The Development of Self-Directedness in Public Health Nurses

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Abstract

This qualitative study examined the perceived thoughts, feelings and experiences of seven public health nurses employed in a southern Ontario health department, regarding the initial phase of the introduction of a self-directed orientation program in their place of employment. A desire to understand what factors facilitate public health nurses in the process of becoming self-directed learners was the purpose of this study. Data were gathered by three methods:

1) a standard open-ended interview was conducted by the researcher with each nurse for approximately one hour;
2) personal notes were kept by the researcher throughout the study; and
3) a review of all pertinent health department documents such as typed minutes of meetings and memos which referred to the introduction of the self-directed learning model was conducted.

The meaning of the experience for the nurses provided some insights into what does and does not facilitate public health nurses in the process of becoming self-directed learners. Implications and recommendations for program planners, nurse administrators, facilitators of learning and researchers evolved from the findings of this study.

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Dedication

This thesis is dedicated to the loving memory of my father.

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CHAPTER ONE: INTRODUCTION AND BACKGROUND

As a nursing supervisor in a large southern Ontario health department, one of the many responsibilities I had was to facilitate the orientation of new public health nurses (PHNs). Learning in the workplace is especially important for new employees. Orientation included activities and experiences planned and implemented for new employees to assist in the transition of the orientees into the new work environment. It generally addressed such topics as the department's strategic plan, philosophy, objectives, roles, and communication systems. The program was delivered through a variety of teaching methods such as group discussion, lecture, individual counselling, and observation. A team of nursing supervisors and senior public health nurses jointly planned and implemented the program.

At the end of each orientation session evaluation sheets were completed by the participants. Over the past few years some of the comments that had been made at the time of evaluation or a few months later were: "We didn't learn that during orientation," "We didn't get this information soon enough," and "We need more information." These types of comments and observed behaviour of new staff led to the belief that the varied learning needs of all new PHNs were not being thoroughly met. This in turn could lead

to job dissatisfaction, high staff turnover, and poor employee performance.

A new employee brings certain skills, attitudes and knowledge to a job. Professionals rarely bring all that is ideally required because job requirements change rapidly to accommodate technological and conceptual innovation. A new staff person has educational needs which may be met if there are opportunities to do so. In a study conducted by Quastel and Boshier (1982), their findings suggested that, when relevant learning opportunities are available, a state of congruence exists between the employee and the work environment, and the individual experiences satisfaction with the job and increased feelings of competence. When there is a discrepancy between educational needs and available opportunities, there is lack of balance (incongruence) which in turn gives rise to feelings of dissatisfaction.

Perhaps the statements made by the new nurses reflected their response to some of the traditional education methods used in the orientation program. The goal of traditional education has often been cited as the transmission of knowledge and skills by teachers to students. This teacher-centred approach imposes subject matter on students who are expected to passively receive the content. This belief has been radically challenged in recent adult education literature with the goal of adult education to develop self-

directed learners (Brookfield, 1985; Knowles, 1975).

Self-directed learning has been defined by Knowles (1975) as a process in which individuals take the initiative, with or without the help of others, in diagnosing their learning needs, formulating learning goals, identifying human and material resources for learning, choosing and implementing appropriate learning strategies, and evaluating learning outcomes.

The teaching and the learning process is the mutual responsibility of the teacher and the learner. The teacher's role is one of resource person, co-inquirer, and guide (Cranton, 1992). There is much evidence that adults have a need to be self-directing (Knowles, 1989; Rogers, 1969; Tough, 1979). But since most adults have been conditioned in educational settings to accept what and how they are to learn by teachers, the process of self-directed learning is a new experience which often causes anxiety. Preparation and assistance is needed by most adult learners to become self-directed.

The need to guide new PHNs toward self-direction became increasingly apparent. The health department's orientation program needed to facilitate new staff to acquire the concepts, skills, and attitudes required to become self-directed learners.

In January 1992, as a nursing supervisor at the health department, with a personal interest in adult education, I

introduced the idea of developing a self-directed orientation program for the nurses. A written proposal suggesting the development of a self-directed orientation program based on Knowles' (1975) andragogical model and the creation of a half-time staff development coordinator position was accepted by the nursing management team. On February 28, 1992, a public health nurse was chosen as the new staff development coordinator to plan and implement a new self-directed staff development and orientation program. She was an experienced public health nurse who had graduated from McMaster University in a long-standing self-directed learning nursing program. In March 1992 the staff development coordinator, in consultation with a supervisory advisor, began the process of planning for the change. After increasing her knowledge base about adult education with specific focus on Knowles' model, she developed a six-month operational plan of action to introduce the new model of learning to all nurses working at the health department. During the introduction of the new learning model I was on a leave of absence from my position in the health department and therefore did not participate in any of the implementation activities.

During my work absence I began to desire to understand more about what factors facilitate learners in the process of becoming self-directed, which became the purpose of this study.

This study is an examination of the perceived experiences of seven public health nurses regarding the initial phase of the introduction of a self-directed orientation program in a health department.

Statement of the Problem

This study investigated what facilitates the process of becoming self-directed. The study focused on public health nurses' own perceived experiences, thoughts and feelings during the initial phase of the introduction of a self-directed orientation program. Within this context, two research questions were formulated.

Research Questions

1. What are the nurses' perceived experiences of the introduction of a self-directed learning model in the workplace?
2. What are the perceptions of the nurses as they are encouraged to become self-directed learners in the workplace?

Rationale

Research is important to give us rich and complete descriptions necessary for more fully understanding how adults learn to become self-directed learners and what the roles of adult educators are in this process. During a six-month period between April to September 1992 the initial phase of introducing a self-directed orientation program took place in the health department. I thought this had potential to provide an excellent opportunity to examine the process of learners becoming self-directed and determine what facilitates this process.

The literature provided very little research-based information about the process of becoming self-directed and even less about what helps learners through this process. Although Knowles (1990) described a model of self-directed learning, few studies provide descriptions from the learner's or facilitator's perspective on what actually helped him/her through the process of becoming self-directed. Brookfield (1986) provided descriptions of the facilitator's role and techniques to encourage self-directed learners. Brundage and Mackeracher (1980) listed 36 learning principles and provided facilitating and planning implications for educators to practice.

Cranton (1992) confirmed these findings in her most recent book Working With Adult Learners. In the chapter

entitled Working Toward Self-directed Learning, she stated very little has been written about the process of becoming self-directed. Many practical guidelines do mention that self-directed approaches should be introduced gradually, although many self-directed programs (cf. Fierrier, Marrin & Seidman, 1982; Ash, 1985) have not taken these into account. While little consideration is given to the transition process of becoming self-directed in the practical literature, even less is placed on it by researchers. One important exception was a qualitative study of graduate students at the Ontario Institute for Studies in Education (Taylor, 1987) which described four phases and four transition points involved in the process of moving toward self-direction. Taylor's findings will be reviewed in greater depth in the literature review section of this research study.

My professional and educational experience, in conjunction with a comprehensive review of the literature, led to the evolution of the research idea for this study.

Assumptions

This study was conducted under the following assumptions:

1. Self-directed learning is an ongoing process in which adults actively participate by defining

their learning needs, choosing appropriate learning resources, and implementing and evaluating their own learning outcomes.

2. Learning is a process and self-directed learning is a particular way of going through that process.
3. Self-directed learning is a goal of adult education.
4. Learners need to learn to be self-directed.

Limitations of the Study

I chose to study a sample of public health nurses in an agency in which I was employed as a nursing supervisor. Although this presented a valuable opportunity to examine important learning issues of staff members, my potential biases must be acknowledged.

Direct supervision was the responsibility of the investigator/supervisor with only one of the study participants for a period of one month.

Since the participants were interviewed about work-related factors, one could predict that their responses could be guarded in nature. As the interviewer, I was aware of this possibility and strongly stressed confidentiality and anonymity to the nurses and hoped this would limit this potential problem. Personal interviews were conducted in a private location of each nurse's choosing to promote

comfort. As well, interviews were conducted in what I perceived to be a nonthreatening and relaxed manner.

All nurses employed by this particular health department were females. The male point of view and meaning of experience was absent.

Definition of the Terms

Andragogy: The art and science of teaching adults (Knowles, 1990).

Health Department: This is a provincial government health care agency mandated by the Health Promotion and Protection Act (1983) to promote health and prevent disease by providing health programs and services.

Pedagogy: The art and science of teaching children (Knowles, 1990).

Public Health Nurse: A university-prepared nurse employed by a health department to promote and preserve the health of communities, groups, families and individuals across the life span.

Self-directed Learning: An ongoing process in which adults actively participate by defining their learning needs, choosing appropriate learning resources, and implementing and evaluating their own learning outcomes (Knowles, 1990).

Supervisor: An individual designated by a health department to orientate, monitor and evaluate PHNs.

The outline of the remainder of this study consists of Chapter Two: Review of the Literature, Chapter Three: The Methodology, Chapter Four: The Research Findings, and Chapter Five: The Summary, Discussion, Implications and Recommendations.

CHAPTER TWO: REVIEW OF THE LITERATURE

This chapter will begin with a review of literature related to the theoretical foundations of andragogy. This will be followed by a discussion of research conducted by health professionals who have integrated aspects of andragogy with staff educational program in practice. In conclusion, the last area to be discussed with be literature related to the process of adults becoming self-directed learners.

A Review of Andragogy

The purpose of this section is to critically review the theoretical foundations of adult education with specific emphasis on andragogy. Self-directed learning is seen as a goal, an underlying assumption of andragogy, and a prevailing philosophy for adult education (Mezirow, 1985).

The study draws heavily from Knowles (1975, 1984, 1989, 1990) who has had the strongest influence on adult education since the mid 1970s. Although there is not a unified theory of adult education, Knowles is often called the father of adult learning theory and is also a well known human resource development consultant (Knowles, 1989). The single most influential person guiding Knowles' thinking was Lindeman (Knowles and Associates, 1984). Lindeman laid the

foundation for a theory of adult education in the first book written specifically about adult education, entitled The Meaning Of Adult Education. Lindeman's (1926) concept of adult education is a cooperative venture in nonauthoritarian, informal learning, the chief purpose of which is to discover the meaning of experience. Warren (1989) summarizes Lindeman's four assumptions that form the core of his approach to andragogy:

1. Education is life--not a mere preparation for an unknown kind of future living.
2. Education revolves about non-vocational ideals.
3. The approach to adult education will be via situations, not subjects.
4. The resource of highest value in adult education is the learner's experience.

Influenced by Lindeman, Knowles (1990) popularized the term andragogy which is defined as the art and science of helping adults learn. Originally, Knowles (1990) viewed pedagogy as "the art and science of teaching children" (p. 64) and andragogy as two opposing models. Over time he began to see pedagogy and andragogy as a continuum. The major difference between the two models is that the teacher of pedagogy perceives pedagogical assumptions to be the only realistic assumptions, and will expect the learners to remain dependent on the teacher. In contrast, the teacher's role in the andragogical assumptions is desirable and will

do everything possible to help learners take increasing responsibility for their own learning to become self-directed. Knowles does recognize that learners will be at different places on the continuum and not all learners will move towards self-direction at the same rate. This has implications for facilitators and learners which will be explored in this theoretical review.

Knowles' Assumptions of Andragogy

Andragogy is described by Knowles (1990, 1980) as a model of basic assumptions about learners which are:

1. The need to know. Adults need to know why they need to learn something before undertaking to learn it. If learners understand the value and methods of real-life application of new knowledge and skills, they are more likely to excel in the learning environment.
2. The learner's self-concept. Adults have a self-concept of being responsible for their own decisions. They also have a deep psychological need to be treated by others as being capable of self-direction. Facilitators have the responsibility to attempt to create learning experiences in which adults are helped to make the transition from dependent to self-directed

learners. Knowles provides five implications of practice for this assumption which are:

i) The learning climate. The physical learning environment and psychological climate should make adult learners feel at ease and respected.

ii) Diagnosis of needs. The emphasis is placed on the involvement of learners in a process of self-diagnosis of needs for learning. Once a competency model has been constructed, describing an ideal model of performance, the learners are expected to assess their present levels of competencies compared to the model, measure gaps between their competencies and those expected by the model and, thirdly, identify specific learning needs.

iii) The planning process. The learners need to be involved in planning their own learning with the facilitator serving as a procedural guide and content resource.

iv) Conducting learning experiences. The teaching-learning process is the mutual responsibility of learners and the teacher. The teacher's role is defined as facilitator, resource person, guide, co-inquirer, and catalyst.

v) Evaluation of learning. The emphasis is on self-evaluation by learners in which the facilitator helps the learners to get evidence for themselves about the progress made toward their learning goals.

3. The role of the learner's experience. Adults come into an educational activity with both a greater volume and different quality of experience than youths. This experience affects learning. Three implications for practice are:

i) Emphasis on experimental techniques. Participatory techniques for learning such as role play and case study are used with the assumption that the more active the learners' roles are in the process, the more they are probably learning.

ii) Emphasis on practical application. Facilitators should not only present new concepts which are illustrated by life experiences of learners but emphasize how learners can apply their new knowledge and skills to their day-to-day lives.

iii) Learning from experience. Activities are designed by facilitators to help learners look at themselves more objectively. Adults need to examine their old habits and biases

and open their minds to new approaches.

4. Readiness to learn. Adults become ready to learn those things they need to know and are able to do in order to cope effectively with real-life situations. Timing learning experiences to coincide with developmental tasks of adults is crucial. For example, an orientation program should start with the real-life concerns of new staff such as role expectations and time schedules rather than the history of the organization. The concept of developmental tasks also provides guidance in the grouping of learners. While some homogeneous groups are effective, at times heterogeneous groups are preferable for learners.
5. Orientation to learning. Adults are life-centred or problem-centred in their orientation to learning. Three implications for practice are:
   i) Facilitators must be in tune with the existential concerns of adults and be able to develop learning experiences which elate to these concerns.
   ii) The organization of curriculum. The organizing principle for sequences of adult learning is problem areas not subjects.
   iii) The design of learning experiences. The most appropriate starting point for every learning

experience is the problems or concerns that adults have as they enter. The problems which the facilitator or institution expects to be dealt with must also be acknowledged so that negotiation between facilitator and learner is expected.

6. Motivation. The most potent motivators of adults are internal pressures such as increased job satisfaction, self-esteem and quality of life. They are deeply motivated to learn things they see the need to learn in which the ultimate goal is self-improvement.

In summary, the andragogical teacher (facilitator, resource person) prepares in advance a set of procedures for involving the learners in a process with these elements:

1) establishing a climate conducive to learning;
2) creating a mechanism for mutual planning;
3) diagnosing the needs of learning;
4) formulating program objectives;
5) designing and conducting learning experiences with suitable resources; and
6) evaluating learning outcomes and rediagnosing learning needs (Knowles, 1990).

Knowles' assumptions have important implications for people responsible for developing orientation and staff development programs for adults. Many educators would agree

with Bard (1984) that andragogy, probably more than any other force, has changed the role of the learner in adult education and human resource development. Knowles' set of assumptions has determined the course of teaching/learning practice for hundreds of academic settings, businesses and agencies for the past fifty years (Knowles, 1984, 1990) and for this reason has been chosen as the leading theoretical model for the author's research study.

Criticism of Andragogy

Knowles has stimulated the field of adult education to the extent that, for some, andragogy has become a philosophical position that has been integrated into professional behaviour; for others, it remains a set of hypotheses to be explored and a learning theory yet to be validated (Lewis, 1987). Andragogy has caused more controversy, philosophical debate, and critical analysis than any other concept, theory, or model proposed thus far (Merriam, 1987). According to Jarvis (1983), while andragogy is not a theory of adult learning, its implications are quite profound for the practice of teaching adults.

Brookfield (1986), an important theorist during the past ten years, has analyzed Knowles' work extensively and will provide the primary criticism of andragogy in this

study. Brookfield (1986) stated Knowles correctly described andragogy as "a model of assumptions and not as an empirically based theory of learning painstakenly derived from a series of experiments resulting in generalizations of increasing levels of sophistication, abstraction and applicability" (p. 91).

Although Brookfield's (1985) views were grounded upon some of Knowles' assumptions, he believed it is just as dangerous to accept the andragogical model as it is to accept the traditional mode of learning in which students are the passive recipients of knowledge transmitted by experts. The two different schools of thought need to be critically challenged by practitioners. Brookfield felt it is simplistic for us to think of self-direction in terms of command of self-instructional techniques. There is more to self-directed learning than goal-setting, instructional design and evaluative procedures. These techniques are mechanistic. Self-directed learning is concerned much more with an internal change of consciousness than with external management of instructional events.

> When the techniques of self-directed learning are allied with the adult's quest for critical reflection and the creation of personal meaning, after due consideration of a full range of alternate value frameworks and action possibilities, then the most

> complete form of self-directed learning is exemplified. (Brookfield, 1985, p. 15)

This is a valid criticism of Knowles' model. While evidence of learning such as behaviour change and reports of knowledge acquired by individual learners were emphasized by Knowles, he did not describe the actual internal change of consciousness of the learner which Brookfield pointed out so well.

Another criticism by Brookfield (1986) was that the majority of studies of self-directed learning have been limited to samples of white, middle-class adults. He suggested that many people living in totalitarian regimes and disadvantaged cultures may not be self-directed. He stated if "self-directedness was an empirically undeniable aspect of adulthood, then the continued existence of a totalitarian regime would be inconceivable" (p. 94). This argument of people being able to liberate themselves from such regimes seems very condescending to people living in disadvantaged cultures and is in strong opposition to Knowles' core concept of the importance of all learners being treated as self-directed learners. Cranton (1992) pointed out that "perhaps the political events of 1990 will allow us to question Brookfield's statement" (p. 15). Brookfield (1985) was not giving any credit to each individual living in what could be very oppressive conditions. For example, a person in jail could be

extremely self-directed but not be allowed to practice this ability. In fact, self-directedness may be one of the reasons a person ended up in jail.

Brookfield's (1985) belief that self-direction is limited primarily to white middle-class adults is a myth, according to Brockett and Hiemstra (1991). They contended other research has demonstrated that various groups are capable of self-directed learning. Caffarella and O'Donnell (1988) also pointed out that various studies confirmed that the majority of adults, from all walks of life, are actively involved in self-directed learning.

A perceived benefit for adults practising self-directed learning, according to Brookfield (1986), is despite the initial frustration and resentment felt by learners who are asked to depart from their normal pattern of teacher dependence and take control over aspects of their learning, the majority of learners and facilitators approve of the introduction of techniques of self-directed learning. This is particularly so for learners who speak of the liberating aspects of being told that their judgements concerning appropriate learning activities are as valid as those of the instructor.

The aspect of liberation felt by learners practising within an andragogical model, which is mentioned here by Brookfield, was strongly emphasized by Freire, a well known critical theorist. Freire (1970), who practised as an

educator in third world countries, presented a radical approach to teaching as a process in which learners act upon their sociopolitical environment to change it and/or liberate themselves from oppression. In this model of Friere's, humanistic elements similar to Knowles' are evident with the teacher acting as a facilitator of learning, rather than one who teaches the "correct" knowledge and values that have to be acquired.

Brookfield (1985) strongly criticized Knowles' description of the role of the educator as a resource person. Within this definition, the educator is constrained from offering the value systems, ideologies, behaviour codes, and images of the future that the adult has yet to encounter. He believed adults need to be prompted to analyze their own behaviours and beliefs and to consider alternate ideas and values to facilitate the learning process. "As teachers, we are charged with not always accepting definitions of felt needs as our operating educational criteria" (Brookfield, 1986, p. 125). He added,

> The particular function of the facilitator is to challenge learners with alternative ways of interpreting their experience and to present to them ideas and behaviours that cause them to present to them ideas and behaviours that cause them to examine critically their values, ways of acting, and the assumptions by which they live. (p. 23)

This may be unfair criticism or perhaps even an incorrect interpretation of Knowles' description of the role of a facilitator of learning. In part, it supports the myth which thousands of people believe that self-directed learning means "do your own thing." In Knowles book, The Adult Learner - A Neglected Species (1990), he clearly described the importance of learners and facilitators constructing models of desired behaviour, performance and competencies to assist in determining learning needs. The three major sources of data for building a model of competency are the individual learner's own perception of what she/he wants to achieve, as well as the organization's and society's perceptions of desired performance and competencies. The competency model represents an amalgamation of the perceptions of desired competencies from all three sources. In the case of conflicting sources (e.g., the organization and the individual), it is the responsibility of the facilitator and the learner to negotiate. Knowles also reinforced the role of the facilitator to make clear that there are certain "givens" in every learning situation, such as minimal organizational requirements that must be accepted. A learner may have "felt needs" to learn to basket weave. This may be quite acceptable in a craft class but certainly not in a university education course. Knowles emphasized the necessity of collaboration between the learner and the

facilitator during each stage of the self-directed learning process.

Brookfield (1985) advocated six principles of critical practice in adult education which are:

1) Participation is voluntary.
2) There is respect for self-worth.
3) Adult education is collaborative.
4) Praxis is at the heart of adult education where participants are involved in a constant process of activity, reflection on activity, collaborative analysis of activity new activity and so on.
5) Adult education fosters a spirit of critical reflection.
6) The aim of adult education is the nurturing of self-directed, empowered adults who develop a sense of control and autonomy.

The concept of andragogy has been thoroughly analyzed by Brookfield who provided valuable contributions to the field of adult education. Wisely put, Cranton (1992) stated, "What Brookfield has done is to encourage people to question andragogy as a theory of adult education rather than routinely put the principles into practice" (p. 17). It is essential for all professionals to reflect on their practice critically, to be aware of their own values and assumptions to make responsible choices based on their expertise and values and, through critical thought, become

aware of and develop their philosophy of practice.

Recently another perspective of self-directed learning was introduced by Candy (1991). He provided a comprehensive review of the literature to date regarding self-directed learning in his book entitled Self-direction for Lifelong Learning. Candy stated that the term self-direction refers to four distinct but related phenomena:

1) self-direction as a personal attribute (personal autonomy);
2) self-direction as the willingness and capacity to conduct one's own education (self-management);
3) self-direction as a mode of organizing instruction in formal settings (learner-control); and
4) self-direction as the individual, noninstitutional pursuit of learning opportunities in the natural societal setting (autodidaxy).

Candy's view of self-directed learning provided valuable guidance in completing the discussion of the findings of this research study.

Conclusion

Cross (1981) noted that andragogy has been more successful than most theories in gaining the attention of practitioners, and she credited Knowles with sparking debate on educators' assumptions regarding adult learning processes

and with "setting forth a plan for critique and test in an otherwise barren field" (p. 225). Popularization of andragogy has been accompanied by numerous debates for and against the concept (Brookfield, 1986; Davenport & Davenport, 1985; Pratt, 1988; Yonge, 1985). Theorists have all offered divergent interpretations of the concept. Researchers, educators, and administrators continue to focus on research questions prompted by Knowles. With Brookfield's (1983) suggestion in mind "a spirit of self-scrutiny should infuse the research efforts of those who, like myself, spend time investigating the efforts of self-directed learners" (p. 44).

Being able to understand some of the assumptions and criticisms of andragogy hopefully promoted the flexibility and consistency needed to work with public health nurses in their development of self-directedness.

To explore the use of the andragogical learning model in health care settings, the next section will review literature describing some examples of self-directed learning programs based on Knowles' assumptions.

Self-directed Learning in the Education of Staff Nurses

According to Brookfield (1985), the use of self-directed learning in the health professions has been increasing in recent years. The way in which nurses

function and the lives they affect as a result of their practice require them to possess a high degree of competence. Self-directed learning must often be relied upon. The requirement of orientation and inservice education challenges educators and administrators to be creative and innovative in developing programs to meet the needs of individual nurses.

This section will review some self-directed training initiatives in health care institutions.

Prociuk (1990) examined the reactions of nurses to a self-directed orientation program in one hospital. Results showed that most nurses preferred to use self-directed learning over learning directed by educators. This study also identified factors that educators should consider prior to implementing self-directed hospital orientation programs such as:

1) Self-directed learning needs to be introduced properly with respect to both the concept and the resources to be used.
2) Self-directed learning is not the preferred method of learning for all nurses.

A hospital in New York City converted a staff orientation program to self-directed learning in an effort to develop a more functional nurse as the end product. The learning activities facilitated by nursing educators were based on the results of a needs assessment of the nurses'

learning needs. The benefits of this new program were:

1) The development of a closer relationship between the educator, new nurse and nursing unit;
2) performance problems could be analyzed quickly and participants provided with necessary materials for remedial work; and
3) orientees' feedback was positive as they progressed at their own rate (Lingeman & Mazza, 1986).

Hamilton and Gregor (1986) reported a learning program in which learners develop a contract which consists of diagnosis of learning needs, formulation of learning objectives, determination of strategies and resources and determination of evidence of accomplishment and target dates. Based on questionnaires completed by the learners and their supervisors, the quality of the program was consistently rated above average.

Some criticism must be made about the evaluation of these programs. The feedback was based on perceptions and opinions of staff. No research studies reporting long-term follow-up of measured learning outcomes of nursing staff have been conducted, although one study described the outcome of self-directed learning with nursing students.

Historically, McMaster University School of Nursing has used self-directed learning methods. In response to a class of students requesting a structured laboratory setting to

learn psychomotor nursing skills, the faculty designed a randomized control study to compare the effectiveness of teaching in a structured laboratory with self-directed self-taught modules. The students were randomly assigned to either a control group which was self-directed or to an experimental group which was taught skills in a lab. The results of an objective-structured clinical examination administered to the students showed no statistically significant difference between the two groups. The results substantiate the hypothesis of no difference between psychomotor skill performance of students who learn in a self-directed manner and those taught in a structured lab (Love, McAdams, Patton, Rankin, & Roberts, 1989).

Self-directed learning is complex. Studies to date have described the phenomenon experienced in a variety of nursing education settings although there is an absence of research studies that specifically address self-directed orientation programs in health departments. Just how effective self-directed learning is still appears to be poorly understood or not thoroughly examined by researchers. Brookfield (1985) pointed out "the results of the application of strictly defined and tightly administered quantitative measures in the investigation of self-directed learning is that the quality of the learning is overlooked" (p. 13). He believed a crucial area for further research is the congruence between adults' own judgements regarding the

quality of their learning and that quality is measured by some external objective standard.

The process which individual learners experienced to become self-directed learners was not addressed in any of these studies, but some valid and practical suggestions were given about implementing such programs in the future.

To conclude the literature review, the next section will describe some pertinent research in the area of the process of individual adult learners becoming self-directed.

Becoming Self-directed

An abundance of literature discusses the topic of self-directed readiness (Gulielmino, 1977; Brockett, 1985; Herbeson, 1991; Field, 1990; Long & Agyekum, 1984). Gulielmino's (1977) Self-Directed Learning Readiness Scale is a prominent research instrument designed to assess the degree to which individuals perceive themselves to possess skills and attitudes associated with self-directed learning. It has rapidly expanded the body of knowledge about self-directed learning and provided a rich topic for critical researchers to analyse. Unfortunately, to date very few researchers have actually described the process of becoming a self-directed learner. The only research-based example found in the literature was a qualitative study by Taylor (1987). This study was based on the reports of the

experiences of eight learners in a thirteen-week graduate course which promoted self-direction at the Ontario Institute for Studies in Education. Four different phases in the process of becoming self-directed were revealed which are summarized as follows:

1) disconfirmation--a major discrepancy between expectations and experience;
2) disorientation--intensive disorientation and confusion accompanied by a crisis of confidence and withdrawal from other people who are associated with the source of confusion;
3) naming the problem (phase transition)--naming the problem without blaming self and others;
4) exploration--beginning with relaxation with an unresolved issue, an intuitively-guided, collaborative, and open-ended exploration with a gathering of insights, confidence and satisfaction;
5) reflection (phase transition)--a private reflective review;
6) reorientation--major insight or synthesis experience simultaneous with a new approach to the learning (or teaching) task;
7) sharing the discovery (phase transition)--testing out the new understanding with others;

8) equilibrium--a period of equilibrium in which the new perspective and approach is elaborated, refined and applied.

Taylor's research study provided a practical model for the process of becoming self-directed. Her findings are valuable to learners and educators to promote and further clarify learning process patterns. However, since the small number of study subjects were educationally advantaged, claims could not be made that this particular group was representative of all adult learners.

In an article written by Grow (1991) a model based on the Situational Leadership model of Hersey and Blanchard (1988) is presented: the Staged Self-Directed Learning Model. This model proposes that learners advance through stages of increasing self-direction and that teachers can help or hinder that development. Effective teaching matches the learner's stage of self-direction and helps the learner advance toward greater self-direction. The model consists of:

Stage 1--dependent learners need an authority figure to give them explicit direction on what, how and when to learn. Learning is teacher-centred.

Stage 2--learners are interested and respond to motivational techniques. Teachers act as motivators and guides.

Stage 3--learners of intermediate self-direction share

in decision making with teachers who act as facilitators.

Stage 4--learners of high self-direction set their own goals and standards with or without help from teachers who act as consultants.

This model is a concept, based on observations and plausible guesses, which has not been validated. It can be used as a guide to educators as Grow suggest.

Recently, Cranton (1992) proposed that the process of moving towards self-direction involved learners moving through the stages of curiosity, confusion, testing the boundaries, withdrawal, exploration and reflection, turning to others, renewed interest and excitement, reorientation, equilibrium, and advocacy. Cranton believes not all learners go through the process in the same way. Although this model sounds very realistic, it has not been empirically validated.

Summary

In summary, as more research is conducted regarding the process of becoming self-directed, hopefully educators will become more aware of why learners often react with anxiety when confronted with a self-directed learning format, what to expect as a person moves through various stages of learning, and how to facilitate this process.

CHAPTER THREE: METHODOLOGY

Overview

This chapter describes the research design, sample, data collection procedures, and data analyses for the study. A description of the methodological limitations and measures to establish trustworthiness will also be addressed.

Research Design

A retrospective qualitative research design was chosen as the method of investigation, in order for depth and detailed information to emerge regarding the facilitation of the process of becoming self-directed among adult learners.

A qualitative approach of study seeks to capture what people have to say in their own words and describe their experiences in depth. The data are open-ended in order to find out what people's lives, experiences, and interactions mean to them in their own terms and in their natural settings. The qualitative design is naturalistic in that the researcher does not attempt to manipulate the research setting which is naturally occurring. This research method permits the researcher to record and understand people in their own terms (Patton, 1980).

The researcher attempts to make sense of the situation

without imposing preexisting expectations on the research setting with an inductive approach. Categories of analysis emerge from open-ended observations as the researcher comes to understand the organizing patterns that exist in the phenomena under study (Patton, 1980).

According to Merriam (1988) cited in Bilsky (1991), with qualitative research, "meaning is embedded in people's experiences and mediated through the investigator's own perceptions" (p. 39).

Selection of Participants

Stratified purposeful sampling was conducted in order to select key informants for this study. According to Bogdan and Bilken (1992), with purposeful sampling you choose particular participants because they are believed to facilitate the expansion of the developing theory. The stratified sample was composed of two senior public health nurses hired more than two years ago, two public health nurses hired not more than two years ago, two nursing supervisors and the staff development coordinator. The staff development coordinator helped in the selection process by providing a list of nurses who had participated in all of the various activities which took place to promote the self-directed learning model. I then contacted potential participants in person or by phone to give a

verbal explanation of the study, the expectations of the study participants and a description of the strict measures of privacy, confidentiality and anonymity that would be followed. Once the eligible nurse participants had listened to the explanation of the study, all seven agreed to participate in the study. Each participant was sent a follow-up letter confirming the time and date of the interview and each received a thank-you letter following the interview. Each participant signed a consent form prior to the interview. See Appendix B for the consent form.

The nurse participants have been given fictitious names to ensure anonymity. Specific identifying information concerning each nurse will not be described to ensure privacy. Three of the nurses received their nursing education at McMaster University in a self-directed program. Three nurses completed traditional "other-directed nursing programs." One nurse completed a nursing program which she described as self-directed.

Although two participants were supervisors and one was a half-time staff development coordinator, all participants are identified as "nurses."

Data Collection

Data triangulation, the use of a variety of data sources was implemented in this study. Data were gathered

through three main strategies:

1) A standard open-ended interview was conducted by the researcher with each of the seven participants for approximately one hour in length. One week prior to the interview each participant was given a copy of the interview questions in order to prepare for the interview. The interviews took place in December, 1992. The interviews were audiotaped with the permission of each participant. Each taped interview was transcribed word for word into a typed format for analysis.
2) Personal notes were kept on a regular basis by the researcher during the implementation of the study.
3) A review of all pertinent documents, such as minutes of meetings and written evaluations by the nurses of the activities which promoted the introduction of self-directed learning, was conducted.

More than one source of information was sought because no single source of information could be trusted to provide a comprehensive perspective. By using a combination of interviewing and document analysis, the researcher is able to use different data sources to validate and cross-check findings (Patton, 1990). Using a combination of data types increases validity, as the strength of one approach can

compensate for the weaknesses of another approach (Marshall & Rossman, 1989).

Data Analysis

Description and Organization of Data

The analysis of data was implemented with a cross-case analysis approach. Through inductive analysis patterns and categories emerged from the data.

Guba (1978) suggested a researcher must first deal with the problem of convergence which is figuring out what things fit together. This leads to a classification system for the data. Recurring regularities were looked for, which represented patterns that could be sorted into categories. Categories were then judged by two criteria which were internal homogeneity and external heterogeneity. Internal homogeneity concerns the extent to which data that belong in a certain category hold together in a meaningful way. External heterogeneity concerns the extent to which the differences among categories are bold and clear. I then worked back and forth between the data and classification system to verify the meaningfulness and accuracy of the categories and the placement of data in categories. After categories have been developed, some priorities must be established to determine which categories are more important than others based on credibility, uniqueness, feasibility,

special interests and salience.

Divergence must also be practised during data analysis. The researcher must be able to flesh out the patterns or categories. Guba (1978) suggested this is done by processes of extension (building on items of information already known), bridging (making connections among different items), and surfacing (proposing new information that ought to fit and then verify its existence).

The mechanics of working with the data first involved the cut-up-and-put-in-folders approach which Bogdan and Biklen (1992) described. The transcribed data notes were cut up so that units of data were placed in file folders with each folder labelled with one code. Each piece of data always had the name of its source clearly marked on it to avoid confusion. The data in each file folder were then further analyzed. Certain data were cut and pasted together according to certain sub-categories. Connections between folders and sub-categories were identified. Analysis then continued into the writing stage as the findings were described.

The researcher brings closure to this process when sources of information have been exhausted, when categories have been saturated so that new sources lead to redundancy, when regularities have emerged that feel integrated and when the analysis begins to overextend beyond the boundaries of the issues guiding the analysis (Patton, 1990).

Interpreting the Data

Interpretation involves going beyond the descriptive data and attaching significance to what was found, offering explanations, drawing conclusions, extrapolating lessons, making inferences, building linkages, attaching meanings, imposing order, and dealing with rival explanations, disconfirming cases and data irregularities as part of testing the viability of an interpretation (Patton, 1990). The interpretive explanation will emphasize illumination, understanding and extrapolation.

Establishing Trustworthiness

The basic issue in relation to trustworthiness is: How can an inquirer persuade his or her audience (including self) that the findings of an inquiry are worth paying attention to, worth taking into account (Lincoln & Guba, 1985)?

Lincoln and Guba (1985) propose that the conventional criteria for trustworthiness be replaced with four new terms that have a better fit with qualitative methodology. They named credibility (in place of internal validity), transferability (in place of external validity), dependability (in place of reliability) and confirmability (in place of objectivity).

The trustworthiness of this particular study will be

discussed by a review of certain operational techniques which the investigator used to establish trustworthiness.

Credibility is the extent that the investigator has represented reality adequately, and that the findings and interpretations are credible to the participants of the study (Lincoln & Guba, 1985).

The technique of triangulation was practised to improve the probability that findings and interpretations would be found credible. The three modes of triangulation that were used were methods, sources, and investigators. Data were gathered from the methods of interviews, document analysis and my personal notes.

The consistency of different data was checked out from the different sources of data. The findings and interpretations were then reviewed by an experienced advisor.

At the time of each interview, each nurse was given the opportunity to validate the information reported to me, to ensure that I had not introduced any biases. I achieved this by reviewing some of the content of each interview with the nurses to ensure clarity and understanding.

Precise transcription of interviews enhanced the trustworthiness of the data collected from the nurses' perspective.

Lastly, negative cases which did not fit within patterns and trends were identified. Complexities and

dilemmas posed by negative cases were dealt with to enhance credibility and trustworthiness.

Transferability. The qualitative investigator cannot specify the external validity of an inquiry. To promote transferability, an investigator must provide sufficient descriptive data necessary to enable someone interested in making a transfer to decide whether a transfer could be a possibility (Lincoln & Guba, 1985).

Descriptive data about the nurses, their place of employment and activities which took place to introduce a self-directed learning model were provided. As well, to provide rich description, stratified and purposeful sampling was engaged.

To promote dependability and confirmability an audit trail is available for review:

a) raw data including the taped interviews, verbatim transcripts of interviews, field notes, and copies of memos and minutes of meetings;

b) copies of correspondence with the nurse participants;

c) a copy of the letter requesting approval for conducting the study at the health department;

d) a copy of a summary of the research proposal sent to the director of nursing of the health department at the time of requesting permission to conduct the study;

e) a copy of the correspondence with the ethics committee of Brock University;

f) labelled file folders of all the categories of data and synthesized sub-categories;

g) a copy of the investigator's personal notes; and

h) all copies of draft summaries of this study.

According to Patton (1990), the researcher is the instrument in qualitative inquiry. The study therefore includes information about the researcher to establish researcher credibility. Any personal and professional information that may have affected data collection, analysis, and interpretation was reported.

Limitations of the Methodology

Several methodological limitations have been identified. The first limitation of this study was its limited generalizability. Although I did strive to establish trustworthiness, the small sample size of seven participants must be kept in mind at all times when determining how generalizable the conclusions and implications of the findings of this study are.

Second, this investigation centred around a sample of middle-class, university-educated professionals, which was a strikingly consistent feature of other research studies in the area of self-directed learning (Brookfield, 1986). The

findings demonstrated by this well educated and specialized group of nurses was limited in generalizability due to the highly class-and education-specific nature of the sample. Claims cannot be made that this particular group was representative of all adult learners or even the general population of nurses.

Third, the degree of data triangulation was not as strong as I had first planned. The amount of written data sources collected from the health department turned out to be quite limited and of little value other than to verify a few of the findings from the interviews.

Fourth, the fact that this study was retrospective was somewhat of a limitation. Although the nurses were interviewed soon after the implementation of the six-month operational plan, participants may have forgotten relevant aspects of their experience. Participant observation by the researcher and the interviewing of participants throughout the experience would have strengthened this study but, unfortunately, it was not possible.

Finally, this study would have also been strengthened if an arrangement had been made for a written summary of the investigator's findings and interpretations of the results to be sent to some or all of the participants to verify the meaning of their experience. This would have further established the credibility of the study.

The above identified limitations were potential

weaknesses of this research study and should be taken into consideration when reviewing the findings and implications.

Summary

This chapter discussed the study in terms of research design, selection of participants, data collection procedures, analyses of data, establishing trustworthiness, and the limitations. Chapter Four will present the findings.

CHAPTER FOUR: RESEARCH FINDINGS

Introduction

This chapter describes the themes which emerged from the data regarding the initial phase of the introduction of a self-directed orientation program based on Knowles andragogical model, in a health department. The data are described mainly in terms of events or activities which occurred in chronological order in the health department over a period which lasted approximately six months. Themes developed from the nurse participants' perceptions about their personal thoughts, feelings and experiences during this time. Quotations from the participants, collected immediately at the seven-month point in time, illustrate the identified themes. Fictitious names were given to the nurses to ensure confidentiality.

The Meaning of Self-directed Learning

All seven participants said that they saw themselves as self-directed learners, although the term <u>self-directed learning</u> meant different things to different people. Most of the nurses had more than one definition for self-directed learning. The term <u>self-directed learning</u>, from the point of view of the nurses, was found to refer to four phenomena:

a) a method of planning one's own instruction;

b) a life-centred activity;

c) a personal quality or attribute; and

d) a method of learning which facilitates a sense of personal control.

Each of the four perspectives are described with quotations from individual nurses explaining their understanding of self-directed learning.

1. A Method of Planning One's Own Instruction

A set of behaviours or skills were described by six nurses who saw themselves as self-directed learners:

- ability to accomplish a self-learning assessment;
- ability to identify one's own personal learning needs;
- ability to identify one's own personal learning deficits;
- ability to identify one's own strengths and weaknesses;
- ability to develop one's own learning objectives;
- ability to form a learning plan to meet one's own learning needs;
- ability to identify resources to facilitate one's own learning;
- ability to gain knowledge and skills to accomplish one's own defined learning objectives; and

- ability to accomplish continuous self-evaluation.

This method of planning one's own instruction was summarized in Debbie's words as,

> You draw from what you have done in the past, pull out what your strengths are, analyze where you need more development and proceed in the areas you perceive to be weaker in.

The only participant who strongly resisted this description of self-directed learning was Liana, who explained her definition of self-directed learning by saying,

> My perception of self-directed learning is very different, perhaps not having been educated in the McMaster system. Prior to a year ago I would have said self-directed learning was McMaster based. I have a bit of a bias against McMaster where it doesn't suit me or didn't suit my learning style as I perceived it.

Liana went on to describe her belief about self-directed learning as being:

> a natural and everyday occurrence in which people seek

> out answers to questions, answers to needs and easier ways of doing things.

This definition will be viewed in more depth in the next section.

2. A Life-centred Activity

Three nurses saw self-directed learning as a life-centred activity.

Liana described self-directed learning as something that is normal and natural and an everyday occurrence:

> specific to being adaptable to change... . We all go through a million variations on theme in our life span whether that is adapting to life crisis, and seeking out the skills you need to survive. Human beings are generally curious, we seek out answers to questions, answers to needs, and easier ways to do things. I truly in my heart of hearts believe that everyone is self-directed to a degree.

Nancy explained,

> I don't see it as something I was taught in a formal sense. My mother was a teacher...she was constantly asking us to be that way...she would always put us in the situation of figuring it out for ourselves.

Carol stated self-directed learning is:

to do the best that you can with what you are working on.

3. A Personal Quality or Attribute

Some natural characteristics or traits of people were mentioned by the nurses in their descriptions of themselves as self-directed learners:

- being curious;
- being inquisitive;
- having the ability to seek out answers;
- being a problem solver;
- taking initiative;
- having self-awareness;
- being independent; and
- being self-reflecting.

4. A Method of Learning Which Facilitates a Sense of Personal Learner Control

The personal control that a learner has in self-directed learning is evident in the previously described section on self-directed learning as a method of planning one's own instruction. As well, a few nurses specifically emphasized their perception of the control they had in a self-directed learning experience.

Jane said,

I like directing myself to learning.

Nancy reported,

I identify what it is I want to do and then I set about...to do that, rather than wait for someone to say this is how you are going to do something.

Some very common threads found in the four perspectives of self-directed learning described by the nurses facilitated the development of a working definition of the term self-directed learning which is described in Chapter Five.

Past Learning Experiences

In some nurses' discussions concerning past learning experiences their descriptions about the traditional lecture style of education outside of the workplace was commented on as follows:

Debbie: ...having completed one degree I knew I couldn't sit through lecture situations where you are not spoon fed...but very directed.

Carol: My university nursing program was very didactic... . At my fifteen-year reunion professors actually said they were surprised that people were doing what they were in nursing because the information given to us through university was so sparse.

Elizabeth: In the past I never was a self-directed learner. All through high school I would want people to tell me what to do and I would get my As.

As well, Liana and Elizabeth said that in a lecture style system of education there was not the same drive to go out and find information.

An interesting finding opposite to Liana and Elizabeth's was experienced by four nurses. They described a dissatisfaction with the traditional style of learning which increased their drive in a more independent approach to learning. They stated:

Debbie: When I didn't understand something instead of getting up in front of hundreds of people to ask a question...instead of embarrassing myself...I would go off on my own and if I still didn't understand, I would access other resources. You then know if your question is going to be stupid or not after you have done some homework on the problem because you have done all the research, you have all the background and when you

present yourself you can validate why you don't understand something. I think this applies to all aspects of one's life...I do a lot of thinking before I act.

Jane: I will listen to a lecture but don't always understand it. I have to...tear it apart, think about it and then there will always be areas that I just don't get. I go off and ruminate. When I have a fear or feeling insecure about an area it nags and nags at me until I start doing a plan to get the knowledge...like a constructive way to deal with it.

Susan: If there is something I don't know it doesn't sit well with me and makes me feel uncomfortable. So the way I cope with it is by seeking out information... this is just my approach to everything. I like to ask the right question...whether it reduces stress level...enables me to grow and develop...go after my aspirations.

Elizabeth: If I feel incompetent in an area that really makes me feel uncomfortable, my first route is to go to someone with that knowledge or experience and ask questions. If I feel I need more I go to the books and do research.

These four nurses described a feeling of discomfort or insecurity in not understanding something, which precipitates a learner to go off and independently research a topic or skill to feel more secure and competent. Rather than passively rely on a teacher for further assistance to explain and clarify a topic, these learners felt a need to independently seek information from other sources to meet their learning needs.

Two of the most recently hired nurses described impressions of their learning experiences in the previous staff orientation program. The comments by these nurses seemed to verify dissatisfaction with the past orientation program and the need for a change.

They both expressed feelings of being left alone with insufficient support from the busy staff.

> Elizabeth: When I came to the health department...I hated it. We didn't have a preceptor. You kind of had team leaders, but they were really busy and they kept handing you off to someone else. It would be nice if someone was designated a preceptor.

> Debbie: The supervisor was busy, and I was left to the other nurses who were busy and stretched.

Dissatisfaction with aspects of the group orientation

sessions were also made.

Debbie: I came at a time just before staff cutbacks began. A group of nurses had just been hired and given some group of orientation, then I came and no one was hired for months. In my orientation one year ago there was limited time and resources.

Elizabeth: I don't think you can do the same orientation for every person hired on. When you compare me with another nurse that was hired at the same time who had tons of years of experience in public health nursing she didn't have to go through some of the orientation I had to go through, so you have to think of the individual. I remember her saying a couple of times that she resented having to go to group orientation sessions when she knew a lot more about it than the person who was teaching it.

These two nurses also suggested the need for application of learning as new employees to encourage a more proactive approach in their nursing practice.

Elizabeth: I got handed the green book (a document Community Health: Public Health Nursing In Canada [1990] which was used by staff as a resource regarding

nursing practice is referred to as the green book) when I was new. It is hard to apply that type of formal writing when you have not seen it. It has to go hand in hand with the application. This has been a major experience of mine at the health department.

Debbie: Discussing resources and case studies would have helped. We would then become more proactive in our approach as new staff. I think problem solving as a group around specific cases would have been so beneficial...and goes hand in hand with the self-directed approach.

Debbie and Elizabeth reported their experience in the past orientation program. They certainly reinforced the need for revisions or changes to be made. Their comments verified the reason why a new orientation program would be implemented at the health department at this point in time.

Introducing a Self-directed Learning Model

To begin to introduce the concept of self-directed learning in the health department, the staff development coordinator asked all nursing staff to complete Guglielmino's (1977) Self-Directed Learning Readiness Scale (SDLRS). This request was made in memo form since the

nurses were spread throughout five offices. Prior to the memo being distributed, the staff education coordinator met with the nursing supervisors to explain the rationale for asking staff to complete the SDLRS and ask for their input and support.

The results of Guglielmino's (1977) SDLRS for 46 staff nurses were above average with a mean score of 240.

The themes which emerged regarding the nurses' feelings and thoughts about this experience are described below and illustrated with direct quotations. Nurses were unclear about the rationale and directions for completing the SDLRS. Some hunches were made about the possible reasons for asking the nurses to complete the SDLRS. Comments which reflect this are:

> Jane: I didn't understand the purpose of doing it unless it supports the idea that we must be self-directed to be in public health...and if they were not self-directed perhaps this wasn't a type of nursing to consider.

> Nancy: It felt like you were being asked to do something when you were not 100% sure why. For some reason people couldn't get their head around why they were doing it. Is this part of an exercise to determine readiness across the health department. What

are we doing this for?

Elizabeth: I can see it would be a valid sort of way to start...a self-directed process at the health department. You need to see...if people are interested in it and if they have that sort of learning style.

Liana: It was important to establish a baseline of where people were at as far as their thinking and views on self-direction. That baseline is important for future things such as staff development, orientation...

The nurses described an array of feelings about completing the SDLRS. For some it was a positive experience which reaffirmed their self-perceived belief that they were self-directed learners as noted below:

Susan: It was a positive experience because it reaffirmed for me all the kinds of skills I am already using. I see self-directed learning as something positive...so for me to check off that yes I am able to identify my learning needs...it give me a sense of accomplishment or positive feedback.

Debbie: I knew I was self-directed...so when I filled in the scale I could see the slant of the questions and

I knew what side of the line I fell on. The result was not surprising and I was in the high end of being self-directed.

Carol: All the way through I did see myself as a self-directed learner. I knew I placed fairly high on the scale. There was nothing surprising.

Jane: I saw it as the first step to look at my feelings...and my readiness to learn. I saw it as a growth experience because it was along the same lines as assessing myself and my needs and it was another tool to do this.

Others were insulted to be asked to complete the scale. They described their feelings as follows:

Nancy: I think in some cases people felt insulted by it. I think they felt beyond this in self-directed learning. People were thinking, "So why are you assessing my readiness when I already feel like I am doing this?

Carol: One nurse who was somewhat disgusted said, "Self-directed learning had been around for a while...she had lots of experience in it. The rest of

us out of respect...filled it in. It was another piece of paper.

Two nurses described the reaction of their peers at the time of completing the SDLRS which expressed anxiety that their score could influence their employment status. Comments which reflect this include:

Liana: One issue with the SDLRS was the timing. There was so much going on with organizational restructuring, this added one more concern to people. While we introduced the idea to raise awareness some people wondered--if they didn't put the "right" answer down, would this influence their employment status? People were up tight about job security, the economy...all of these factors into how a person perceives any particular tool. It was a sign of the times.

Susan: Some said, "Oh, so are we going to lose our job if we are not self-directed? Some of this was said in a humorous way but I sensed there were some concerns under all of this.

Presentations to the Nursing Teams

The staff development coordinator met with all of the

nurses in the various locations to present her role description, the results of the SDLRS and the topic "self-directed learning--a framework for orientation." The framework was based on Knowles' andragogical model of self-directed learning.

The nurses' perceptions and reactions to the proposed self-directed orientation program are described in terms of three main themes: the individual nurse, the nursing team, and the organization.

The Individual Nurse

Although three nurses thought a self-directed learning program in the workplace would be a positive experience for them, they were quite empathetic for some of their coworkers who might not feel the same way. There was a voiced concern that not everyone welcomed a self-directed learning program. They thought some nurses might not be comfortable with this approach and might even feel insecure about the jargon used to describe self-directed learning. This view was expressed as follows:

> Elizabeth: I think going to self-directed learning is great...the concern I have is for the people that (sic) are not used to it. Everyone is at a different stage at this and that has to be accounted for. I think the idea needs to be sold to some people. It needs to

benefit them in some way or another.

Susan: I think it is a great idea. It created energy for me. Then I started to think about the staff who have not been through a self-directed learning process. I wonder how they will react and think? I heard some nurse mention, "Have you reviewed other models?"; "Why this one?"; and "Feeling like a student again?" There was a lot of concern about criteria for evaluation and who was going to develop the evaluation.

Liana: A lot of the younger nurses who are coming on board are aware of self-directed learning and the terminology that frames that concept or model. I think we have to be careful about...the jargon. If people come with one particular learning style, talking jargon, it tends to put people off. It makes you feel less than secure in your own knowledge base in understanding what self-directed learning means.

Only one nurse, Carol, expressed disinterest in the newly-proposed self-directed orientation program by saying:

I was not terribly interested. I don't remember anything else to comment on although I was present for the meeting.

Some nurses reinforced the idea that being a self-directed learner in the workplace today is imperative. Job requirements change rapidly to accommodate technological and conceptual innovation. A self-directed learning model is a tool for change.

> Jane: Our health department is so dynamic. It is nice when you are undergoing change to look at the positives...it helps to adapt to change. I think a self-directed learning model will be a tool to help us with change. If we want to stay abreast of the changes we need to be able to recognize certain skills are needed for a certain direction.

> Carol: I don't see how you would be able to work in these times if you were not a self-directed learner. Technology and information is growing so rapidly that you might as well keep up or give up.

> Jane: I am in support of the program. I think it will fit in...directing myself in what skills I might need and what I see...with our changing role.

Many other ways self-directed learning could benefit the individual nurse were expressed such as:

Liana: I see the activity of goal and objective setting for learning needs much more valued today. At a time when there are a lot of stresses in people's lives and in the workplace, if we can take an objective and actually be able to say in six months time I did that...it gives us one more opportunity to pat ourselves on the back and we need that.

Carol: A learning plan should be used as an evaluation tool. Goals and professional growth will come from this, which is positive and exciting.

Debbie: It would help someone going into a new position...What is important to this position?, How do I go about filling in the gaps and meeting needs?, What are my learning resources and how do I know I have accomplished it if I do?

Four nurses saw themselves functioning in the role of facilitator of learning in the future with coworkers, especially new staff. They stated:

Elizabeth: If someone new came onto a team...my role would be to act as a role model, facilitating their learning experiences, making sure they get to all the activities they need to see and feel comfortable doing.

Liana: I see myself in a supportive role by ensuring new staff can access the various things that they need. When you look at the whole issue of self-directed learning I would...encourage people to be more self-directed...value networking and sharing.

Nancy: I see myself helping staff to identify learning needs and to provide feedback.

Debbie: With any new staff I would emphasize with them the need of using self-directed learning skills.

Elizabeth: There may be some walls with some people...I might need help in breaking some of these walls. I would need help with the people who are not buying into it. It is easy to turn and forget them but I don't want to see that happen.

The Nursing Team

Three nurses also discussed the way in which a self-directed learning model could benefit team functioning in the workplace. They thought the same skills used by individuals to be self-directed could be transferred to the different groups of nurses who worked together on teams. Each team working as one unit could function in a self-directed manner. The following comments explain this

belief.

Debbie: The new self-directed learning program may really be a directive for our new team to look at what we are doing...evaluate our team functioning.

Carol: As a new team, together we will grow and decide what the needs are for the region. We will set out to do some self-directed learning related to the needs.

Susan: I want to focus on the team approach with the nurses which they see as a positive aspect of this process.

The Organization

Not only will a self-directed learning model benefit individuals and team functioning, but there is also the opinion that it may benefit the organization as a whole.

Two nurses thought one example of this was that a self-directed learning model promotes structure and consistency in an organization. They stated:

Jane: It is a positive experience where I am not having to do it on my own. It is nice for us to all be talking about the same thing...and being on the same wave length with philosophy or theory. It just makes

it easier.

Liana: This is formalizing a process to ensure some consistency in the way orientation is implemented across the division. Self-directed learning needs a structure around it...part of the structure is the formalization and acceptance of the model so that we give people the support that they need to be self-directed. The support is important or else we will have practitioners who will...go out and hang themselves or get themselves in trouble.

Another benefit to the organization with a self-directed learning program was the opportunity to evaluate outcomes which would demonstrate the effectiveness of the organization. This perception by three nurses is described below.

Jane: With objectives I like the idea of being able to measure them. It lets me know how I'm doing and it is good for our organization to show how effective we are.

Susan: It is a good opportunity to gain some experience in writing objectives. The directive from the Ministry of Health is for us to evaluate and provide some evidence of outcomes to determine what we are doing is effective. So we are right on line with

what the ministry is asking and what we are trying to do here.

Nancy: I think it is a good model. It is the best approach which best fits our organization.

The nurses conceptualized many positive and constructive benefits which a self-directed learning model could have for the individual nurse, the nursing team, and ultimately the health department as an organization.

Constructing a Competency Model

The next activity which the staff development coordinator began was to collaborate with staff in identifying the skills and roles of public health nurses. This was accompanied by the coordinator facilitating what she called a focus group meeting. A focus group interview is an interview with a small group of people on a specific topic. Focus group interviewing was developed in the 1950s by market researchers as a way of simulating the consumer group process of decision making in order to gather more accurate information about consumer product preferences (Patton, 1990). All nurses were asked to attend one meeting and given three different dates and locations from which to choose.

The idea of having focus groups of nurses was a recommendation from the staff nurses. Nurses wanted the opportunity to provide their views about their role as public health nurses because they were concerned about who was going to set criteria which would be used for their evaluation. There was no written list of competencies regarding the role of the public health nurse at the health department. The document Community Health Public Health Nursing In Canada (1990) was informally used by staff as a resource regarding nursing practice.

Reactions of the nurses were quite mixed regarding the construction of a public health nurse competency model during the group meetings. Some thought:

It was a valuable learning experience.

> Jane: I liked being involved in the focus group. I was eager to give my opinions. It would really show what we do here and what skills are needed.

> Liana: There needs to be a system in place where people can demonstrate a certain level of competency on the continuum somewhere between novice to expert... . Looking at roles and competencies we have struggled with that...what does a public health nurse do anyway? It was a really tough job.

Debbie: One of the problems I see with this process is being able to recognize. It is easy to recognize certain...gaps...but there is a developmental phase that you go through in reaching a higher level in everything. It is hard to know what level you are dealing with qualitative and very subjective often.

It was a waste of time.

Carol: I was resentful of that time spent. She asked us to define our job as pubic health nurses. I felt we were beating a dead horse. The green book is excellent. We could have just taken the book out...looked at every part of it to develop learning goals.

It was confusing.

Elizabeth: I remember thinking, "What did we just do for three hours?" I had some different feelings; I wasn't sure how the focus group connected to what was going on. It wasn't clear.

Review of Summarized Draft Competency Model

The data gathered at the focus group meetings were summarized and then circulated for additional input from the nurses, supervisors, and nursing director. The nurses' reactions to this task were varied as seen in the statements below.

This task was not welcomed by people.

> Liana: There was an awful amount of material that went out and perhaps it may have been overwhelming at times...a lot to digest.

> Susan: People thought it was too big a task...overloaded. They felt it was too big a job right now because of factors such as timing, commitments and changes in the health department now.

One person who did not attend the focus group meeting stated:

> Nancy: People don't review written things well. It takes too much time. What might have been useful to have fanned out the responsibility for particular parts of developing behavioural objectives...and involving

them in the whole development of it rather than just the review. She has participation but hasn't really used the people and said "Where are we?"

As noted, there were mixed reactions to accomplishing the huge task of beginning to develop a competency model for the role of the public health nurse.

The Orientation Manual

While the previously described activities were taking place, the staff development coordinator was also developing an orientation manual for new staff. The nurses' perceptions regarding the draft manual are summarized as follows:

The idea of a manual is valued.

Susan: I feel this (the manual) is important. Although...the process gone through with the nurses has been very valuable...we need to provide some evidence of the past six months.

Debbie: The manual...will help a lot. It is something for team leaders that is concrete to use to help new staff to understand the different parts...to clarify things...to understand.

The manual may not represent reality.

Nancy: The manual may change. You can develop a manual and have it not totally represent what is going on.

Not enough staff input into the manual.

Nancy: I don't think we had a lot of input into the manual. We got these things and were asked to comment on them, a huge amount of papers that came with no preparation other than "Please review it" and "This is where it came from."

Reactions to the Overall Process

The themes which emerged describing the nurses' perceptions and reactions to the overall process of implementing the initial phase of the introduction of a self-directed orientation program are illustrated below.

Validates I am self-directed.

Susan: Overall, it is very positive. I have not come across anyone who said this is an unwise idea. It reawakens the whole model in you at least for me. It

reinforced some skills I had used as a nursing student. It brought to my attention that these are skills that we use on an everyday basis.

Debbie: If anything it brought about the realization that what I was doing in school was continuing in my job. It has encouraged me to continue in self-reflection.

Liana: I think the formalization of the process and helping people work through "Yes this is what I do anyway," this putting a framework around it. It has been an empowering process for me. It strengthened my belief that the democratic process works within our group.

Dissatisfaction.

Carol: Initially we understood it was part of the staff coordinator's job. As things got more stressed with other changes in our office...I did become somewhat resentful to attend meetings giving up from other items which took time.

Liana: It was one more thing that was added to my workload which is the reality of the situation.

Nancy: I think there are a lot of resources that have not been tapped in terms of ideas. I think there are contributions that have not been brought forward. I sort of feel on the fringe. I have a feeling as being not well utilized to facilitate the process. I would like to feel more part of it. I see it as "out there" and everything else is here. Periodically it parachutes in...but it is not a theme yet that is inherent. It is not mainstream. I don't have a feel for what this is going to mean. It is always this way when you are introducing things.

The process: in hindsight.

It was felt by one nurse that not enough people in positions of authority were supporting the introduction of the self-directed orientation program. She commented:

Susan: It would have been very helpful from the beginning of the process if there were more people in the position of authority and decision-making power in the system, on board with...introducing the whole idea...because it is from this core of people that we are going to set the tone for the rest of the process. It was often referred to as something that the staff development coordinator was doing, and spearheading.

Another nurse perceived the staff development coordinator to be working in isolation. She stated:

> Nancy: I think she (staff development coordinator) needs to work less in isolation and more consistently with the nurses or team leaders or supervisors. Somehow it has to stop being in isolation over here with reports and more connected. I don't know how physically that would work in terms of bringing people on board.

The Next Phase in the Introduction of a Self-directed Orientation Program

The next planned activity of the staff development coordinator was to provide inservice to nursing team leaders, who would act as facilitators of self-directed learning in the health department. The inservice would cover topics such as formulating learning objectives, identifying resources and examples of evidence of learning, and developing criteria for evaluation. As team leaders would formally share this information with all of the nursing staff, the implementation of a self-directed orientation program based on Knowles' andragogical model would then begin to take place.

The inservice just described had not taken place yet at

the time I conducted the interviews for this study but the nurses had strong comments about this proposed activity. One concern voiced by three nurses was that there were already too many other organizational changes going on. They wanted the inservice to be postponed. They stated:

> Susan: We have to be very sensitive to all the changes going on in our division now. If they want to put this off, I think we should. This is part of the ongoing assessment of readiness to learn. I can see staff thinking they do not have the time or energy for this now. Sometimes it's easy to go through a process but then you have to realize that people are not part of the process and this is what complicates things.

> Debbie: We are so busy and apprehensive with the changes and staffing cutback that this may not be a good time for staff to learn. I would ask that this be postponed. I think some staff would be threatened by this as being one more change, see it as more paperwork, and less time at service delivery. Staff would react in a more positive way at a later time.

> Liana: I'm not sure we have the luxury of doing this the way we would like based on the current economy and financial restraint.

Unlike the belief of the nurses just described, Nancy thought the inservice should proceed as planned so that the self-directed learning model would be practised sooner rather than later. She said:

Nancy: I think it is going to be good when it gets going but it is time to move on and start doing some of it.

Summary

In summary, the perceptions and feelings of nurses at a health department, regarding the introductory phase of a self-directed orientation program, have been analyzed and described. Chapter Five will include the summary, discussion, implications and recommendations.

CHAPTER FIVE: SUMMARY, DISCUSSION, IMPLICATIONS AND RECOMMENDATIONS

This study examined the perceived experiences of seven public health nurses regarding the initial phase of the introduction of a self-directed orientation program based on Knowles' andragogical model in a health department, their place of employment. The study investigated those factors which facilitate the process of becoming self-directed through two research questions:

1) What are the nurses' perceived experiences of the introduction of a self-directed learning model in the workplace?
2) What are the perceptions of the nurses as they are encouraged to become self-directed learners in the workplace?

A desire to understand what factors facilitate nurses in the process of becoming self-directed learners was the purpose of this study. Seeking to understand specific information, grounded in the nurses' point of view, was regarded as meaningful and quite valuable to me as the investigator.

The study was based on the assumptions that, first, self-directed learning is an ongoing process in which adults actively participate, by defining their learning needs, choosing appropriate learning resources and implementing and

evaluating their own learning outcomes and, second, that learners need to learn to be self-directed.

This chapter will summarize and discuss the research findings. Implications resulting from the discussion will be explored, and recommendations for research and practice will be suggested.

Summary and Discussion of Research Findings

The Meaning of Self-directed Learning

The definition of self-directed learning differs widely in the literature (Knowles, 1990; Candy, 1991; Cranton, 1992; Brockett & Hiemstra, 1991). This was quite evident in the findings of this study as well. According to the nurses, self-directed learning was found to refer to four phenomena:

- a method of planning one's own instruction;
- a life-centred activity;
- a personal quality or attribute;
- a method of learning which facilitates a sense of personal control.

Self-directed learning is a complex and multifaceted domain. The scope of these findings is reflected by Candy (1991) who states "self-directed learning is really several concepts whose differences are submerged and obscured by the use of a single term" (p. 22). Brockett and Hiemstra (1991)

describe the term self-directed learning as an umbrella concept with more than one dimension. The different definitions of self-directed learning described by the nurses seem to mirror some of the theoretical development in adult education to date, reflecting the complexity of self-direction and the lack of a universal definition.

A working definition of self-directed learning based on the understanding of the nurses is:

> Self-directed learning is life-centred and fosters a sense of personal learner control. Some learners claim this learning process to be naturally engrained or a personal attribute while others need to learn it by establishing collaborative working relationships with supportive facilitators of learning, as they proceed through the process of becoming self-directed learners.

In explaining what self-directed learning meant to them, four nurses described their perceptions about past learning experiences within a more traditional style of education in which teachers transmit information to their students. They discussed feeling "spoon fed" and directed by the teacher in their pursuit of learning. There is a belief by some authors that students have been socialized by years of experience in formal education into a passive role and do not associate learning with a more active function (Candy, 1991). One interesting finding experienced by the

nurses contrary to this belief was that unmet learning needs experienced during the traditional mode of learning increased their drive to pursue a more independent approach to learning. This increased drive was precipitated by a feeling of discomfort or insecurity in not understanding something which a teacher had introduced. Rather than passively relying on the teacher for further assistance to explain and clarify a topic these learners felt the need to independently seek information from other sources to meet their learning needs. Once the learning needs were met, the learners described a feeling of security and competence.

This finding reinforces certain adult education theorists' beliefs about adults as self-directed learners. Knowles (1990) assumes adults have a self-concept of being responsible for their own decisions and a need to learn from experience. Brookfield (1986) emphasizes the adult's quest for critical reflection and the creation of personal meaning in learning.

These four nurses described personal experiences of being natural self-directed learners enrolled in a traditional school of learning. They described a strong inner drive to accept responsibility for their own learning, the necessity to ensure some personal control of the learning situation and a feeling of personal security in accomplishing their perceived high level of competency. This finding supports the particular meaning of self-

direction as a characteristic or personal quality of certain individuals. Candy (1991) and Brockett and Hiemstra (1991) illustrate an overview of studies which have examined learner self-direction as a personality characteristic. Learner self-direction or as Candy describes through the term personal autonomy, centres on a learner's desire or preference for assuming responsibility for learning. One of the most vital qualities is having a self-concept of autonomy which is largely beyond the ability of the educator to influence (Candy, 1991). For the type of learner who falls under this category, a carefully planned learning plan and environment set up to foster self-directed learning similar to that which Knowles promotes, may not actually even be necessary. The learners naturally take control of the learning situation to satisfy an inner drive of self-direction to accomplish their learning goals. Wang (1983) calls this phenomenon "a sense of personal control" (p. 214) which he defines as students' beliefs that they are personally responsible for their school learning.

For other learners, there is a need to learn or a process to go through to become self-directed. Program planners and facilitators must keep this important factor in mind when planning self-directed learning programs. Although all the nurses interviewed for this study stated that they were self-directed, they acknowledged the concept of a continuum of self-direction. The nurses would be at

different stages on the continuum of self-directed learning and not all move towards self-direction at the same rate. Candy (1991) even stresses that self-direction is not a quality that exists in a person or situation independently but rather is a result of the interaction between a person and a situation. He points out that a person's ability to be fully self-directing is constrained by the nature of the learning situation, by the nature of knowledge, by the learner's social context and by his or her own view of the situation.

This belief of Candy's might explain the finding that all seven nurses reported being self-directed. The nurse participants may have felt some pressure in their work environment to state that they were self-directed. Perhaps factors such as job security and advancement played a role in the nurses' reported perceptions of being self-directed and should be noted as a potential limitation of this study.

Acknowledging that all staff were at different stages in self-direction, various activities were conducted for the nursing staff to be introduced to the idea of a self-directed learning model in the health department. These activities were planned to facilitate the transition from the more traditional teaching/learning approach which had historically taken place in the health department to a more self-directed method of learning.

The nurses' feelings, thoughts and perceptions

regarding the four activities implemented to facilitate the introduction of a self-directed learning model in the health department will be discussed under the following headings:

1) Completion of the Self-Directed Learning Readiness Scale;
2) Group discussions with nursing teams;
3) Constructing a competency model; and
4) Completion of an orientation manual.

Introducing a Self-directed Learning Model

Completion of the Self-directed Learning Readiness Scale

To first introduce the idea of self-directed learning and assess the nursing staff's perceived readiness for self-directed learning, all nurses in the health department were asked to complete Guglielmino's (1977) Self-Directed Learning Readiness Scale (SDLRS). One apparent gap in the literature is the learners' opinions and voiced feelings about completing the SDLRS. As Brookfield (1986) and Candy (1991) point out there has been an overemphasis on the quantitative and quantifiable dimensions of self-directed learning endeavours, without regard to its meaning to individual learners. The number of reported studies that deal adequately with the varied experiences of individual self-directed learners through a qualitative approach is small. The nurses in this study shared their thoughts and

feelings about completing the SDLRS in their workplace.

Some nurses felt this was a growth experience which reaffirmed their perception that they were self-directed learners. This provided certain individuals with a sense of accomplishment. Overall, the strategy of completing the SDLRS to increase awareness about self-directed learning was not highly effective. Some nurses were unclear about the rationale for completing the SDLRS which caused their anxiety levels to increase. Others saw it as a test of their abilities which might affect their employment status. Since health department restructuring activities were simultaneously going on within the health department at this time, this was understandable. Others were insulted by being asked to complete the SDLRS. They believed since they were already practising in a self-directed manner their "readiness should not need to be assessed." In other words they felt the self-directed learning skills which they felt quite competent in practising, were not being acknowledged by the health department. Clear communication about the purpose and rationale for completing the SDLRS seemed to be lacking. The varied meaning of this experience for this group of nurses demonstrates the importance of providing clear and detailed communication regarding the rationale of completing research instruments like the SDLRS and its purpose. As well, the appropriateness of using such a scale to increase awareness of self-directed learning with

employees in a work setting needs to be further addressed in future studies.

The second activity which took place with the nursing staff was group discussions with the nursing teams.

Group Discussions with the Nursing Teams

The staff development coordinator met with the nursing staff to present a self-directed learning model as a framework for the orientation of new staff. This method of communicating the newly proposed concepts seemed quite effective. There were plenty of opportunities in small groups (approximately six to twelve nurses) to discuss issues, concerns and answer questions. The nurses' perceptions and reactions to the proposed program are described in terms of three themes: the individual nurse; the nursing team and the organization.

The individual nurse. Senior nurses saw themselves as being responsible to act as facilitators of learning for new nurses. To them, this meant acting as role models, resource consultants, peer evaluators and support people to new staff. The nurses strongly pointed out a cautionary note though, which is also discussed by Knowles (1990) in which he states everyone is at a different stage on the continuum of self-directed learning and this definitely has to be taken into consideration in facilitating learners to become

self-directed. Not everyone will be comfortable with this method of learning and needs to be supported in becoming self-directed. According to Candy (1991), the success of a self-directed project depends largely on the extent and type of assistance obtained by individual learners, and on the quality of the personal relationships established between the learner and his or her helper. Assistance must be viewed as an act of sharing, marked by warmth, empathy and authenticity.

The nurse participants not only saw themselves as facilitators in the orientation process but also as learners themselves. They described the self-directed learning model as a guide for all nursing staff to follow in their quest to meet the everchanging staff development learning needs.

One nurse stated, "A self-directed learning model is a tool for individuals to cope with change." With job requirements of nurses rapidly changing in the health department to accommodate new trends in meeting the public's health care demands, the nurses saw the self-directed learning model as a tool for individual staff to cope with change. The new competency model would be constructed by staff and administration to describe the expected performance behaviours of public health nurses. The nurses saw themselves continually assessing their present levels of competencies compared to the model, measuring gaps between their competencies and those expected in the constructed

model and lastly identifying specific individual learning needs. Personal and professional goals would then be promoted by developing learning objectives which would be implemented and evaluated. Since the health department was described by the nurses as a dynamic organization, they felt the self-directed learning model would assist them in staying abreast of some of the necessary changes and facilitate the development of new skills needed for a new direction. The development of skills required to promote self-direction in individuals was not regarded as an end in itself. The nurses saw this as an opportunity to lead to a broader goal to include nursing team and organizational outcomes.

The nursing team. The nurse participants believe the skills which are needed to function in a self-directed learning model such as determining needs, developing objectives and evaluating outcomes are transferrable. Not only would individual nurses strive to be self-directed but each team of nurses could perform in a self-directed manner as a unit by performing these skills to develop, implement and evaluate public health nursing programs and promote team functioning. This finding is in contrast to Candy (1991) who states there is limited transferability of competence from one learning situation to another since the nature of self-directed learning has a social as well as a cognitive

component. Each learning situation is unique with potential internal and external elements present which inhibit or promote self-directedness in individuals. The nurses believed a self-directed learning model in place at their workplace would enhance the transferability of skills necessary to function as individual self-directed learners to a team approach of self-directedness.

The organization. As the nurses developed competencies to fulfill new job expectations, ideally the ultimate outcome in their eyes would be that the goals of the organization, the health department, would then be met. One way this could be facilitated would be through the evaluative component of a self-directed learning model. The evidence of outcomes are evaluated based on predetermined criteria. The measured outcomes of programs compared with the organizational goals should demonstrate how well the organization functions and ultimately how effective it is. They should demonstrate the effectiveness of employees, the effectiveness of the programs and ultimately the effectiveness of the organization.

The nurses also felt that a self-directed learning model would promote structure and consistency in the health department. It would provide a philosophy of learning which could be shared by all nurses. The goal of encouraging self-directed learning would be promoted by people sharing

similar theoretical language and beliefs.

Overall, discussions with the nursing teams seemed to be an effective method of communicating to staff about introducing the concept of a self-directed learning model. They were able to conceptualize many positive and constructive benefits which the model would have for the individual staff nurse, the nursing teams, and ultimately the health department as an organization.

The third activity which will be described is the development of a competency model.

Constructing a Competency Model

Interestingly, when the time came for the nurses to take part in actually constructing a competency-based model the majority of nurses did not particularly appreciate the task.

A competency is the ability to do something at some level of proficiency and is usually composed of some combination of knowledge, understanding, skill, attitude and values (Knowles, 1980). According to Knowles there are three major sources of data for building a competency model:

1) the individual learner's own perception of what he or she wants to achieve;
2) the organization's perception of desired performance of employees, and

3) societal perceptions of desired performance obtained from professional organizations such as the College of Nurses of Ontario.

It was thought by the staff development coordinator and some staff to be imperative to ensure staff had the opportunity to build the model and be part of the process. Through experimentation, Knowles (1980) has found the technique of pooling lists of competencies compiled by groups of students and supplemented by the facilitator of learning produced the model to which students have the greatest commitment. Nurses wanted to be able to provide information about their role as public health nurses but more importantly to them, they wanted "a say" in the setting of criteria which would be used, ultimately, in the staff evaluation process. Heron (1981) claims that control over evaluation of learning is a key issue where problems of power are often found. Collaboration between the learners and facilitators of learning needs to take place throughout the whole process of self-directed learning.

What Knowles and other authors fail to mention are the frustrations, pitfalls and difficulties in building a competency model. Although some nurses thought the process of building the competency model was a valuable experience, most people felt overwhelmed by the exercise. Nurses were resentful of the time spent in the activity and saw the task as enormous. One person did not even understand the concept

of a competency model and why she was part of the process in developing one. The nurses who appreciated taking part in developing the competency model stressed a future need to identify certain levels of competency. These competencies would be placed on a continuum to reflect expectations of nurses from novice to expert. They felt the competency model needed to acknowledge the developmental phase that learners go through in reaching higher levels of expertise. Benner (1984), a prominent nurse researcher, describes five levels of expertise of nurses:

Stage 1: novice;

Stage 2: advanced beginner;

Stage 3: competent;

Stage 4: proficient; and

Stage 5: expert.

Each stage requires unique implications for teaching and learning.

The experience of developing a competency model was perceived quite differently by various nurses for various reasons. One can only postulate the reasons for this. Many factors need to be considered such as the size of the working group, sufficient time to accomplish the task, adequate resources and the need for clearly stated rationale for asking staff to take part in such an undertaking.

The last activity which the nurses commented on was the completion of an orientation manual for self-directed

learning which is described below.

Completion of an Orientation Manual

The idea of having a reference manual on the self-directed orientation program was welcomed. Nurses felt it would be a good resource to explain and clarify information for new staff regarding the self-directed orientation program. Like all manuals, though, it would have to be continuously evaluated and revised to reflect the reality of nursing practice.

At this phase in the process of introducing a self-directed learning model, the seven nurses were interviewed for this study. More activities were planned to introduce the model in the health department but, since the activities had not taken place at this point in time, they cannot be discussed in this study.

By describing a situation from the perspective of the participants, no matter how carefully and systematically this is done, one must remember individuals are often caught up in crucial problems of social conflict and social change, some of which they are unaware (Carr & Kemmis, 1983). Many external factors regarding the social reality of the nurses' experience were very influential in shaping their perceived experience.

Some issues will be explored in the next section of this study which will help to summarize some of the factors

which may have shaped some of the nurses' perceived experiences described in this study and begin to answer the research question, "What facilitates the process of becoming a self-directed learner?", through a discussion regarding implications for practice.

Implications for Practice

The results of this study have implications for program planners, nursing administrators, nurse educators and facilitators of learning. The results described the nurses' perceptions of experiences, feelings and thoughts regarding the initial phase of the introduction of a self-directed learning model in a workplace. Planned activities were implemented to begin to ease the nurses through the transition of becoming self-directed learners. By listening to seven nurses tell what it was like for them to go through such an experience, meaningful implications for future practice have evolved as noted below.

1) One nurse stated, "A self-directed learning model is a tool for individuals to cope with change." With job requirements of nurses rapidly changing in the health department to accommodate new trends in meeting the public's health care demands, the nurses saw the self-directed learning model as a tool for individual staff to cope with change. As

new competency models would need to be constructed to describe the often changing, expected work performance behaviours, staff must continually assess their present levels of competencies compared to the model, measure gaps between their competencies and those expected in the constructed model and lastly identify specific individual learning needs. Personal and professional goals would then be promoted by developing learning objectives which would be implemented and evaluated. A self-directed learning model is a tool for employees to continue to stay abreast of changing role expectations in a dynamic organization.

2) Nurses who perceived themselves as self-directed learners were pleased overall with the introductory phase because it reinforced for them that they were in fact self-directed, and that the organization that they worked in valued and supported such a concept. They saw the skills developed as self-directed learners to be transferable to different situations, to benefit individual learners, nursing teams and ultimately the health department.

3) Although most nurses welcomed the idea of implementing a self-directed learning model, they

resented the time and additional workload of being part of the process of developing such a program. Theorists such as Knowles and Freire emphasize the importance of facilitators working collaboratively with learners in the planning, implementation and evaluation of learning to promote learner empowerment. Factors which facilitate learners to be part of such a process in a workplace need to be further explored.

. Time provided: A realistic time frame must be planned to allow employees to actively participate in activities such as building a competency model.

. Timing: The timing of introducing a new program needs to be planned very carefully. The readiness of individuals to accept a new concept depends on other factors in the organization such as the employee's concern for role changes, job security, personal commitments and responsibilities and his or her tolerance level in an already turbulent environment with many organizational changes.

. Number of staff: Should all staff be encouraged to participate in the development of a new self-directed learning model or should a group of staff representatives form a working group to accomplish the tasks? Perhaps it was unrealistic

to expect all staff to be part of the developmental stage of initiating a change. If the workload was adjusted for some staff representatives to participate in the development of the competency model possibly there would have been less feeling of resentment and work overload.

4) One nurse made a statement that she thought the concept of a self-directed learning model was "on the fringe." It periodically parachutes in but is not yet an accepted theme in the health department. This is probably a common finding in a large organization when a new program is first introduced. It could also be the beginning of a symptom of a problem in an organization when a new concept is not readily accepted by individuals. Successful strategies must continue to be communicated and evaluated on an ongoing basis to promote acceptance of a new program.

5) Communication: In this particular study, in many instances the nurses did not seem to understand what they were expected to do or why, in the process of implementing the self-directed learning model. Staff input was valued but the staff were unsure of what was being asked of them. Staff must understand the new concepts and rationale for instituting them. The clarity and interpretation

of the communication is extremely vital. To be truly self-directed this new self-directed learning model needed to have been initiated by the nurses and not the administration via the staff development coordinator. The nurses' reactions were quite understandable since the introductory activities were "other-directed." The self-directed model was literally imposed on the group of nurses which strongly contradicts the true nature of self-directedness. Is the imposition of a self-directed learning model realistic in terms of an organization promoting a certain philosophy of education?

6) There is a need to acknowledge that with a new learning model such as self-directed learning, there also comes new jargon or terminology that makes some people feel anxious and left out if they do not understand it. According to a few nurses, this jargon tends to "put people off" making them feel less secure in understanding what self-directed learning really means. Facilitators must be aware of these feelings of inferiority and pave the way in a nonthreatening manner to assist learners in a language they will understand which will promote learning.

7) The staff development coordinator was perceived by

some nurses to work in isolation. This idea was reinforced with the belief that more people in the position of authority, with decision-making power in the system needed to "be on board" with introducing the idea of a self-directed learning model. It is from this core of people that the tone for the rest of the process will be set. Administrators and facilitators of learning must be, or appear to be, in full support of a new program or concept for it to work. They also need to be actively involved in the process to instigate the change.

The findings of this study have implications for practice and, as well, recommendations for further research.

Recommendations for Further Research

This study has precipitated questions and themes to be explored which are recommended for further research as follows:

1) Only the initial phase of the introduction of a self-directed model of learning was examined in this study. As time moves on, the perceptions of nurses involved further in becoming self-directed in the health department could be explored. To what degree are the nurses' initial perceptions of

themselves as being self-directed accurate? What will the nurses think about setting their own written learning objectives? Will the evaluation of learning really be perceived as being done in a collaborative way? Will the nurses feel learning in a self-directed manner to be effective? Is self-directed learning conducive to the workplace? Brookfield (1987) provides an interesting overview of literature related to critical thinking in the workplace but there are still many unanswered questions yet to be studied.

2) Is the quantity and quality of learning that has taken place in a self-directed manner any different from the learning outcomes of another approach to learning?

3) The topic of becoming self-directed continues to be a ripe area for researchers. This study has only lightly touched upon the process of learners moving towards self-direction. Further ongoing research is recommended, to continue to answer the question, "What facilitates the process of becoming self-directed?"

4) Is the use of the SDLRS in a workplace setting appropriate? The nurses in this study did not seem to think so. Since the findings of this study may not be generalizable, other studies

would have to address this question.

5) Although I found Knowles' assumptions to provide a sound model to guide the introduction of a workplace self-directed orientation program, it did not adequately explain or reflect the nurses' perceptions regarding self-directed learning described in the findings of this study. Other theories must be considered and developed by researchers to guide practitioners.

6) Researchers need to continue to search for the true meaning of self-directed learning. This seems to be a monumental challenge. At the present time, in the field of self-directed learning research, there seem to be as many definitions of self-directed learning as there are researchers.

Much excellent work has been accomplished in the field of adult education regarding self-directed learning to date. The findings of this study help to demonstrate that much more research data are called for to build a firmly based theory in self-directed learning.

Summary and Conclusion

The summarized experiences, thoughts and feelings described by the nurses in this study provide a magnified true to life view of the first few phases of Cranton's (1992) model of "Working Toward Self-Directed Learning: The Process." The nurses had a diverse set of expectations and individual characteristics. They all reacted differently to the newly-proposed approach to learning, which for some caused anxiety, fear, and resentment, while for others precipitated feelings of joy and a sense of accomplishment. Some wanted to withdraw, while others saw it as an opportunity to explore and reflect.

If one accepts the idea that learners are on a continuum of self-directedness which is everchanging, depending on the learning situation and environment, the diversity of the nurses' varied perceptions of their experience can begin to be explained. The nurses described their thoughts, feelings and perceptions regarding the initial phase of the introduction of a self-directed learning model in the health department in which they were employed. The meaning of this experience for the seven nurses provided some insights into what does and what does not facilitate public health nurses in the process of becoming self-directed. Implications and recommendations for practitioners and researchers evolved from the findings

of this study.

The most meaningful finding for the researcher of this study is that at the beginning of this inquiry I thought that I knew what self-directed learning meant. Now, at the completion of this study, I know that my understanding of self-directed learning was quite limited. The nurses helped me to discover this valuable insight. They helped me to view self-directed learning as a multifaceted concept which I and other researchers need to continue to explore.

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Appendix A

Letter to Participants

November 26, 1992

Dear

Thank you for agreeing to participate in an interview with me for approximately one hour _____

_____

_____.

A copy of the interview questions is enclosed. The interview will be audiotaped with your permission. Confidentiality and anonymity will be maintained. You have the right to withdraw from the interview at any time without penalty.

During the past six months the concept of self-directed learning in the workplace has been discussed with you by the staff development coordinator. The idea of a self-directed orientation/staff development program has been introduced.

As you know I am in the Master of Education Program at Brock University, St. Catharines. To complete my studies, I am planning to conduct research on the development of self-directedness in public health nurses at Halton Regional Health Department.

The purpose of the study is to examine public health nurses' own perceived experiences during the initial phase of the introduction of a self-directed orientation/staff development program. What you have to say about this newly proposed self-directed program is very important and valuable information. Through your input, this study will provide insight into the development of self-directedness in public health nurses. This information will in turn help educators and nursing leaders to strengthen their understanding and ability to facilitate nurses' learning needs in the future.

Thank you so much for your participation in this study. A report of the results of the study will be distributed to you on completion.

Yours truly,

Cathy Bennett

Appendix B

Participant Consent Form

Research Study: The Development of Self-Directedness in Public Health Nurses

Investigator: Cathy Bennett - Master of Education Student, Brock University, St. Catharines, Ontario (under the supervision of Professor Richard Bond).

Description of the Study: This study is an examination of the development of self-directedness in public health nurses employed in the Halton Regional Health Department. It will focus on the participants own perceived experiences during the initial phase of the introduction of a self-directed staff development program.

I,_____, consent to participate in the research study stated above.

I understand the purpose of the study which has been explained to me by Cathy Bennett.

I understand that one week before the scheduled interview I have agreed to participate in, I will receive a copy of the interview questions.

I understand that if I agree, the interview will be audiotaped to help promote accuracy and comprehensiveness of the interview.

I understand I can refuse to answer any questions or stop the interview at any time without negative consequences to me.

I understand that my name will not be used in any reports of the study.

Date _____

Signature_____

Agree to taping interview._____

Do not agree to taping interview._____

Appendix C

Interview Guide

Research Study

Investigator: Cathy Bennett

During the past six months a model for self-directed learning has been gradually introduced to nurses in the health department.

1. How long have you worked for the Health Department?

2. How many years experience do you have as a public health nurse?

3. Do you see yourself as a self-directed learner? Please explain.

4. Describe any experiences with self-directed learning you have had in the past.

5. Can you describe what you think about the Self-Directed Learning Readiness Scale you completed?

6. What did you think or feel during the introduction of the self-directed orientation process?

7. How would you describe your experience with the process so far?

8. How do you see your involvement in the program in the future?

9. Is there anything else you would like to share?

Thank you very much for preparing for our interview. Please bring these forms with you on the day we meet.