and Palmer (2000 p. 189) as:

Someone who provides an enabling relationship that facilitates another's personal growth and development. The relationship is dynamic, reciprocal and can be emotionally intense. Within such a relationship the mentor assists with career development and guides the mentee through the organisational, social and political networks.

One of this study's informants noted that: *'some mentors can generate enthusiasm and interest in the learner, but may be others don't do that'*. The latter perception contrasts with another view that students are perceived as having the characteristics of being lifelong learners: *'they are definitely sort of more critical and analytical'*.

Northcott (2000 p. 30) sees mentorship as 'a longer-term relationship in which the junior colleague seeks or is offered the assistance of a senior colleague'. Daloz (1987) conducted a study of mentoring, and concluded with a diagrammatical presentation (figure 7.1) signifying the value of the mentor role in providing both challenge and support to the mentee. Figure 7.1 shows that high support and high challenge promotes growth and attainment of vision by the student; but low support and low challenge leads to stasis and apathy, and therefore no or little learning occurs. Spouse (1996 p. 35) researched the mentor role and noted that 'with increased competency, the length of time in the dependent stage shortens, but continues to exist'.

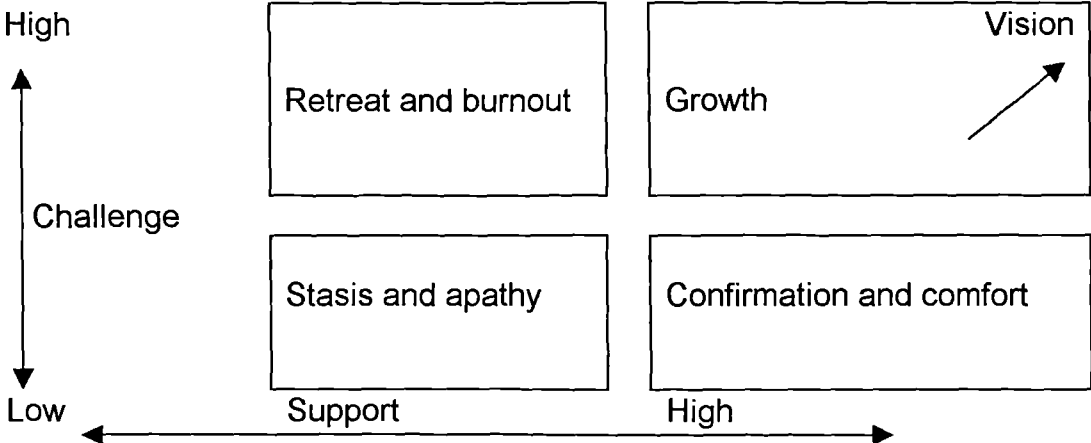


Figure 7.1: The value of the mentorship role (Daloz 1987)

In their study of mentorship, preceptorship and clinical supervision, Morton-Cooper and Palmer (2000) identified various aspects of the mentor role, including its benefits as well as limitations and constraints. This shows that despite this role having been in formal existence for at least a decade, there are possible problem areas that need monitoring and addressing. Studies on mentoring and preceptorship (e.g. Bick 2000, Crawford et al 2000) reveal how appropriate systems could be installed. Kaviani and Stillwell (2000) who studied the effectiveness of a structured preceptorship programme, found that there was a need for formal recognition of the preceptor role in practice, and of the importance of formal preceptor preparation in enhancing teaching and learning opportunities for preceptees. However:

Preceptorship, (is) not in practice at the moment, ... the junior nurses who have just started, a lot of the time they are left to get on with it, which is not very fair on them because it's a heavy unit, it's very busy (Emergency Assessments Nurse).

This statement suggests that there is possibly a range of issues that still need addressing, so that new RNs can adapt to their newly acquired status. Preceptorship is thought to be even more important in clinical areas where patients are more critically ill than in other areas. This is because *(in EAU) ... it's bad enough if you are a senior nurse, but if you are a junior nurse, and you just haven't got a clue (Emergency Assessments Nurse).*

In practice, preceptoring means allowing junior staff to observe one's actions towards patients aimed at meeting health care needs or solve health problems. The

learning can take the form of: *'... you encourage them, guide them, and inform them. When you work together they learn by watching you, and see how you relate to other people, and to patients'.*

The mentor's role encompasses skills teaching, but this may need to be staged as

The student's sort of giving her first injection, you've got to give them certain amount but you don't want to put them off, coz they're already anxious (Emergency Assessments Nurse).

Teaching in the clinical area also involves advising and directing colleagues informally towards appropriate means of easing into academic education, e.g. by doing the study skill module first. Having a teaching role towards colleagues and students may constitute being a role model, as identified by Darling (1984). Additionally if the junior staff or students are motivated to learn in the first place, it encourages the RN to pursue with teaching them despite the acute shortage of time and space.

Teaching junior medical staff and the concept of multiprofessional education

Nurses increasingly have to adopt a teaching role towards medical staff and students in both the clinical area and as lecturers in universities. These are often the function of clinical nurse specialists:

Once a year I go to Warwick University, and talk to SHOs with Nick Spencer. They are a wonderful group of doctors, they're dying to know more, and they get such a tiny little bit in their training. But they want to know more because they know that it's one of those awful things, it happens very rarely to you, but when it does, you don't half wish you knew it all (Child Protection Nurse).

In one instance, the practice nurse also explained her role in enabling an individual to gain admission to a medical school. The latter was initially refused a place on the

course but, by accepting him on placement with her for a year, his chances improved markedly. He subsequently did very well, but, as a sidespin to the placement, she also capitalised on the opportunity of having a teenager supervise design a health promotion leaflet for teenagers. This seems to have hit the necessary 'genre' of the health promotion leaflet as it used the values and language of the particular age group, *'and Paul loved it'*.

The teaching role of specialist nurses at times extends to other health care professionals, such as *'anybody who wants advice, well doctors, physio.....'* as indicated by one practice nurse. Healthcare professionals learning from each other is currently being formalised in the context of interprofessional learning and shared learning (e.g. Sanders 2000) of skill and knowledge. Lloyd (1999) distinguishes between multi and inter-disciplinary practice, indicating that while the former may imply each discipline or profession works for the benefit of the patient, with little or no awareness of other disciplines' work, the latter requires integration or even modification of efforts of the contributing disciplines. A study for the ENB by Miller et al (1999 p. 1) on multi-professional and shared education and practice revealed that there is:

... a lack of congruence between the knowledge needed to function effectively in a multi-professional team and the majority of the current education provision. It was argued that new models of shared learning/education were urgently needed.

Actual examples of movement towards multi-professional education include those cited in the *Times Higher Education Supplement* in August 2000 (Anon 2000a). At St George's and Kingston universities medical students, biomedical science students,

physiotherapists, diagnostic radiographers, therapeutic radiographers and nurses study together for a term on a common foundation programme. The learning includes basic anatomy via problem-based learning. Similar programmes are offered at Leeds, Bradford, and Southampton universities. Another informant pointed out that in some areas, such as midwifery, junior doctors learn alongside midwifery students in the clinical areas.

There seem to be several problems with the concept of multi-professional education at the moment, although there are examples of instances where it works quite well.

Problems include (Miller et al 1999 p. 2):

- > educational disparity at point of entry to courses;
- > appropriateness of content of topic areas because of difference of emphasis and philosophical stance between professions;
- > attitudes of the medical profession seen as inhibiting multi-professional education;
- > differences in period of education as for instance medical courses are of five years duration, while most other health profession programmes are three years long; and
- > numerical dominance by one group can mean that lectures are tailored to meet the needs of the majority group.

MPE is consistent with the notion of shared learning. Based on the interview data, it seems that one of the functions of lifelong learning is to make people want to share knowledge. An example of this is illustrated by the following quote from the data:

It's also the huge variety of people that are on the BSc, the Health Sciences ... we've got paramedics, and physios. So you don't get a totally nursing perspective. There are nurses from all sorts of branches different disciplines, from all over the West Midlands. There are some really good discussions (Community Nurse).

Shared learning was systematically explored by Clifford and Mhaolrunaigh (1995), wherein study informants reported that they saw this as mutually beneficial. In the Department of Health's (1999b p. 28) nursing strategy document *Making a Difference* the government aims for MPE is that ' (it) want(s) to kick-start to more multi-professional learning and teaching and to ensure the systematic sharing and spreading of good practice'.

Teaching patients, clients and their relatives

Teaching patients is a substantial part of the nurse's role, which is also an effect of the RN being a lifelong learner. It entails at least two key concepts in health care provision: empowerment and health promotion. The former is discussed in the context of professionalisation of nursing in chapter one. Health promotion may be practised at three levels, namely primary, secondary and tertiary, as was originally proposed by Caplan in the 1960s, has endured over time and brings the teaching role of the nurse to the forefront (Katz and Peberdy 1997 p. 70). Thus, primary level health promotion entails preventing an illness occurring in the first place. At secondary level, the nurse teaches appropriate health care to the patient subsequent to an illness episode to prevent recurrence. Tertiary health promotion or illness prevention involves teaching that can prevent relapse or exacerbation of a longer-term illness. The various ways in which nurses teach patients involve:

I spend a lot of time, months it will take, you know to educate them, so that they become comfortable with their diagnosis. A lot of them try to deny it and are still looking for a cure, when there isn't a cure, so you have to bring them round only through education, and explaining what the condition is, and how it comes about (Dermatology Nurse).

An illustration of the nurse's health promotion role at primary level is 'well I have developed a leaflet that is printed up for the city now, I did it when I was doing the health promotion course' (Practice Nurse). Additionally the nurse perceives such teaching as enabling patients to become lifelong learners.

I will correct any deficiencies in their knowledge base, which is completely different from other ways of approaching the patient. Because you know I am really there to teach the patient how to cope with what's happening to them and put them through the processes, and discover any gaps, and by golly I do find some gaps' (Practice Nurse).

Teaching patients with the use of illustrations can be very informative for patients, particularly if they have little or no knowledge of anatomy and physiology of the human body:

and the kids will look at that and say ooooooh! That's what I look like inside, and immediately, once they've asked a question. Curiosity drives, the minute somebody says why, how, what, you're in, and then you can open up their minds and teach them' (Practice nurse).

The health promotion role of the practice nurse also includes community-wide health screening for older people, which is consistent with the government's *National Service Framework for Older People* (DH 2001b) quality assurance guidelines. The purpose of this would be to help individuals take responsibility for preventing ill health.

We have older people, we did community development screening with them in the autumn at the health centre, over 75 screening, and we brought in people like the police, with crime, fire brigade, and free smoke detectors. We had people from social services, talk about benefits, ... gave them a cup of tea,

we had the health visitors as well, and Natalie and myself, we did the sort of urine test, blood pressure, pneumonia jab, flu jab, ... and that was very very successful (Practice Nurse).

Effects of lifelong learning on personal life

The data indicated that lifelong learning signifies learning in both components of one's life, personal and professional, and the consequence of learning in one can have positive or negative effects on the other. Informants also raised the point that learning from one's personal life cannot be completely separated from one's professional life. As we have to spend approximately one third of our lives at work (Handy 1984), it is inevitable that personal and professional lives influence each other. One positive effect is that professional lifelong learning provides the individual with the ability and confidence for challenge and change.

Learning in whatever sphere has got to be a positive development, because you can never know too much. And it's only through learning that you can challenge and change ... clinical practice, your lifestyle, and maybe the direction that your life is taking (NVQ co-ordinator).

On the other hand, it was also indicated that learning should not be seen as 'a chore', as some individuals might perceive it to be, but to do with changing attitudes, which then bring personal benefits. However, it is also reported that lifelong learning may be a cause of relationship problems within a household. It appears that as people change through learning, if the partner of the individual isn't also involved in personal or professional development, then perceptions and values may change and can cause widening of interests between the two.

My first husband saw my development if you like as threatening. I think my decision to develop as quickly perhaps as I did, probably ended my first marriage because with learning, when you start to become this inquisitive person, it's not only in your job. You become inquisitive about everything in

life, so many things that before you accepted, you don't accept anymore. And also then you become stronger (Respiratory CNS).

The beneficial effect of lifelong learning by the nurse can manifest itself in other areas as well. For instance, it can have positive effects on the family in that those growing up realise that education is a normal ongoing activity throughout life, that it doesn't end at the end of formal studies and starting work, as without it, even one's job may not be safe. This then also constitutes being a role model for younger ones in the family.

Coz they (one's children) may go and do a job at 20 ... and at 40 if they haven't kept abreast, somebody could be looking to oink them out. So you're setting role models. It's a hard role model (Child Protection Nurse).

Being successful gives more pleasure if it can be shared with close ones, as noted in the final quote in table 7.1. The effects of learning also interface with one's social context. Although learning as a foundation for prosperity is emphasised in the Kennedy Report on participation in FE (Kennedy 1997), Field (1999) adds that the concept should no longer be seen as just 'an accumulation of individual human capital'. Learning must also be considered in the context of 'social capital' in that much learning benefits not just the individual, but the community as well. A great deal of learning is social in nature as when people: '... learn in corridors, over tea, in the car park, as well as through unnoticed patterns of behaviour and interaction in the classroom itself' (Field 1999 p. 12). The non-economic, that is social, benefits of learning also need to be considered.

Tight (1998a), while exploring other aspects of lifelong learning, observes that *The Learning Age* document emphasises the social component in indicating that it is the

individual's responsibility to participate in learning, (and for '.. meeting a significant part of the costs of doing so') because 'The threat of economic and social exclusion hovers over those who do not take on this responsibility'. Tight (1998a p. 262) concludes that '... given the direction of recent educational policies, much of this kind of learning activity may necessarily have to take place outside the established further and higher education institutions'.

The knowledge and competence acquired through lifelong learning, undertaken as a professional activity, can be transferable, as they are skills appertaining to several aspects of living. This is illustrated by the first example of data presented in table 7.1.

It seems that learning from personal life impacts on professional life and vice versa. When skills and knowledge have been 'internalised' (Steinaker and Bell 1979), they become part of the individual's repertoire of expertise. For instance one informant felt that it was almost natural to intervene in a situation in public life if that's the sort of situation she's sensitive to.

For example, there was a lady in the hairdresser's last week. She suffered with MS. And, they had taken her from her wheelchair to wash her hair. And as she was getting back, they didn't put her leg straight, her legs were like this, ... I could just see vaguely that there was something wrong, so I stopped her doing me, and I said excuse me, can I just show you how to stand her up (Palliative care nurse).

Dickinson (2000) views transferable skills as those skills that are acquired during undergraduate courses and which can be utilised on gaining employment. The Dearing Report (NCIHE 1997) refers to these skills as key skills, and also notes that

employers report on a deficit in these. Dickinson (2000) reports on a programme to address this and urges other universities to do so too.

Lauder et al (1999 p. 480) refer to transferability of skills as the 'transfer of knowledge and skills from the campus to the clinical area and from one part of clinical area to another'. The authors note that this ability to transfer knowledge and skills from one area to another can be seen as the ultimate goal of education for lifelong learning, and, in exploring the concept in detail, note that 'transfer is a part of a self-perpetuating cycle of continuous development and reconstruction of meaning and practices' (p. 481). However, they also note that there can be barriers to transfer, which include the lack of time, interruptions to clinical work and lack of support from 'unsympathetic colleagues in circumstances where the skill-mix is inadequate' (p. 485).

Conclusion

This chapter has identified a range of positive and some possible negative effects of lifelong learning on nursing and healthcare. These effects, however, need to be seen in the context of issues discussed in the preceding chapters, which include perceptions that lifelong learning can be viewed as compulsory learning, and reservations about the concept of mandatory CPD.

In exploring the effects of lifelong learning on nursing and nurses, the findings of the study have been summarised under three headings. One very important area is the effect that lifelong learning has on attitudinal change towards learning. This

includes the dynamics of professionalism in that the individual who sees himself or herself as a professional is always open to new learning, and actively engages in seeking new knowledge and competence. This approach impacts on the quality of care delivery in the current quality conscious NHS ethos, and this itself positively influences continuing learning. Attitude change also impacts on evidence-based health care, adaptation to change and engaging in innovation.

A second area comprises the RN's role in teaching and facilitating learning. Back in the early 1980s, Fretwell (1982) discovered that if the ward sister shows leadership in teaching students, then other RNs in the clinical area also engage in teaching; if she doesn't, then others do not engage in it neither. Now teaching is accepted as very much a component of nursing care, as is clinical practice (Wright 1990). The teaching role includes teaching colleagues, students and patients, but has developed more significance, as lifelong learning has become a key feature in nursing. The role becomes stronger, more needed and more prevalent as society in general becomes more aware and conscious of taking care of their own health.

The third area comprises the transferability of skills and knowledge between one's personal and professional life. Thereby, the impact of lifelong learning also has an effect on the individual nurse herself, her colleagues and her family members.

In summary, the findings in this area of the study are:

- 7.1 Lifelong learning impacts on attitude change towards learning in areas of nursing professionalism, quality of care delivery and EBHC.

- 7.2 Most nurses participate in ongoing learning to enhance their knowledge and competence, because this is a key feature of professionalism; however some are less enthusiastic.
- 7.3 Expanded nursing roles are encouraged from various quarters, but mostly from the profession itself and the individual nurse.
- 7.4 Expanding roles lead to increased accountability without extra remuneration, and therefore on both counts some staff try to avoid developing their roles further.
- 7.5 Quality issues find new emphasis at policy level with the introduction of clinical governance and related concepts, which in themselves necessitate continuing learning.
- 7.6 Evidence based health care is consistently becoming established in nursing care, and there is increasing consciousness of this leading to challenging and changing clinical practice.
- 7.7 In addition to the key role of the nurse in teaching students, patients and others, the nurse also tends to act as facilitator of lifelong learning.
- 7.8 On becoming a teacher in the clinical area, the RN realises that this requires self-assessment of her own knowledge and competence, and this leads to further learning.
- 7.9 The teaching role starts soon after qualifying, but develops over a longer period of time.
- 7.10 Professional and personal learning interact with each other in mutually beneficial ways.

The next and final chapter provides a discussion of these themes in the context of the research and policy literature on lifelong learning. It endeavours to synthesise the themes arising from the data, and then addresses the notion of how the study contributes to the body of knowledge on lifelong learning in nursing.

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Chapter Eight

THE FINDINGS OF THE STUDY AND THEIR IMPLICATIONS**Introduction**

This final chapter of the thesis presents an in-depth discussion on the findings of the study, which were critically examined in chapters four to seven, and considers their likely implications. The discussion is directly related to the aims of the study, and the relevant literature, much of which was explored in chapters one and two, and the analytical framework identified in the Introduction of this thesis. The chapter focuses on the extent to which gaps in knowledge (articulated at the end of chapter two) have now been addressed by the findings of the study; reflects on the overall strengths and limitations of the study; and then argues that the findings can be developed and, based on the above-mentioned analytical framework, synthesised into a framework of lifelong learning in nursing. This framework can help contribute to a systematic implementation of the concept within nursing. The penultimate section specifies recommendations for further research, and is followed by the overall study conclusions.

On comparing the ideas examined in chapters one and two with the findings of the study, it is clear that a number of unanticipated perceptions and issues have emerged, which are incorporated in the discussion in the findings chapters along with their implications. As indicated in chapter two, empirical studies on lifelong learning were sparse at the time of literature review and data collection for this study, but relevant literature published since then is incorporated in the discussion.

The gaps in knowledge suggested by the literature review include the absence of

research literature on perceptions of lifelong learning held by RNs, the structures necessary for facilitating this activity, the day-to-day factors that might encourage or discourage learning, and the effects lifelong learning might be having on nursing. These four perspectives were seen as distinct elements of the analytical framework, the implications of which are now discussed.

Nurses' perceptions of lifelong learning

One of the issues arising from the literature review was that there was little documentation or research on how far RNs had accepted lifelong learning and how they perceived it. This relates to aim 1 of this study, and the areas that emerged as significant issues (discussed in chapter four) are: (i) the indication that learning is a natural human activity, but there can be reservations about the concept; (ii) nurses who are lifelong learners tend to have particular personal characteristics; (iii) PREP acts as a trigger or launchpad for professional lifelong learning; (iv) lifelong learning is related to career development and career opportunities; and (v) the newly qualified nurse progresses from learning core or generalist nursing skills to developing specialist ones.

This indicates that many RNs perceive lifelong learning as a natural human activity, in that individuals generally tend to learn continuously from either formal education or daily life experiences. The literature was helpful in corroborating this (e.g. Courtney 1992, Tight 1998a, Sargant 1991), implying that lifelong learning is not a novel activity in nursing, as argued in chapter two, but that its value is now more emphatically recognised and it is recommended for all RNs. Most RNs endorse

lifelong learning's place in nursing as it makes continuing learning beyond the period of professional preparation or initial education acceptable. However, other RNs either do not recognise or accept the concept, or they do not show the inclination to participate in formal lifelong learning. Some RNs have reservations about the concept because of its never-ending connotations.

As noted in chapter two, Jarvis and Gibson (1997) indicate that not all life experiences necessarily present themselves as learning opportunities. Becoming a lifelong learner might have its foundations in childhood, as noted by Courtney (1992) for instance. The implication of this is that the learning that occurs then and in adulthood is likely to be self-directed and continued. Both the literature (e.g. ENB 1994, 1998b), and the data indicate that certain personal characteristics might be present in RNs who are lifelong learners. The informants elaborated in detail on these characteristics, which include the desire to self-improve, and argued why they were significant. Motivation to learn is another of these characteristics, but it seems that the apparent absence of enabling characteristics in some RNs might be due to personality or other personal or social factors.

PREP seems to act as a trigger for lifelong learning, and Knapper and Cropley (2000) observe that after several decades of evolution, lifelong learning must have 'truly arrived'. However, the data revealed mixed impressions of PREP, in that, although a number of informants in this study perceived the concept as plausible, some also expressed concerns about its compulsory and academic overtones. However, it seems that RNs who have reservations about PREP and MCE can be

helped to develop ownership of the idea, as undertaking mandatory professional updating could instigate further educational participation.

It seems that although regular updating of knowledge and competence as and when required is favoured, it is the perceived compulsory nature (Tight 1998a) of study for diplomas and degrees that is resented by some nurses. The issue is complicated by some RNs' view that to reach all RNs, PREP and lifelong learning should have been introduced through a more systematic marketing strategy. This could have taken into consideration which CPD product the individual RN wants, at what price, which personnel will facilitate it, in which place, and how it is promoted, as suggested by the Further Education Unit (1990).

However, RNs can meet PREP requirements either by attending courses identified by their line managers or by self-directed learning (SDL). As noted in Lunyk-Child et al's (2001) study, integral to SDL are the concepts and practices of empowerment of students. Lunyk-Child et al also found that, through SDL, students undergo a transformation that begins with negative feelings (i.e., confusion, frustration, and dissatisfaction) and ends with confidence and skills for lifelong learning. In contrast to this, in a study of the role of SDL in problem-based learning, Mifflin et al (1999) found that because there are different interpretations of SDL, this could jeopardise students' achieving self-direction.

A study by McGowan (1995) indicated that there was no difference in perceptions of lifelong learning between graduates of PBL curricula and traditional curricula.

However, PBL is not universally implemented as yet, but with the increasing need for and availability of open and flexible learning, SDL is likely to flourish.

In a Department for Education and Employment funded study of participation in education by adults aged 17 and over, Sargant et al (1997) interviewed 4673 individuals in the UK. The findings revealed that the government's aims for much wider participation in education had only partly been achieved. As to participation in education by RNs, nursing as a mass activity in higher education was still a relatively novel notion in many UK universities in the 1990s. This could be why some nurses were reluctant to participate in higher education based CPD. However, the issue of locating nurse education within higher education can also be viewed from another standpoint in that, in the USA, nurse education has been a part of higher education for several years. This is likely to be the reason why many theories and models of nursing emanate from there (Fgelland and Gjengedal 1994).

The discussion in chapter four also suggested that lifelong learning in nursing is related to career development and progression. Thus learning can be instigated by interest in seizing career opportunities when they present themselves, a certain degree of ambitiousness, and actions taken to realise one's potential. Nursing now has a fairly robust career pathway with a range of opportunities, including the more recent introduction of consultant nurse posts. Individuals have the freedom to progress as far as they choose to go, and need not aim for higher positions if they do not wish to do so because they are content with their current career attainments.

Another perception of lifelong learning is related to the professional experiences of the newly qualified nurse, in that it seems that the restructured pre-registration programme Project 2000, and latterly post-registration courses, aimed to lay the foundation for nurses to become lifelong learners (UKCC 1986, ENB 1994). As noted in several studies past and recent (e.g. Kramer 1974, Bick 2000), the newly qualified nurse experiences a steep learning curve on starting employment as a RN. After several years of developing nursing competence and expertise, RNs can attain the position of clinical nurse specialists. The role includes being a role model, and therefore the CNS has to continuously update and further develop her professional knowledge and competence.

The discussion indicates that RNs tend to perceive lifelong learning largely as a positive notion or activity, as long as they have the appropriate personal characteristics and are relatively clear about their career goals. There are still areas that could benefit from further research, for example, why some RNs resist formal professional learning, and which avenues should be pursued to enable them to engage in this.

As some informants indicated that PREP was not marketed very well, this is another possible area that could be studied either from the point of view of management of change or of marketing novel concepts in healthcare professions. It was also noted in chapter four that nurses who do not specialise to the level of becoming a clinical nurse specialist might find it easier to change specialisms. This may not be completely true, as many of the skills in the CNS's repertoire should be transferable.

How far do CNSs feel either trapped or more fulfilled and satisfied in their specialisms? What proportion of clinical nurse specialists' transferable knowledge and competence in the four components of nursing (Wright 1990) - teaching, organising care, research and clinical practice - are transferable if she wishes to change specialism? These could constitute further areas for empirical investigation.

Structures and processes that facilitate lifelong learning

The literature review revealed little documentation on structures or mechanisms necessary for the realisation of lifelong learning in nursing, but the findings of this study identified them as a key factor in the facilitation of lifelong learning. The themes that emerged from the analysis of the data are: (i) funding for lifelong learning and CPD; (ii) time and release from duty for CPD; (iii) work-based learning and in-service training; (iv) changes in nurse education; (v) professional regulation and mandatory continuing education; and (vi) clinical supervision, reflective practice and peer review.

The ENB (1994) suggested a number of organisational requirements for the achievement of lifelong learning in nursing, and research (e.g. by McGivney 1990, Sargant et al 1997) on other sectors of education has shown where the likely deficits (and strengths) are. One of the avenues for addressing such deficits is advocated by Mullins (1999), who suggests that management strongly influences the availability of such structures and facilities. Managers' roles include apportioning funding and release from duties for CPD. However, this study revealed that although there are structures in place e.g. block contract, WDCs, etc to facilitate CPD, some

RNs felt that these facilities were either inadequate, or that when they were available, they were inequitably allocated. It seems, therefore, that some of the perceptions of those who manage funding for CPD and those of nurses may be quite wide apart.

In particular, it seems that increasingly RNs have to fund their own CPD and are not released from duty to do so. The implication of this is that it may affect participation in CPD. This issue was also highlighted by Gould (2000 p. 27) in relation to widening participation in higher education courses. Whether RNs should fund their CPD themselves is also an issue, because there are varying extents to which CPD courses are of benefit to the individual RN as well as to patient care. In a study by Dowswell et al (1998, p. 1326) that explored RNs' motives for participation in CPD, it emerged that '... dependence on willingness and ability to pay for post-registration degree-level studies is unlikely to be an efficient or equitable means of ensuring lifelong learning for healthcare staff'.

Release from work to attend CPD events has become increasingly difficult, and consequently more staff have to attend in their own time, many of them reluctantly. Several informants argued that formal CPD, even if it is merely to meet PREP requirements, should be achieved in work time. Schuller (2000 p. 230) reports on a study in which informants referred to time taken for education as 'time stolen from the family', and that nurses are not necessarily regarded with any more esteem for gaining further qualifications. The DH (2001c) publication *Working Together – Learning Together* makes a strong case for extending knowledge and skills but only

to remain up to date, and for re-registration or re-validation of one's professional qualification. It does not discuss the issue of release from duty for doing so.

It is argued that even though formal structures are instituted to enable RNs to attend CPD courses, the spontaneous reaction of managers to requests for CPD tend to be moderated by their concern for staff replacement in the clinical area while the RN is away on the course. Although this reaction is founded on having to ensure that staffing levels in the clinical area are adequate for effective healthcare delivery, it is also influenced by continuing problems with recruitment and retention of RNs in the 1990s and 2000s.

The nature and mechanics of CPD and CPE were analysed in chapter five, where various perspectives, such as those by Madden and Mitchell (1993), Cervero (1988, 1985), Waddell (1991) and Nolan et al (1995) were delineated. Because the aim of CPD is to improve patient care and funds are specifically allocated for this purpose, it seems logical that the quality and effectiveness of CPD needs to be monitored. At the national level, the DH (2001c p.41) notes that CPD is quality assured in various ways, including regulatory bodies' requirements for re-registration and re-validation.

However, in a study of knowledge and skill development in a range of occupations, Eraut et al (1998) found that formal education and training provide only a small part of what is learnt and used at work, and that substantial learning occurs informally while working in the clinical area. Current literature tends to refer to this as work-based learning (WBL). Further insight is provided by Spouse (2001), who, in a study

of WBL in healthcare settings, found that WBL requires substantial investment in staff at all levels as well as changes to staffing structures in trusts. These arrangements should be designed to free people up so that they can work and learn collaboratively. The data in this study indicated that WBL is recognised and valued by healthcare staff, but Guile and Young's (1996) caution that such learning could be confined to behaviourist approaches, or 'know how' levels, should be noted.

Clinically based learning mechanisms include the availability of a resource room in the clinical area, which could stock various professional reading materials. In a survey of 1406 RNs, Armstrong and Gessner (1991) found that RNs do read clinical journals, books, newsletters, etc, fairly regularly. Additionally, in-service training remains a key provider of non-academic CPD programmes. Although there is a fair range of courses on offer, some of them may be seen as repetitive by some RNs. The implication seems to be that courses should be more learning needs oriented, as noted by several writers including Ausubel et al (1980).

Another aspect that emerged is increasing accessibility of academic education through wider availability and through newer education methods. Recent changes in nurse education include an increase in ODL or flexible learning programmes that lead to wider participation in CPD, and this seems set to increase further. There is increasing access to study skills type courses, and recent developments include accessibility through e-learning (e.g. Jairath and Stair 2002).

Mandatory continuing education is also seen as a structure that would facilitate lifelong learning, and it is linked to professional regulation and modernisation of accountability. For nursing, professional regulation is the responsibility of the Nursing and Midwifery Council, and the Department of Health's (1999b p. 28) strategy for nursing sees modernisation of professional regulation as one of its aims so as 'to anchor lifelong learning more securely in the complex and rapidly changing needs of patients, and to open up career pathways suited to the needs and values of individuals'. Individual Performance Reviews (IPR) and special interest groups are key factors in instigating and supporting learning to achieve career goals, but, although valued by RNs, the provision of IPR remains patchy.

The notion that PREP constitutes mandatory or compulsory CPD seems to reflect Hewison's (1999) suggestion that lifelong learning may be making nurses leave nursing. A number of RNs have never had experience of studying in a university setting, and are apprehensive and even resentful of having to do so. Hewison questioned whether RNs whose nurse education so far has not been in the higher education setting have to become academic nurses. Impressions emerging from this study indicate that they shouldn't have to. They should be presented with the choice of academic education, but with the assurance that they will not be denigrated or undervalued if they don't participate.

One weakness with studying to meet the minimum PREP requirements is that it may not necessarily be sufficient for the RN to fulfil her job requirements effectively, because it does not serve any 'guarantee that assures a resulting change in nursing

practice' (Hewlett and Eichelberger 1996 p. 177). The government's modernisation agenda (e.g. DH 2000) is seeking to address this.

The finding that some RNs undertake academic studies merely to meet PREP requirements, and therefore to be able to keep their jobs and an income, relates to the notion of mandatory continuing education (MCE). Various commentators in the UK and abroad (e.g. Carpenito 1991, Hewlett and Eichelberger 1996) have questioned the value and principles of this concept. Hewlett and Eichelberger (1996) argue that MCE does not work, and indicate that although MCE for relicensure began in the United States in the 1970s, it remains a controversial issue. They also report on a survey that showed that although 'the primary reason given for MCE was to protect the public, no data was however available to support the premise' (p. 176). As a result of this and other significant problems with MCE, state nursing leaders in the USA now support a voluntary continuing education system. Thus, there seems to be a tension between the underlying philosophies of lifelong learning and the concept MCE.

It seems that clinical supervision, reflective practice and peer review are also important facilitators of lifelong learning. This study suggests that while there are endeavours to implement clinical supervision and reflective practice in all nursing specialisms, their availability is erratic. Yet, where they are available, they do support learning. Informants indicated that they value clinical supervision although, on evaluating its implementation, Wolsey and Leach (1997 p. 24) noted that this mechanism has not yet demonstrated its efficacy in improving patient outcomes.

Conversely, in an audit of clinical supervision conducted in the same year, Webb (1997) reported that the benefits of clinical supervision as perceived by respondents included the development of their reflective practice skills along with maintaining and improving standards of care.

Bishop's (1998 p. 50) study revealed that 'lack of resources, training and competing priorities have hampered progress' with the implementation of clinical supervision. The implication of this is that, to reap the benefits of such systems, continuing auditing needs to be performed to identify weak links and take remedial and developmental actions. It also seems that the practice of peer review is expanding at individual, specialism and trust levels, and this could also facilitate learning.

Again, there are still areas that could benefit from further research. Since both the literature and the study data indicate that MCE as a structural mechanism can be ineffective, and may lead to 'surface' rather than 'deep' learning, there is a need to explore how resistant RNs can be eased into participation into higher education based CPD. The development and impact of peer review in nursing could also be empirically tested, as they appear to be increasingly relevant for CPD in nursing.

Day-to-day factors that instigate or obstruct lifelong learning

The study also sought to look beyond the formal mechanisms that facilitate learning and to explore other factors that were perceived by RNs as necessary for learning to occur. The themes that emerged from the analysis of the data in relation to such day-to-day factors are that: (i) nursing might be seen as either just a job or as a

career; (ii) lifelong learning provides a basis for rectifying missed education opportunities earlier in one's life or career; (iii) it is related to clinical developments and new thinking; (iv) the clinical setting being an effective learning environment; and (v) social and governmental factors can influence learning.

One of the findings of this study is that some RNs see nursing as just an income-providing occupation for the 'trained' individual, while many others see it as a career. This is an issue as for some nurses, particularly those with very young families, it appears that nursing is merely a job with other aspects of their lives having equal or higher priority. Dowswell et al (1998) interviewed twenty-nine nurses, midwives and allied professionals on a part-time health degree course with regards to their motives for and effects of participation in post-registration courses. Their study revealed that participation in CPD by nurses is encouraged by both professional and personal factors. It is also associated with (largely negative) changes in home and family life and with additional financial burdens.

The literature (e.g. Field 1999, NAGCELL, 1999, DfEE 1998) indicates that, in the light of ongoing developments, all employees need to continually acquire new skills or update existing ones. For many RNs, professional updating is primarily employer-driven, which is consistent with Handy's (1984) suggestion and Investors in People UK's (1994) principles that employers need to see employees as assets and invest in them. However, Tight (1997) found that increasingly, the responsibility for this is placed on the employee. This issue relates to how much CPD, and in which specific areas, the RN should engage in, which may have implications for the extent of the

role of Workforce Development Confederations in facilitating CPD. The notion of the skills escalator (DH 2001c) forms part of the vision and strategy for a framework for lifelong learning in the NHS, encouraging career development from being an unqualified individual to gaining professional qualifications.

This research highlighted another area related to academic education, which is that learning might also be undertaken to redress missed education opportunities earlier in life. The individual can engage in formal learning at a convenient stage during their lifetime, although when this is resumed, it might initially need to be facilitated by study skills type courses. This study also revealed that resuming learning could eventually lead to degree level studies. It seems, therefore, that the concept of lifelong learning is a suitable remedy for insufficient early academic or professional education. Informants indicated that education deficits could have been because of the absence of an education-oriented culture in their household, or disruptions caused by other factors such as family demands. In a study that aimed to identify factors that influenced qualified nurses pursuing lifelong learning, Wagner (1989) deduced that lifelong learning is a value that is developed very early in life through supportive family environments. The findings in this study indicate that RNs who are motivated to subsequently rectify education deficits seem to fare well academically and in their careers.

Ongoing clinical developments and new thinking also emerged as more routine day-to-day factors that tend to encourage and guide the individual towards continuing learning. This is noted by the Department of Health (1999b) but as a basis for

learning these developments could also be seen as related to the notion of the clinical area being a learning organisation. This requires that the local organisational culture, management attitudes and other factors do not deter learning. Teams of RNs in the clinical area consist of a mixture of individuals who range from those who are highly motivated to learn and innovate, to those who are much less enthusiastic. The balance between the two groups varies, depending on the local culture and probably specialism.

Clinical teams may decide that learning in the clinical setting can also be an interdisciplinary activity, which is consistent with the government's multiprofessional education agenda (e.g. CVCP 2000, Anon 2000a). For this to happen, an appropriate organisational culture is vital, and it needs to be supported by effective professional leadership provided by clinical managers in healthcare settings. Crucially, the study showed that learning could also be facilitated by creating positive attitudes towards it amongst clinical colleagues in the work setting.

The DH (2001c) supports this outlook in its strategy for lifelong learning, and links it directly to improvements and enhancement of patient care. The literature, however (e.g. McGivney 1990), notes that individual differences and dispositional factors must also be recognised, as they may affect the consistency with which appropriate learning outlooks are held.

Another area that seems to affect continuing learning is the apparent negative social and governmental attitudes towards nursing, which in turn can act as demotivators

for learning. This study found that within healthcare, nursing colleagues and friends, doctors, spouses or partners, family and parents, and tutors could act as instigators and supportive mechanisms for learning, or as inhibitors. The notion that learning and encouragement for learning are spurred on by social networks, and family support, is consistent with human and social capital theory (Putnam 1996). It seems that this is a developmental resource that employers do not provide and yet benefit from. The study by Wagner (1989) also revealed that one's socialisation has a major role to play in participation in lifelong learning.

Areas that could benefit from further research include the linkage between nurses' undertaking degree courses and patient care benefits. On exploring the impact of CPD on patient outcomes, Jordan (2000 p. 461) noted that despite the 'unparalleled expansion of CPE and CPD programmes' over the last two decades, there is still 'little empirical evidence that these enhance the care delivered to patients'. She reports that only 12 out of 2000 papers on CPE for healthcare professionals evaluated their impact on professional practice. One of the conclusions therefore was that nurse educators must also endeavour to demonstrate the clinical effectiveness of the CPE they deliver in higher education.

Effects of lifelong learning on nurses and nursing

The study also sought to ascertain the direct effects or impact of lifelong learning within nursing, as although there is little doubt that lifelong learning should be advantageous for nursing, no empirical evidence could be found for this. The findings indicated that the effects of lifelong learning on nursing and nurses covered

three key areas. These are (i) the impact of attitudinal change to learning which includes the context of professionalism, quality of care provided, evidence based healthcare and changing practice; (ii) the role of RNs as facilitator of lifelong learning; and (iii) the effects of professional and personal learning on each other. These themes build on the findings in chapter four where it was noted that some sections of RNs see themselves as unacademic and therefore an attitude change may be required. Then in chapter six it was noted that management and social attitudes towards nursing and nurses might themselves discourage uptake of CPE. These notions link back to a mixture of perceptions about pre-registration courses and about nurse education in university settings, to personality factors, clinical areas as learning organisations, and also social perceptions of the nursing profession.

The impact of attitudinal change to learning

One of the effects of lifelong learning on nursing is the development of a more positive attitude towards learning. The Department of Health (2001c p. iii) indicates that the benefits of lifelong learning are that it should equip staff with the skills and knowledge to work flexibly in support of patients, and enable individuals to grow, develop and realise their potentials. This expectation is supported by the findings of Dowswell et al's (1998) study that participation in post-registration courses is encouraged by either future-oriented motives, and having a positive attitude and optimism about the benefits of the course; or they were founded on individuals' past- or present-oriented motives that were based on gaps in their previous education. However, Dowswell et al (1998) also found that this had problematic effects on the RN's work life and her personal life. The problem areas at work were mostly related

to suitable work arrangements to be able to attend lectures. The difficulty at home was related to lack of time that led to 'strain and tension in relationships' (p. 1331). However, as noted above, the DH (2001c) views the notion much more positively, which is confirmed by the data in this study indicating that lifelong learning was likely to have positive effects in areas such as the professionalism of the RN, and in the quality of care delivered to patients.

Professionalism is therefore a key feature that leads nurses to participate in ongoing learning to enhance their knowledge and competence, and which in turn is reinforced by continuing learning. This can imply that to ensure lifelong learning amongst nurses, they need to be seen and respected as professionals of equal status to any other. Quality of care also finds new emphasis at policy level with the introduction of clinical governance and related concepts, which themselves induce continuing learning.

Evidence based healthcare is consistently becoming established in nursing care, and there is increasing consciousness of this leading to challenging and changing clinical practice. There are now various Internet websites containing resources on various aspects of nursing that have been critically appraised and meta-analysed for benchmarking purposes. Although most RNs seem content to link learning with EBHC and quality of care, they are less keen on expanded roles as these increase their accountability with no obvious immediate recognition or reward. Expanded nursing roles are encouraged from various quarters, but they are mostly instigated by either line managers, doctors or by individual RNs themselves. For these

reasons, some RNs try to avoid developing their roles further. This notion is consistent with the findings of a study of factors that encourage RNs or deter them from returning to practice (Randhawa and Durand 1999 p. 10), which revealed that nursing roles had changed with 'greater level of responsibility resulting in more accountability'. But, as Schuller (2000) found, accountability for a greater range of nursing activities along with additional responsibilities are not accompanied by extra remuneration.

Since expanded roles are an essential component of current day healthcare delivery, it seems appropriate that recognition would be required to encourage RNs to embrace the extra accountability that these roles bring. Both increasing expanded roles and professionalism foster and result in enhanced autonomy in one's clinical practice. The data indicated that practitioners see professional autonomy as a feature of professionalism, although at the more micro level, several RNs feel that local managers tend to block autonomy. This is despite Wagner's (1989) indication that professional role expectation constitutes a major learning stimulus, and that RNs experience a sense of empowerment as a result of their learning activities, which enhances self-actualisation and contributes to an enabling and liberating process. Wagner (1989) also concluded that the major outcome of lifelong learning for the professional nurse is an expanded personal and professional knowledge and understanding of self that provides a source of empowerment, and this is strengthened in their professional education programme.

Furthermore, a King's Fund Centre (Meadows et al 2000) survey on nurse satisfaction found that professional autonomy in the workplace is one of the key determinants of job satisfaction. This is confirmed by the data from this study for instance, that '*RNs need to be happy in the environment where they work*'. Otherwise alienation and discontentment may develop which in turn can weaken interest in continuing professional learning.

The role of the nurse as facilitator of learning

Another effect of lifelong learning concerns the RN having to fulfil a teaching role towards a wide group of professional and lay people, ranging from pre-registration students to patients' relatives. As was discussed in chapter seven, the teaching role starts soon after qualifying, but develops over a longer period of time, and could culminate into becoming a facilitator of lifelong learning. Guidelines indicate that if the RN wishes to extend her teaching role she could progress to become a practice educator, as delineated by DH/ENB (2001), or a university nurse lecturer.

The role may comprise being a mentor (or preceptor), whereupon direct teaching occurs when engaged in care delivery, indirect teaching through supervision, or through directing individuals to relevant learning resources. The RN also has a role towards herself, in that becoming a teacher requires her to engage in self-assessment of knowledge and competence regularly, and this leads to further learning. The RN also has a work-based role in helping various parties by providing a medium for learning. Research in this area tends to be in the context of clinical

areas as learning environments (e.g. Fretwell 1982), and of official guidelines such as that issued by the ENB (1997).

I could not find any empirical study directly addressing the range of personnel the nurse teaches, but the recent RCN general secretary Christine Hancock estimated that a third of the ward sister's time is spent training and supporting junior doctors (Anon 2000b). Formal professional preparation is necessary for the teaching role, such as through the mentor preparation course guided by the DH/ENB (2001). Generally nurse managers expect RNs to possess this qualification, both for mentoring subordinates, and for seeking promotion.

Interaction between professional and personal learning

Learning from normal day-to-day life experiences can be applied to professional life, and vice versa. Professional and personal learning interact with each other in mutually beneficial ways. This notion could be related to the context of transferable skills, as discussed by Dickinson (2000). It is also related to human and social capital theory, in that the application of much learning is instigated and supported through social interactions (Wagner 1989, Schuller and Field 1998, Kwong et al 1997).

Strengths and limitations of the study and data analysis processes

Because this study focused on exploration of perceptions of a concept, eliciting qualitative data was deemed appropriate. However, one limitation of qualitative studies is that they tend to be conducted with smaller samples than quantitative

studies, and consequently their findings are less generalisable. It is conceivable that the themes derived from the interview data could have been somewhat different if RNs from other parts of the country had been interviewed, or if the informants were other grades of RNs, or if a much larger sample was used. If RNs from other countries were interviewed, taking a much broader and more international perspective of the notion of lifelong learning in nursing, then again different or extra themes could have emerged.

Suggestions and guidelines in the current literature informed the analysis and interpretation of the data. Tight (1998b) for instance, notes that, although it is generally inappropriate to generalise from qualitative data, the findings can nevertheless be suggestive of trends and patterns. Dey (1993 p. 262) notes that:

Qualitative analysis often provides a better basis for inferring generalisations than for applying them ... but it provides an opportunity to do a thorough analysis, and thereby a solid basis for inference. ... but not for applying these inferences to a wider population.

In discussing the generalisability of qualitative data interpretations, Dey asserts that, based on the likelihood that the cases may be insufficient in number, or selected on non-random basis, generalisability is likely to be low. Therefore, it is argued that it is necessary to identify the conditions under which generalisations may hold true. Dey (1993 p. 263) notes that for generalisation beyond the data, 'qualitative analysis is more likely to be suggestive than conclusive. On the other hand, in so far as our inferences are well grounded in our analysis of the data, at least we can be more confident that our suggestions are worth pursuing'.

According to Crowe (1998 p. 340), the two fundamental assumptions for qualitative approaches to research are that:

- i) qualified observers can with objectivity, clarity and precision report on their own observations of the social world, including the experiences of the others; and
- ii) a belief in a real subject, or real individual who is present in the world and able in some form, to report on his or her experiences.

Based on my own experience in nursing and of this research, it is apparent that there are various 'truths', which challenges the assumptions that reality can be captured. Consequently, reflexive methods were frequently used during interviews to enable mutual and comprehensive linguistic rapport with informants. Misunderstanding could have occurred in instances when informants used metaphors to verbalise their perceptions of lifelong learning, and of concepts such as professionalism, expanded roles and reflective practice. The significance of metaphors is that they 'reveal the fundamental values and assumptions underpinning' the culture of a given society (Froggatt 1998 p. 333). They are seen as a 'creative force, which reflects and creates reality'. I had to try and ensure that I thoroughly understood the perspective being portrayed by individual interviewees.

Both Crowe (1998) and Barr (1999) observe that the analysis and interpretation of qualitative nursing research data needs to be seen in the context of current socio-political, economic, scientific and historical issues and events. Barr (1999 p. 11) notes that research reports should also 'pay attention to the social structures and processes under which knowledge is produced and legitimated'. This is because

they represent 'a personal journey' within the context of 'changing social and cultural conditions', and (p. 18) 'ideas, beliefs and research practices are shaped and formed within their specific cultural and historical' as well as political contexts.

Barr's (1999) view is supported in this study, as the exploration of several aspects of nursing, such as professionalisation and reflective practice are seen as the current cultural values and political media within which nursing care is delivered. Consideration of these contexts is important, as the same data could be interpreted differently at a different time in history. I've endeavoured to take the contexts affecting healthcare in UK into consideration.

Barr (1999 p. 139) notes that an approach that is appropriate for analysing research data could be that in which the researcher is 'located on the same critical plane' as the subjects being researched. This approach applies to this study, because as a nurse with several years of unbroken service and as an academic who values being a RN and an academic equally, I feel I have been able to remain on the same 'critical plane' as the clinicians who provided the data.

Proposed actions for the enhancement of lifelong learning in nursing

The current state of knowledge on how to promote, facilitate, support and enhance lifelong learning in nursing has been examined in this thesis in relation to perceptions, structures, day-to-day factors and effects. These features constitute the four elements of the analytical framework identified in the Introduction of this thesis, and the study shows that they constitute a relatively wide range of key components

of lifelong learning in nursing, which can help to fill some of the gaps in knowledge identified in the literature review.

A conceptual framework for lifelong learning in nursing

Knapper and Cropley (2000 p. 190) argue that at this point in time 'a model for implementing lifelong learning' is lacking. Earlier on, when Courtney (1992 p. 154) searched for a comprehensive theory or model of Participation in Adult Education (PAE) that would offer a framework for lifelong learning, he found that the existing ones did not address the concept adequately. He proposed that a more appropriate theory would have to:

- do more than deal with reasons for learning as an activity associated with life-cycle or motivational factors;
- take account of sociological factors;
- recognise learning as a discretionary activity singled out in competition with other activities; and
- place adult education in the context of capitalist economy.

Courtney (1992 p. 154) studied the Smith-Cookson model of PAE, Houle's typology of motivational factors for PAE, Boshier's Educational Participation Scale and other relevant instruments, and concluded that a broader framework should be instituted with the concept of 'change' as the predominant element. This suggestion was based on the finding that most cognitivist definitions of learning consider change in human disposition as a key factor in learning. Courtney (1992 p. 155) added that

adult education ‘.. thrives in a world which knows only change’, and which therefore militates the need for sound structures.

Such structures and a number of key components of lifelong learning in nursing have been discussed so far in the context of the aims of the study, from which a conceptual framework can be developed. Morse et al (1996 p. 267) refer to this activity as ‘conceptual mapping’. As indicated in the Introduction of this thesis, an analytical framework was drawn from the literature review, but in the context of the themes emerging from data analysis, a modified and more detailed framework for lifelong learning is suggested (figure 8.1). This framework represents a synthesis of these themes and findings and their implications, as well as of the knowledge that arises out of the literature. It provides a form of ‘scaffolding’ (or skeleton) for systematically facilitating RNs becoming and remaining lifelong learners. These components are identified under organisational, socio-political, and individual or personal factors and it is suggested that they are areas that need to be addressed for effective implementation.

Lindberg et al (1998 p. 62) describe a conceptual framework or model as ‘a structure comprising concepts that are associated so that they form a whole, for example a developmental model with concepts of infant, child and adult’. They suggest that a concept is:

... a mental image or classification of things and events in terms of similarities. In nursing, person, health, environment, and nursing itself are concepts of primary interest to theory and practice. Scientific concepts are building blocks of theory and refer to the abstract notions that are related within a theory (Lindberg et al 1998 p. 62).

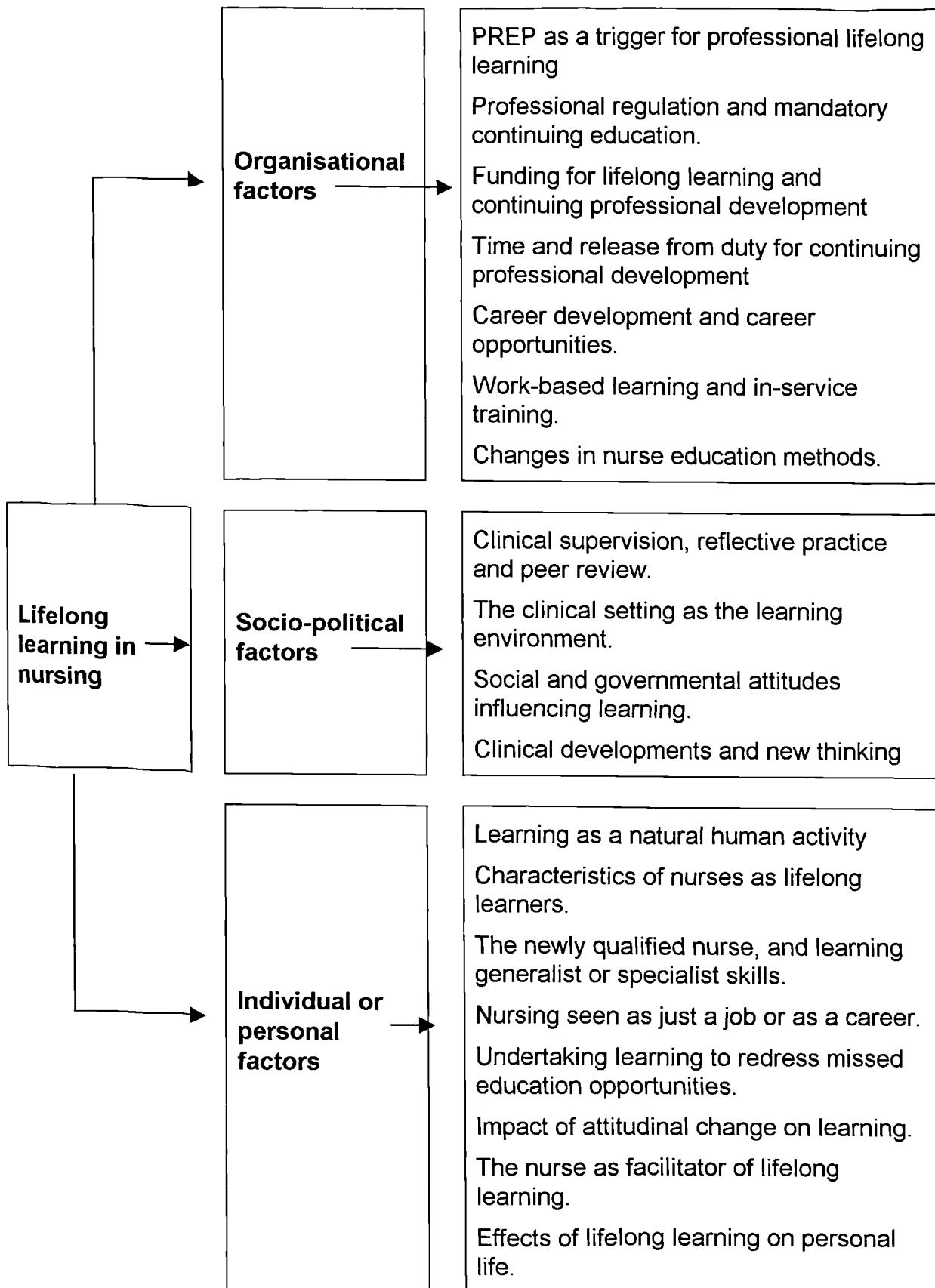


Figure 8.1: A model of lifelong learning for nurses

Using the terms framework and model interchangeably, Glaser and Strauss (1967 p. 237) note that there are four requirements of a model, which are that:

- 1 It is closely related and applied to the daily realities of the area in which it is to be used.
- 2 It is understandable to the people using it.
- 3 It is general enough to cover the ever-changing practice situations, yet concrete enough to be relevant to and account for everyday situations.
- 4 It enables the user of the theory (practitioner) to have enough control over everyday situation to make its application productive.

It would appear that the framework of lifelong learning presented in figure 8.1 can fulfil these requirements. This is illustrated by the following two examples. Firstly, the Human Resources (HR) Department in NHS or Primary Care trusts could heed and implement many of the components detailed under the three groups in the following way. 'Organisational factors' can be addressed by the HR Department by, for instance, putting on effective courses through their in-service training provisions to enable RNs to meet PREP requirements; through identifying adequate CPD funds and staffing for staff release to attend CPD courses; providing career guidance; recognising the value of WBL; and utilising e-learning and flexible learning courses on offer by HEIs.

These possibilities are supported at national level through Department of Health guidelines and policies. For instance, in *HR and the NHS Plan* (DH 2002b), the Department of Health identifies Workforce Development Confederations as the key bodies for workforce planning and for implementing the lifelong learning framework,

and anticipates that the NHS would become a model environment for learning and personal development. Other key bodies that would support lifelong learning include (DH 2002b, 2001c):

- The Department of Health itself (through policies, guidelines and funding)
- NHS University
- NHS Employers
- Trade Unions and Professional Organisations
- Strategic Health Authorities
- Regulatory and professional bodies, and
- Education providers and HEIs.

The DH (2002b p. 29) adds that 'staff will see their employer's commitment to investing in them and through systematic appraisal and personal development plans, they will know what is possible for them'. The DH's lifelong learning framework includes providing leadership, and establishing organisational infrastructures such as e-learning.

To implement the lifelong learning framework, including the 'skills escalator' concept (DH 2001c), it seems that a co-ordinated partnership approach is essential. To apply the model of lifelong learning for nursing suggested as figure 8.1, it seems that it is the above-mentioned key bodies that could address 'organisational factors' through 'NHS Employers' at the point of delivery.

The study indicates that the trust's HR Department could address socio-political factors by:

- supporting staff to adopt and adapt to novel clinical developments and new thinking;
- provision of clinical supervision, and facilities for reflective practice, and peer review;
- developing the whole trust as a learning organisation, and.
- realising that patient care would ultimately benefit from this activity.

Furthermore, *Working Together, Learning Together* (DH 2001c p ix) addresses socio-political factors to the extent that it recognises 'multiple knowledge and learning sources, partnerships, and inter-professional learning', and building creative learning organisations. This argument is also consistent with Tight's (1998b p. 262) suggestion of a redefinition of human resource development with 'greater inclusion of informal and incidental learning strategies' outside the established further and higher education institutions' by personnel responsible for this role.

Socio-political factors also fall in the arena of human and social capital, which was discussed in chapter six, and in one study of social capital and levels of participation, Field and Schuller (1995) found that social capital has marked levels of influence on stimulating participation in both non-formal and informal learning. Both Coleman (1994) and Baron et al (2000) suggest that HSC should be endorsed and the notion cultivated especially because high levels of social capital seem to be germinating already within networks of friends or colleagues.

Instances of how the HR Department can heed 'individual or personal factors' identified in the framework ensuing from the study include: explicitly valuing their

self-motivation and other qualities in the RN that makes them amenable to learning; and structured support, guidance and facilities to enable progression from being newly qualified to becoming specialist RNs. The implementation of 'individual or personal factors' could also be addressed by NHS Employers through the new pay structure being finalised (DH 2002c), and possibly through the implementation of the recommendations of *Improving Working Lives* (DH, 1999d), and of *A Health Service for all the Talents*' (DH 2000c). Moreover, e-learning is also an 'individual or personal factor' in that this should enable the individual to undertake learning which fits in with their own lifestyles.

Another example of how this framework for lifelong learning in nursing can be implemented, other than at NHS Employers level, is at team level. The clinical leader in most nursing teams in the work setting is the ward sister or charge nurse. To mobilise the organisational factors, she would need to be sensitive to the functions of the components of the framework, e.g. how having to meet PREP requirements can trigger lifelong learning. The ward sister would subsequently need to ensure her staff know that she recognises and values the learning that the latter has undertaken as part of meeting PREP requirements; and she encourages and supports WBL and effective use of the in-service training department, for instance.

Socio-political factors could be addressed by instituting teamwork, and by being open to staff's suggestions for clinical developments. As the figurehead of nursing (Mintzberg 1973), the ward sister would recognise and implement clinical supervision, reflective practice and peer review for instance to support and maintain

learning, and develop her ward along the lines of 'key features of a learning organisation' (ENB 1994). In this context, the DH (2001c p. 14) recommends that the infrastructure for lifelong learning needs to include skilled mentors and supervisors, recognition of 'coaching on the job, job rotation and sabbaticals'.

The ward sister could also recognise 'individual or personal factors' by viewing learning as a natural rather than concerted activity; treating staff as individuals who are keenly interested in their profession and its development; being aware of personal interests and personal circumstances that could instigate or hinder CPE; undertaking regular IPRs; and being interested in each individual's personal and professional development aspirations. This is complemented by the individual RN's responsibility, which according to the DH (2001c p. 64), is to:

- seek opportunities to participate in personal learning and development and to influence and shape team and/or organizational strategies for lifelong learning;
- agree a personal development plan with their line manager which identifies and addresses their learning needs, links with core skills and organizational goals for lifelong learning and supports improvements in patient care and services; and
- take responsibility, wherever appropriate, for supporting the learning and development needs of others.

Further thoughts on the framework of lifelong learning

In constructing the framework suggested in figure 8.1, other conceptualisations of lifelong learning were also taken into consideration. These include Dave's (1976) view of lifelong learning as a comprehensively unifying idea which includes formal,

non-formal and informal learning, as well as the three key areas of lifelong education suggested by him, namely personal, social and professional areas. Knapper and Cropley's (1991) view of lifelong education as incorporating organisational, financial and didactic principles were also considered. They also suggested that lifelong education could be implemented through administrative, methodological and procedural measures. Another categorisation, which was taken into account, is the notion of STEP [or PEST] (social, technological, economic and political) analysis (Howkins and Thornton 2002) in ascertaining a framework for the facilitation of lifelong learning in nursing. Each of these classifications seems to leave some gap when all the findings of the study are taken into account against the analytical framework identified in the Introduction of this thesis, which is why the framework in figure 8.1 is suggested. The framework could possibly redress a wide range of barriers and practical problems of lifelong education so eloquently documented by several key writers including Knapper and Cropley (2000) and McGivney (1990).

There is an abundance of literature in nursing on the construction and analysis of models and concepts (e.g. Lindberg et al 1998, Walker and Avant 1995, Manley 1997). In a book, which guides nurses to build and use models of nursing, Wright (1990 Preface) notes that a model is 'not a panacea, nor a cure for nursing's ills overnight'. He suggests that it must not be seen as a fixed nursing bible, but as a growing, dynamic and evolving framework. Instead of being merely the theoretical underpinning of the activity or some 'esoteric notion at a conference', it is the 'living, breathing activities' that it enables which is the best test of a model.

A model of lifelong learning for nurses is also no more than a framework that coordinates and provides shared thinking at the practical end of lifelong learning for nurses. It should however provide a 'cohesive and coherent sense of direction' for organisations and their employees (Wright 1990 p. 3). Wright (1990) notes that a model is not a call for conformity but a framework for following common goals and shared understanding. Therefore, after implementation, the model would need to be tested to ascertain whether it does constitute a comprehensive framework, and possibly adjustments made.

A conceptual framework for the advanced practitioner/consultant nurse role was similarly constructed by Manley (1997 p. 179) by using a number of categories and 16 themes that emerged from her research. However, because of the tentative nature of such ventures, it is difficult to be certain about how sound the suggested model really is. To some extent though, this is can be contextualised by Burns and Grove's (1997) suggestion that following continuing reflection, the researcher becomes more and more sure that the conclusions are correct and that the emanating model does in fact explain the situation.

Likely future work on the topic area of this study would entail endeavouring to make links between the components within the conceptual framework more explicit and expand on the processes used. Meanwhile, it is hoped that the conceptual framework will go some way to making explicit the multi-dimensional nature of lifelong learning and speculate on the potential and powerful impact it can have if

implemented systematically '*for the benefit of patients, clients and their loved ones*' (Community Nurse).

Recommendations for further research

A number of areas for research are listed here, but the reasons for them were presented in previous chapters.

- 1 Based on the reported resistance to mandatory updating and apprehension regarding studying in higher education, a sample of nurses who are not practising as nurses should be questioned about the reasons for having left nursing, and what could have been done to retain them (chapter four).
2. As some informants indicated that PREP was not marketed very well, this is another possible area that can be studied either from the point of view of management of change or marketing novel concepts in healthcare professions (Chapter four).
3. It was noted in chapter four that nurses who specialise to the level of becoming clinical nurse specialists might find it difficult to change specialisms afterwards. This may not be true, as many of the skills in the CNS's repertoire should be transferable. How far do CNSs feel either trapped (glass walls) or more fulfilled and satisfied in their specialisms? What proportion of clinical nurse specialists' transferable knowledge and competence in the four components of nursing namely teaching, organising care, research and clinical practice, are transferable if she wishes to change specialism (Chapter four)?

4. The literature and the study data indicate that MCE as a structural mechanism can be ineffective, and may lead to 'surface' rather than 'deep' learning. There is therefore a need to explore how resistant RNs can be eased into participation into higher education based CPD (Chapter five).
5. In the context of professional regulation, CPD and lifelong learning, it seems that the perceptions of 'grassroots' level nurses and those of NHS managers and leading nursing commentators may be quite wide apart, and research is required to ascertain this with the eventual aim of widening participation in higher education nursing courses (Chapter five).
6. The development and impact of peer review in nursing could also be empirically tested, as they appear to be increasingly relevant for CPD and work-based learning in nursing (Chapter five).
7. Since some informants did not notice any patient care benefit directly ensuing from undertaking nursing degree courses, it seems that this is another area for further exploration. What are the patient outcomes of RNs who are already diplomates going on to study for a degree, for instance? That is, how does patient care benefit from CPE (Chapter six)?
8. On exploring the impact of CPD on patient outcomes, Jordan (2000 p. 461) noted that despite the 'unparalleled expansion of CPE and CPD programmes' over the last two decades, there is still 'little empirical evidence that these enhance the care delivered to patients'. One of the conclusions therefore was that nurse educators must also endeavour to demonstrate the clinical effectiveness of the CPE they deliver in higher education, which constitutes another area for further research (Chapter six).

9. Morse et al (1996 p. 264) note that 'when a well-developed theoretical definition (of a concept) has been identified, then the next step is to use quantitative methods to validate and refine the concept with a strong emphasis on the epistemological and pragmatic principles'. Therefore the conceptual model suggested in this chapter should be quantitatively studied to ascertain its soundness (Chapter eight).

Study conclusions

In concluding this study, I will reflect on where I started from and where my understanding of lifelong learning in nursing is at the time of completion of this thesis. In essence, the study started with my impression that the nursing literature reflected bland and broad recommendations for lifelong learning to be an integral feature of nursing. It was probably not understood sufficiently comprehensively within nursing and probably not universally accepted by nurses. And yet the nursing literature seemed to present the notion as a 'fait accompli' with scant empirical evidence of how the RNs it is aimed at perceived this activity, and how the theories of lifelong learning can be implemented in nursing practice.

Lifelong learning was seen as a relatively novel notion in nursing in the mid-1990s. The concept gradually evolved as a closely related activity or extension of PREP, which constitutes CPD and professional self-regulation in nursing. The literature was thoroughly searched to ascertain how far lifelong learning was endorsed, adopted and assimilated by those nurses who were directly involved in patient care, and for whom the concept has been, by implication, more directly advocated. The

search also focused on other related concepts. Gaps in the literature were identified and subsequently a number semi-structured individual interviews and focus group discussions were conducted to collect data on the areas where the gaps were.

The emerging themes and findings indicate that my doubts about complete acceptance of the concept in nursing had substance, as even mandatory periodic professional updating is not accepted by all, mainly because the word mandatory implies compulsory and imposed. This study has addressed the gaps identified in knowledge in relation to lifelong learning for nurses in that it has identified how RNs directly involved in nursing care delivery perceive lifelong learning and its practicalities, their views on the mechanisms and availability of facilities for achieving continuing professional learning, the other day-to-day factors that need to be considered, and the impact and effects of this notion. These findings suggest that while many nurses understand and accept lifelong learning as a necessary component of nursing, others do not perceive this in the same way.

The study has provided me with the opportunity to focus on an issue that has been of personal interest to me as a lifelong learner myself and as a nurse who believes that lifelong learning is indispensable in nursing. The research has revealed that many RNs see lifelong learning positively, but substantially more structural facilities are required, that various day-to-day life experiences impact on the uptake of lifelong learning, although there are benefits to be derived from effective implementation of the notion and activity. In particular, it has pointed to the need to recognise the need for formal and informal support for becoming a lifelong learner.

A framework for facilitating lifelong learning is suggested comprising a range of components that would be necessary for the RN to be a lifelong learner. On condition that the reservations voiced in relation to the model are taken into account, it seems that its components have implications at both policy and individual levels. This means that both policy-makers and individual RNs have to be aware of all the factors identified within these components and each manage the ones within their remit but with conversation and understanding of each other's responsibilities.

As the researcher and writer of this thesis, my next actions will comprise dissemination of the findings of this study and further research in some of the identified areas. Some dissemination has already occurred through publication of the six peer-reviewed articles and two editorials mentioned at the beginning of the thesis.

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