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


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THE CONSTRUCTION OF AN EVALUATION MODEL FOR USE IN CONJUNCTION WITH CONTINUING EDUCATION COURSES IN THE NURSING PROFESSION

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Ph.D. THESIS

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ABBREVIATIONS

ANA American Nurses' Association
CANO Chief Area Nursing Officer
CCNS The Committee for Clinical Nursing Studies
CI Central Institution
CIPP Context-Input-Process-Product
CNAA Council for National Academic Awards
DNE Director of Nursing Education
DNS Director of Nursing Services
ECNM Experienced Charge Nurse Module
GFE Goal Free Evaluation
HB Health Board
NBS National Board for Nursing, Midwifery and Health Visiting for Scotland
NHS National Health Service
NO Nursing Officer
PS Professional Studies
PSI Professional Studies I
PSII Professional Studies II
PSI&II Professional Studies I & II
P2000 Project 2000
RGN Registered General Nurse
SN Staff Nurse
UGM Unit General Manager
UKCC United Kingdom Central Council
WS Ward Sister
GLOSSARY OF TERMS

A short explanation is given here of some of the terms that have been used in the text, as they are specific to the nursing profession.

Chief Area Nursing Officer
The individual responsible at Health Board level for the provision of nursing services in that area.

College of Nursing and Midwifery
The institution which is responsible for nurse preparation in a particular locality at basic and post-basic levels. In Scotland there is usually one College in each Health Board, except for larger Health Boards which have one for each of several designated districts.

Charge Nurse / Ward Sister
The Registered Nurse with the responsibility of managing the nursing care of patients, and the nursing staff in a ward or unit. This can be in either a hospital or a community setting. The term Charge Nurse is usually used to describe a male nurse at this level, and Ward Sister to describe a female nurse. Where the term is used collectively (thus including both male and female staff) the term Charge Nurse is used (as in the Experienced Charge Nurse Module).

Course Leader
The Registered Nurse Teacher with responsibility for a specific continuing education course in a College of Nursing and Midwifery.

Director of Nurse Education
The Registered Nurse Teacher in charge of a College of Nursing and Midwifery.

Director of Nursing Services
The Registered Nurse with overall responsibility for a hospital, or in the case of larger hospitals, the nurse with responsibility for a designated area within that hospital.

NBS / UKCC
The statutory bodies responsible for the regulation of nurses, nursing practice and nurse education. The United Kingdom Central Council controls registration and policy; the National Board for Nursing, Midwifery and Health Visiting for Scotland have responsibility for nurse education in Scotland.

Nurse Manager
A Registered Nurse with responsibility for a number of wards, or a specific unit, within a hospital or community setting.

Staff Nurse
A first level registered nurse, who works in a ward or unit, generally in a hospital setting.

Unit General Manager
An individual appointed by a Health Board, to administer a hospital, or a particular range of services across a number of hospitals.
ACKNOWLEDGEMENTS

"And now here is my secret, a very simple secret:
It is only with the heart that one can see rightly;
what is essential is invisible to the eye."

(from The Little Prince, by Antoine de Saint-Exupéry)

I think the acknowledgements are the hardest part of this thesis to write. Many people have been invaluable over the months and years in helping me to produce this work, and merely to mention them all seems scant reward for their efforts. In the following passage therefore I shall mention some key people, and to everyone else who has helped me at any stage, I am extremely grateful.

My first thanks must go to the NBS and Queen Margaret College for all the support that they have provided. In particular Maureen Gillon at the NBS, and the library staff at QMC (who shall remain anonymous!). Thanks also to all the respondents throughout Scotland, who have been a part of the two evaluations that were carried out. Without their willingness to give of their time and information, the work would not have been possible.

In providing moral and practical support over recent months many people have been invaluable. To friends at home and at work THANK YOU! (with a special mention going to Maxine Moy at QMC). Finally, I have been lucky enough to have had two supervisors - Ruth Schröck and Sinclair Broomfield - who have been, quite simply, wonderful. Thank you to you both.

This thesis is dedicated to Carol and the cats.

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THE CONSTRUCTION OF AN EVALUATION MODEL FOR USE IN CONJUNCTION WITH CONTINUING EDUCATION COURSES IN THE NURSING PROFESSION

SARA J. WHITELEY

Continuing education in Scotland underwent radical changes in the early 1980's, when the National Board for Nursing, Midwifery and Health Visiting for Scotland responded to the proposals of a working party report (Working Party 1981). They began re-designing their continuing education provision for qualified nurses, and in conjunction with this development, they commissioned two consecutive evaluations. One was to look at a course entitled 'The Experienced Charge Nurse Module', and the other was of a more complex modular development, entitled 'Professional Studies I and II'.

This thesis uses the work that was carried out by the author in executing the two evaluations, to propose a new model of evaluation for use in conjunction with continuing education courses. The need for the model became apparent in the early stages of the research, after the relevant nursing, evaluation, and continuing education literature sources were considered. No existing models appeared to completely meet the demands of the complexities of adult, continuing education courses, although it was considered that the 'Illuminative Evaluation' model of Parlett and Hamilton (1972) was a good basis to work from.

Through the initial evaluation of the Experienced Charge Nurse Module, certain methodologies - predominantly qualitative - were tested, and used in conjunction with progressive focusing (Parlett and Hamilton, 1972) and grounded theory techniques (Glaser and Strauss, 1967). This based the research strongly in the phenomenological field, and these techniques were pursued and strengthened through the second, much larger evaluation of Professional Studies I and II.

The main development at this stage, was that of a monitoring exercise. This complemented the evaluative component, and when the two elements were combined, they formed the 'Structure-Process-Outcome' model of evaluation (based on the categories used in the quality assurance field (Donabedian, 1966)). This is proposed as a flexible and comprehensive model which can be adapted for use at either the macro or micro level of evaluation.

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PART ONE:

BACKGROUND
CHAPTER 1 - INTRODUCTION

Why evaluate - why not maintain the status quo? Who needs evaluation anyway - or more specifically, why do you need a model of evaluation?

If a programme of education exists, there are three choices open to the providers (both educational and financial), in terms of continuation of that programme. Either the status quo is maintained (presumably through a strong belief that because the programme exists it is 'right' and necessary); or, small in-house evaluations are carried out each time the programme is run, to facilitate minor alterations; or, the commitment to a larger, more complete evaluation is made, to enable the answers to a series of questions (relating to issues such as quality of product, cost and benefit) to be found.

By choosing the latter of these three options i.e. the commitment to large scale evaluation, the National Board for Nursing, Midwifery and Health Visiting for Scotland (NBS) laid themselves open to the questions posed above. Ironically though, they also facilitated the search for the answers.

Background

In 1981, the report of a working party (referred to hereafter as the Auld report, after its chairman, Miss Margaret Auld) was published in Scotland (Working Party, 1981). It set out a series of recommendations relating to how, in future, qualified nurses should receive continuing education. This presented a radical shift in thinking and planning, since prior to this time, continuing education provision had been sparse, and wholly dependent on local initiative. There were a series of post-basic courses guided by the Committee for Clinical Nursing Studies
(CCNS), but these had been limited to specific nursing specialities, and demanded full-time student status of the participant for anything up to a year. The Auld report sought to redress the imbalance created by this situation, and suggested that continuing education should be available to all staff (see figure 1 overleaf), in order to meet a number of challenges that nurses face. These challenges included the increasing knowledge of the patient population in relation to their care, and the ever changing knowledge base of the profession itself. The definition of continuing education that was given was that of the American Nurses' Association (1975, p.1):

"Continuing education in nursing consists of planned learning experiences beyond a basic nursing educational programme. These experiences are designed to promote the development of knowledge, skills and attitudes for the enhancement of nursing practice, thus improving health care to the public."

The simplicity of this statement and, it is suggested, the almost naive notion that continuing education should be available to all qualified staff (which in 1981 amounted to 27,320.6 whole time equivalents in Scotland (Working Party 1981, p.44)), strive to conceal the overwhelming difficulties which can beset this kind of initiative. In addition, continuing education is:

"..by nature markedly different from other forms of education. Its major differentiating characteristic is diversity, given that all nurses comprise the target population, and that learners have diverse interests, educational background and types, as well as years of experience." (Mitsunaga and Shores 1977, pp.7-8)

With these parameters, it would be easy for such an ambitious plan never to succeed. It was the task therefore of the NBS, to translate the Auld report recommendations into practical and concrete guidelines for the profession. With the right support and nurture the recommendations could then become a reality.
FIGURE 1 - Professional Development and Continuing Education

It was decided by the NBS in 1983, that the way forward would be to run a pilot programme for charge nurses, to begin to address the feasibility of their plans. Work therefore began on the development and implementation of the Experienced Charge Nurse Module (ECNM). This fitted into the level of the Working party proposals at level four (see figure 1). The module was nine months in length and comprised two teaching inputs, based in a college of nursing and midwifery, separated by work based experience (see figure 4, page 50). The stated aim of the module was:

To enhance the ability of the charge nurse to fulfil her composite role as a practitioner, manager and teacher.

This proposal was followed up by the NBS, with the development of the Professional Studies (PS) Diploma - a more complex modular system of continuing education, designed particularly, though not exclusively, for staff nurses (see level three, figure 1). There are two separate parts to the Diploma, Professional Studies I (PSI), and Professional Studies II (PSII), each comprising a set of three modules (see NBS 1985, and appendix 1). These modules are validated by the NBS through a pre-determined review process, under the auspices of the post-basic nursing committee.

PSI is generically orientated for any type of nurse i.e. general, psychiatric, mental handicap or sick children's, and consists of two core modules (learning, teaching and counselling, and inter-personal relationships) and one optional module. PSII conversely is a specialist programme for which the nurse should choose three modules relating specifically to her proposed field of work. e.g. intensive care or community psychiatric nursing. If both PSI and PSII are completed, then the nurse is eligible for the PS Diploma. If however, she wishes to undertake only one or two individual modules e.g. as a type of refresher course, then it is possible to do this instead. The minimum length for any one module is nine weeks. This is usually divided
(though not always) into two weeks theoretical input, followed by seven weeks supervised, supernumary practice (see figure 6, page 59).

Evaluation

In parallel with these developments, and in accordance with the Auld report recommendations, it was decided that an evaluation should be carried out of the programmes, to ensure that:-

"...the benefits to the National Health Service of a coherent pattern of continuing education for nurses can be clearly demonstrated." (Working Party 1981, p.xv)

The NBS needed to know whether the programmes had any effects on individual participants; how the profession adapted to the modular nature of the scheme; what costs were involved; and how the Colleges of Nursing and Midwifery prepared and supported their input. In other words they committed the whole scheme to scrutiny, rather than trying to impose what could be seen as an over ambitious and cumbersome structure, without proof of worth.

The implicit link that is being generated here, between evaluation and continuing education, is not coincidental in terms of the prevailing economical and political climate. Accountability within the National Health Service (NHS), and therefore within education, has gained increasing ground in the last decade. Not only in terms of the rationale of the care provided to patients and clients but also in the associated costs and benefits. One only has to look at the proliferation of, and interest in, performance indicators and the extended debates about quality assurance to see the underlying trends. To meet these increasing demands, education has an important role to play for the practitioner, but ironically, this in turn then becomes subject to the accountability factor.
Evaluation of continuing education has to be seen in this context, and ultimately serves two purposes. One is to prove the worth or otherwise of the programmes in question, in terms of the effects for the participants at a practical level. The other is for the managers of the system, in order to assess the value of running the programmes in terms of participant and patient outcomes, against associated costs. This thesis does not directly address the issue of costs, but work has been carried out in this area for the NBS (see Whiteley and Broomfield 1987, chapter 16).

In recent years, two pieces of evaluation work directly related to a continuing education initiative in nursing have been carried out in England (Lathlean and Farnish 1984, and Lathlean et al 1986). The first of these reports was available at the beginning of this research, and provided some useful indicators to the state of the art of evaluation generally. It did not however, provide a framework that could be used with the evaluation that was to be carried out in Scotland. Other attempts to provide a model for evaluation of continuing education in nursing were also considered (Jones et al 1981, Ediger et al 1983 and Clark et al 1983), but again, none of these seemed to provide a satisfactory outline for the study to be undertaken.

There appeared to be many conflicting ideas about how evaluation should be carried out and even dispute concerning the aims of an evaluation. This is neatly summarised by Crane (1988, p.469):-

"A useful metaphor for evaluation as it is presently practiced...is a public grazing area, on which almost every species of social science may be found. Each is able to use the flora of the grazing area as nourishment for itself."

It appeared that evaluations were being designed specifically for one situation, thus allowing for a wide spectrum of interests and ideas to be pursued. There were no clear guidelines that seemed to be flexible enough to
consider the demands of a truly diverse continuing education initiative. The decision was made therefore that a model of evaluation was needed for use in this situation.

The first evaluation of the ECNM acted as a prototype, and was developed to meet the demands of that particular course in much the same way as the existing studies. This set a methodological precedent however and allowed developmental research to be carried forward to incorporate Professional Studies I and II (PSI&II), which in turn helped to clarify an emergent framework.

Presentation

Chapters two to five provide a background to the fields of evaluation, continuing education, and social science methodology through a review of the pertinent literature. The next two chapters are based on this foundation, and they present the design of the research and the methodology used to implement it. Following this are the results of the application of the theory to practical research, addressed in chapters 8 to 18.

In all cases, the ECNM is considered before PSI&II because of the chronological and sequential nature of the research. A dialogue is also maintained throughout, to facilitate the comprehension of the decision making processes that occurred. Each stage of the project is grounded in the preceding structure and thus demands this type of explanation.

The model of evaluation is presented in chapter 19, entitled 'The Product'. The usage of this is explained in relation to the broader field introduced at the beginning of the thesis, and its applicability to continuing education outlined. Finally, there is a short critical overview of this research presented in chapter 20.
CHAPTER 2 – EVALUATION THEORY

Introduction

As a preamble to describing the path of evaluation history and methodology, it should be noted that evaluation as a discipline is still very young. This is well illustrated by Shadish and Epstein (1987, p.560), when discussing the results of a survey that they carried out, amongst members of two established evaluation societies in the USA, concerning patterns of programme evaluation practice:

"Fully 91% of the evaluators received their terminal degrees between 1966 and the present, with the median year being 1976 - vivid testimony to the youth of evaluation as a profession, and to the massive increase in the number of available social scientists in the last 20 years."

Not only does this tell us about the relative youthfulness of evaluation practice but it also infers that evaluation is carried out by social scientists. This in turn adds fuel to the fire of the debate surrounding evaluation methodologies, in conjunction with the long standing dilemmas of the social sciences concerning qualitative versus quantitative procedures. Two of the three chapters that constitute a review of the literature therefore, consider the fields of evaluation theory and social science methodology. The third chapter relates to important issues concerning continuing education, since this is the educational process which is to be evaluated.

The History of Evaluation Theory

The Traditional School

It is generally accepted that Ralph Tyler provided the first recognisable prototype of evaluation practice in the 1930's when he generated the 'traditional' or 'orthodox'
approach. He concentrated on looking at curriculum development through the rigorous development of objectives with concomitant evaluation, as described in the following model:-

1 Secure agreement on the aims of the curriculum
2 Express these aims as explicit learner behaviours or objectives
3 Devise and provide experiences that seem likely to enable the learners to behave in the desired way
4 Assess the congruence of pupil performance and objectives
5 Vary the 'treatment' until behaviour matches objectives" (Hamilton et al 1977, p.25)

Schools of behavioural objective supporters appeared and it is only more recently that non-behavioural objectives have come to the fore within evaluation practice. The extent to which Tyler subscribed to the traditional method is demonstrated in the following quote:-

"The process of evaluation begins with the objectives of the educational programme. Since the purpose is to see how far these objectives are actually being realized (sic), it is necessary to have evaluation procedures that will give evidence about each of the kinds of behaviour implied by each of the major educational objectives" (Tyler 1949, p.110)

A similar traditional approach also appeared in management evaluation (albeit not until the 1960's), in this instance using cost-benefit analysis to measure the value of training. Performance based measures were taken before a training initiative and repeated again afterwards. Any changes identified were attributed to the programme undertaken, and if proven to be statistically significant then:-

"In the case of standardised jobs it may be possible to estimate the value, in terms of productivity, that would be yielded by a given increase in performance, hence providing an indication of the value of the programme." (Easterby-Smith 1981, p.28)
The behaviourist code that is being used here also helped to sustain the quantitative school of evaluation - if you want to specify achievement in terms of fixed behaviours then psychometric testing and statistical analysis will be first choice tools. Texts such as Bloom's Taxonomy of Educational Objectives (1956) exist to help people along this route. It is interesting to note however that as more sophisticated data analysis has become available in recent years, this has served to put the results thus gained under more and more question. This is neatly summarised by Abrahamson (1984, p.13):-

"Finally there is one practice among professional evaluators that seems to have become a kind of trend: increasing use of more sophisticated statistical tools. Sometimes it really appears to be using a cannon to kill a fly...When one considers the grossness of the data being collected, one must question the use of statistical tools that might show a significance that becomes truly spurious when examined in the light of the hypothesis under study."

The behaviourist form of evaluation has in the past also been labelled the 'agricultural-botany paradigm' (e.g. Parlett and Hamilton 1972, p.11), due to its strong resemblance to the scientific testing involved in that discipline. The analogy is that of a crop of seedlings being weighed and measured, grown under certain conditions, the yield and growth calculated and then the changes attributed to factors such as efficiency of method, or fertiliser used. The educational analogy relates to a selection of students being given a pre-test, undertaking a specific programme, and undergoing a post-test. Any changes in this case being attributed to educational input. The hard numerical data realised in either situation can then be subjected to lengthy statistical analysis which is subsequently accepted as proof of the outcome.

The use of the agricultural-botany paradigm however, does little to extricate evaluation from straightforward measurement. It tells little about programmes and curricula, but leads to a mass of data pertaining to
individual performances. Moreover, these performances are norm-referenced, i.e. each result is interpreted in relation to the average or 'norm' within the group being studied. This method is not of the most use to evaluators, since if norms are to have meaning:

"...all subjects must be tested under identical conditions, as objectively is possible, and in ways consistent with predetermined rules of administration. Establishing norms became a tricky business that called for adequate sampling and the maintenance of the most strict field controls." (Guba and Lincoln 1981, p.3)

In fact, a more useful type of result for the curriculum evaluator, would have been one that was criterion-referenced i.e. instead of obtaining scores that are linked to some hypothetical norm they relate to the achievement (or otherwise) of specific criteria that are sought through the implementation of the programme and its stated aims. This then tells whether the programme is having an effect on an individual and whether it is achieving a useful outcome, rather than knowing the range of the results (which may all be below a suitable level of achievement).

The conditions suggested above by Guba and Lincoln as necessary for norm-referenced objective measurement, were those aimed at in the agricultural-botany tradition. The main problem inherent in this methodology however, is that educational programmes cannot be strictly structured and packaged in the same way as plant crop experiments.

A classic example of the lengths to which researchers have gone to try and produce a suitable educational form of experiment, is characterised by the text of Campbell and Stanley (1963). They present sixteen experimental and quasi-experimental designs. The possible assets and drawbacks of each are noted, in terms of applicability, validity, and reliability. To begin to understand the relevance of these designs to educational programmes, with all the confounding factors involved is difficult. It shows however the emphasis given to the pursuit of producing the
ultimate experimental design, as being the only possible way of proving an educational point. To quote the authors:-

"This chapter is committed to the experiment: as the only means for settling disputes regarding educational practice, as the only way of verifying educational improvements, and as the only way of establishing a cumulative tradition in which improvements can be introduced without the danger of a faddish discard of old wisdom in favor of inferior novelties." (Campbell and Stanley 1963, p.2)

This reliance on evidence produced through experimentation on specified behavioural objectives, raises the issue about what exactly is the point of evaluation. Would a set of behaviours specified by the programme initiator or the evaluator really represent the whole picture, and the only desirable picture in relation to the programme in question? Evaluation of this genre missed out several vital factors (as well as being of questionable method,) and these were to form the basis for others to propose different models in future years.

A Commitment to Change

In the late 1960's a flurry of evaluative activity began aimed specifically at questioning the use of objectives as the only means of evaluating an educational programme. It was recognised at this juncture that there was more to a programme than the resultant effects that it had on the participants, and that the context as well as the content had real value in judging its effectiveness. In 1967, Michael Scriven wrote 'The Methodology of Evaluation', which introduced amongst other things, the concept of 'formative' and 'summative' evaluation. This divided the type of study undertaken into two separate fields. A summative report is produced once the programme is already running and is ready to be reported on in total. The evaluator should try not to interfere with the programme, but rather collect information and provide a summary
report. Alternatively, formative evaluation is an integral part of establishing and running a programme. Information is collected and fed back to those running the courses, to help with adjustments and improvements in situ.

In Scriven's 1967 paper, he also looked at the concept of goal-orientated evaluation and determined that it was important to ascertain if goals were worth achieving in the first instance, as well as whether they have been achieved or not. He then went on to distinguish between:-

"....'intrinsic' evaluation - of the content, goals, grading procedures, teacher attitude, etc. - and 'pay-off' evaluation - of the effects of the teaching instrument on the pupil." (Stenhouse 1975, p.103)

and finally asserted that it was part of the role of the evaluator to act as a judge of the results that were being portrayed i.e. not just to assemble the data.

Others too recognised the problems associated with the behavioural objectives school, including Elliot Eisner and Myron Atkin. They both sought to shift educational evaluation to a wider base and to take into account the expertise of a variety of disciplines to enhance the process. Eisner points out:-

"Educational objectives are typically derived from curriculum theory, which assumes that it is possible to predict with a fair degree of accuracy what the outcomes of instruction will be.....Yet the outcomes of instruction are far more numerous and complex for educational objectives to encompass." (Eisner 1967, p.88)

He attacked the concept that educational objectives were all of one sort. He identified three different metaphors that guide educational thinking, and called them:-

"....the industrial metaphor (already noted as having sprung from the era of scientific management), the behaviouristic metaphor (stemming from behaviourial psychology), and the biological metaphor (based on developmental theories in biology)." (Guba and Lincoln 1981, p.9)
The three different metaphors were seen to have been developed chronologically, with the latter representing the thinking of the twentieth century. Eisner then went on to argue that how educational objectives are stated and used is a question not only of technique but also of values. He formulated two categories of objectives called instructional (based in the first two metaphors) and expressive (based in the third). The former he purported were evaluable by Tylerian methods, whilst the latter could not be dealt with in terms of a common standard. Expressive objectives came from the very simple concept:–

"...that certain outcomes are complex, or unpredictable, or both; that in some subjects it is legitimate for the end-result to surprise the teacher and the student;" (Hamilton et al 1977, p.86)

These objectives represent the outcomes of encounters, which the student may be expected to be a part of, but does not specify what the result of that encounter should be. The direction of this argument leads on to suggesting a more responsive type of evaluation in terms of description and interpretation.

Here is a clear reference to unintended outcomes and their important place in the context of any given programme. Atkin argued in a similar vein, but made the case for multidisciplinary research in this field. He strongly criticised adopting the behavioural model for educational research purposes, saying that:–

"Inasmuch as we have not yet learned to assess behaviourally some of the most important educational changes for which we strive, the sophisticated research models that are used often manipulate insignificant variables.....An elaborate research methodology was evolved around the investigation of inconsequential events." (Atkin 1967-8, p.78)

He believed that if practitioners from a range of disciplines all made their own observations of a particular educational setting, then they could begin a dialogue that
could only enhance the level of research in education. He placed this approach firmly in the phenomenological field and writing as he was in the late 1960's was ahead of his time (within evaluation methodology) in proposing this solution.

5 Models Representing the New Theoretical Thinkers

As this debate progressed (notably within American circles), the next few years were characterised by the emergence of numerous models of evaluation. According to Guba and Lincoln (1981) there were more than forty of these, but it is possible to discern a trend that emerges if they are considered in a roughly chronological way. Just as the moves already proposed widen the notion of evaluation to beyond the behaviourist code, the models that follow take things to an ever broader plane. They describe situations where it is possible to undertake evaluation using predominantly qualitative modes of enquiry, thus leaving measurement behind. Five separate models will be discussed here, proposed by researchers whose names are now pre-eminent in the history of evaluation.

Stake

In 1967, Robert Stake proposed the 'Countenance Model'. He produced a framework that could supposedly be followed by anyone choosing to utilise it (see figure 2 overleaf), but unfortunately made it so all embracing that he confounded his intentions and made it difficult to implement. Broadly he proposed that a programme should be looked at in terms of antecedents, transactions and outcomes.

Antecedents are the conditions which obtained before teaching or learning occurred, e.g. the individual's ability, or willingness to learn. Transactions represent all the processes that are engaged in, in relation to teaching and learning e.g. teaching methods, examinations
or tests. Finally, outcomes represent the product of the antecedents and transactions and are characterised by amongst other factors ability and achievements.

In addition to these three factors, Stake placed the information in two separate matrices, one representing judgement and the other description. He then finally linked these together through contingency and congruence. The reason for this being:-

"For any one educational programme there are two principal ways of processing data: finding the contingencies among antecedents, transactions and outcomes and finding the congruence between intents and observations." (Stake 1967, p.152)

<table>
<thead>
<tr>
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<th>OBSERVATIONS</th>
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DESCRIPTION MATRIX  JUDGEMENT MATRIX

FIGURE 2 - The Countenance Model of Evaluation (after Stake, 1967)

The rationale behind the design was to allow for a large expansion of the database available for use in an evaluation compared with the objectives model. It also urged evaluators to seek unintended outcomes and to include contextual factors in the account.

Problems emerged with the model however, not least that the table suggested as a framework was rather complex to operationalise, and for some, even to comprehend. Stake also failed to issue guidance on how to recognise and deal with unintended outcomes.
Stufflebeam et al
Four years later, in 1971, a model that was based on discerning the decision making processes that were in play for a given programme was produced and was labelled the 'CIPP' model - Context-Input-Process-Product - (Stufflebeam et al 1971). This meant that:-

"An evaluator taking decisions as the organizer for his activity does not require information about objectives but about what decisions are to be made, who is to make them, on what schedule, and using what criteria." (Guba and Lincoln 1981, p.14)

The decisions to be made related to the four categories in the title of the model, the terms being self-explanatory in relation to the type of information each was designed to represent. The possibility of making the categories link up to form a loop was built in via a feedback mechanism, and the modification of the programme as it developed became theoretically possible (see figure 3).

![Diagram](image.png)

**FIGURE 3 - Stufflebeam et al's Model of Evaluation**
(taken from Clark et al 1983, p.55)
The disadvantage of this method was primarily that, by using decision making to operationalise the model, an assumption was made that this process would be open to scrutiny. This proved not to be the case, either through unwillingness or inability of the managers to examine their own operations. Add to this the fact that it was not always easy to identify the so-called decision makers and the model became difficult to work.

**Scriven**

In 1972, Michael Scriven again emerged with a new concept. His paper introducing the idea (Scriven, 1972) whilst being widely acknowledged, created a storm of disbelief in the evaluation world. He had been working on a particular project in America, when:-

"It seemed very natural to start off the evaluation with a rating of goals of the project and to go on with a rating of the effectiveness in meeting them, costs, etc. By the sixth draft of the form, another item had become very prominent, namely side-effects." (Scriven, 1972, p.130)

This phenomenon lead him to postulate the idea of 'Goal-Free' evaluation (GFE). Ultimately, he felt that to specify the goals at the outset of a piece of work could not only lead one to missing a lot of important information, but also that it could actively stop people from acknowledging these issues as they appeared - thereby goal setting could become a contaminating factor.

The following is a definition of goal-free evaluation given in Scriven's own Evaluation Thesaurus (1981, p.68):-

"**Goal-Free Evaluation** - In this type of evaluation, the evaluator is not told the purpose of the program but enters into the evaluation with the purpose of finding out what the program actually is doing without being cued as to what it is trying to do. If the program is achieving its stated goals and objectives, then these achievements should show up (in observation of process and interviews with consumers (not staff)); if not, it is argued, they are irrelevant." (the author's own emphases)
One of the key features of the method involved in this form of evaluation is the use of 'needs data' of the target population, instead of merely using the static goals of the programme (Hamilton et al 1977, p 141). The information that is then collected by the evaluator of the actual effects of a programme are regarded as relevant or otherwise, when compared with these needs. No information or effect can be considered in this context as being a 'side-effect' or 'unintended'.

The proposal of this model was somewhat overstated at the outset, in an attempt to get people to listen. It remained at a conceptual level, never really addressing the issue of needs assessment in concrete practical terms, or suggesting how to identify effects. Scriven himself acknowledged this fact and suggested that GFE:-

"...is best used as an auxiliary, parallel activity (to goal-based evaluation)." (Guba and Lincoln 1981, p.18)

Finally, one of the major problems with this type of evaluation is, that it is a complete risk for both the evaluator and the sponsor. Without anything to regard as concrete at the outset it is impossible to judge along what lines the work will progress, and many will not start without some sort of reassurance of product.

**Eisner**

Before the final move was taken by various researchers towards a less prescriptive and more flexible form of evaluation, Elliot Eisner (1975) once again produced an innovation, this time demanding 'connoisseurship'. This involved the evaluator getting to know and understand the situation in question, and providing a commentary on it in the same way as, for instance, an art critic would:-

"The point here is that criticism requires for its successful execution an understanding of the context, the symbols, the rules and the traditions in which an object or event participates." (Eisner 1975, p.97)
In an educational setting, these ground rules advocate the knowing and understanding of issues such as teaching styles, curriculum design and materials, and organisational factors. The corroboration of any reported findings then relies upon other people's knowledge of the situation, and details support or refute the evaluator's position. In fact the very mode of reporting underlies one of the functions of this model, in that it makes accessible to everyone (including the lay reader), information regarding educational environments and their functioning.

"Lay people as well as professional educators are able to enter into the life of schooling through descriptions that are emotionally evocative and hence 'understand' aspects of educational life that slip through F ratios, 't' tests and the like." (Eisner 1975, p.98)

The key to this type of evaluation however is also its greatest weakness. To produce this type of work demands great skill, in understanding and interpreting the environment in question accurately. It cannot be carried out therefore, by anyone lacking in experience or competence, in relation to education or evaluation. This problem is compounded by the fact that the model also fails to produce any concrete guidelines for its implementation. It did however provide the first real attempt to structure evaluation in a form that completely left the traditional positivistic approaches behind.

Parlett and Hamilton
The last model that is to be described here comes from a series of innovations that were put forward by a group of evaluation researchers who have become known as the 'new-wave' evaluators. The term new-wave was adopted to signify an alternative approach to the issue of programme or curriculum evaluation. The previously used scientific methods were finally laid to rest, and the emphasis was based in a more naturalistic approach to inquiry.
The model called 'Illuminative Evaluation' as proposed by Parlett and Hamilton (1972), is one of a number that were put forward by participants of the 'Churchill College Conference' — others include Stake's 'Responsive Evaluation' model (1974) and MacDonald's 'Holistic Approach' (1971). The conference took place in Cambridge, in December, 1972:-

"...at which a small group of 'non-traditional' evaluators sat down and pooled their experiences. Each was sharply critical of traditional, orthodox evaluation. Each had tried to develop radical alternatives...It had been a case, we discovered, of multiple simultaneous discovery." (Parlett 1974, p.185)

The result of the Conference, was a general agreement amongst the participants on the thrust of future evaluation practices, although there was not complete agreement over the precise structure of a single model. The essence of the conclusions, pointed towards the fact that in the past, evaluation strategies had placed too much emphasis on psychometric testing. This meant that educational processes had not been given a lot of consideration, which was felt to be a weakness in any approach to evaluation. They resolved that in future, evaluators should aim to produce responsive and flexible work, that used observational data, and was applicable and understandable to those for whom it was meant. It was also felt that the value positions of the evaluator should be clarified so that any interpretation or recommendations were not taken as biased (Hamilton et al 1977, pp.vii-viii)

The Illuminative Evaluation model was introduced as:-

"...belonging to a contrasting 'anthropological' research paradigm. Attempted measurement of 'educational products' is abandoned for intensive study of the program as a whole: its rationale and evolution, its operations, achievements, and difficulties. The innovation is not examined in isolation but in the school context or 'learning milieu'....Observation, interviews with participants (students, instructors, administrators and others), questionnaires, and analysis of documents and background information are all
combined to help 'illuminate' problems, issues, and significant program features." (Parlett and Hamilton 1972, p.10)

The approach is based in description and interpretation rather than measurement and prediction. It aims to be a different research strategy, eclectic by nature, rather than a standard methodological package. By using the different investigative techniques mentioned above, Parlett and Hamilton advocated a process known as 'progressive focusing'. This enabled the most important issues to be studied as and when they had been identified.

The paradigm does not preclude the use of quantitative techniques, though much of the data produced will be of a qualitative nature. According to Guba and Lincoln (1981, p.33) models of this persuasion can be characterised as follows:-

"Compared with the classic models, they tend to be more extensive (not necessarily centred on numerical data), more naturalistic (based on program activity rather than program intent), and more adaptable (not constrained by experimental preordinate designs)."

Criticisms of this approach include the questioning of the validity of results in terms of researcher bias, since to 'tell it as it is' inevitably involves some self judgement. It is also a non-prescriptive method demanding adaptation by the evaluator to the situation being studied. Finally, even amongst those supporting this new-wave of evaluation:-

"There was however no agreement among the evaluators on whether evaluation should consist of observations being interpreted by the evaluator himself or whether the evaluators' role was simply to present data." (Lawton 1980, p.175)

Conclusion

Although the field of evaluation theory has developed rapidly and diffusely since Tyler's early statements of the 1930's, there is still little consensus on the 'right way'
to carry out a piece of evaluation work. The pros and cons of any sort of methodology therefore have to be assessed and applied according to the situation under consideration. The epistemological bias of the individual carrying out the work also has a bearing on this decision. The preceding description of evaluative theories, shows that there are many ways to structure and organise the work, but as specified by Pearsol (1985, p.132):-

"Although these differences are important ones, I suggest that a more fundamental difference lies in the philosophical bases of their respective treatments of evaluative inquiry. This is particularly the case with respect to the contrast between interpretive or qualitative evaluation approaches and more conventional or quantitative modes of evaluation inquiry."

It is obvious that the more objectives orientated the approach, then the more quantitative the methods chosen will be; conversely, the more explorative the approach, then the more qualitative the methods.
CHAPTER 3 - ADULT AND CONTINUING EDUCATION

This section of the literature review seeks to explain some of the important features of continuing education today, which in turn have some effect on the planning of a structured evaluation.

Why Continuing Education?

As stated by Abrahamson (1984, p.4):

"...no profession is better than its current practices."

If it could be stated that all staff were cognisant with current practices, then perhaps there would be no need for continuing education. It is obvious however, that not all individuals can, or do, keep themselves constantly up to date. In addition, there are gaps to be considered which are left in - or generated by - the basic education that a professional receives. Continuing education (structured or otherwise) therefore becomes an apparent necessity. Add to this the issue of professional accountability and the necessity becomes even more acute.

There are many assumptions made about the efficacy and usefulness of continuing education (Rogers and Lawrence 1987, American Nurses' Association (ANA) 1978, Mitsunaga and Shores 1977). In nursing there is debate as to whether it should be mandatory or not. Indeed mandatory continuing education has been required in a variety of American states for some time now, and is currently being considered in the United Kingdom (United Kingdom Central Council (UKCC) 1987). In light of recent moves in this country, some caution should be advised, as concerns have been expressed in America about the value of mandatory continuing education (Young and Willie 1984, Gosnell 1984). There are
however, already certain pre-requisites concerning qualified nurses' accountability, contained within the professional code of conduct (UKCC 1984), implying that continuing education is a necessary means to an end:-

"Each registered nurse, midwife or health visitor is accountable for his or her own practice, and in the exercise of professional accountability shall...take every reasonable opportunity to maintain and improve professional knowledge and competence."

Project 2000 (UKCC 1986 pp.51, 53) is more specific in stating that continuing education should exist:-

"It is vital, therefore, that there is a coherent, comprehensive and cost-effective framework of education beyond registration.....It is no longer wise to think that a single preparation can serve a lifetime of practice."

Nursing is not the only profession to begin to look at continuing education seriously. Other professions such as medicine, dentistry, accountancy, pharmacy and dietetics are all examining this process (Dunn and Hamilton 1985, Petersen 1982, Young and Willie 1984), as a means of ensuring competent and accountable professionals:-

"What is evident to any researcher in this field is that when one talks of competence one is also implicitly speaking of continuing professional education for the two concepts, competence and continuing education, are symbiotically linked in that the maintenance of competencies first acquired at undergraduate level and in early practice, the improvement of these same competencies can all only be achieved...by means of a programme of continuing education." (Dunn and Hamilton 1985, p.278)

It was upon the premiss that continuing education is a necessity, to enable nurses to continue to practice in a safe and competent manner (including helping those with break in service return to work), that the proposals of the Auld report were built (Working Party 1981, p.X). Further evidence of the need for continuing education specifically in nursing, comes from work done by Redfern (1981). She
researched the attitudes of Ward Sisters to their work on a variety of counts, the conclusions of importance in this case being:

"...some of the sisters who did leave may have done so because the organisation failed to give them sufficient opportunity for personal growth. It may be that changing ward or speciality, changing her management style, attending a course, taking on a research commitment, or learning about research and carrying out a project related to her work...would give the sister the challenge she needs." (Redfern 1981, p.86)

The implication of this work, is that providing some type of stimulus for staff, not only benefits them through the direct input that they get, but also in terms of promoting their retention. At a time when staff availability is diminishing, this is no mean consideration.

One final argument in this domain of - why continuing education? - relates to the concept of enhancing the professional status of an individual who undertakes a programme. This is a very large area for debate (see for instance Etzioni 1967, Vollmer and Mills 1966) especially within nursing, where there are some advocates of the theory that nursing is not, and never has been a true profession (whatever the definition of a profession is taken to be). This is not the place for a complete dialogue on the existence or otherwise of professionalism in nursing or any other discipline. Assuming however that there is at least an element of professionalisation (Wilensky, 1964) within nursing, it has been said that:

"If the purpose of our professional [nursing] education is professional competence, then the logical pattern is surely the mastery of the underlying principles of the discipline in the basic programme, and then opportunities for the continuing mastery of new knowledge and skills throughout professional life." (Pembrey 1984, p.542)

From a multidisciplinary point of view, Jarvis (1983, p.27) presented a very similar argument through his text on professional education:-
"...the professional is one who continually seeks the mastery of the branch of learning upon which his profession is based, so that he may offer a service to his client."

In terms of continuing education, it provides the opportunity for the continuing mastery of the professional base that both of these authors advocate.

**Adult and Continuing Education**

Pertaining to another area mentioned by Jarvis (1983) is the concept of lifelong education. This refers to the idea that learning and/or education should be a constant facet in a person's life:-

"Lifelong education is the provision of any planned series of incidents throughout the lifespan of individuals that have a humanistic basis, and are directed towards learning and understanding." (Jarvis 1983, p.15)

Definitions are never as straightforward as they might seem however, as Knapper and Cropley (1985) point out. The terminology was only introduced in the early 1970's, yet already it has come to mean a variety of different things to different people. They cite at least five different interpretations, from 'a new term to mean adult education' (p.15) to 'a reaction against certain features of existing educational practice' (p.16). The consensus is, however, that it represents a new philosophy of education, particularly applicable to the continuing learning processes undertaken by adults. This is a useful notion when considered in conjunction with continuing education in nursing. In this area there is a large emphasis placed on the fact that the individual should take responsibility for their own learning. It should be an ongoing process, not simply dependent on the input of others in a formal setting (ANA 1978, Working Party 1981, and UKCC 1987).

It is also useful to consider the other side of the debate, which worries about the threat to the spontaneity and
freedom of the individual if constantly encouraged to take part in educational settings. Or, at worst, encourages the formalisation and institutionalisation of educative processes for all individuals:-

"Just as suffering has been medicalized (sic), existence has been scholarized, and even become the subject for an apprenticeship. The medical profession in forcing people to be born and die in hospital, succeeded in inculcating the idea that life is a disease. Now professional educators, through the institution of permanent education, succeed in convincing men of their permanent incompetence." (Illich and Verne 1976, p.14)

It is easy to see how this cautionary and sceptical note, could have relevance to the educative processes of today. It is also interesting however, that it has been prompted by the continuing efforts of educationalists to improve the conditions of educational practice, especially in relation to adults.

In the area of adult education, one of the most forthright developments was that proposed by Malcolm Knowles (1970). He introduced the term 'andragogy', to describe the education of adults, compared with 'pedagogy', which literally relates to the education of children. The division that he created between these two forms of education has been recognised as artificially widened in order to put the ideas across (Jarvis 1983 p.81, and Boud 1986 p.240), but nevertheless the proposals that he made introduced a series of new issues for consideration in the education of adults. Interestingly, the concepts put forward by Knowles were not different from the principles applied in some child education settings, notably Summerhill School (Neill, 1968). The essential difference therefore is the application of the principles to the adult setting.

The main premiss upon which the delineation between the two forms of education was made, was that adults bring to a learning situation their own experience, which if ignored,
inhibits the learning processes. There were four other tenets of this proposal which were:

"1 The concept of the learner: the learner is self-directing.
2 Readiness to learn: adults become ready to learn when they experience a need to know or do something in order to perform more effectively in some aspect of their lives.
3 Orientation to learning: adults enter an educational activity with a life-centered, task-centered, or problem-centered orientation to learning.
4 Motivation to learn: although adults will respond to some external motivators...the andragogical model predicated that the more potent motivators are internal." (Knowles 1984, pp.11-12)

These factors have all been recognised by various authors when considering the construction of continuing education programmes (Cooper 1982, ANA 1978, and Boud 1986). The knowledge that there is a vast depth of experience in the participants, that they all have their own particular motivation for being there and different capacities for learning have implications for programme design. David Boud (1986, p.238) contrasts these points well with some existing assumptions about teaching and learning:

"- Staff define the aims and objectives of the course, how it is to be taught, the programme and how it is to be assessed;
- the academic disciplines determine the structure and sequencing of courses;
- students are expected to accept the aims and objectives, the teaching methods, the programme and the assessment procedures. They are expected to enter with prerequisite knowledge in certain subjects and they may have the option of choosing some topics in the later stages of their course;
- learning is seen as an induction into the world of the discipline and the particular view of it as perceived by staff."

Taking these arguments one step further is to look at how continuing education can adopt some of the theoretical constructs, especially in relation to professional education. One method that has been adopted is that of competence based learning. This requires that the needs of the professions, in terms of the skills a practitioner must
possess (Dunn and Hamilton 1985), should form the basis of any given programme. This may seem self-evident, but the important point that is at issue here is, that to be able to provide education for competence, the needs of the individuals involved in the educative process must be assessed.

Needs assessment has been recognised by a number of authors (e.g. Knowles 1984, Rogers and Lawrence 1987, Abrahamson 1984) as a route to providing successful education to adults. If there is a mismatch between what is needed and what is being offered, then there is little chance of improvement occurring. This is often a problem, when there is limited choice relating to what programmes are available for individuals. In this situation people will attend anything, either because they are told to, or because there is nothing else available. Given however, that there is some choice of continuing education available, an important measure for participants is one of needs assessment, and matching of these needs to courses and course content.

Considering needs assessment for the individual, an important distinction can be made between felt needs and ascribed needs (Cooper 1982, p.109). The former are those needs perceived by the individual, and the latter those perceived by someone other than the individual. Relating this to the contrasting theories of andragogy and pedagogy, it can be seen that ascribed needs are more prevalent for the latter form of educational practice and felt needs for the former. Or described another way, ascribed - pedagogical - needs are encapsulated in education from above, compared with felt - andragogical - needs which are dealt with by education amongst equals. It is vital to take account of felt needs, since these are what the individual perceives as being the block to better practice or understanding. No amount of education for ascribed needs will produce a satisfied practitioner, if there are felt needs that have not been resolved.
A need (and therefore the possibility for learning) can be said to exist when:-

"The professional recognises...that he is deficient in specific aspects of knowledge and skill necessary to practice professionally." (Jarvis 1983, p.46)

A key to successful programme planning in continuing education should then encompass this information, and utilise the concept of needs assessment in relation to course content (Knowles 1984, Cox and Baker 1981).

The Theory–Practice Divide

If, having accepted the necessity of continuing education and having established needs led programmes, the delivery of courses is in progress, one of the last remaining factors for consideration is the application of theory to practice (Usher and Bryant, 1987).

The problems surrounding this area (especially in terms of the evaluators role) are neatly summed up by Young and Willie (1984, p.119):-

"People cannot be forced against their will to acquire knowledge and skills that have no value or meaning for them, nor, possessing the knowledge and skills, can they be forced to practice consistently according to the highest standards. Continuing education provides opportunities for professionals to acquire knowledge, improve skills, and develop professional attitudes and values, but ultimately the incorporation of all these into daily practice rests with the professionals themselves."

The translation of theory into practice is a very important issue for all professional, practically orientated work. If the individual has all the knowledge that they can possess, it is of no use if they cannot use it in the practice setting in which they work (Levine 1985). This may be due to personal or institutional factors (Pratt 1979) that provide a barrier to effective practice. Evidence of the latter phenomenon has been produced by Petersen:-
"In speculating about why some of the targeted behaviour changes did not occur, it is useful to note that...respondents reported that they encountered obstacles that inhibited implementation of the information they learned. The following three obstacles were reported as being either occasionally or often problematic: (1) time constraints (2) staff constraints and (3) budget limitations." (Petersen 1982, pp.265-266)

The critical point that is being made here relates to the disparity that exists between the 'espoused theory' of the institution and the 'theory-in-use' (Argyris and Schon, 1974). Espoused theory is alternatively described as 'theory of action', and relates to the way either an individual or someone external to that individual describes what they would do in a given situation:--

"When someone is asked how he would behave under certain circumstances, the answer he usually gives is his espoused theory of action for that situation. This is the theory of action to which he gives his allegiance, and which, upon request, he communicates to others." (Argyris and Schon 1974, pp.6-7)

In contrast, a theory-in-use is what an individual actually uses when acting in a given situation:--

"...the theory that actually governs his actions is his theory-in-use, which may or may not be compatible with his espoused theory; furthermore, the individual may or may not be aware of the incompatibility of the two theories." (Argyris and Schon 1974, p.7)

An illustration of this incompatibility, is what is being manifested in the evidence cited by Petersen above, i.e. the assumption must be that the institution has stated that continuing education should occur for practitioners (the espoused theory), as the opportunity has occurred for their attendance at a course. In reality however, they provide no support on return to work (the theory-in-use), made apparent here through the institutional problems with staff, time and budget constraints. This incompatibility on behalf of the institution can cause dissatisfaction and scepticism amongst staff and can make the whole exercise of education provision counterproductive.
The former problem (relating to the personal application of learned knowledge) is different, and some elements of choice and individual motivation play a part in dictating the outcome of a given situation for any participant. According to Jarvis (1987, p.96):-

"New knowledge is established in the learning situation when practitioners bring their knowledge to the situation and reflect upon their experience of the situation...it has been argued that professional practice is at the interface of theory and procedure rather than the application of theory to it."

This particular interface can also be interpreted as the amalgamation of an individual's espoused theory and their theories-in-use. The reflection-in-action that Jarvis is referring to has been recognised and described by Donald Schon (1983). Schon stated that it was important for practitioners not only to do their job, but also to think about what they are doing. It is evident that this does not occur all the time, and indeed there are times when it is more threatening to an individual to question what they are doing, than to remain un-reflective and safe.

Drawing these ideas together, before any input of theory can occur, the theories-in-use of the practitioner have to be challenged, and one way that this can happen is through reflection-in-action. If the individual can be made to recognise their modus operandi and ask themselves whether or not they are adequate, then there is the opportunity for felt needs to be realised. Once these have surfaced, new theories of action can be learned and the synthesis of the two levels of knowledge can produce new behaviour.

Various other studies have been done in this area (Alexander 1983, Bendall 1971, and Boud et al 1985), concluding that the timing and presentation of material in relation to the practice setting has implications for the way things are learned:—

33
"In the professional context, the human capacity for reflection operates, so that the procedure is an interpretation of thought and action and knowledge and skill...the education and training of professional practitioners may be more true to the basis of practice if theory and practice were learned concurrently and interrelatedly." (Jarvis 1983, p.77)

Also:

"Bendall's results showed that order [of theory and practice] was of value in terms of learning efficiency provided the time interval between theory and practice was not more than six months, and where some form of sandwich, i.e. theory, practice, theory, could be devised, learning would be further enhanced." (Alexander 1983, p.27)

Finally, Usher and Bryant (1987 p.210) suggest that the implications of the theory-practice debate for teaching would be to:

"...create situations where practitioners, in the relative safety of the classroom, come to see their practice as problematic and are supported to subjecting it to serious scrutiny and theoretical 'review'...It is about developing your own learning in your own way...A critical consciousness of oneself and one's actions can bring about the possibility of change through the recognition that the mode of practice is not immutable."

These concepts lend themselves well to the ideas of andragogy and participant involvement in their own educational experiences.
CHAPTER 4 - SOCIAL SCIENCE METHODOLOGY

Introduction

This section of the literature review is concerned with the problems and debates of differing methodological standpoints. On one level the debate presents itself as an argument about quantitative versus qualitative approaches. This is a naïve division however, serving to cloud the more fundamental issue of the researchers epistemological viewpoint. This, above all else, dictates the approach (and to some extent the methodology) taken in any research, and evaluation is no exception. The various schools of thought described in the previous section already give an indication of the extremes of persuasion that reflect this debate. Interesting too, that they also reflect the chronological nature of the argument, as steadily over the past two decades the more qualitative approach, based in the sociological and anthropological schools (Davie 1987, p.198; Engel and Filling 1981, p.16) has gained in strength and credibility.

Positivism versus Phenomenology - Methodological Issue or Way of Life?

'Quantitative' and 'qualitative': these two words represent frequently used descriptive labels, to ascribe a methodological allegiance to either one 'side' or the other in the above debate. How to decipher the meanings, either in literal terms or in terms of application to research has exercised the minds of many over recent years (see Bryman 1984, Guba and Lincoln 1981, Glaser and Strauss 1967), yet still individuals argue - and feel that they have to argue - about the relative merits of one versus the other. The level of debate that obtains is to some, overly enthusiastic:-
"Once immersed in the discussions or debates, it is easy to forget that the focus of all this attention is directed on two different methods of data collection and analysis rather than two different philosophies of life!" (Goodwin and Goodwin 1984, p.378)

In its extreme form however, this could be seen to be the case. In taking the argument as being solely about data collection and analysis is to miss the point, for the development of alternative methodological means was to meet the need of the emerging alternative epistemological outlook on sociological research.

The epistemological debate involving quantitative versus qualitative methodology, is about two conflicting paradigms for social enquiry - positivism and phenomenology. When social research was first proposed, it was felt that society could be studied in the scientific mode, following the rules of enquiry generated through the natural sciences, thus producing a positive science of society (Easthope 1974, Haralambos 1985). Broadly, the assumptions and theoretical background to this approach - which was given the title 'positivism' by Auguste Comte (1798-1857) in the nineteenth century (Von Wright 1971, p.12) - are based in the belief that the behaviour of man, like the behaviour of any other object or phenomenon, can be divided up into identified component parts (or variables), which can then be objectively manipulated and measured. This can be done from an external viewpoint, and takes into account the framework of a priori assumptions, e.g. hypothesis generation and verification, operational definitions, validity, reliability and generalisability (Glaser and Strauss 1967, p.16). To sum up:-

"The positivist's aim is to generate objective knowledge that means knowledge that conforms to the true structure of reality. Insofar as knowledge is objective, it is independent of the circumstances (historical, social, psychological) of its generation." (Pearsol 1985, p.133)

In contrast, the phenomenological view of social enquiry, seeks to understand and interpret societal behaviour, and
to see the social world 'from the point of view of the actor' (Bryman 1984, p.77). This approach emphasises a non-prescriptive and contextual understanding of the area under study, and actively seeks unexpected findings, with a concomitant commitment to adapting research plans to cope with any new information encountered (Miles and Huberman 1984, p.22). Weber (1864-1920) was one of the first sociologists of note to advocate this mode of enquiry, using the term 'verstehen' (understanding) to represent his perspective.

In terms of a human's interaction with the world that s/he inhabits, phenomenologists accept that the response to a situation is not one merely of action, but reaction, based upon amongst other things, thoughts, intentions and awareness (Haralambos 1985, p.20). It is not possible therefore merely to observe apparent behaviour from an external standpoint, but the internal logic which feeds the reaction must be sought.

To do this the researcher must question not only what is occurring, but also why something occurs, and through interpretation be prepared intuitively to pursue meaning. It also necessitates that the researcher becomes involved in some way with the world that s/he is studying - often by acting as the data collection 'instrument' - thus providing a striking contrast to the positivist's external and distance based approach, based on the fear of contamination and threats to validity and reliability.

The differences between these two paradigms is summed up neatly by the following table, which compares and contrasts the interpretation of certain criteria in relation to positivism or phenomenology. The contents of the table are adapted from Guba and Lincoln (1981, p.65) and Pearsol (1985, p.134):--
TABLE 1 - Comparison of Selected Criteria in Relation to Positivistic and Phenomenological Paradigms

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Positivist</th>
<th>Phenomenological</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred techniques</td>
<td>Quantitative</td>
<td>Qualitative</td>
</tr>
<tr>
<td>Quality criterion</td>
<td>Rigor</td>
<td>Relevance</td>
</tr>
<tr>
<td>Source of theory</td>
<td>A priori</td>
<td>Grounded</td>
</tr>
<tr>
<td>Purpose</td>
<td>Verification</td>
<td>Discovery</td>
</tr>
<tr>
<td>Stance</td>
<td>Reductionist</td>
<td>Expansionist</td>
</tr>
<tr>
<td>Design</td>
<td>Preordinate</td>
<td>Emergent</td>
</tr>
<tr>
<td>Instrument</td>
<td>Paper and pencil</td>
<td>Inquirer:</td>
</tr>
<tr>
<td></td>
<td>or physical device</td>
<td>often</td>
</tr>
<tr>
<td>Setting</td>
<td>Laboratory</td>
<td>Nature</td>
</tr>
<tr>
<td>Context</td>
<td>Unrelated</td>
<td>Relevant</td>
</tr>
<tr>
<td>Treatment</td>
<td>Stable</td>
<td>Variable</td>
</tr>
<tr>
<td>Analytic Units</td>
<td>Variables</td>
<td>Patterns</td>
</tr>
</tbody>
</table>

Qualitative versus Quantitative Methodology

To fit specific methodologies into these two conflicting paradigms begins to highlight the importance of understanding which epistemological standpoint is being followed - and therefore in a sense what outlook on life is adopted (see Goodwin and Goodwin, above). Whilst there are certain types of methodology that readily lend themselves to one or the other viewpoint (as noted in table, 1), there is nothing that dictates that any methodology should not be used in a particular piece of work. It has been suggested that the type and scope of the research should rightly dictate the methodology to be used. This is backed up by Davie (1987, p.198):-

"The important difference between qualitative research and various positivistic approaches is not the methodology, nor the kind of research material, but rather with epistemology....Those who approach research....from a positivistic point of view believe that there is an independent reality and the goal of the researcher...is to discover, describe and understand this independent reality whilst controlling for various external influences. For those who approach research...from the qualitative point of view, there is no independent reality. Reality is constructed by the observer and is inherently limited by the observer's values and point of view."
In the eyes of many however there is still an inherent association of quantitative methods to a positivistic standpoint and qualitative methods to a phenomenological one:-

"Perhaps the most questionable dichotomy appears when the claim is made...that positivism and its associated companions are essentially focused on a certain kind of data - namely, quantitative - and that the interpretive-idealists views of the world necessarily emphasize qualitative data." (Miles and Huberman 1984, p.21)

There has also been the impression, that some researchers feel that qualitative data are of lesser stature somehow than quantitative data. It has been noted on occasion that 'proper' research is only being pursued when the method is one of 'rigorous, scientific enquiry'. This seems to be based on the belief that because of the relatively unstructured nature of qualitative work, the data provided simply generates preliminary guidelines upon which verificationist methods can be used, to assess the 'real' truth of the situation:-

"A concordat of this kind between the two methodologies is clearly attractive to those engaged in quantitative research. It provides them with a continuous supply of leads, hunches, or hypotheses which they can confirm, reject, or qualify, while simultaneously retaining their methodological ascendency over qualitative research." (Bryman 1984, p.84)

The irony of this situation is, that whatever the quantitative researcher decides upon to study, it is necessarily from the outset, an interpretation of the world that has been presented to them:-

"His observations are, once articulated, typifications relating that which there is to that concern which brought it to his attention...Thus, the positivist who thinks that he can obtain objective data merely by trying hard not to be biased is deluding himself." (Tilley 1980, p.30)

This usage of qualitative data as an exploratory phase for quantitative study is now being widely refuted by those who base their research within the phenomenological paradigm.
How can one type of methodology feed the other with preliminary data, if they are based in two contrasting and conflicting philosophical bases? The use of quantitative and qualitative data should therefore be seen as concurrent and not hierarchical, and it should be accepted that each can contribute to the other when and where appropriate. There are no rules that say both methods cannot be used in one study, but it is important to note how and why they are being used, in order not to perpetuate the myth of quantitative supremacy.

"In many instances, both forms of data are necessary - not quantitative used to test qualitative, but both used as supplements, as mutual verification and...as different forms of data on the same subject, which, when compared, will each generate theory." (Glaser and Strauss 1967, p.18 - their italics)

Methods of Data Collection

The actual means of collecting data attributed to quantitative and qualitative methods, range from classical experimentation to participant observation, with a variety of methods in between.

Participant observation and life history were introduced in the 1920's by the so-called 'Chicago School' of sociologists, in order to assist them in their quest for a rich description of the problems of society that they saw within the population of Chicago (e.g. Shaw 1930 and Zorbaugh 1929). They were undertaken in the mode of an experiment using the natural setting of the population as the 'laboratory' (Melia, 1981), in order to elucidate the underlying causes of the problems that were manifesting themselves in society, such as delinquency, accommodation issues and competition. It was partly a reaction to these lengthy unstructured pieces of research that the ascendancy of quantitative techniques began (Glaser and Strauss 1967, p.15).
"The social survey is typically seen as the preferred instrument of research within this [positivist] tradition. Through questionnaire items concepts can be operationalized; objectivity is maintained by the distance between observer and observed;...replication can be carried out by employing the same research instrument in another context; and the problem of causality has been eased by the emergence of path analysis and related regression techniques." (Bryman 1984, p.77)

The use of the survey was developed to emulate some of the experimental method's attributes, in relation to the proof of causality between factors observed in society. Lazarsfeld and associates (1948) were proponents of this form of study which grew in stature due to the coincidental development of computers and more sophisticated statistical techniques. The purpose of a survey is the:-

"....collection of standardised information from a sample selected as being representative of a particular group or population....Standardized information is obtained by asking the same set of questions to all members of the sample." (Haralambos 1985, p.515)

The important point here is that a 'representative sample' should be taken, in order that the results are not biased in any way prior to data collection. This is normally done through random sampling. A good example of what can happen, if sampling is not accurate at the outset, was the Literary Digest presidential poll of 1936. They collected data from their readership to try and predict the outcome of the forthcoming presidential election. Far from being accurately predictive however, they produced a completely inaccurate set of results. This was later attributed to the fact that their readership was not representative of the total American population - merely the middle classes, from whom the subscription was drawn. Thus, in no way could the sample have been labelled 'random', and the results were not generalisable to the whole population. (Haralambos 1985, p.516)

The usual format for collecting survey data are questionnaires and structured interviews. These forms of
data collection however, can also be used in more unstructured, qualitatively based research, though in a less rigid format. In general terms, questions can be either closed or open-ended, and interviews can be structured, semi-structured or unstructured. In both cases, the first category will lead to a more uniform set of responses, and the latter to a more interpretative account. The type of question used in the analytic survey therefore would tend towards the closed / structured format (see Sudman and Bradburn 1982).

In terms of a more qualitative approach the techniques used have their basis in some of the approaches already mentioned i.e. questionnaires, interviewing, life histories and observational practices. All these are classified as a form of 'participant observation'. The decision to pursue this form of research cannot be taken lightly, as conceptually, it demands flexibility of thought and process:--

"'Participant observation' is a rather broad term, in that not only does it encapsulate a wide range of observational practices, it is also used to denote a fieldwork strategy which includes general interviewing, usually of a relatively unstructured kind, the perusal of documents, and the interviewing of key informants." (Bryman 1984, p.78)

**Grounded Theory**

One of the most widely known texts that offers advice on how to follow an essentially qualitative approach to research - although not precluding the use of quantitative data in a complementary role - is by Glaser and Strauss (1967), who put forward the concept of 'Grounded Theory'. They do not offer a definitive text on 'clear cut procedures and definitions', but rather offer a starting position 'as a beginning venture in the development of improved methods for discovering grounded theory' (1967, p.1). Grounded theory is used in this sense to mean theory
that is discovered from data. This immediately puts the
emphasis on theory generation, rather than verification,
thus putting it into the epistemological domain of
phenomenology.

Broadly, the basis of grounded theory lies in 'theoretical
sampling' and the use of the 'constant comparative method'
to put data into conceptual categories that are themselves
suggested by the data. This process starts as soon as the
research process starts, as notes are taken and
observations made. Once the first categories are produced –
mostly through the knowledge of the researcher about the
broad conceptual areas within the study – then a further
set of data can be collected through theoretical sampling.
This entails choosing sources of data that will
prospectively produce rich sources of information about the
identified key concepts. Essential to this activity is
'theoretical sensitivity' (Glaser and Strauss 1967, p.46).
This is guided not only by the researcher's constantly
developing knowledge base, but also:-

"...his personal and temperamental bent...[and]...the
sociologist's ability to have theoretical insight
into his area of research, combined with an ability
to make sense of his insights."

This has also been described as 'purposive sampling' by
Miles and Huberman (1984, p.25). It is apparent from this
method that future data collection cannot be planned in
advance, thus showing once again the flexibility of this
type of approach.

The new information that is collected through the chosen
sample, is then compared with the existing data in a
process of review, and category reduction. Eventually, a
theoretical category will no longer need further evidence
attributed to it, since it will have reached 'saturation':-

"Saturation means that no additional data are being
found whereby the sociologist can develop the
properties of the category." (Glaser and Strauss
1967, p.61 - their italics)
The process of generating grounded theory, finally concludes when 'delimiting features' begin to appear. These relate to such properties as saturation, and the reduction of categories to form smaller, more overarching categories that begin to point towards the theory that is being developed:

"To make sense of so much theoretical diversity in his data, the analyst is forced to develop ideas on a level of generality higher in conceptual abstraction than the qualitative material being analyzed." (Glaser and Strauss 1967, p.114)

The theory presented should explain much of the relevant behaviour observed, since as McDonald (1985, p.37) states:

"...a theory is a theory because it explains or predicts something."

Finally, it should be remembered that the theory thus generated is necessarily the product of the researcher, and it is possible that someone else looking at the same evidence would propose a different scenario. The important point that is being made here however, is that the processes of conceptual induction and deduction can be followed by others, and that the group from whence the data was drawn should be able to recognise - and make sense of - the results. This latter point is not the sole domain of grounded theory though, as discussed above. The need to provide cogent argument to support qualitative study is an ongoing process and one that was addressed by Glaser and Strauss (1967), and more latterly Miles and Huberman (1984).
CHAPTER 5 - SYNTHESIS

Decisions involved in evaluation have been summed up by Shadish (1986, p.151) as follows:-

"1) Is Evaluation Needed?
2) Evaluation for What Purpose?
3) What Evaluative Question to Ask?
4) What Technologies are Available to Answer Those Questions?"

The first two of these questions are frequently posed by the sponsoring body and the evaluator is left with the latter two to address. The evaluation may be called to make judgements, provide answers, list information or provoke comment. All of these issues should be clarified at the outset however. Kogan (1986, p.138) takes this notion of what is involved in an evaluation even further and puts forward a list of 11 issues which he says evaluators must face:-

"1) Who sets the criteria for evaluation?
2) What are the criteria?
3) Who is intended to benefit from the evaluation?
4) What is its focus: inputs, process, outputs, impact?
5) Is the evaluation made over a time series? And does it start before any intervention?
6) Are there formal controls (for example, randomised, double-blind)?
7) What sources of data and information are employed?
8) Is change measured quantitatively?
9) Are there predefined hypotheses?
10) Is either replicability or generalisability an objective?
11) Is the evaluation:
    a objectivist-summative-instrumental; or
    b expressive; or
    c participative-formative in intention?"

Underpinning all these factors is the fundamental question of 'why evaluate'? Is it merely because political accountability is more prevalent and money is not as forthcoming as it used to be, or is it due to a genuine desire to know the efficacy of a given programme? As long
ago as 1974, Parlett noticed the increasing trend towards evaluation expansion. He postulated three possible reasons for this:

"First, there is the official enthusiasm, both at government and at other levels, for increased accountability and attention to cost-effectiveness. Second, there is an abundance of innovations and alternative curricular schemes in circulation ....The third, and major reason for the new initiatives and questioning stems from a worrying realization about evaluation studies in the past: namely, that they have often been hopelessly inadequate aids to practical decision-making of any sort." (Parlett 1974, p.185)

The dubious quality of evaluation practice has been recognised by other authors (Abrahamson 1984, and Shadish 1986), so that to construct an evaluation that is to have use and credibility the sponsor and the evaluator must be serious in their intention. This is summed up neatly by Abrahamson (1984, p.18):

"...the problem of political pressures always accompanies attempts to evaluate real, ongoing programs. The desires of the program planners (to be found to be successful), of the sponsors (to be informed as to cost-benefit), and of the evaluator (to do a high quality job) can all too often come into direct conflict with each other."

The ground rules therefore have to be drawn up at the outset and the evaluator can then be left to carry out the work without the problem of ongoing interference from any other source. The decisions that then remain to be considered refer to the choice of evaluation methodology, the posing of the initial questions that will guide work and as Shadish mentioned the existing 'technologies' that will serve to facilitate the process of evaluation.

Conclusion

In making these decisions for this piece of work, the coincidental rise in the importance and sophistication of qualitative approaches, in both evaluation and social
science methods, was seen to be timely. Add to this the changes in emphasis within continuing education for adults, in the way that their teaching should be approached and a pattern began to emerge.

The first point to be made, is that the role taken by the evaluator with respect to the sponsoring body in this case, the idea was to present salient, descriptive and insightful information on which decisions could be made, about the efficacy and viability of such an initiative. Also, the evaluation to be undertaken was not on a micro-scale i.e. located solely within a classroom or even one institution. The fact that information would be being collected from individuals involved in giving and receiving the modules, did not mean that their performances were to be critically judged at a personal level.

If the evaluation models are considered in light of this information, then it would seem that the 'new wave' approach described above (see page 20) would present the greatest opportunity to enable the investigation to proceed. The basis of these approaches is largely located in participant observation and description, and also takes into account the perspective of participants. The most appropriate epistemological standpoint therefore has to be that of phenomenology, with concomitant predominantly qualitative methods.

With respect to the new wave models available on which to base an evaluation, the Illuminative approach (Parlett and Hamilton 1972) appeared to be the most promising in this particular exercise. There were various reasons for this, one being that it provided a broad based framework which offered the possibility of studying more than one facet of any given programme. Secondly, the emphasis was not on strict experimental design with rigorous psychometric and behavioural testing - thus fitting the methodological requirements. In addition, using this paradigm in conjunction with the concept of 'grounded theory' (Glaser
and Strauss, 1967), the programmes in question would be allowed to generate their own important areas for consideration (rather than being pre-determined for hypothesis testing), which could then be followed up in a logical manner.

Thirdly, bearing in mind that there were questions posed at the outset of both programmes - determined in conjunction with the sponsoring body - it was necessary to be able to study the context of the courses as well as the outcomes for participants. To this end the context, input, process, product model of Stufflebeam et al (1971) could be seen to be applicable, but decisions are taken as the focus for this model (see page 17), and this was not to be the case for this evaluation. In addition, because of the fact that decisions play such an important role in Stufflebeam et al’s model, the emphasis is on the programme planners and implementers. For the current study, although these groups of people would be included in any data collection, it was seen that most importantly the course participants should provide a lot of the information, and they are no part of the structural decision making process.

The basis for the construction of an evaluation model for use with continuing education courses in nursing was therefore grounded in the illuminative evaluation approach. Through the physical process of evaluating courses, this would be refined and the resulting changes in emphasis and method of enquiry should generate the new model for use.

- o - o - o - o -
PART TWO:

DESCRIPTION
CHAPTER 6 - RESEARCH DESIGN

The fundamental decision to evaluate the continuing education courses relating to this research, was taken in both cases by the sponsoring body (the NBS). Already in existence were stated aims for the programmes, and guidelines which colleges of nursing and midwifery were to follow. The structure of the two programmes was different, though the concept of practice based continuing education was strongly emphasised by the design. For each there was a period of college input, followed by some practically orientated experience. The Illuminative Evaluation model (Parlett and Hamilton, 1972) in conjunction with predominantly qualitative methods, was chosen for use in relation to these courses (see pages 46-48 for a description of this).

The presentation of the evaluation design is strictly chronological in terms of progress. The salient issues relating to the development of the model of evaluation will be highlighted in this chapter, including points where something was tried and then rejected or modified, in light of its efficacy. For each course, the development of the evaluation design is described, followed by the sources of data, and data collection techniques.

Initial Development

The development of the research methodology involved in this work began with the evaluation of the ECNM. The module was being piloted in three colleges of nursing and midwifery, which represented rural, semi-rural and urban environments (for reasons of confidentiality, these will be referred to in future as college A, college B and college C). The consistency of the module length and format (see figure 4 overleaf) between the three colleges, meant that in the first instance the design could be straightforward.
This gave time to test out the instruments being used and consider the overall approach that would illuminate as fully as possible this initiative. In light of the successive evaluation of PSI&II, this firm foundation proved to be invaluable, since elements of the 'real world' began to appear and things were no longer so straightforward.

College time: 3 weeks 1 week Study
------------- |--------|--------|--------|-------------------| day
Work time: 8 weeks 6 months

FIGURE 4 - Structure of the ECNM

The two areas particularly emphasised for investigation in an illuminative evaluation, are the instructional system and the learning milieu (Parlett and Hamilton, 1972). The former represents what could be described as the hardware and software of an educational programme i.e. the physical equipment and personnel required and their mode of application in the educational setting. The latter is then the interface of these and the associated 'network of cultural, social, institutional and psychological variables', (Parlett and Hamilton, 1972). This also places the particular instructional system and the overall context of the module in relation to the larger system within which they are located.

Bearing all these points in mind, the questions raised at the outset of the ECNM were:-

1. What changes in knowledge, skills and attitude are experienced by the course participants?
2. How is their role as manager, practitioner and teacher affected by the course?
3. How has the course developed in the three colleges?

TABLE 2 - Questions Posed at the Outset of the ECNM

Following the concept of progressive focusing, a broad base of information was required at the outset, so that the
context and content of the courses was taken into account and a variety of sources of data utilised.

Sources of Data

For each college running the course there were four different sources of information. The two most important were the course participants and the course leaders as they were both directly experiencing the functioning of the modules. The other two were the nurse managers of the course participants and any documentary information that was relevant e.g. timetables and course objectives. The participants provided the most information since they were receiving the educational input. Their self-reporting was used on three occasions; at the start of the course, three months later after the main college input had finished and at the end of the course on the final study day. Background data was collected from two of the groups at an extra study day that was inserted into the six month period back in post, and also from the course leaders each time a visit was made to the area. Other information was gathered from the nurse managers, after a participant had finished the course and from the course leaders.

To help overcome the problem of the lengthy unsupervised period back in post (when participants were once again open to learning and developmental situations not associated with the module input), as well as to provide a source of comparison for the data, a further group of charge nurses was formed from a Health Board not involved in running this particular module. The members of this group were obtained by contacting the Chief Area Nursing Officer (CANO) of the area in question. A request for a selection of charge nurses with between eight and twenty five years experience from a cross-section of work areas was made (the figure was based on the response to the first of the courses that had been run), and permission was given to contact charge nurses who would be put forward by their Director of Nursing Services (DNS). Forty one names were obtained in
this way, of which thirty five responded to the initial letter requesting an appointment to meet with them. This was a high response (85%) to a postal request, especially when it was discovered that some of the charge nurses had not heard of the project before they were contacted - even though their names had been put forward. Once they had been seen and the project explained to them, all but three agreed to take part. This left a total group of thirty two who formed the comparator group. This group will now be referred to as area D.

The information collected from this group was used not only to compare with that of the course participants, but also to provide additional baseline information about the needs and expectations of the experienced charge nurse in terms of continuing education. This then gave another body of information, collected in the same way as the rest of the data.

Data Collection Techniques

The development and content of the methodological tools will be discussed here and their use in the evaluation outlined. The instruments to be described are:-

1. The pre-course questionnaire, the semi-structured interview; the post-course questionnaire - Course Participants and Members of Area D
2. Process recording forms; semi-structured interview - Course Leaders
3. Questionnaire - Nurse Managers

The Pre-Course Questionnaire

This was used to elicit a baseline of information from the respondents that could be followed up in either the semi-
structured interview or the post-course questionnaire (see appendices 2 and 3). It was divided up into three sections for ease of use and instructions added to the front to make it self-explanatory.

The first section was made up of a series of biographical questions about age, qualifications, post held, years experience and reasons for attendance. This allowed a picture to be built up of the target population of the courses, and provided details that could be used to create sub-groups according to any of these biographical categories. Also in this section were two open-ended questions which asked about the expectations of the individual in relation to the course and their perception of the role of the charge nurse. The members of area D were not asked about their expectations of the course, but were otherwise required to provide the same information.

To address the issue of changes in knowledge, skills and attitudes, a series of forced choice questions was used in the two sections. The first of these consisted of a general list of fifty two statements relating to the role of the charge nurse, derived from a previously used ward sister assessment form (Allen, 1982). The role of the charge nurse was taken to comprise of the three categories - management, practice and teaching. The respondents were asked to put a check against one of the categories of the five point scale that was used, so that a picture of how the charge nurse perceived her job could be obtained. Initially, the scale ranged from very important to very unimportant, but this was changed after piloting, into always (through often, sometimes and rarely) to never. The change was made since the first scale provided virtually no discrimination between respondents as everyone thought everything was very important!

The third section consisted of a series of Likert-type agreement scales (see Moser and Kalton 1971, pp.361-366), designed to elicit the charge nurses' attitudes towards
management, practice, teaching and also continuing education. The five point scale in this case was from strongly agree (through agree, undecided and disagree) to strongly disagree. Initially there were forty eight questions, but this was reduced to thirty two after the pilot had enabled an item analysis to be carried out.

Item analysis consists of taking the top twenty five percent and the bottom twenty five percent of respondents, and analysing the responses to each individual question according to the answer that has been recorded. Once this is done, it can be seen whether the question discriminates between positive and negative attitudes, and also if it elicits the attitude appropriate to the question (see King 1984, pp.145-147).

The questions in both of these scales were randomised before administration, so that the categories contained were not readily identifiable. It also meant that they could be re-randomised when used again without prejudicing the results.

The Semi-Structured Interview

This was designed to allow each respondent to give more descriptive information than is possible in a written questionnaire. Through necessity, they differed quite widely in content between the course members and area D, but they were each used to explore attitudes and knowledge relating to issues such as continuing education and the role of the charge nurse (see appendices 4 and 5).

In deciding what to include in the course members interview a visit was made to a group attending one of the modules not included in the evaluation sample. A guided discussion was conducted with this group, based on some questions that had been formulated before the visit. From the response to these questions, some important points
were highlighted which were then incorporated into the structure of the actual interview. The questions raised with the group were:-

1) What had the course taught them?
2) What were the benefits from this?
3) What advice would they give to others coming on the course?
4) What were the disadvantages of the course?

Combining the results of the discussion with some of the information given in the pre-course questionnaire three distinct areas emerged for enquiry and the questions in the interview were divided up accordingly. The first area related to the teaching input received in the college, the second to the needs of the individual charge nurse in relation to continuing education and the third to their thoughts about the whole module and how it had affected them. Some of the questions demanded no more than a yes/no response, others required a choice to be made from a list of alternatives, but many of the questions demanded that the respondent give a descriptive account of their opinion.

The basis of the interview for the members of area D was taken from the more general questions included in the interview already described e.g. Do you see continuing education as a necessity? Other questions were added so that the structure became not dissimilar to that of the course participants' interview, although the content differed. The three sections this time referred to the general subject of continuing education, how they might feel about attending a course such as the experienced charge nurse module and concluded with some questions about their work situation. Some comparable information was thus obtained in conjunction with other more diverse data.
The post-course questionnaire

A large part of this particular instrument contained a replication of the forced choice questions used in the pre-course questionnaire (see appendices 6 and 7). These were the 52 general statements and the 32 attitudinal statements described above. The two sets of statements were re-randomised to ensure no recall of answers, but otherwise remained exactly the same.

The major difference of this questionnaire was therefore the first section. This was divided into two parts, the first of which (in the case of the course participants) consisted of a forced choice scale of questions about how the module had helped them with specific aspects of their job. The aspects contained in the scale were based on the aims of the module as set out in the course documents. The question asked how much the module had helped them in e.g. planning and organising work, on a scale of 1 – 4 (a lot, to not at all). The second part asked open ended questions about the outcome of their action plan, which they had now spent six months completing. In addition there were some other questions designed to find out the last of their overall perceptions about the course. For the members of area D, most of these questions (as in the case of the semi-structured interview) were not relevant, but two of them were used with just one additional point being raised.

Course Leaders

The process recording forms used by the course leaders were designed to elicit information about the changes that were made to the module each time that it was run (see appendix 8). Since this evaluation did not commence in tandem with the very first of the courses, the changes noted apply to some of the later ones, but nevertheless indicate the types of changes deemed necessary and the reasons for carrying them out. The form requires
information on all aspects of the delivery of the courses
ie teaching style, materials used and programme structure
as well as variations in content.

The semi-structured interview was used to consolidate the
information that had been received from the course leaders
during informal visits to the three colleges (see appendix
9). Some of the questions related to the more practical
aspects of setting up a course such as this, and also to
the support obtained from within both the education and
service sectors. Other questions related to their
perceptions regarding the efficacy of the module and the
benefits of this compared with what has been available in
the past.

Nurse Managers

In this category of respondent, only the nurse managers of
the course participants were used i.e. the managers of area
D were not involved in giving any information to the study.
Initially it was envisaged that this group might be
involved in some kind of interview as well as completing a
questionnaire. It was decided however that this would not
be necessary, and that enough information could be gained
through the use of a questionnaire only. The questionnaire
was given to the course participants to hand on to their
nurse managers at the final study day of their course. The
reasons for doing this were twofold. Firstly it would allow
the participants to see what the managers were being asked,
and secondly (from a purely practical point of view) it
would mean that the questionnaires were hand delivered
rather than sending them through the post.

The actual questions asked were identical to those of the
charge nurses' as far as they were relevant (see appendix
10). This meant that another, external, opinion was being
gained to p alongside the self reporting of the
participants. Other questions were then added to find out
if there were any deficits in the information received by the managers, and also if they would be interested in attending a continuing education course such as the ECNM, if the opportunity arose. This questionnaire was accompanied by a comprehensive set of instructions and returned by post.

To conclude, the following diagram provides a picture of how these various instruments were used in conjunction with the module:-

```
START

MONTHS 0 1 2 3 4 5 6 7 8 9
|----------------|----------------|----------------|----------------|----------------|
ACTIVITY Q1 SSI S/D SSI Q2/Q3
TARGET P/D P/D P CL P/D/NO
GROUP

Q1 = PRE-COURSE QUESTIONNAIRE  P = PARTICIPANTS
Q2 = POST-COURSE QUESTIONNAIRE  D = AREA D
Q3 = SENIOR NURSE QUESTIONNAIRE  CL = COURSE LEADER
S/D = STUDY DAY VISIT  ND = NURSING OFFICER
SSI = SEMI-STRUCTURED INTERVIEW

FIGURE 5 - Timing of ECNM Research Interventions
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**Subsequent Development**

Through the use of these instruments, within the design of evaluation for the ECNM, it was possible to develop the methodology for the more complex modular system of PSI&II (see figure 6 overleaf, and page 4). Essentially, the approach of progressive focusing using the various groups of people associated with a course was successful in producing results and the translation of this, with concomitant adaptation will be described here.
FIGURE 6 – Most Prevalent Structure of a PS Module

The questions posed at the outset of these modules were not dissimilar from those of the ECNM, reflecting the basic similarity of the aims and philosophy of the modules. The first major concern that arose however was that the instructional system should be given more attention. This meant spending a lot more time in investigating the contextual factors affecting the development and implementation of modules, before an appreciation of the products could be attempted.

The questions posed at the outset of PSI&II are in table 3:-

1) In what ways do staff nurses benefit from involvement in PSI&II?
2) In what way is the delivery of patient care affected by the new continuing education programme?
3) Are the courses cost-effective?
4) How is the nursing profession adapting to and coping with this new initiative?

TABLE 3 – Questions Posed at the Outset of PSI&II

One of the most fundamental differences between PSI&II and the ECNM was the more fragmented pattern of development that was emerging throughout Scotland. This meant that instead of having three neatly delineated colleges running four intakes of a nine month module, there was the possibility of anything up to nineteen colleges of nursing and midwifery plus universities and central institutions, who could potentially offer any number of Professional Studies modules. The repercussions of this for the planning of an evaluation meant that a considerable monitoring exercise had to be carried out first, to outline the state of the art within all the possible institutions – which, if
looked at in terms of the illuminative evaluation strategy, represents the initial trawl of information to enable progressive focusing to begin (albeit on a very large scale).

This time, therefore, a plan was constructed that could be expected to take the work forward and lay the foundations for the whole, whilst allowing for future developments which would necessarily be dependent on the outcomes of the first stages. The plan is contained in the following table:-

1) Carry out a pilot survey of representative staff within the three health boards in Scotland
2) Obtain an up to date copy of the NBS database
3) Follow up the initial interview survey with a mailshot plus associated interviews, to all the eligible nurse training institutions in Scotland.
4) Begin to develop a nursing log
5) Look at the history of submissions to the NBS and examine the different modes of delivery being proposed
6) Take the results of items 3 and 5 and begin to evaluate the logistics of the setting up and running of PSI&II
7) Implement the nursing log and carry out semi-structured interviews with participants, line managers and course leaders
8) Evaluate the relative merits of the different modes of delivery that have been highlighted by the work carried out under item 5

TABLE 4 - Initial Work Plan for PSI&II

Sources of data

In each stage of the plan there were different people involved in the data collection. The pilot survey was used in conjunction with a cross-section of staff (23 in total) ranging from Unit General Managers (UGM's), DNS's and Directors of Nurse Education (DNE's), to staff actually involved (or potentially involved) in the running or receiving of modules. In addition, staff associated with
the NBS were used. The different grades of staff were chosen based on the following categorisation of interested parties:-

1) NBS – the initiator
2) Service – the consumer
3) Education – the provider
4) Management – the facilitator (both nursing management and general health board management)

Thus, a balanced sample was assured. The three Health Boards involved in this survey represented the three different stages of PS production i.e. one that had modules up and running for some time; one that was developing modules but had none validated at that time; one where no development at all had begun, or was envisaged for the near future.

The mailshot was sent to the DNE's and Heads of Departments of all institutions associated with nurse training in Scotland. From the responses, those who had, or planned to have PS courses were followed up by interview which then included a member of the continuing education team i.e. a nurse teacher as well. The ensuing evaluation then took the form of the ECNM work and participants from modules formed the largest group of respondents, in association with the course leaders, some nurse managers and a comparator group.

The comparator group were requested from two health boards, one of which was not offering PS modules and another which was. The logic behind this sample being that although information was required from staff nurses (with between six and eighteen months experience) who were not going to attend a module over the next six months, there may be some palpable differences between those who had contact with others who were attending modules and those who were in a more isolated situation. Once again the data from this group would help add to the profile of staff eligible for
this sort of initiative and also provide comparative data on the experience of a nurse over a six month period.

Additional sources of information included documentary and background data. Contained within the plan it can be seen that items 2 and 5 relate to already existing information of this nature i.e. the NBS database and the documentation concerning the history of the submissions to the NBS. Other sources such as course documents and college timetables were also used in relation to the evaluation.

**Data Collection Techniques**

For PSI&II, a distinction was made between monitoring work and evaluation work that took place. The tools used in both were of a similar nature (in that they were designed to elicit qualitative data for the most part) though the distinction between these two types of enquiry should be noted. It should also be stated that the groundswell of information collected through the monitoring process (which was carried out first), served to feed the evaluative work and as such the two were intrinsically linked.

In relation to monitoring, the essence of this first level exercise is to prepare a picture of the system which is under review, and then use this to build up a profile of the relevant issues for closer scrutiny within the evaluation. Information gained through monitoring is descriptive by nature, and literally looks at the processes that are at work in any particular situation. Data collected from this type of exercise has instant value and can be used to provide immediate feedback to the sponsoring body - in this case the NBS - for discussion and possible action.

The second level of work is the evaluative mode of enquiry. It relates to the more long term work that should be carried out, requiring a longer term research strategy. It
is interested in the outcomes of a given system and requires pre-determined methods of analysis to be used on the data collected. The results should then be interpreted within the context of the whole that is under scrutiny. Consequently, only limited information is available for feedback, until the initiative is complete.

In terms of the plan that is given above (see table 4), this meant that results from items 1, 2, 3 and 5 provided the NBS with information in the near future. Feedback from item 6 provided the next level of input and finally data from items 4, 7, and 8 took the longest to achieve and therefore provided the final input.

This feedback can be summarised in the following way:-

<table>
<thead>
<tr>
<th>EVALUATION OF THE MODULES</th>
<th>Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>EVALUATION OF THE LOGISTICS</td>
<td>as and when available</td>
</tr>
<tr>
<td>MONITORING OF THE PROCESSES AT WORK</td>
<td>Specific constant</td>
</tr>
<tr>
<td>THE NBS DATABASE</td>
<td>feedback</td>
</tr>
</tbody>
</table>

FIGURE 7 - Feedback Processes for PSI&II

The actual tools developed in addition to those used in the ECNM evaluation, and the amendments made to the ones already described will now be outlined:-

1 Exploratory Interview - Representatives of three health boards
2 Mailshot questionnaire; semi-structured interview - Directors of Nurse Education (DNE's)
3 Nursing Log; biographical questionnaire; pre-course questionnaire; semi-structured interview; post-course questionnaire - Participants of PSI&II and comparator group
1 Exploratory Interview

Based on the knowledge of PS development to this point, and from preliminary conversations with members of the NBS, the structure of this interview was devised (see appendix 11). The interviews were carried out to try and get an informed picture of some of the important points relating to the development and running of PSI&II modules. To do this, respondents were asked for their opinions and attitudes on a variety of topics, including funding, validation procedures and possible benefits. A cross-section of staff was taken from each of three health boards representing different stages in the development process, plus two members of the NBS. It was generically designed, to be applicable to all the respondents i.e. from UGM through to staff nurses at ward level.

2 Mailshot Questionnaire and Interviews

These were developed in response to the general opinions elicited by the exploratory interviews. They were designed to ascertain the state of the art of PS development within all establishments connected with nurse training in Scotland (including strengths and weaknesses), and to begin to build up a database of PS availability. Due to the fact that there are some differences between the way that colleges of nursing and midwifery and central institutions (CI's) or universities are funded and run, there had to be two versions of the mailshot questionnaire. This was then further divided into four versions, by those establishments who were known to have one or more validated PS modules and those who as yet had none. The four versions were entitled
Mailshot; Mailshot 1; Mailshot 2; and Mailshot 3 (see appendices 12, 13, 14 and 15)

Information relating to the developmental stage of any proposed PS module in Scotland is available through the NBS database which was created to store the constantly updated information. The validation state of modules within all the establishments being approached was therefore already available. Taking this data, the following numbers of questionnaires were sent:-

Mailshot 13 colleges of nursing and midwifery
(validated modules)
Mailshot 1 8 colleges of nursing and midwifery (no
validated modules)
Mailshot 2 1 CI (validated modules)
Mailshot 3 8 CI's / Universities (no validated modules)

The questions contained in all the four versions covered the areas that were known to be important in relation to the development and running of modules. This included, amongst other things, staff involvement across service and education sectors, recruitment, funding and supervision arrangements. For those who had at that time, no validated modules, there were questions relating to the possible future provision of PS and what alternatives they provided in the interim.

Interviews were carried out at those establishments either running or planning to run PS modules in the foreseeable future. Points that had arisen through the questionnaire responses were put into the semi-structured format and respondents allowed to add their own perceptions of problems and difficulties that they were encountering (see appendix 16). These issues ranged from funding and budgets, to validation procedures and the production and running of modules, concluding with questions about the overall effectiveness of the courses and their impact on the individuals involved.
In relation to the PSI sample and the members of the comparator group, it was felt that in addition to the methodology developed for the ECNM, there needed to be some other form of enquiry that looked at the needs of the individuals involved. It was apparent that even if the provision of modules was of a high standard and the subject areas chosen had face validity, if the content did not actually meet the needs of the participants, then amendments would need to be made to avoid the mismatch (see Chapter 3, pp.30-31). For this purpose, the 'Nursing Log' was developed to look at the needs of the individual and how these may or may not be being addressed by the module or series of modules that they attended. The theory behind the Log is that there is a possibility that learning can take place whenever there is a disjuncture between biography and experience (Jarvis 1987, p.56). This means that when a situation arises where previously learned knowledge does not allow an individual to cope fully with the new experience, then there is a possibility that learning could take place. The aim of the Log is to try and isolate these instances for each individual, to give a picture of the types of problem that they are encountering.

The individual is the best person to identify these points, since neither observation nor the use of a critical incident technique could not be so precise in the interpretation of what is happening. If as a researcher, you watch someone performing an exercise e.g. changing the dressing of a patient with a leg ulcer, it may appear that the nurse in question performs the job perfectly adequately. However, there is no way of telling what thought processes are occurring for the individual nurse involved, and although she provides an adequate service to the patient, it may be that she has had some misgivings about one or more aspects of her performance. These are the precise points that the Log aims to capture. Also, if a log of specific incidents is made then it means that the individual is reporting
actual deficiencies rather than being able to respond in an idealised way to proposed situations. This latter distinction is the point made by Argyris and Schon (1974, pp.6-7), when describing theories of action and theories in use i.e. how we respond to a situation when asked about it in a classroom is the 'espoused theory of action for that situation', but what is actually carried out in practice is the theory in use and frequently differs from the theory of action.

Completing the Log involved individual participants who were about to attend a module (or series of modules). They completed the forms (see appendix 17) for one week prior to attendance, and one week at some predetermined point after completion of the module(s). For the time that they were involved, they were asked to record twice a day, any instance that they came across in the previous three or four hours, where they identified a deficit in their knowledge or skills. These instances then formed the Log. When used in conjunction with the other information collected using the same methods as those of the ECNM, it is postulated that the Log will put some perspective onto the relative gains for an individual, in relation to the module(s) attended. Finally, as the Log was sent out to participants before any contact had been made, it was accompanied by a full set of instructions and a covering letter.

The use of a biographical questionnaire has been listed as a separate component, since not only were participants of target modules asked to fill them in, but everyone from every FS module over a six month period was asked to complete them. In this way, a full profile of the type of response to this continuing education initiative could be built up. This would help in assessing whether the target population had indeed been the uptake group, and also what regional variations – if any – might have occurred.
The use of the pre and post course questionnaires and a semi-structured interview for all members of the sample group and the comparator group follows the design already established. The only departure from those used with the charge nurse groups was that there were no forced choice scales, as these did not prove to be a satisfactory component when used previously.

4.5 Course Leaders and Nurse Managers

The format of the interviews and questionnaires for these two groups followed, once again, the structures used for the ECNM. The information collected serves to triangulate the results, thus contributing to their trustworthiness.
CHAPTER 7 - RESEARCH METHODOLOGY

Introduction

As with the design, the methodology will be described in chronological order as it relates to the instruments used. Due to the qualitative nature of the data collection this mostly involves contact with people who are associated with the continuing education in question, plus the comparator groups. Contacts were set up for all the research involvement through the appropriate nursing channels, facilitated by the Projects' associations with the NBS.

Where appropriate, the instruments described were administered by the researcher. For the evaluation of the ECNM, this involved taking the questionnaires to the different groups as they were starting or finishing a course, meeting with all the members of area D individually to gain their co-operation and explain the questionnaires to them, carrying out the semi-structured interviews for the total population and interviewing the course leaders (see figure 5, page 58 for structure). The total numbers involved in all of these activities were:-

63 course participants
  3 course leaders
32 members of area D
25 (out of a possible 63) nurse managers

For PSI&II, questionnaires and interviews were also administered by the researcher, though this time there were exceptions. For two of the instruments, there was no face to face contact with the groups. The Nursing Log was administered by post, and the biographical questionnaire was given out by the course leaders for all modules that had no other research intervention. All these methods worked satisfactorily, once the contacts had been set up.
The timing of the research interventions now had to follow a more flexible pattern. With participants potentially involved in one, two or three modules from the date of recruitment into the evaluation, their questionnaires and interviews had to be delivered accordingly. The theory remained the same for all participants, in that they received the Nursing Log (if required to complete it) prior to the first contact; the pre-course questionnaire was given on the first day of the module chosen for recruitment; the interview was given just prior to completion of the last module that they were involved with; and the post-course questionnaire was completed on the last day of their last module. Finally, if they had completed the Nursing Log they would be asked to complete a follow up Log one month after completion of their last module. Thus the structure was the same as that of the ECNM, though some individuals took longer to complete the set of instruments than others, due to their prolonged involvement with more than one module.

Validity and Reliability

Validity and reliability pose an interesting question in terms of qualitatively based methodologies. Within the whole epistemological discussion concerning the use of a qualitative or quantitative mode of enquiry (see chapter 4) this issue reflects the diversity of debate. Contradictory ideas exist and there are differing answers to the question from differing authors. An overview will be given here to exemplify some of the issues that exist.

In order to consider the alternatives, it is first necessary to establish what is meant by the classical definitions of reliability and validity. An instrument is said to be valid if it really does measure the characteristic that the investigator is looking at. Alternatively, reliability is the extent to which the instrument used produces consistent results (see Abramson
1979, and Scriven 1981). If a measure is reliable, it is not necessarily valid, however if it is valid then it is necessarily reliable.

A good example of this is a thermometer which, when put into boiling water consistently reads 90 degrees (Scriven 1981, p.135). This is known scientifically to be an inaccurate reading, since it should be 100 degrees. It is therefore not valid. It is however reliable since it reads 90 degrees each time it is used. Alternatively, a thermometer which will consistently read 100 degrees when put into boiling water is said to be both reliable and valid. Using this knowledge, it is possible to ensure that any thermometer used in experimentation, is calibrated correctly to produce both valid and reliable data.

The argument within the qualitative domain, is whether this type of rigour can and should be applied to qualitative data, or whether it is totally inappropriate given that qualitative methodology is governed by its own very different philosophical base. Should then another approach be found?

Miles in 1979, described the issue of data presentation and analysis as:-

"...essentially intuitive, primitive and unmanageable in any rational sense." (McDonald 1985, p.25)

But if everyone involved in data presentation were to be merely intuitive, then the results being produced would have no credibility and those attuned to the quantitative approach would have further grounds for implying the 'softness' or 'haziness' of qualitative data. Some attempt therefore has been made to clarify the issue of validity and reliability, but there is no unanimity on the way it should be done. Miles, writing with Huberman some five years after the above comment states that:-
"Despite a growing interest in qualitative studies, we lack a body of clearly defined methods for drawing valid meaning from qualitative data. We need methods that are practical, communicable, and not self-deluding: scientific in the positivist's sense of the word, and aimed toward interpretive understanding in the best sense of that term." (Miles and Huberman 1984, p.21)

More recently Hutchinson et al (1988) also addressed this point. They provided a check list of eight strategies to be considered in qualitative evaluation, which they thought could counteract the inherent difficulties presented by the problem. The first of these however was 'be alert to threats of validity'. It can be seen that both of these statements confront the problem by starting from the baseline of expectation provided by the scientific mode of enquiry. Compare this with Guba and Lincoln (1981), who not only address the issue of validity and reliability, but actively produce their own alternative strategy. This is a major move, since it leaves the concept of justification through neo-scientific methods aside and presents a completely new perspective. They identify four main areas of concern and introduce the concept of 'trustworthiness' to represent the whole issue. The four areas of concern are shown - in relation to their quantitative counterparts - in table 5:-

<table>
<thead>
<tr>
<th>ASPECT</th>
<th>SCIENTIFIC TERM</th>
<th>NATURALISTIC TERM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Truth Value</td>
<td>Internal Validity</td>
<td>Credibility</td>
</tr>
<tr>
<td>Applicability</td>
<td>External Validity/</td>
<td>Fittingness</td>
</tr>
<tr>
<td></td>
<td>generalizability</td>
<td></td>
</tr>
<tr>
<td>Consistency</td>
<td>Reliability</td>
<td>Auditability</td>
</tr>
<tr>
<td>Neutrality</td>
<td>Objectivity</td>
<td>Confirmability</td>
</tr>
</tbody>
</table>

TABLE 5 - Scientific and Naturalistic Terms Appropriate to Various Aspects of Rigour (Guba and Lincoln 1981, p.104)

Sieber was another researcher who produced alternative concepts to represent validity and reliability, he coined the terms 'auditable', 'confirmable' and 'credible' (Sieber, 1976) - not unlike those used by Guba and Lincoln. The methods suggested by both these authors essentially
call for the researcher to build up contact with the research site over a long a period as possible; to continually check the results with others external to the work; to crosscheck different sources of data; and to constantly be sensitive to the essential problem of researcher bias. This last point is an interesting one, since unlike scientific enquiry that calls for experimentation with a variety of instruments, very often in qualitative research the individual carrying out the work is the research instrument! These steps are similar to those proposed by Glaser and Strauss (1967) in their development of grounded theory, and are designed to lend strength to research findings.

In relation to the cross-checking mentioned, the term 'triangulation' has been taken to represent this activity (see for instance Bryman 1984, Cleave-Hogg and Byrne 1986, or Guba and Lincoln 1981). This term is described by Scriven (1981 p.159):-

"Originally the procedure used by surveyors to locate ("fix") a point on a grid. In evaluation, or scientific research in general, it refers to the attempt to get a fix on a phenomenon by approaching it from more than one independently based route."

To triangulate, one should try to take information gained from either a variety of sources, e.g. in the case of the work of this research, ward sisters / line managers / course leaders, and compare the different reporting on the same issues to see whether there is corroboration of different attitudes and beliefs. Alternatively, one should use different methods of obtaining information from the same people e.g. take information given in a questionnaire and follow it up again at an interview. Eisner (1979) incorporated this concept into a methodology he called 'structural corroboration', which attempts to build up a picture of the whole in the same way as completing a jigsaw i.e. build a picture by piecing all the individual components together in the manner that gives a coherent and comprehensible result.
An approach taking the use of data as pieces of a jigsaw which constructs the whole, does not provide an unassailable package that is proven by statistical or other means. It does however, lend credibility to the trustworthiness of the results obtained - which as the ultimate test must be recognisable to the group from whom the data was collected. It strengthens the case for qualitative data which says, the results presented are not necessarily the only ones possible, but if the reader can follow the logic of the presentation and comprehend why the conclusions have been drawn, then this represents a valid interpretation of the situation.

Equating this information with the proposed methodology of this research, there are two issues that arise. First, the questionnaires designed for the evaluation obviously required some form of pre-testing to ensure that they were understandable to the respondents, and were self-explanatory in relation to how they should be completed. In addition, the forced choice scales had to be subjected to item analysis to ensure their validity and reliability in the more classical sense. These processes are described in the preceding chapter (see pp.53-54). The interviews that were used, were all derived from previously gained information, either through the responses to questionnaires or other information gained through documentary and background sources, so that they did not require any form of pre-test. They were also semi-structured in design which meant that not only were they flexible enough to incorporate any issues that arose in situ, but the nature of the questioning did not mean that the wording would be constant throughout. This is very dissimilar to classical survey interviewing where there are stringent rules of engagement for the interviewer, and inter-interviewer (and inter-interview) reliability can become a problem (Sudman and Bradburn 1982, and Moser and Kalton 1971).

Secondly, the point about ensuring the 'trustworthiness' of the results was approached in this study through all four
of the points listed above i.e. the researcher had an in-depth association with the research ground not only through visiting and getting to know the particular areas involved in both evaluations, but also through the history of having been part of the nursing profession for six years prior to commencement of the study. Secondly, the awareness of researcher bias, is something that has to be borne in mind constantly, and through involvement with others, in terms of triangulating results it becomes apparent when there is a threat of this. Thirdly, the methods of triangulation not only involved using differing data collection instruments with each respondent, but also through comparing the sets of data between the different groups involved. Finally, in the case of the ECNM, the results when presented to the sponsor and the profession were met with acknowledgement of the findings (Whiteley and Broomfield, 1987).

Method of Implementation

1 – Experienced Charge Nurse Module

The Pre and Post-Course Questionnaires
The first point that had to be explained to each individual taking part was the fact that although they were each being asked for their own attitudes and opinions, they were not themselves being judged or assessed in any way by their answers. It was rather, that the module was being evaluated through their reporting. For this reason, and to ensure confidentiality, the respondents were all allocated a code number, so that any response could not be attributed to them directly on an individual basis. An explanation of the context of the work was given to all course members and the questionnaires administered in the presence of the researcher in all except two cases (these two received their questionnaires via a different route for logistical reasons).
Most groups answered the questions without any queries. It was interesting to note however, that if an individual began questioning the procedure or content of the questionnaire, then the level of questioning within the whole group was high. Conversely, if no-one took the lead in asking questions, then the overall level of questioning remained low. Any questions asked in this context that were anything other than purely factual were not given a direct response, since this would be adding the researcher's own interpretation (and bias) to the results. Respondents in both types of environment took equal lengths of time to answer the questions, and neither showed any tendency to omit a particular question.

The members of area D all received their questionnaires postally. They were sent out in two halves for ease of handling, and a record kept of who was sent what, and when. Follow up letters were sent to those who did not respond to either questionnaire within four weeks and a further non-response was taken to mean that the individual had either moved on or that they no longer wished to take part.

The Semi-Structured Interview
To interview the course participants a series of appointments were made so that they could all be seen individually. For colleges B and C the charge nurses were mostly seen in their place of work at a time convenient to them. The interview took between half and three-quarters of an hour, so that it was possible to spare this time at some point during one of their shifts, whether it was during the day or at night. In just a few cases an individual was interviewed at the college if for some reason, e.g. holidays, it would have proved difficult to see them at their workplace. For college A, because the geographical spread of the area was much larger, the participants were all seen actually in the college, at the end of the second teaching module. The fact that they had not completed
absolutely all their college input had to be taken into account in answering some of the questions, but it did not make it impossible to carry out the interview at this point.

For area D the interviews all had to be arranged separately at the individuals' place of work. This entailed re-establishing contact with the charge nurses and arranging a suitable time when they could be seen. This interview was slightly shorter in length than that of the participants, taking on average between twenty and thirty minutes.

All these interviews were tape recorded and then transcribed for use in the analysis of results. This method of record taking was decided upon after speaking to others who had already been involved in this type of situation, and referring to the literature (for instance Moser and Kalton 1971, and Belson 1967). If the interview is recorded manually, the attention of the interviewer is not fully on the respondent, and any hand written notes that are taken immediately become the subjective perception of the interviewer. This can be easily proved by both recording and taking notes from the same interview. If the results are compared, the hand written notes are scant in relation to the full text and it is noticeable that certain pieces of information are completely absent:-

"Open questions present a more difficult recording task. Should the interviewer record everything that the respondent says, only remarks that she considers relevant, or should she paraphrase the respondent's answer. The danger with the last two procedures is clear, that the interviewer will introduce a bias....One possible solution is the use of tape recorders to record everything the respondent says." (Moser and Kalton 1971, p.281)

There is a problem with tape recording however, in that a lot of people find it threatening. There is also the possibility of affecting the answers given by asking to use this technique, though there is always this risk, when you perform an intervention of any sort (Sudman and Bradburn
1982, p.18 and Belson 1967, p.253). Within the ECNM evaluation, three people refused to be recorded (all from area D), two took some persuasion and the rest accepted it without comment. The fact that a tape recorder was going to be used was initially mentioned to each individual at the time of the interview, so that the respondent had no idea that they were to be recorded before that point. This proved to be unpopular though with both the interviewee and the interviewer. Unfortunately this could not be avoided with area D members, since there was no contact immediately prior to interview. For the course participants however, the method was changed and they were informed as a group, with a full explanation given as to why it was necessary, that this was to happen. This was a more positive approach, since if there was any initial dissension, persuasion was brought to bear through peer group pressure from those who accepted the situation. Ultimately, nobody was recorded against their will or without comprehension of the situation.

The Course Leaders and Nurse Managers

Data from the course leaders was collected both formally and informally. Each time a visit was made to the college, some discussion took place which necessarily imparted information about how the courses were progressing. The more formal process recording forms were given to each of the three course leaders and filled in at the appropriate times between the courses (with a reminder when necessary). These were then either returned postally, or by hand at the next point of contact - other documentary information was also collected in this manner. The semi-structured interviews were carried out at each of the colleges during one of the regular visits. They were also tape recorded and transcribed for use in the final analysis.

The nurse manager questionnaires given to course participants to hand on were returned postally in the prepaid envelopes provided. They were covered by their own
complete set of instructions, but provision was made for contact with the researcher if there were any queries. There was in fact only one, and this was purely logistical. It related to the length of time that the particular manager had had contact with the charge nurse, rather than the content of the questionnaire.

2 - Professional Studies I and II

The Exploratory Interview
To set the interviews up, letters were sent to the General Managers and the CANO's of the health boards involved. The names that were given through these initial contacts provided the sample, with the DNS involved in each case providing the names of the representatives of the other levels of nursing staff within her hospital. The interviews were then carried out in the place of work for each individual involved at a time convenient to them. Recordings were made of each of these interviews and transcriptions obtained.

Mailshot Questionnaires and Interviews
Based on the responses from the exploratory interviews, areas of importance were beginning to arise in relation to the PS initiative. Using the method of progressive focusing therefore, these areas were taken and expanded upon for use with the mailshot questionnaire. The finished document was circulated to all the DNE's and heads of departments and returned in a pre-paid envelope. The only hiccup with this particular mode of collection - which in the past had worked quite successfully - was an unforeseen postal strike. Due to this unfortunate intervention a series of letters were sent out after the final requested return by date (and after the end of the strike), and colleges were able to affirm whether they had in fact responded and the delay was not of their doing, or whether they had not as yet completed the document. In the final event, a 100%
response rate was achieved, thus providing a total state of the art picture at that time.

Within all versions of Mailshot, there had been a question asking for permission to contact the colleges at a future date to arrange a follow up interview if required. For those that were part of this next sample i.e. all establishments offering or proposing to offer PSI and/or PSII who were agreeable to interview, again a visit was made to the interviewees place of work. The interviews thus obtained were tape recorded and transcribed.

**Nursing Log and other modified instruments**

The first issue that is different for this set of staff compared with the charge nurses, is that a total sample could not be taken. The numbers that could potentially be involved in one or more modules during even six months were prohibitively high, therefore a smaller, representative sample had to be decided upon. For PSII it was relatively straightforward since at the time of proposed involvement with participants, there were a limited number of courses, allowing all of them to be addressed. For PSI however, the proliferation of courses at this level meant that three colleges were taken, representing once again urban, rural and semi-rural environments. In addition to these criteria, the colleges involved offered a range of modules that had been running for differing lengths of time i.e. some were just beginning, whereas others had been running for a number of years.

Once the target colleges had been chosen the method of recruiting individual participants to take part, was carried out in the following manner. A date was set in conjunction with each of the course leaders, and the intake on that day for a specific module became the target group. Each time, there was a cross-section of people who were either just starting PSI or PSII, who had done one or two modules previously, or who were just doing the module as a
'one-off'. This meant that within the total sample it was possible to draw on the experiences of a whole range of individuals all of whom were using the new system in a potentially different way, to suit their own needs.

Setting up the comparator group was also different for this set of modules. It was possible to find a health board that did not have any provision of PS modules at all. It was also felt necessary however to include a group of staff nurses who had no PS experience, but who were in a situation where they were mixing with others who were attending modules and where they themselves may be waiting to attend.

The development of the Nursing Log had taken place over a number of months and had been pre-tested on two occasions to assess and ensure its viability. The first pre-test had been with a set of final year nursing degree students who had achieved their final examinations, but were not yet registered. Although this group were not directly comparable to those about to undertake PS, they were considered to be useful as a preliminary test. Half of the group were engaged in discussion about the Log, to discover any possible stumbling blocks that they could foresee and to assess whether the proposed wording of the instructions would be understandable. One of the initial problems that had been envisaged for the Log was, that it was in essence asking people to list their shortcomings. This is not something that would necessarily be well received, unless couched in a reasonable form, with sufficient - though not too lengthy - explanation.

The second half of the group were given the completed instrument and asked to try and fill it in, in the ward situation. This proved to be rather unsuccessful as an exercise, with only one person providing a response. The reasons given for this were that they did not have / were not allowed enough time to fill it in. The one response that was received however showed the type of reporting
required, thus when the next pre-test was arranged the wording of the instructions and the examples given were left unaltered.

The second pre-test was arranged through a college of nursing and midwifery who had a PSII module about to start. It was the first PS module for all these candidates and as such they were in a similar position to those about to begin PSI. The documents were sent out to them 'blind' i.e. they had no idea that they would be receiving them. There was a covering letter written explaining how their names and addresses had been obtained and what the forms were about. The response this time was good. The researcher went and collected the Logs in, and asked the group for difficulties that they may have had. In fact there were no difficulties other than holidays coinciding with the week prior to attendance when it was requested that the Log be filled in. The completed Logs were therefore satisfactory, and the instrument was ready to use.

The set of papers constituting the Log were sent out to each participant of the PSI modules prior to the first contact that was to be had with the group as a whole. Each time, they were collected in when the researcher went to administer the pre-course questionnaire, so that complete confidentiality was maintained. Anyone who had not for any reason completed the Log would be exempt from the follow up, but still included in the sample for interviewing and questionnaire purposes. The second Log was designed to be sent out to participants once they had completed the total number of modules that they were involved in. This time they would be returned by post, thus giving a set of Logs for each individual.

The information contained within the two Logs for any individual can be compared, to assess whether any changes in reported situations has occurred. Comparison between sets of Logs from participants attending the same modules is also possible to try and identify common shifts in
reporting. Using individual information the semi-structured interview situation is used to explore some of the responses with the participants. This can be used to explore the points that they have identified within the Log and also to discuss how the course has had any relevance to the issues raised.

The other instruments used with course participants and also members of the comparator group were distributed and collected in the same way as those of the ECNM.

**Course Leaders and Nurse Managers**

Course leaders were dealt with in the same way as those involved with the ECNM. The method for the nurse managers varied slightly however. The questionnaires were handed out in the same way, but a sample was taken of the respondents so that follow up interviews could take place.

**Method of Analysis**

Due to the different sorts of data collected a variety of methods were used in the analysis, including both qualitative and quantitative techniques. The methodologies fall into three main categories which are:-

1) Descriptive
2) Statistical
3) Content analysis

These will be dealt with separately in the following account.

1) **Descriptive**

Certain information collected contributed to the evaluation by providing a factual dialogue about different aspects of
the courses. This was particularly true for the monitoring exercise carried out in conjunction with PSI&II, specifically through the mailshot questionnaires. Examples include a profile of what modules are developing and being run and where, and dates of prospective module intakes. Also included in this category is the information taken from all course participants. For instance, the biographical data collected for PS, plus data from the pre-course questionnaires which when collated provides an overall description of the items such as age, qualification and years experience of the total group. This then gives an indication of the type of population that the course has been attracting.

To help collate this information databases are created on micro-computer. For the ECNM, dBase II (registered trademark of Ashton-Tate (UK) Ltd.) was used allowing all the biographical details to be entered onto a file and stored, using the fields defined by the questions asked (see appendix 18). Once this had been done, multiple subsets of the data could be created by calling up a combination of one or more of the seventeen categories specified. The results from this exercise were then printed out and a record of the collated material obtained. Also kept in this database were the scores from the two forced choice question sections of the pre and post-course questionnaires. These records and their usage will be discussed in the next section (statistics).

For PSI&II the database of biographical information was put onto SuperCalc 4 (registered trademark of Computer Associates International Incorporated), the advantages of this being that the information could be defined graphically as well as being produced in printed, tabular form. Other descriptive information was also produced through SuperCalc 4, by drawing up spreadsheets for data presentation and simple calculations where necessary. Other descriptive data was produced in report form using straightforward word-processing software (Wordstar 2000 –
registered trademark of Micro-pro International Corporation; release 2.0), thus enabling the electronically stored files to be constantly updated as and when necessary.

2) Statistical

There were two levels of statistical analysis that occurred within this work. At the first level, simple descriptive statistics were used for presentation of data concerning numbers and distributions of responses to the various questions contained within the questionnaires and interviews. e.g. 12% of respondents did not feel that their individual needs had been met; 65% of the charge nurses worked in general wards; average length of experience was 17.5 years.

The frequency scales of the ECNM were also presented as percentages, though the forced choice attitudinal scales demanded the second more complex level of analysis. Both scales however, shared the initial steps of the calculation using dBase II. The method used involved the computer in totalling both pre and post scores for the subsections of each scale for every individual, and the scores were then converted to percentages manually (the software used would not do this). These figures were used to calculate the shift in response whether positive or negative for each person and it was this shift that was used in the following calculations.

For the attitudinal scales the four subsections of management, practice, teaching and continuing education were taken separately and Wilcoxon's matched pairs signed ranks test applied to the percentage shifts (see Ferguson, 1976 and Hammond and McCullagh, 1974). This particular test was chosen, since it is nonparametric and it was not certain that the data available was a normally distributed sample from the whole population so that a more rigorous
parametric test e.g. the T-test, would have been inappropriate. Wilcoxon's test takes the difference between pairs of data and ranks them, thus creating an ordinal scale for use in the calculations. Therefore it is not the absolute size of the scores but the distribution of the them between positive and negative which provides the significant measure. The figures involved in these calculations were derived from the members of each of the biographically defined subgroups created through the database, with comparative data created by taking the scores for members of area D separately.

For the frequency scales, the data could not be analysed in this way as the shifts represented by the scores could not be said to be better or worse for being positive or negative i.e. if an individual's score was 10 points lower on the post-course questionnaire, this did not necessarily mean that she had not benefited or learned from the course. Rather, it showed that there had been some adjustment in the way that she carried out her job. Further analysis using Wilcoxon's test therefore was inappropriate.

3) Content analysis

This was the most frequently used mode of analysis in this work, since the data collected was qualitative by nature. The concepts generated through the use of grounded theory (Glaser and Strauss, 1967) were applied enabling the questions posed at the outset of each continuing education initiative to be addressed.

To do this, the recordings of the interviews were transcribed into a type written format, so that this information and the information written on the questionnaires was available for analysis. Each question in each section of either the interview or the questionnaires was taken separately, and initially the overall response was determined. Key phrases or words were then noted for
each question and categories generated from this data. As many categories were used as necessary each time and all the answers fitted into them, creating a situation where ultimately the point was reached where 'saturation of categories' occurred (see chapter 4, page 43). This means that for all the data available on any particular subject is contained within one of the categories generated and a pattern begins to emerge, suggesting where the priorities lie for that particular issue. The data is thus reduced into a manageable form, where it is possible to construct further overarching categories, spanning more than one question pertaining to the same subject area. In this way, all the information contained in a set of questions relating for instance to provision of courses within colleges, can be summarised and presented using only four categories.

In the analysis of the Nursing Log, this methodology is used in a different way. For each respondent, the answers given on each form are taken and put into a conceptual category. This means for instance, that a statement that is ostensibly about not being able to get a member of staff to carry out a particular job, becomes a statement that is categorised as a communication problem. Alternatively there may be situations where the respondent has actually identified for themselves that they need input in counselling skills, which in itself is a conceptual category. A pattern should then emerge for individuals and also between groups of individuals with similar amounts of experience. The second, follow-up Logs are analysed in the same manner and the two are then compared to assess what contrasts - if any - are highlighted in the type of problem being reported. Factors such as number and type of module should be taken into account here.

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PART THREE:

PROCESSES AND OUTCOMES
PART THREE:

PROCESSES AND OUTCOMES
CHAPTER 8 - ECNM PRE-COURSE QUESTIONNAIRE

Introduction

The aim of the following section is to explain - through the use of the findings from the various methodologies previously described - the processes that were at work in designing an evaluation model for use with continuing education courses in nursing. Where a particular method was used more than once in the two projects, only one set of findings will be presented.

Chronologically, the ECNM produced the first findings and these are presented in separate chapters, according to the instrument used and the group of respondents involved. A discussion of how these findings influenced the design process will then follow before the reporting from the PSI&II evaluation is considered.

Quotes are used throughout this text to illustrate points that are made. None of them is attributed to a specific source, but all are taken from information collected during the evaluations. The lack of any identification is deliberate, to ensure total confidentiality for all respondents.

Pre-Course Questionnaire

The data to be discussed in this section consists of the biographical information from the pre-course questionnaire, particularly in relation to the participants of the modules. The open-ended questions also contained in the questionnaire will not be dealt with here, as the information gathered was used in the semi-structured interview. These findings are therefore reported in the appropriate section (see pages 99 and 104).
Biographical Information

There were ten categories within this data which provided a descriptive outline of the respondents, whether from the comparator group or a module. The data from module participants was collated, to give an overview of the results. This was done through the use of dBase II. By specifying any particular category of the information stored in the database, a list of all the members of that category could be printed out and used in the construction of the overall picture.

The data represented in the diagrams on the following pages (see figures 8 - 17) is from module participants (the relevant questions from which this data was gathered, can be referred to in appendix 2).

Over 70% of the course members were within the 31-50 age range (see figure 8). The average length of experience (figure 9) was 17.5 years and time in present post (figure 10) was 8.5 years, although it can be seen that the range for all of these categories was wide. The majority of charge nurses (88%) came from a hospital setting (figure 11) which was either a general (the most prevalent), psychiatric or midwifery ward or clinic (figure 12). There were no mental handicap nurses on any of the six courses even though two of the colleges had been chosen with this particular group of nurses in mind. It was established that this was due to lack of uptake rather than a failing of the course organisers. Each area had three community nurses (in total) on the courses. All three were district nurses in the rural setting; community midwives in the semi-rural setting; and two community midwives and one health visitor in the urban setting.

The primary registration of 65% of the charge nurses was general, with mental illness being the second most common (figure 13). Qualifications in the 'OT' category were either fever training or enrolment and again, mental
FIGURES 8 TO 13 - ECNM Course Participant Biographical Data
14 - FURTHER REGISTRATION

15 - COURSES

16 - QUALIFICATIONS O & H

17 - ATTENDANCE

CN = Charge Nurse
MI = Mental Illness
SC = Sick Children

MH = Mental Handicap
MW HOSP. = Midwifery Hospital

FIGURES 14 TO 17 - ECNM Course Participant Biographical Data
handicap was not represented. 70% of the total population had at least one further registration (figure 14). This factor is representative of the normative behaviour which has been practised up until now i.e. a further registration has been taken regardless of whether there was any intention to practice in the secondary area. The number of courses attended (these were more than single study days) by most respondents was within the 1 - 4 range (figure 15). Those who had done more than this tended to be midwives who had done three or four refresher courses, as well as one or two others such as first line management. Academic qualifications (defined in terms of five or more 'O' grades/levels and one or more higher/'A' levels) were held by only 30% of the group (figure 16). Most of these being held by participants in age categories 1 or 2 (67% of those in the 21 - 30 age group, and 30% of those in the 31 - 40 age group). This result is biased by the fact that this type of qualification had not always been offered in schools, thus putting the older respondents at a disadvantage. It was noticeable however, that most of those in the older age groups did not have the corresponding school leaving certificate.

The final point in this biographical information, relates to how each participant came to attend the course (figure 17). This point has been expanded in figure 18 (see overleaf), where it can be seen that most people fell into one of the first three categories i.e.:-

A  Put name forward for any continuing education available
B  Asked specifically to come on this course
C  Was asked to but given the option to refuse

In the rural area, the responses were fairly equally distributed between the three categories (i). In the semi-rural area (ii) the number of people asking for any continuing education was noticeably less than the other two categories, but in the urban area (iii) nearly half the
candidates were asked to attend but given the option to refuse. In each area there is only one person who would have refused to attend if given the option (answer Y) and a slightly higher percentage in the rural and semi-rural areas of those who would have agreed to attend had they been given the option to refuse (answer N).

FIGURE 18 - ECNM Attendance Categories
CHAPTER 9 - ECNM PARTICIPANTS' SEMI-STRUCTURED INTERVIEWS

The results of these interviews will be presented according to the three sections of the interview schedule (this can be referred to in appendix 4). The first set of questions dealt with the teaching received in college, the second with the individual needs of the charge nurses and the third with their thoughts about the whole module and how it affected them.

Teaching Received in College

Problems concerned with taking this group of nurses into a college (in some cases not having studied since they qualified) for prolonged periods were not manifold. Most found it easy to adapt to being in the college situation, those who did not being either on night duty, or having to travel for lengthy periods to and from the college. These latter groups obviously present special problems, which in the case of night duty nurses are difficult to avoid.

Actually studying again was difficult for just under half the participants, though the problem was not insurmountable:

"It took a wee while to get away from the hustle and bustle, but once I was into it, it wasn't too bad"

The structure of the teaching was satisfactory throughout, apart from one or two lectures or lecturers who were singled out on different occasions by different individuals. This is commonplace however on any course as not all topics or modes of delivery suit everyone. A variety of teaching methods were used in all three colleges. These included lectures, tutorials, discussions, videos, modified lectures, role play and personal study. The modified lectures and discussions were deemed to be
most effective, especially where visual aids were used. Straight lectures on the other hand were reported to be the least effective, although only a third of the respondents would actually specify a least effective method. Role play was an interesting issue as it was mentioned as being both the best and the worst teaching method in a number of replies and most respondents had something to say about it whether good or bad! The main point about role play is that there will always be some people who find it too stressful to be useful and though this fact should not be ignored, they tend to be in a minority compared with those who either like it and find it beneficial or those who come to like it with use.

Two issues raised in this section generated divided feelings amongst the charge nurses. One concerned the style of the teaching in its broadest sense, and the other, the structure of the course. The style as perceived by all the participants was much less rigidly structured than they had been used to, so that there was a lot more emphasis put on their own input to the agenda and content of the course. This was appreciated by many, perhaps summed up in the following statement:-

"I enjoy the way teaching is done nowadays - the involvement, the treating you like an adult bit - giving you some teaching material and then being asked to use the information to solve certain problems and be involved in groups."

The already stated effectiveness of the modified lecture and discussion also emphasises this point. However, there were some who found this very hard to cope with:-

"I am concerned that things were not assessed, merely the fact of doing them was supposed to be enough."

"I found the free time hard to cope with."

"I feel guilty about being away from my place of work, so condense the college time or fill it up."
These statements came from people who did not appear to appreciate that the 'free' time was in fact meant for personal study, and who would rather have had some formal input from morning to night every day.

The other point of debate concerning the structure of the course was based on the total college time. The module had been structured so that the participants received a three week block, plus a one week block and the single study day at the end (see figure 4, page 50). 15% of the respondents felt that this total of four weeks would have been more beneficial if it was divided into two equal blocks of a fortnight. The reasons for this were that three weeks away from the work situation was too long to take all at once, and for some the amount of information received in three weeks was too great, to be able to assimilate it all. Others though who had felt that two fortnights would be better later changed their minds:-

"At first I thought two and two, but looking back, because it takes a week to settle - that would only leave one more week, so three is probably best."

The only other concrete suggestion, which came from those in college C, was that a study day during the six months back in post would have been a useful contact point to maintain the momentum of the course. This affirmed the move by the course leaders in the two other colleges who introduced just such a day.

Apart from these issues, there was some small debate about the length of time given to carry out projects and action plans, but it was generally agreed that work expands to fill the time available. Bearing all these things in mind and the fact that the interview was carried out before the six month period back in post, it was encouraging to find that the overall length was deemed to be satisfactory:-

"The structure did not seem to disrupt the work situation, but allowed time for thought and consolidation."
"The information will stick longer, because we come back three times and consolidate."

**Individual Needs of Charge Nurses**

The first question in this section asked whether continuing education is a necessity. There was a 100% yes response to this, followed by a variety of suggestions as to how it should be carried out. A mixture of ideas ranging from study days to longer courses such as their own were put forward, though some people seemed to confuse the idea of continuing education with that of in-service education. A strong emphasis was given to the fact that education should be given away from the place of work. It was recognised that unless you are given the time and space to concentrate outwith the pressures and distractions of the workplace the input given cannot be so effective. The other advantage of being in a neutral environment is that this can provide a chance of mixing with a variety of staff from different specialities. This can be beneficial as an information exchange point or as a chance to put your own job into perspective alongside others in similar situations.

"Hearing other people's views on different things gives you a better insight into what you could be doing and what changes you could make in the ward environment."

"It's good mixing with people from other areas, you think that you're bad in your workplace until you hear somebody talking about their work area."

When asked whether this particular course had taken into account and catered for individual needs 88% of respondents reported that it had. Of the 12% who said that it had not, the main complaint was that their particular speciality had not been addressed. This however had never been the aim of the module, in that it was designed to be multidisciplinary within nursing. Bearing this point in mind, this question was followed up by asking whether the course had met the individual's own needs. Interestingly, only 5% said that their needs had not been met which means that 95% felt that
they had. Therefore, although some people felt that the course did not cater for individual needs, the content that was provided met this demand anyway.

In trying to determine exactly what the needs of the charge nurses were as they saw them, the responses received were very cautious and non-specific in nature. It seems that if the course design had been in the hands of the participants it would have taken much longer to develop! However, the following is a list of the areas covered in the replies, divided into four categories (table 6):-

1) General
More awareness needed of what is happening.
To make you think more about your role as leader and manager etc..
Security or reassurance, especially from your peer group.
A refresher situation

2) Update
An awareness of what is going on nationally to see new trends in nursing and higher management levels, and see what is happening in the future.
A clearer understanding of the direction nursing is taking.
An explanation of Project 2000 etc..
New techniques, innovations and ideas.
Information about what is going on in the advancement of nursing and management.

3) Specific
To get an idea of how to teach students.
To be able to plan more effectively and therefore increase staff satisfaction.
Communication skills addressed and explained.
Counselling skills.
To increase confidence in managing the ward and people.

4) Don't know
More a case of realising what you needed once you were presented with things rather than identifying things prior to the course.
It is only since you have been on it that you realise how dumb you have been.
Don't know what is needed.
Unable to identify needs prior to course - I thought I was coming along fine until all this hit me

| TABLE 6 - Needs Specified by ECNM Participants | 98 |
It is interesting to compare these identified needs with the expectations of the course listed by the participants in their pre-course questionnaires. These have been divided into just three categories (table 7), as everyone had some kind of expectation before they attended:-

1) General
To discuss things with colleagues
Educational
To be motivated to initiate new developments in the department
To improve skills as a charge nurse
To gain fuller understanding of the charge nurse role
To expand thoughts on other aspects of nursing apart from clinical
To help act up better for the nursing officer
To be able to face future changes confidently
To take a fresh look at own career and identify areas which could do with improvement

2) Update
To be brought up to date
To be given new ideas and thoughts
To gain insight into the educational future of nursing
To see how nursing is changing its format

3) Specific
To become more proficient as a manager
To help with the teaching and counselling of learners
To become a better manager and leader
To gain help in identifying strengths and weaknesses
To learn more about the ethics and psychology of nursing
To help in areas of interviewing and counselling
To be able to listen to the views of the general manager
To gain a better understanding of the Induction and Consolidation course

TABLE 7 - ECNM Course Expectations

The first statements in each of these categories combine to form the three most widely held expectations of all the course members. In broad terms they correspond to the needs specified above, with the other statements in both lists combining to cover similar areas. The exceptions were the people who did not know what their needs were, but who had had some expectations of the course.
Relating this to the finding that 12% of the participants did not feel that their individual needs had been met it would seem that this was not due to false expectations being held prior to the course commencing. Also taking into account that they were disappointed in terms of information pertaining to their own environment it is interesting to note that no-one had stated specific learning requirements about their work speciality when asked what their expectations of the course were. In all, 82% of the population responded that their expectations had been met, with only 5% saying that they had not (the other 13% being either not sure or only partially satisfied), which corresponds to the 88% satisfaction rate for needs. It would appear then that expectations of the course had not been unrealistic in the first instance and needs were actually met.

The other questions asked in this section referred to the action plans carried out by each individual. As the rest of the data on this particular subject was collected in the post-course questionnaire, the sum of the findings will be reported in the relevant section (see page 122).

thoughts on the module

In this section the participants were asked their thoughts about the module so far and what effects it had had on them (the question of expectations was also addressed here, but this has been reported already – see table 7).

They were asked about the practical applications of the module and the first response was to say that there had been none in particular. However, this was taking 'practical' to mean the way things were actually done from day to day i.e. routines or tasks. On reflection therefore, everyone was able to identify practical applications in a more generalised way and said that they tended to be indirect and stemmed from a subtle change of awareness in
themselves, which promoted more positive and objective thinking about the way in which they did things. This included in certain cases a development of new or already existing skills - mostly in the cognitive domain. This then had a 'knock-on' effect to their staff and therefore affected the quality of care that the patients were receiving. These feelings were equally prevalent in all groups of staff from different work situations, from night duty staff to nurses who worked in the community. It is important that these two latter groups of staff should also feel these benefits, since they tend to work in a more isolated way within a peer group, rather than having particular responsibility for a team of staff on a single ward:

"I feel more confident because I have knowledge I didn't have before to back up what I'm doing, and the way I'm doing things. I feel stronger because of it."

"It's an awareness, and I've gone back and sat down with the rest of my staff and we've discussed what I heard on the course....I think it's opened their minds a good bit."

"Going to give patients more information. For staff, I now have a better idea of counselling and interviewing and assessing students."

These practical applications are similar in many cases to the benefits reported by the participants, which give a clear indication of the direction that the module gave to the charge nurses from all three areas. The benefits can be divided into two categories with one or two exceptions. The two categories are 'awareness' and 'general', with the rest of the statements listed under 'other' (see overleaf, table 8).

It should be noted here that the benefits gained were, in some cases, tempered by inherent difficulties in the work situation which made it hard to feel positive about any improvements that were perceived. This point is highlighted by the last two statements in the awareness section of table 8.
Awareness
A new awareness of things going on above our level and why a particular thing has to be done in certain ways because of the management and financial set up.
My attitude has benefited - I was getting to a sort of stalemate.
Regained awareness of other areas in the health service - inclined to get into a niche and think yours is the only department.
It's good to get in touch with other people and hear what is happening in the outside world.
They have given me a maturity I think I should have had years ago, so that instead of arguing about every little new directive, I can see why it's taking place.
Realising that you're not out on a limb.
Realisation of my own shortcomings.
Being aware that nurses have sheets of armour and people are trying to stab us in the back all the time - from within the profession at a higher level, academics and politics as well.
Gained in confidence in one way, but when you go back into the job situation it's still there. The problems are still the same, staff shortage is still the same, you still have x amount of patients to look after and the workload is the same.

General
Useful to hear from different specialities
There is no connection between hospitals for charge nurses so to find out what is happening in the whole of your area is good.
Being away from the ward - it gives you a chance to sit back and look at the ward.
Time out to look at what I'm doing.
Meeting colleagues from different situations makes you realise the problems you have and very often fears and hopes are similar to other people's.
Getting away from the ward situation has made me do something about one or two problems I've identified.
We're seeing managers and talking to them and what we're getting is a much broader outlook of what's happening in the profession at a time when an awful lot is happening.

Other
When I thought about coming on the course I wasn't too keen, I thought it was another case of teaching your granny to suck eggs. However it has actually taught me management skills I didn't have.
I recognise the systematic approach to nursing and cost-effectiveness now.
I got into reading which I would not have done otherwise and have learned to talk more confidently about the areas I'm researching into.
Much more understanding of teaching, I'll be more positive now.

TABLE 8 - Benefits of the Course (ECNM)
Comparing the benefits with the needs and expectations already identified there are great similarities in the overall tenor of the statements. The direction of improvement for the charge nurses came from the up-dating, and meeting with other colleagues (stated in both needs and expectations), which in turn lead towards increased awareness either generally or in a specific area (stated in benefits). It is important to reiterate at this point that these findings were the same across the three areas and also across all disciplines included on any of the courses.

Also given to the respondents was a list of benefits that had been derived from the visit made to one of the first groups undertaking the module, who were not involved in the evaluation. The list can be seen in appendix 4 at the end of the semi-structured interview schedule. The following bar graph shows the percentage agreement with these statements (figure 19).

![Bar Graph](image)

**FIGURE 19 - ECNM; Agreement with Stated Benefits**

Out of the eight statements, only three fall below the ninety percent agreement point and of these one is much lower than the rest. This refers to the feeling of involvement with the course being attended (f) and although low, still represents over 50% agreement. There was
division within courses about this point, so it does not relate to one particular style of course management, but rather the individual's feeling of whether it is really possible to influence what is being presented. Even though disagreeing with the comment some reported that they had been asked what they would like to see included, but followed this up with the disclaimer 'but it would have been included anyway'! The other two comments which were rated slightly lower than the others were c and g, which refer to the comments 'learned a lot' and 'renewed enthusiasm for the job' respectively. In both these cases, any disagreement came from the lack of need perceived by the individual for either of these functions i.e. they did not have particular gaps in their knowledge, or they were already enthusiastic.

Two more points that were addressed in this section related to the charge nurse's perception of her role. The participants had been asked to summarise this in no more than two hundred words in the pre-course questionnaire. This produced a wide variety of responses which are listed in appendix 19 for interest. In the interview they were then asked whether their (individual) perception had changed in any way since coming on the course. 93% said that it had not and that their perception was something that they had derived through experience over a number of years, although it might have been strengthened by attendance. Of the other 7%, one person was radically affected by the course in that it had prompted her to really sit down and consider what she was doing, instead of just letting herself get carried away by the responsibility which she perceived that she had. This produced quite a lot of discontent for her at the time, but from her post-course questionnaire, it would seem that this reduced over the next six months and was translated into a more positive approach compared with how she had been at the outset.

The other part of this question asked the respondents to list in order of importance the three broad divisions of
the charge nurse role ie manager, practitioner and teacher.
The results can be seen in figure 20:

\[ M = \text{MANAGER} \\
P = \text{PRACTITIONER} \\
T = \text{TEACHER} \\
\text{Other} = \text{ONE OR MORE CATEGORIES PLACED EQUALLY} \]

FIGURE 20 - ECNM Participants' Division of Role

Two categories were prominent in this response (ignoring the 'other' category as this represented those who could not separate the three completely), one with the role of manager put first and the other with the role of practitioner. The teaching role was not popular as a first choice at all, and if points are allotted to each category and totalled (three points for first place, two for second and one for third for each combination) then teaching comes a poor third place, with practising first and management second. It is interesting to note (not conclusively, although the results for area D show the same overall order of importance) that charge nurses still see themselves primarily in the practising role, even though they feel that they are increasingly being asked to fulfil the role of manager to the detriment of their practising and teaching skills.

The last issues addressed in this interview asked for any criticisms or recommendations about the course and also what participants would say to someone who was about to attend the module. Criticisms were few and far between, as
were recommendations. There were a few isolated comments
again about particular lectures or lecturers, and someone
mentioned the spare time. A few other comments were made,
for instance:

"My only complaint would be that there is no
certificate of completion"

"Maybe some time on a one to one basis with the co-
ordinator because there may be some things you
don't want to bring up in the group."

"I would like to have been told more in advance
that I was to attend."

"We should get taught more how to teach."

Apart from these statements, the attitude of many was
summed up by the following statement:

"I can't say that I have any criticisms or
recommendations - well I wouldn't think I'm
qualified to judge."

As well as representing a not uncommon opinion, this
highlighted one of the problems that became apparent during
these interviews. That is, it was difficult to elicit
impressions or opinions from many of the charge nurses
about things which were more conceptual, compared with
relatively practical issues. It is said that nurses are not
renowned as being particularly vociferous about issues
which affect them. In this case, this meant that many
people simply reported being happy with what they had
received rather than being able to construct 'ely look at
what they had experienced and make some judgement about it.
The total number who did respond to this question was small
as indicated above, in fact only 20% of those interviewed
actually made some comment when asked if they had any
criticisms or recommendations.

This does not mean that the participants were unhappy with
what they received on the course, nor that the courses
needed a lot of criticism. This can be seen in some of the
statements made about what they would say to others about
to attend the module. Most comments were positive, many made general statements, others referred to the work involved, but one or two were more cautious:

"It's not as bad as you think it's going to be."

"Relax and enjoy it because it's good and beneficial, and you'll find something that you require."

"There's nobody that expert in the grade that they can't learn something."

"I would say that it was worthwhile going and that it would wind up your brain again."

"I'd say how I'd benefited and maybe take them to the ward and show them the changes and how it's working for me."

"Go because you will learn. Even the dissertation is not too high powered and once it was over, you felt you had achieved something."

"Be prepared to do a lot of work - reading and researching - and if you're not prepared to then don't go."

"You need experience otherwise you might be overawed at the level of some of the things."

Once again this was followed up by a list of statements that all respondents were asked to agree or disagree with. There were just four items on the list and virtually 100% agreement was reached for them all. The only dissension came for the statement:-

It is necessary to be an 'experienced' charge nurse in order to gain most benefit from the course.

In relation to this, 10% of the respondents thought that it should be available to any charge nurse whatever their length of experience. Those that felt some experience was necessary however, pointed out that it took about two years to really settle into the role of charge nurse. Without this security, it would be difficult to contribute to, or take as much from, the numerous discussions which were an integral part of the course. It was also pointed out that
the situation would become more of a direct learning situation rather than the more discursive atmosphere which prevailed.

Finally everyone was asked if they had any other comments to make. Again very few had anything to say to this, though there were some pertinent comments:-

"I didn't start nursing until I had four children and my ambition was to become a sister and a midwife and that's exactly what I've done. However I still feel the need for education in spite of the fact that I don't want to go any further."

"It makes you feel important that your peer group - or whatever - has selected you. Whether it is true or not, somebody has cared for you. I do think you need courses to refresh you, bring you up to date and take you out of the work situation."

"Nurses have never been very good at putting into words what they want. This is our main problem."

- o - o - o - o -
To reiterate, this interview differed quite widely from that of the course members although where relevant, identical questions were asked (see appendix 5). It was divided into three sections, the first relating to the general subject of continuing education, the second to how the respondents might feel about the experienced charge nurse module and the third to their own work situation.

Continuing Education

When asked about the need for, and the structuring of, continuing education the response was unanimous in saying that it is a necessity and it should be structured:-

"Yes, it is a necessity nowadays, I maybe wouldn't have said that twenty years ago, but I do now."

"You need to be consistent in it and not going back and repeating things that you've already done because that tends to happen."

"Once you're qualified, you're forgotten and that's basically a sore point."

"I think you have to look at it, because you're taking staff from the wards, so you have to make it worthwhile."

The suggestions for how to carry this out were the same as those of the course participants i.e. ranging from study days to long courses. Once again there was some confusion about the difference between continuing education and in-service education. In this case however, there was some recognition that single days offered as in-service education were more effective for teaching a specific topic. There were a mixture of ideas about who should be responsible for carrying all this out. 52% thought that the responsibility should be with the colleges, whilst 38% thought that it should be with the hospitals. The remaining 10% put forward a suggestion that it should be a
combination of both these sources. Finally, when asked if there was enough continuing education being offered, again there was a unanimous response, saying that there was not.

Continuing education was seen as being beneficial for a number of reasons. Primarily because the charge nurse would be able to assess her own work away from the ward environment and increase her knowledge. Staff and students would then benefit from the increased knowledge that could be passed on, from better management techniques, and from working in a more interesting and stimulating environment. Patients would also benefit through better standards of care and a better use of resources:

"With more knowledge it makes it more interesting for staff and makes it more understandable for them."

"You would certainly know more about what you were doing – you would be up to date with the modern trends and therefore in a better position to teach students."

"Freshens ideas, stimulates you, therefore beneficial to patients and staff."

In terms of benefiting the profession as a whole, this was thought to be useful to nursing because it would help others (medical and paramedical staff) see nurses in a more professional light. It would also increase nurses' own esteem, as they would feel that their own professional development was being catered for:

"Hopefully nurses would develop and be seen as professional in their own right."

Finally in this section the respondents were asked how they kept up to date with nursing issues. Everybody mentioned at least one source, whilst others used two or more. The most common source by far was nursing journals, whilst students were the next, followed by colleagues and study days. The use of students as a source of information was interesting, though it could be seen as encouraging in relation to
charge nurse / student interaction. Many people admitted that they did not read as much as they would like to due to the pressures of a busy working environment.

"If people were being honest, they would say that they didn't read nearly as much as they should. If you're working in a busy area, you don't have time to read as you would like, as there is always something else more pressing that takes that chunk of time. It then depends how much of your off duty time you're willing to allow."

Thoughts on the ECNM

These were mostly hypothetical questions for this group of nurses as they related to the possibility that they would be able to attend the experienced charge nurse module, about which they had no previous knowledge. 90% of the respondents reported that they would be willing to attend a module of this kind, the other 10% being either unsure or too near to retirement! Just one person said that she would not be willing to attend, and another when asked how she would feel about it said 'shattered' (though willing to attend)!

"It seems a good pattern, rather than being away from the ward for a whole nine months. Sometimes too when you haven't done any studying for a while it takes a while to get back into it."

"I'm about to retire, but say ten years ago I would have loved it."

The effect that this might have on their ward (if they were away), produced an interesting split in attitude. Half of the respondents said that it would depend whether there was any cover or not and that staff shortages and the financial situation would make it difficult for them to leave the ward. The other half however, felt that although it would mean leaving the ward that this should not present a problem:-

"I don't think it would be affected - it can be a hassle at times and it's quite nice to get a wee break every now and again from the pressure of it."

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"It depends on cover, if adequate then you would be happy about it, but if you were coming back to hassle, it wouldn't be worth it."

The idea of carrying out a project within their own work situation was well received by 78% of the respondents. 35% said that they would definitely like to do this and 43% said that they would be interested. A further 13% said that they were unsure and 9% said that they would not be interested. This was a good response considering that many people had previously mentioned problems with finding time to keep up to date or possibly attending the course. The idea of attending a mixed course (in terms of nursing disciplines) was also well received, although two people were unsure and one thought that this was not a good idea. Interestingly, the reasons given for supporting this concept were similar to those stated as benefits by those actually attending the module (see table 8, page 102):

"Seeing that you're not the only one with problems, and others may have even worse problems."

"It's OK, because fundamentally you're all charge nurses and you don't differ from anyone else, just your immediate working things are different."

"You'll find out what's happening in other areas."

The last point in this section relates to the needs that the charge nurses thought that they had which could be met by attending an experienced charge nurses module. The suggestions are listed overleaf (table 9), using the same categories as for the course participants needs (general, up-date, specific, don't know).

These needs do not differ widely from those of the course participants, though there is slightly more mention of specific items, especially teaching related topics. The points relating to meeting with colleagues and being brought up to date are both mentioned here, and again these appeared to be important needs for this group of charge nurses.
General
To develop skills i.e. to take things out of books and use them, because you get out of practice when you don't study
Meeting your colleagues from other areas and just even talking to them

Up-date
To learn about new things like Griffiths
Just the changing aspects of the profession and to be kept up to date with and interact with sisters from other specialities
Changes in policies, national and local
New technology, new developments

Specific
Legal matters and dealing with relatives
Administration and teaching
Counselling, management and communication
Teaching skills. You're not trained for it, just expected to do it
New modular form of training - what exactly students are expected to know and when they are allowed to do things

Don't know
The difficulty in setting something up like this I would imagine is to satisfy people from all disciplines and specialities
Nursing care is a basic thing and that will never change unless they get robots

TABLE 9 - Possible Needs of Area D Members

Respondents Work Situation

This final section concluded the interview with some questions concerning the work situation of the respondents. Firstly they were asked if they thought that changes occurred in their working style over a nine month period. The answers were all in agreement, and stated that changes occurred, though these were dependent upon factors such as numbers of available staff, the patients who were currently being treated, and the medical staff that worked on the ward. Particular changes in basic nursing were not necessarily made as these alterations tended to happen gradually over a long period of time. This point was
followed up in the post-course questionnaire when the members of area D were asked to report any changes made over the previous six months (see page 135).

The question of perception of role was addressed next, and based on what they had written in their pre-course questionnaires, respondents were asked to comment on how their perception was arrived at. The overwhelming response was to say that this was all due to experience, and even with a little prompting, no-one could see what educational input they had had that contributed to this! Important points that were mentioned related to the attitudes and comments of patients and colleagues and basic experience of on the job situations, all of which combined to form their perceptions. When prompted again to think of things that could usefully be taught, that would lessen the difficulties learning by experience can bring, everyone had problems in specifying any particular issues. Respondents were also asked to say what factors had influenced how they actually do their job. Again the three categories mentioned were attitudes of patients and colleagues, and experience of actually doing the job:-

"It depends somewhat on feedback you get from patients and colleagues."

"Maturity comes with experience, therefore you change over the years."

This provides a fascinating paradox. As mentioned, the prevailing attitude was one of total support for continuing education and the help that this could give nurses in being more prepared for their role. Yet when asked what things could be learned or indeed that they had learned in this situation, nothing could be readily identified. Assuming that this is based on the experience of these respondents (who it must be remembered were not part of the pilot scheme), it is fair to say that continuing education up to this point does not appear to have had a great impact. There was one enlightened comment however:-
"Continuing education courses help because it takes you away from the work situation and lets you see things more objectively ... everyone who says it doesn't help is actually seeing it in terms of, what facts can I be taught, rather than seeing the reflective element as being constructive."

From this debate, it would appear that some nurses perceive continuing education as something that will answer all their problems in a very concrete way. However, as pointed out in the last quote and in the results of the benefits accrued by course participants, this is not necessarily the whole case. Continuing education it would seem at this level, whilst teaching some facts, has its greatest benefit in allowing the nurses time away from the work situation to reflect, and consolidate with others the way that they perceive their role and what is happening around them.

The final question in this interview was about the order of importance of the three major categories of the charge nurse role (as asked of the course participants). These are represented in the following bar graph (figure 21).

![Figure 21 - Division of Role: Area D](image)

The proportional representation of the three categories remains the same as that reported by the course participants i.e. practitioner first, manager second and teacher third (see page 105).
CHAPTER 11 - ECNM POST-COURSE QUESTIONNAIRES

These will be dealt with separately for the different groups in the same way as they were for the semi-structured interviews.

A - Course members

The complete questionnaire (see appendix 6) was divided into three sections. The first part asked for some general impressions of the course, the second about the results of the action plan undertaken and the third contained the forced choice questions that were identical to the ones in the pre-course questionnaire.

Experience of the Course

The first question here was forced choice and required the respondent to assess to what extent they thought that the course had helped a list of specified criteria. This particular question was also asked of the nurse managers in their questionnaire, and these answers will also be dealt with here.

There were 18 statements in this section and the respondents had a choice from five categories under which they could reply. These answers were then scored on a scale of 1 (the highest) - 4 (the lowest), for each individual participant and nurse manager. The number of 'not applicable' or 'unnecessary' answers was taken into account. The overall mean score for these questions (1.9) indicated that on average the participants felt that they had been helped 'a moderate amount' by the course in relation to the given statements. This corresponds to the result from the nurse managers, though their actual arithmetic mean is marginally lower (2.1), indicating that they perceived the help received by the charge nurses as
being slightly less than the participants themselves. The standard deviation for the nurse manager scores was also greater than that of the charge nurses (0.6 compared with 0.5) showing a greater diversity of response. The other important difference between the two sets of replies, is that the managers identified more of the statements as being unnecessary or not applicable compared with the course participants. This would indicate that they were more satisfied with the pre-course performance of the charge nurses than the participants themselves were, and this could also explain why the charge nurses saw themselves as being helped more by the course according to this rating scale than the nurse managers did i.e. the charge nurses were more aware of their own shortcomings than the managers and therefore perceived the help from the course as greater.

Taking each statement individually, it is interesting to note which ones tended to score above average, indicating that the help received in these areas was greater than for the rest. There were nine such statements for the participants, and five for the nurse managers (see table 10) four of which were common to both.

<table>
<thead>
<tr>
<th>Course participants</th>
<th>Nurse managers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Communication with your colleagues</td>
<td>1 Communication with her colleagues</td>
</tr>
<tr>
<td>2 Responsibility for your own learning</td>
<td>2 Responsibility for her own learning</td>
</tr>
<tr>
<td>3 Research appreciation</td>
<td>3 Research appreciation</td>
</tr>
<tr>
<td>4 Being able to question the way things are done</td>
<td>4 Being able to question the way things are done</td>
</tr>
<tr>
<td>5 Being able to identify weaknesses</td>
<td>5 Communication with her patients / clients</td>
</tr>
<tr>
<td>6 Understanding your role</td>
<td></td>
</tr>
<tr>
<td>7 Carrying out evaluation of care given</td>
<td></td>
</tr>
<tr>
<td>8 Increase in enthusiasm for your job</td>
<td></td>
</tr>
<tr>
<td>9 Managerial skills</td>
<td></td>
</tr>
</tbody>
</table>

TABLE 10 - Help Received for Specified Criteria (ECNM)
Apart from items 3, 7 and 9 in the participants list, all the other statements are related to an increase in awareness and confidence already identified in the benefits (reported earlier in this chapter). The other three concern skill acquisition and application. The first five general objectives contained in the NBS guidelines are also covered by these statements (see table 11). The only one not covered i.e. examine her role as teacher and facilitator of learning, being the one area that was not mentioned in the benefits and was actually brought up as a criticism.

1 Identify the characteristics of 'good' charge nurses
2 Explore role theory in relation to her own practice
3 Examine her role in the management of patient care
4 Determine her sphere of control
5 Select or generate evaluation strategies for nursing practice
6 Examine her role as a teacher and facilitator of learning

TABLE 11 - NBS General Objectives for the ECNM

Finally, it is interesting to note that the item which received the highest score from the nurse managers was number 4 i.e. 'being able to question the way things are done'!

The other two questions in this first section, asked the participants for the single most positive and single most negative aspects of the course. These are listed overleaf in the following two tables (12 and 13) under the headings of 'general' or 'specific'.

Taking table 12 first, the comments have been condensed so that where duplication of ideas occurred, each point has been made only once. Looking at the 'general' list, 32% of the respondents gave the first statement as their single most positive aspect of the course, a further 10% the second, and overall this list is the longer of the two.
General
Meeting with other nurses of same grade from different areas and learning their views
Being able to view problems and ideas from a fresh angle away from the pressures of the ward
Development of confidence and assurance
Those aspects which have helped to consider and manage change and given confidence to effect change
The way it has kindled enthusiasm to be motivated enough to plan and implement ideas and recognise effects of future change and development
Increasing awareness of problems facing nursing in general
The ability to turn negative factors into positive assets
The generation of more confidence to act as a ward sister
Learning about oneself and knowing others meet the same problems
The clarification of previous practice and therefore increased confidence to continue
The reinforcement of how important and valuable a charge nurse should be
Given the ability to see yourself as others see you, and therefore trying to improve and raise standards even higher
Increased awareness of sphere of control and its margins
Stimulation and reawakening of the learning process
The necessity for further education

Specific
Renewed ability to research information and write things down
Interviewing and counselling
Patient education
To think about and actually do a research project
Quality circles and computer appreciation
Communication
Encouragement to read material would not otherwise have done
The understanding of research as essential to the future of nursing
The ability to carry out a project to use as evidence for management
The ability to look at staff roles more effectively through job analysis
An understanding of what is expected of nurses in training today

TABLE 12 - Positive Aspects of the ECNM
This would seem to confirm once more, the fact that an increase in confidence and awareness in relation to the charge nurses' role and sphere of control, was the largest single factor that the participants experienced. Compare this with the list of 'specific' points made and this is further clarified. All the items listed here were mentioned just once by separate individuals and all relate to different topics covered by the module. The general statements however, reiterate the same point time and time again and refer not to actual items taught but more complex considerations.

**General**
- Difficult to adjust to less formal structure - compared with other courses previously attended
- Knowledge of what should be and that for a variety of reasons this can't be attained in reality
- Some lectures of no interest
- Having no time to follow through the project
- Having to try and arrange time when on duty to do project - this didn't work in fact, and much was done in own time
- There is no 'concrete' reward eg certificate
- The discovery of attitudes in others that are not pleasing
- Lack of interest shown by 'nurse managers in their acknowledgement of the course and project
- Lack of support from managers therefore less time to utilise skills in own area
- Received so much input that on returning to the workplace, felt out of step with colleagues
- Learning that acute staff shortages are a problem to everyone and there seems no end to the problem
- No-one else from the same hospital on the course therefore lack of interest and contact for discussion outwith college time

**Specific**
- Computer appreciation (not enough time)
- Quality circles
- Managerial skills - because all colleagues were the same grade
- Lecture and material on research appreciation
- Travelling time
- Use of role play
- Lecture on communication
- Industrial relations in the NHS
- Limited time given to ethical issues
- One particularly boring lecturer
- Inability to carry out work book because no time available

**TABLE 13 - Negative aspects of the ECNM**

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Considering table 13 next (see previous page), there were fewer of these points made as 15% of the participants had nothing to describe as a negative aspect of the course. The 'specific' list here refers to idiosyncratic dislikes of the participants, there being no pattern or repetition between or within colleges that indicated a particularly vulnerable aspect of any of the courses. The 'general' list however shows some of the more pervasive problems encountered. A lack of time within the work situation to carry out course work and also a lack of support are two features of this list that were mentioned on more than one occasion. Both of these may be due to the relative newness of the course, in that there is not widespread knowledge of what the module entails, either by participants or their colleagues. It also highlights another of the problems expressed i.e. the reality of the work situation does not necessarily allow what in theory could or should be possible. Other negative aspects of the course once again show specific problems encountered by individuals, but there are no signs of large-scale deficits in any or all of the courses.

Results of Action Plans

In this section, the participants were asked to report on the results of their action plan and also to comment on the stated aim of the course. The action plan undertaken by each participant constituted a project relating to their work environment. This was decided upon by the individual in consultation with their course leader, and was designed to be undertaken during the six month period prior to the final study day in college. The first questions had been asked about this in the semi-structured interview to gain an idea about how prepared the participants felt immediately prior to undertaking the project, and also where they hoped to gain support from over the next six months. These findings will be reported first.

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When asked how prepared they felt, 86% of the respondents said that at that time they were as well prepared as they could be, given that they had no idea as yet of what problems they might encounter. However, as most participants were embarking on something completely new to them, they could not be entirely sure that their preparation was sufficient. Of the other 14%, 2% withheld judgement and said that they would wait and see, and the remainder reported that they did not feel at all prepared. When asked about support already received for the project, this varied from 'a lot' to 'a moderate amount'. Many who perceived the support as only a moderate amount said that more support was available if they asked for it, and realised that the course leaders could not be expected to have provided more support if they were not aware that it was needed. Whatever the level of preparation and support received though, everybody was confident enough to make a start on their project.

If future support was needed over the next six months, 76% of the participants said that they would contact the college, 19% reported that they would ask their managers and 8% said that they would ask their colleagues. This support was in addition to the fact that everyone knew that the college was always available if needed, and indeed 50% of the charge nurses reported that contact during the next six months had already been arranged - for those in colleges A and B, the support referred to here was distinct from the pre-planned study days.

Moving on to the post-course questionnaire in relation to the action plans, the first question asked for a list of goals and / or aims from each individual, followed by whether these had been achieved fully, partially or not at all. If partial or non-achievement occurred then an explanation was requested for this. For reference the whole set of aims and objectives given by the charge nurses are contained in appendix 20.
Out of the 63 action plans reported on, 14% were fully completed, 81% partially completed and 5% did not succeed at all. Of the 81% partially completed, 45% were reported to be ongoing i.e. work would be continued on them even though the specified six months had finished (see figure 22).

![Pie Chart Representation of ECNM Action Plan Completion]

F = FULLY
PO = PARTIALLY-ONGOING
PS = PARTIALLY-STOPPED
N = NOT AT ALL

The reasons for the relative completion of action plans can be seen to follow certain trends, although ultimately the motivation and situational problems of each individual had the most immediate effect (these will be dealt with shortly). The subject matter of each of the projects falls into one of three categories - task, objective(s) or survey - and this appears to have some bearing on the success of the outcome. The ongoing projects were either in the survey, or most frequently, the objectives categories. Those that chose a task orientated project e.g. initiate quality circles, tended to complete the work, whilst those who chose more nebulous objectives e.g. to improve communication, or opted to carry out a survey e.g. research other departments, only partially completed. This is not surprising, since any work that has clearly defined boundaries tends to be more manageable and the outcomes more assessable, than other wider ranging exercises.
The list of reasons given by the participants as to why they had not completed their plan within the six months supports the notion of manageable criteria and introduces the more logistical problems associated with the work situation. Dealing first with those that did not complete at all, the reasons here were totally related to specific problems. Two could not gain the co-operation of colleagues (either medical or nursing whichever were relevant), one changed jobs half way through, and the other had to go off on long term sick leave.

Considering partial completion next, this was where other more prevalent problems arose. Of those projects only partially completed, just under half (45%) were reported to be ongoing even after the end of the module, which accounted for many of the non-completions at the time of reporting. In all however, some serious impediments were encountered and these divide up into three main categories. The first relates to problems encountered with other staff or staffing. In a small number of cases, co-operation of non-nursing staff was not gained. In a case where action was proposed that needed support or ratification from others this would obviously be a problem. The main problem in this category however, came from nursing colleagues either at the ward or management level. Typical problems encountered here were connected with staff who had been in post for a number of years and resisted attempts to change things, or poor support from managers:

"Staff have been in the department for a number of years and are all in a comfortable 'rut'."

"Project work requires co-operation of nurse managers which is not always forthcoming."

"It takes longer than six months to change attitudes which have been handed down from generation to generation of nurses."

The other main problem in this category was staff shortages. These were reported to be due to either low staffing levels, staff sickness, slow replacement of
vacated posts or holidays. It was noticeable that this type of problem was most frequently (though not exclusively) quoted by those in the urban area, college C. Most of the staff in this area worked in large urban hospitals and found this a particular problem. More problems were also reported in this area related to support from management, poor resources and lack of motivation from other staff. Of the other two areas, college B (semi-rural) were the next group to be most affected by staff shortages and college C (rural), did not report this as a problem at all.

"Lack of time and resources and little interest shown by the managers - their support being vital to anything new."

"Lack of interest by colleagues, managers and doctors. Also changing staff and reduced levels and no money for new resources."

"Disinterest and lack of co-operation by colleagues and managers."

It must be borne in mind that these results represent only a fraction of the total complement of staff in any area, but nevertheless, a definite pattern emerged.

The other two categories which cover the reasons for partial completion were the time factor and extraneous factors. A lack of time was reported by many, which may have been due to the shortage of staff in some areas, but was also due to the size and type of project undertaken. This refers back to the idea of manageable criteria in delimiting the project, as mentioned above:

"Time commitment - having to balance work on the project with a heavy caseload."

"Lack of time - maybe too high a goal set for six months."

"Continuing study to involve more patients."

The problem of extraneous factors relates to situations outwith the control of the charge nurse. Here, information may have been sought from others and was delayed in arriving, or others may have been involved in ratifying one
step of the project before the next could be embarked upon:

"Waiting for a video from the health education unit before discussions can begin."

"Project involves senior medical staff in decision making, therefore don't have complete control over the situation."

Even with these problems, all the charge nurses made some inroads into their proposed action plans and a lot of positive results were achieved. The only people who were unable to see any benefits were the ones mentioned above and three or four others who were moved after they had instigated their proposed work. The benefits arising from the action plans will be looked at shortly, but first, the question of support received will be addressed.

All the participants were asked to state who they had received support from during the six months of the project. The choice was from colleagues, line managers, course staff and others. Most people received support from two or three of these groups depending on their personal needs. The figures represented in the following diagram show the number of people receiving support from each of the four different sources (figure 23).

![Diagram showing support sources]

<table>
<thead>
<tr>
<th>C</th>
<th>LM</th>
<th>CS</th>
<th>O</th>
</tr>
</thead>
<tbody>
<tr>
<td>COLLEAGUES</td>
<td>LINE MANAGERS</td>
<td>COURSE STAFF</td>
<td>OTHER</td>
</tr>
</tbody>
</table>

FIGURE 23 - Sources of Support for ECNM Action Plans
The figures for course staff and line managers are not that different in this analysis. There is however, a difference in the interpretation of the two, since in the follow up comments for this question it was apparent that if no support was received from course staff this tended to be because the individual had not required it. In the line managers case though support was often not available, rather than being not sought after. The reasons for this are hard to be sure of, even though a nurse manager questionnaire was used to try and solve some of these problems. Possible explanations could be a) a lack of knowledge on behalf of the managers about the expectations of the course (as it was still quite new), b) a lack of available time for meeting with the charge nurse, or c) it may have been due to the sometimes difficult gap perceived by many to exist between the last of the truly clinical posts and the first of the recognised management posts:-

"More information could have been given to line managers regarding the course and their involvement. Also they're too busy with their own problems and workload."

"No support from the college because I didn't request it."

The one support that a number of participants mentioned that was lacking, was any time at work given to them so that they could carry on with their studying. This linked in with the lack of understanding shown by some colleagues for what they were trying to achieve. If support had been pre-arranged however e.g. through study days or a planned visit, this seemed to have a beneficial effect, in that the charge nurse knew that they had some definite support from at least one source.

"I would have liked even an hour off during the night to devote to the project."

"More time to study would have been appreciated."

"Because of difficulties in working hours, two or three study days would have been useful to ensure contact with colleagues and course staff."
"Insufficient support because of a lack of understanding of what I was trying to do. It's difficult to do a project, run a home and run a ward at the same time."

Benefits of the Action Plans

It was hoped that some of the benefits stated by the charge nurses could be specified in terms of actual cost savings in order to strengthen the case for such courses. This proved to be impossible as far as actual figures relating to monies saved was concerned. There were however a noticeable amount of benefits which stated that labour saving was introduced, or more efficient use of resources made which in turn one would surmise, would lead to identifiable cost benefits. This was not the sole aim of the course though, and the list of benefits as perceived by the charge nurses covered a wide variety of items which divided up into six groups:-

1) Increase in staff morale  
2) Improvement in patient care  
3) Greater involvement of staff  
4) Patients and relatives happier  
5) Benefits to self  
6) Cost savings

Rather than tabling the whole group of benefits, a selection is listed (in table 14 overleaf), that indicate examples of these six headings. Many of the benefits were couched in broad terms and were repeated from one action plan to another, or were very specific to the charge nurses particular work environment. This list therefore captures the types of benefit to the profession that the action plans of the charge nurses provided. Some of the items necessarily cut across the different categories, but still represent the different ideas involved.
1 - Increase in staff morale
Staff morale improved through staff involvement with, and development of, new programmes.
More contented staff through more socialisation and improved rehabilitation for patients.
A better use of manpower and materials achieved therefore improved motivation and morale.
Staff have benefited because they are now more involved through quality circles, and communication is better.

2 - Improvement in patient care
Increase in the standard of care through an increase in the knowledge available to all staff at ward level.
Patient allocation introduced so that they now get more individualised care.
Prescribing and giving of drugs more carefully reviewed.
Staff better equipped to teach patients; patients benefit from improved communication and psychological support; increase in patient knowledge helps their understanding of illness and may help to prevent admission to hospital.

3 - Greater involvement of staff
Staff more involved with ward management, more able to initiate and supervise projects, and carry out counselling.
Improved communication with the doctors so that nurses feel more part of the team.
Learners now feel more part of the team.
Learners now gain more from their experience and all staff are more aware of their teaching responsibility and the need to update.

4 - Patients and relatives happier
Closer involvement with relatives has helped the transition into hospital of the patient and also allowed a greater depth in knowledge of the patients particular problems.
Staff feel more involved looking after the whole family.
Patients' day has improved; care now given out to suit them.
Attitude to relatives changing so the patients comfort is improved.
Better organised ward, more confident staff, improved care to patients and relatives.

5 - Benefits to self
Found more time for managerial work due to improved performance at all grades.
Greater awareness of my own management commitment.
Now research things that might lead to cost-effectiveness or patient benefits, and don't hesitate if something is challenging.
Now take a different view of my own ability and career prospects.

6 - Cost savings
Able to reduce cost / labour by reducing dressing changes.
Saving of cost because patients are not in for one, two or three days prior to delivery.
Change in one method of practice has led to financial savings as well as releasing staff for other tasks.
Needs of the elderly highlighted and met sooner, data recorded so that changes can be made which leads to the service being more cost-effective.

TABLE 14 - Benefits from ECNM Action Plans
Looking at this table it is interesting to note that from the diverse list of aims and objectives similar types of results have been obtained. There were of course specific problems solved as mentioned, but overall the results were more generic by nature. This, as far as can be ascertained, means that the effect of the projects is likely to be more long term than otherwise, since the benefits are not to any one individual or item.

Finally, in relation to the action plan, participants were asked whether they thought that the allocated six months was long enough and if not, why not. In reply, not surprisingly, almost all those who wished to continue with their project said that the six months was not enough. There were some of this group however, who acknowledged that the six months had been long enough to get them started on their project, and to continue with it thereafter was their own positive decision, and not in that sense to be attributed to the course. Generally speaking therefore, six months was deemed to be satisfactory:

"I think whatever amount of time you are allocated to do something you always think you need more. Work just seems to expand to fit the time available!"

Looking at the overall length of the course, 78% of the participants felt that it was satisfactory. Of the other 22%, half thought that it was too long and the other half too short (see figure 24)!

\[ \text{FIGURE 24 - Overall Course Length (ECNM)} \]
Those that thought the course too short were part of the group who felt that the six months for the action plan had not been long enough. Correspondingly, those that found it too long had difficulty maintaining continuity over the final six months. Variations such as these are not unusual in a large group, and taking into account the fact that opinion was evenly split between too long and too short it would be difficult to alter the time structure of the course on the basis of these results.

The last written question asked the charge nurses to what extent they felt that the stated aim of the course had been met, the aim being:-

"To enhance the ability of the charge nurse to fulfil her composite role as a practitioner, manager and teacher."

From all the respondents, only one questioned whether this aim had been met at all. For the rest, the improvement that they reported was a further clarification of the points that have already been raised throughout the results. In summary, these points are:-

1) The examination of the role of the charge nurse and the ensuing ability to assess the job situation through greater awareness and insight.
2) An up-date on what is happening in nursing and the ability to pass this knowledge on
3) The opportunity to meet with others and expand your horizons through discussion and sharing of information.
4) An increase in self-confidence, thus increasing the ability to question things.
5) A greater awareness and acceptance of the possibilities for change.
6) An appreciation of the value of continuing education.

**TABLE 15 - Summary of Benefits Gained through ECNM**

Depending on the individual, a combination of these factors were present in their answer to this question. One or two singled out specific concepts in relation to one part of their role, with the teaching aspect being mentioned as the least affected. For most respondents however, the answer
was couched in general terms and the overall feeling was that the aim had been met to their satisfaction:

"I have been allowed to stop and identify strengths and weaknesses in all three areas, therefore the aim has been met on all three counts."

"I felt I was well up to date as an experienced charge nurse, but I gained an insight into others' roles and how they saw themselves."

"Now more aware of my role. It has shown that change can be made, and also the need for continuing education."

"I now question the job and the way I carry it out, and it has given me ideas for present and future use."

**Forced Choice Scales**

This is the third part of the questionnaire, which contained the two forced choice scales. The results from both the pre and post-course questionnaires are reported here, as the results have been determined by comparison of the two sets of data. The results from the members of area D (in relation to these scales) will also be dealt with in this discussion.

The first of the two scales was taken as an indication of how the charge nurse carried out her job in terms of the three categories of management, practising and teaching. From both the pre and post-course scales a score was determined for each participant and the difference between the two calculated. Initially it had been anticipated that these would then be subject to statistical interpretation, but on reflection this proved to be a redundant exercise, since a higher post score in this case did not necessarily indicate an improvement.

What the scores from these scales show is how often a charge nurse carries out a particular activity. If their score then changes over a nine month period, this indicates
that they are no longer doing things in precisely the same way. If they have a lower score at the end of the nine months however, this is not necessarily an indication that they are doing their job any less effectively, but merely as stated, shows that things are not being done in an identical manner. This could be for a number of reasons. For instance, an increase in delegation would mean less work in some areas, or a change in hospital policy could affect the emphasis different tasks are given. If a clinical teacher were introduced to a ward where there had not been one before, or staffing levels changed then these too could affect the individual's perception of how they carry out their job.

In this case therefore, the scale as it was used was not the most sensitive for ascertaining any changes in the charge nurses' behaviour. There was however one interesting point, which showed that the scores for the questions related to practising behaviour showed less fluctuation over the nine months than the other two categories (indicating perhaps that this element of the charge nurses' work is the most secure). Overall though, the changes in the scores were not significantly different from those shown by the members of area D, and it would be difficult to attribute any alterations solely to course attendance. This is due to the multitude of factors which occur in the workplace (some of which were mentioned above), over which there is no control; this was always one of the major problems in trying to get as unbiased a set of results as possible. In this case therefore the best indication of changes in behaviour are the self reported results already discussed, and those of the nurse managers which will be considered a little later in this chapter.

Turning to the attitudinal scales (the second set of forced choice questions), the difference between the pre and post scores was also used here, to see whether there had been any significant changes over the nine months. This data was subjected to statistical analysis, since a positive shift
in these results would be a desirable outcome. The test used was the non-parametric, Wilcoxon's matched pairs signed rank test as explained in chapter 7 (pp.85-86).

The data was looked at from a number of perspectives, using the biographical headings as divisions. Each of these divisions was analysed separately for each of the four categories in this scale (namely managing, practising, teaching and continuing education), for both the course participants and the members of area D (where applicable). The list of all the divisions can be found in appendix 21.

After all the analysis had been carried out there were very few statistically significant results. The null hypothesis for each category was 'there is no change in attitude towards management / practice / teaching / continuing education after nine months', and the rejection level was set at 0.05. For both the course participants and the members of area D, only six out of a possible thirty five divisions showed any significant results. In each case there were five positive shifts and one negative.

The results for the course participants showed a positive shift in attitude towards practice in two of the divisions (6 and 32) and towards teaching in three divisions (4, 15 and 32). The one negative shift was in attitude towards continuing education in division 25. Alternatively, for the members of area D, four of the positive results were in the attitude to management (2, 10, 20 and 27), and the fifth towards continuing education (division 8). In this case the negative result was towards practice (division 9). These results do not appear to form any coherent pattern and represent only a small amount of change within the whole.

What can be deduced from this however, is that there is apparently no barrier in terms of factors such as age, years practice or field of work between the participants, which puts any particular group at a disadvantage over another in relation to this particular course.
The follow up questionnaire for this group was relatively small (see appendix 7), as they did not have a nine month course to report back on. Apart from the forced choice scales which have been discussed above, there were just three other questions asked. The first two were related to two of the questions asked of the course participants. They enquired about any changes in the work situation that the charge nurse had implemented over the previous nine months, and what benefits were accrued by the alterations carried out.

Just under half (48%) of the respondents had not made any changes to their working environment, with no resultant benefits over the nine month period. Of the other 52%, the changes made were to specific activities, notably the introduction or modification of patient allocation. Other changes included altering the ward routine to allow more patient/staff contact time in the afternoons and time saving activities to reduce the burden of work on the staff. Only two people reported introducing an activity into the work situation which was not directly related to some aspect of routine. One was a series of lectures for all staff to attend and the other was to increase staff awareness of the cost of stores.

The benefits reported from these changes related directly to the activity which had been introduced, unlike the benefits from the action plans which had a wider sphere of influence. Looking at the six categories which the benefits from the participants' action plans fell into, the second and third of these cover the type of improvements mentioned by the members of area D. These were 'improvement in patient care' and 'greater involvement of staff'. Where patient allocation had been introduced or modified, this benefited both staff and patients as did increasing patient/staff contact time. The increase in involvement for the staff though did not extend to being involved in ward
decisions or increasing their knowledge to the benefit of themselves and others. All changes made were an improvement however, and show that some changes are made during any nine month time span though the scale of these changes was not generally as big as that shown by the course participants.

The final question asked of this group was about what courses or study days that they had attended during the past nine months. Everyone had attended at least one in-service lecture or study day, but no-one had attended anything longer than a three day session. The subjects covered were mostly connected with the new management proposals for the health service, or counselling courses. The rest all related to particular in-service topics for their specific work environment. Many of the charge nurses brought up the time and cost factors related to attending courses and felt that these were big obstacles to themselves or other staff in being able to leave the work situation. There were no other comments in this section.

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CHAPTER 12 - ECNM COURSE LEADERS' AND NURSE MANAGERS' RESPONSES

Course Leaders' Semi-structured Interview

The purpose of this interview was to consolidate the information gained from the course leaders during the informal visits made to the colleges. The questions (see appendix 9) covered the topics of course planning and development; their expectations of the course; what support they had had in the planning and running of the module and the future plans for the module within their own college.

In relation to the NBS guidelines for the planning of the module, the freedom given by the scope of the recommendations was appreciated by all three course leaders, since this allowed them to create their own diversity around the core aims and objectives. The constraints that were at work in the planning of the module included the time allowed for the college input, the level that the charge nurses were assumed to be at prior to the course, and what background they were likely to already have (especially in relation to management skills). The first courses were introduced with a note of caution therefore, so that the immediate feedback from the participants could be used to help clarify the level of the input.

The expectations of the course leaders about the module prior to commencement, were based on the knowledge that continuing education had to be a good thing for anyone attending. Specific expectations relating to this particular course were only expressed by one of the three, these being in terms of an increase in confidence, an ability to put some of the material taught into practice, and some change in managerial outcomes for the charge nurses. These were being met at the time by the course concerned.
The selection of applicants for the courses followed a similar route initially in each of the three areas, in that the dates of the next course were sent out to the service side through the DNS's. Applications were invited, and in two out of the three areas the applicants were interviewed in conjunction with their nurse managers. In the third area, the applications were simply accepted once they had been forwarded by the service managers. These different procedures do not seem to have had any effect on drop out rates between the different colleges, there being only been one person from all the modules who failed to complete for no apparent reason.

The development of the course over the two years of the pilot scheme was connected with three factors. First was the feedback from the charge nurses, second was the course leaders own development in dealing with this particular type of group, and third the developments within the profession itself. These factors meant that all the courses maintained the same basic principles as set out in the NBS guidelines, but added breadth and depth as and when necessary. The underlying assumption behind these developments being that one always strives to keep on improving things further - in this case each time another course was completed.

When asked about feedback from participants / nurse managers / senior nurse and education managers, there appeared to have been a similar trend in each of the areas. The participants had all given adequate and informative feedback (either solicited or unsolicited!) which had been a great help in assessing the benefits and strengths of each of the courses. From the nurse managers the feedback had been slightly more patchy. The service side had provided some feedback in two areas through questionnaires sent out, but in the third area where this had not happened, information was not so forthcoming. Any feedback which was received however had been positive. The benefits accrued by the course participants were perceived by the
course leaders as being similar to those that have been identified in the questionnaires and interviews given through the research project. These included:

1. An increase in confidence
2. Being able to state their opinions and arguing their position through analysing the problems with which they were confronted (especially in relation to nurse managers)
3. Feeling more certain of their role.

TABLE 16 - Course Leaders' Perceptions of ECNM Benefits

Regarding support for running the module, all the course leaders felt that their college had provided them with a lot of back up, through other tutors giving some of the lectures, secretarial support and library support. Commitment from the service side was again more patchy. In some cases the support was forthcoming and in others there was not a lot of interest shown. All agreed however that continuing education in this form was still in its infancy, and that the situation should improve as continuing education became more prevalent. All three colleges proposed to continue with the module, though one of them was looking at possible alternatives through the use of a curriculum development team, consisting of representatives from both the service and education sectors.

Finally, the question of whether this provided the best continuing education for charge nurses was addressed. All three course leaders said that they would definitely not want to revert to the old system which existed prior to this course i.e. first line / middle management. This does not mean however that this particular course is perfect, and as mentioned all were looking for ways to keep improving the module. Indeed, the college with the curriculum development team were looking at other ways of providing similar education, possibly with a different structure. In conclusion this module seemed to provide a worthwhile alternative, and one that was welcomed by all three colleges.
Course Leaders' Process Recording Forms

These recorded the changes made to content, teaching style, materials used and programme structure between modules, and also the reasons for the changes (see appendix 8). The alterations made to the courses were in terms of content mainly. Certain topics were dropped from, or added to the timetable, depending on pressure of time or relevance of the topic. After the very first modules (which were not part of this evaluation) some streamlining of topics took place so that certain titles disappeared though the content was still included. Suggestions from the charge nurses themselves sometimes contributed to the inclusion of certain subjects, each group being asked for ideas about what topics they would have liked to have addressed.

Teaching style was modified slightly each time depending on the size of the group, but otherwise an open, more informal approach with discussion and self learning was adopted throughout (as previously described from the participants' interviews). The materials used also remained constant, including videos, overheads and films. Finally, the programme structure also remained unchanged throughout, apart from the inclusion in two of the colleges of a study day approximately half way through the last six months. This was seen to be necessary to provide the charge nurses with access to peer group and college support, and the facilities offered by the library which were not always accessible to those who lived any distance away. As a modification to the original structure, this was appreciated by the charge nurses to whom it was available, and missed by those to whom it was not.

Senior Nurse Questionnaires

As stated this questionnaire was used to try and put some perspective onto the self-reporting of the course participants (see appendix 10). It was also hoped that it
might indicate the level of understanding and support that existed amongst the charge nurses' managers. The problem with this latter objective was that only 25 out of a possible 63 nurse managers actually returned the questionnaire, though there are two possible reasons for this. One was that the charge nurse did not hand the questionnaire on in the first place, so that the manager did not realise that it existed and therefore had no choice about whether to return it or not; the other being that the charge nurse did hand the questionnaire on, but the nurse manager then failed to return it. Since it is not entirely clear which of these two forces was at work in each case of non-completion, it would be unfair to assume that the 40% return rate was solely due to lack of interest on behalf of the managers (though it must be asked why some of the charge nurses did not wish to pass the questionnaire on, if this indeed was the case). Conversely, it is not unreasonable to assume that the questionnaires that were returned by this group came from those who were motivated to take an interest.

Of the six groups that were given the questionnaire to pass on (voluntarily) to their nurse managers, an interesting pattern did emerge which may reflect to an extent the reasons for non-completion in some cases. When the questionnaires were given out to two of the first courses, the optional side of the case was stressed more strongly than in the latter three cases. This certainly did help the response rate, a fact which was clarified by the fact that the sixth set of post-course and senior nurse questionnaires were sent out postally. The accompanying letter once again stated that to hand the questionnaire on was optional, but this was not over-emphasised, and the response rate from this group was markedly better. Interestingly enough this was the first group where the nurse managers had been involved by the college directly in the selection of the charge nurses and this too could have had some effect on the rate of reply. Figure 25 overleaf illustrates the response rates from the six courses.
Three questions asked of the nurse managers were identical to ones that appeared in the participants post-course questionnaire, and the answer to the first of these has already been dealt with (see pp.116-117) in conjunction with the charge nurses' responses. The second of the three referred to the benefits perceived in terms of improved performance in the charge nurse or her staff, accrued since attendance at the module. The responses given by the nurse managers were listed and compared with those given by the charge nurses themselves. There was a very high rate of agreement (87%) between the two sets of responses, the only difference being that the charge nurses had described their improvements in greater detail.

The nurse managers answers categorised into three sections. 60% stated that there had been an increase in the charge nurses' awareness, which in turn had had an effect on the way that the ward was being run:

"General improvement in her performance. She has shown an improvement in her managerial skills and an increased awareness of her role. This has been shown through her project work."
"Her general job performance has improved. She now has a wider outlook, questions things more, has instituted labour savings by re-organisation and involves her staff more."

"She now has the ability to stand back and look at things objectively. She is much more imaginative in her approach to the patients."

"It has enabled the charge nurse to look objectively at her role and appreciate her own contribution to care. It has also helped her look more objectively at her work and question things and apply sound reasoning. Her project was also beneficial."

24% specifically mentioned the project undertaken as being the route to changes and improvements made:

"The charge nurse has become more cost conscious because of the project and passed this onto her staff."

"Her project work has allowed her to extend into one particular area, in which she is now something of an expert. This has been of great benefit to both patients and staff."

Finally, 12% made more general comments:

"It has stimulated the charge nurse into a more positive way of thinking."

"It has given the charge nurse the opportunity to look at many aspects of her job which has in turn had an influence on others."

The other 4% (actually representing one response) was the only negative answer to this question which stated that there had been no improvement shown so far. Apart from this one however, the overall response seemed to reinforce the idea of noticeable benefits having occurred for the charge nurses, and the fact that these had had an effect on the working environment, in terms of both other staff and patients.

The third of the identical questions asked of the nurse managers, referred to the stated aim of the course and asked to what extent this might have been met for the charge nurse in question. In agreement with the responses
of the participants, the replies received to this question were couched in general terms. All the managers felt that the charge nurses had enhanced their ability in some way, but an interesting (and encouraging) feature of many of these answers, was the statement that the charge nurse had been very able before the course but attendance had added to their already existing capabilities (indicating that the modules had been designed at the correct level):-

"The charge nurse has gained confidence and developed in her management role, though was always keen and interested."

"The charge nurse is experienced in her area, but she has benefited in all three areas."

"The charge nurse only needed the course as an impetus for enhancing her already great knowledge."

Other answers which did not specifically mention this particular point, broadly fell into two divisions. Those that mentioned the increased awareness and capacity to think things through gained by the participants, or those that recognised an enhancement of managerial skills: -

"The course has made the charge nurse more aware of her duties and responsibilities - this has had an impact on herself, her patients and her staff."

"The charge nurse has been stimulated to explore wider concepts of nursing care. I hope this impetus is maintained."

"The course has enhanced her ability and broadened her management knowledge."

The point made in the second of the above quotes referring to the maintenance of the impetus gained was mentioned in one or two other replies, indicating that it would be interesting to see how apparent the results of the course were in six or twelve months time. It had been hoped that this issue could be addressed as part of this project, however this turned out to be impossible due to the timing of the courses and the difficulty of getting the charge nurses back into college for a day.
Four other questions were asked of the managers. The first concerned how the charge nurse came to attend the course, and whether the managers had been consulted prior to attendance. Only two out of the twenty-five respondents said that they had not been consulted prior to attendance, and that this would have been useful. The route of attendance corresponded with the reporting of the charge nurses in every case e.g. if the charge nurse stated that they had requested to attend specifically, the manager reported that it had not been their suggestion, but that they were happy for them to attend. Apart from the two who were not consulted prior to attendance, sixteen stated that it was their suggestion that the charge nurse attend the course, and seven said that it was not their suggestion but that they were happy for them to attend.

In addition to this the managers were asked whether they had received enough information about the course. 64% stated that they had, whilst 36% said that more information would have been useful. One person said that any information would have been useful, and most of the information required was non-specific, referring to anything that would have helped the manager be more supportive to the charge nurse in terms of achieving objectives. This type of information is indicative of the newness of the course. If it was an established part of the continuing education available, it is likely that this group of nurses would be aware of what it entailed, and as more charge nurses take part in the module, this type of information will spread.

In describing the contact maintained with the charge nurse over the nine months of the module, the managers were quite specific in their detail. In 64% of replies there was concurrence with the charge nurses' reporting and each of these specified that contact had been sufficient. However 24% of the management replies had corresponding complaints from the charge nurse. In these cases the managers stated that contact had been kept up, but the charge nurses
expressed some dissatisfaction with the support from this source. In the rest of the cases 8% of the managers stated that there had been little or no contact and the charge nurse agreed, whilst in the last 4%, both parties stated that the contact had been regular and supportive.

Finally in this section, the nurse managers were asked if on the basis of their knowledge of the module - they would be prepared to attend a course of this kind. There were four non-replies to this question, but of those who did respond, 57% said that they would be prepared to attend. A further 38% said that they would not (of which one person refused because she was due to retire) and 5% said that they were unsure. This is a positive reaction to the module from this group of nurses, and gives an indication of the interest at this level for continuing education.

Miscellaneous Information

Many of the initial problems experienced by the course leaders had become apparent before the working group meetings were established at the NBS. This meant that there could be discussion and sharing of information. One of the original difficulties appeared to be the breadth of many of the action plans undertaken by the participants. There was concern that objectives were not being achieved due to the diversity of ideas incorporated in any one plan and methods of getting around this problem were discussed. There was agreement that in some cases, depending on the individual no amount of guidance seemed to have an effect, but that there were certain types of ideas which produced potentially unachievable outcomes, and most participants could be persuaded towards something more manageable.

Questions were also debated in relation to the structure of the course and possible alternatives. This debate was mentioned in the results of the course leaders interviews, and it is interesting that from the results of the
evaluation, the original structure met with the approval of the participants. The possibility of dividing up the college time was thought to be a popular suggestion but this was in fact not so.

At the study day discussions which took place, the charge nurses were asked amongst more general discussion whether they saw the course as being the most effective for them, and what they would have liked to see included in the programme if they could have planned it. The responses given were positive in saying that the course had been at the right level for them, and everyone said that it was more beneficial than first line management (which they had all attended some time during their career). There were no additional suggestions about what content could be added to the timetable everyone professing satisfaction with the current offerings.

The final point of interest in this results section relates to the different sizes of the six groups involved. The average group size was eleven, although the range was from six to fifteen participants. This gave rise to two important points for consideration. The first was that each person, whatever the size of group felt that they were happy with that number of participants. Those in the smallest group felt that any more would have allowed participants to blend into the background if they so wished, whilst there were enough for it to provide an interesting mix, with plenty of possibility for discussion. Conversely, those in the larger groups also felt that it was not possible for anyone to take a back seat within the group and the numbers were not so high that it made it threatening for anyone to express an opinion.

The second point was that all the people in all the groups functioned well together without any great amount of friction. It is usual in groups to find that there may be one or possibly two individuals who do not fit in so well, and who are criticised by others for being awkward or
uncooperative. In this case, this did not happen in any of the six groups which is unusual. Reasons for this are possibly connected to the level of experience of all those involved. Since everyone had been in post for a number of years, they all felt confident that they knew their job, and it was not threatening to enter into debate with others, to express an opinion, or even reveal a problem or weakness. Conversely it may simply have been coincidence, but many of the charge nurses remarked on this point and found it a pleasant phenomenon.

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CHAPTER 13 - INTERPRETATION OF ECNM FINDINGS

The results presented in the preceding chapters, were discussed in three separate categories, namely functional, educational and beneficial. They related to the issues raised through the reporting of the findings and offered the researchers interpretation of them, in relation to the application of the information collected to current and future continuing education initiatives. It was the synthesis of this information into the discursive elements that proved a useful indicator for areas of concern for the construction of the questionnaires in the forthcoming evaluation of PSI&II. The main points of discussion are presented here.

1 - Functional Factors

Many of the issues in this category were related not only to the newness of this particular course, but also to the newness of the complete continuing education strategy proposed by the NBS. Problems encountered in this area included:

a) The difficulty which participants had in specifying their expectations of the course

b) Requests from some nurse managers for more information prior to the charge nurse's attendance

c) Members of area D recognising that continuing education is useful but finding it difficult to specify how

d) A lack of support and understanding from some of the participants colleagues and nurse managers.
e) Problems encountered by the course leaders in judging the precise level at which to set the course prior to commencement

The difficulty shown by the participants in knowing what to expect, the shortage of information felt by some managers and the difficulty of identifying the uses of continuing education (points a, b and c) are three issues which could be resolved partly through wider dissemination of information. This could be overt as in advertising or more covert as people go through the module and act as an advert for the course in themselves. Very few of the participants knew anyone who had been on the previous courses, which would indicate that their managers were also experiencing the module and its effects for the first time.

The problem of lack of support and understanding from colleagues and managers (point d) may also be linked to this debate, but raises other issues as well. Not uncommonly, when someone returns from a course into the work situation, participants are asked if they have had a 'good holiday', or if they have enjoyed having an 'easy time'. That is, courses are often seen as being an opportunity for a break and not as a means for increasing knowledge and skills. In this particular case however, participants returned not only with increased enthusiasm and knowledge, but also with a job to do in the form of the action plan. This represented a very different situation for everyone involved and may also have been threatening for those who had not been on the course, either above or below the charge nurse. Many of those who found resistance amongst their staff complained that it was because colleagues had been in post for a number of years, and had got happily 'stuck in a rut'. Resistance to change in this sort of situation can then manifest itself in terms of antagonism towards the person trying to institute alterations or changes (or even trying to share the information which has been gathered), or lack of cooperation. This kind of situation then calls for all the
skills of the charge nurse in trying to overcome the problems encountered, and support from line managers in this case becomes paramount.

Problems of support from managers may be due to a lack of time available to devote to the charge nurses on their return to the work situation, but a lack of understanding of what is expected of them may also play a part. The situation of the managers can be likened to that of the charge nurses in the initial debate of who should be the first to benefit from the new continuing education strategies - the charge nurses had been chosen in the first instance, so that they would be in a position not only to benefit themselves, but also so that they would be able to help others who ultimately would be passing through the continuing education structure. The nurse managers were therefore in a similar position to that which might have occurred for the charge nurses, i.e. they had not undergone any part of the new continuing education strategy, but they were faced with those who had. This dilemma had to occur at some point within the nursing structure, but study days to introduce the managers to the new courses may have helped alleviate the situation. It would still not guarantee full support as has been shown by the fact that one of the three colleges tried this, but could facilitate the process of integration of the courses.

Point 'e' in this section refers to the initial problems encountered by the course leaders. These were overcome by using immediate feedback from the participants in the first instance and resulted in adaptations being made as the first courses were run. Changes to the content of each course were subsequently made in response to future feedback, and also limitations of time which became apparent as each module was completed. The relative newness of the courses once again generated this situation.

Other functional points highlighted by the results of this evaluation included:-
a) Problems of distance from the college of nursing for participants

b) Difficulties in carrying out course work within the job situation

c) Staffing problems within the work situation

d) The lack of mental handicap nurses attending any of the modules

The first point here relating to distance and therefore travelling time contains two different issues. It is the one point which highlighted a specific difference between the three areas. In college A, because of the wide geographical area, some of the participants actually had to be residential for the prolonged college inputs (weeks 1 - 3, and week 12). This was not altogether satisfactory to the individuals involved, although they were aware of this obstacle and to an extent used to it, since it is a recurring problem for them. Others in this area had a long way to travel each day, but were within a commutable distance. In this situation where being residential is the only way of being able to attend the college for those who are geographically isolated, some people will inevitably be precluded from taking part in this type of learning exercise. Not everyone is able or willing to leave their home situation for prolonged periods and it is not realistic to expect them to do so. This fact, in conjunction with the cost of bringing people into the college situation, means that some other form of teaching within the continuing education strategy should be considered if (as is hoped) everyone can benefit from this initiative. Possible alternatives are open learning or distance learning, involving educational packages developed by the colleges, but carried out in the participants own location.
The second issue here relates to the amount of time spent travelling. Although there were some participants in all three areas who had a reasonable length of journey, it was in college C (urban) where this appeared to be more of a problem. In this sort of location, it is not so much the distance, but the actual time it takes to get anywhere (whether by public or private transport) that can be awkward. This is unavoidable, but some felt that when back in their work situation they were at a disadvantage in gaining access to library facilities and contact with college staff. This could perhaps be overcome if time were allowed from the work situation to visit the college, not necessarily in the form of complete study days, but a few hours or a half day once or twice during the six months back in post.

The idea of allotting some time within the job situation specifically for course work would also help with the second point raised here (point b). This would be difficult and not necessarily acceptable in all cases, but it also links in with the difficulties experienced by some, in terms of support from the service side for this type of educational input. Many of the charge nurses expressed the wish that they had been allowed some time for their project, not on any large scale or regular basis, but for short periods during the six months in post. On the negative side of the argument for doing this however, is the problem already stated, that work expands to fit the time available. Therefore if more time were allotted to the course then eventually, there would be some who felt that even this was not enough. Where the compromise lies within this difficult situation is hard to ascertain, but it is a problem which should be addressed.

Point c, also adds to the dilemma of finding time to carry out course work. Staffing problems were mentioned most specifically by the participants in college C. It is possible that this will always be the case, since the population of staff within large urban hospitals is more
transitory in nature than for instance that found in smaller more rural hospitals. This does not ease the difficulties encountered by the charge nurses, but raises an interesting difference between the problems encountered by staff in different types of location.

The final issue is really a point of information. Two of the three colleges had mental handicap hospitals within their domain, and it was disappointing that there was no uptake from anyone in this speciality. Why this should be was not clear, and it would be preferable if the problem could be remedied for future courses. It may be that information about the course should have been directed more energetically at this particular group, though it is possible that it is pure coincidence that there were no mental handicap participants on these particular courses.

This particular section could not finish without the mention of the cost of the courses. Some work was done in this area as a separate study (Whiteley and Broomfield 1987, pp.90-97), but it was interesting to note that costing was raised as an issue, both by the course participants and those in area D. For those who had attended one of the modules, the point raised was one of 'value for money'. Here, the question posed asked whether the actual monetary cost of putting people through these courses was 'worth it', in terms of the benefits accrued by attendance. All those who mentioned this felt that they could see deficiencies in their work situation which they felt were exacerbated by a shortage of money (e.g. staffing and resources). They were looking therefore at their attendance at the module and wondering how their ward or clinic etc. could have benefited if the money had been spent there, instead of on their education. This was a sad reflection on the situation that some staff found themselves in, and also on how education is seen to be a second priority in terms of worthwhile utilisation of resources. Those in area D who mentioned costing saw lack of funding as being an obstacle for them in terms of
attendance at any form of continuing education, and felt that they would not be released for courses whilst this was presented as a problem.

2 - Educational Factors

These were presented in two sections; factors concerned with the actual delivery of the courses; and those which related to the educational implications of continuing education.

Looking at delivery of courses first, the following points were raised:-

a) Some participants expectations about teaching styles

b) Comparison between courses

c) Consolidation of learning through the course structure

The discrepancy which existed in some cases between the actual mode of delivery and participants expectations about how it should have been, was mentioned on a number of occasions (point a). Here, those participants who had had little formal education (especially where they were expected to participate actively) since their basic training, found the more informal atmosphere which prevailed difficult to cope with at first (this relates to the more student centred type of learning mentioned in chapter 2). Areas specified were issues such as contributing to class discussions, doing work which was not to be formally graded or assessed and having time to study alone.

Having been used to a situation where classes ran from morning to night, and formal lectures were prevalent, all of these methods were alien and therefore difficult to get used to. The hurdle had not been insurmountable however,
and from responses to questions asked in the semi-structured interview about the type of teaching methods used and their relative effectiveness, it can be seen that all the participants ultimately coped with and even enjoyed this mode of delivery.

This point however raised two other issues. One was about the level that the course was aimed at, and the other related to difficulties which these charge nurses felt they had with their teaching role. From the course leaders perspective, their initial anxiety about delivering the course at a level commensurate with the needs and abilities of the participants, had to be addressed. Their position was therefore clarified by the participants (once they had grown accustomed to the style of delivery), who stated that this form of sharing their experience and knowledge had been gratifying and made them feel valued in terms of having a part to play in their education.

In relation to the teaching role of the charge nurse, this has been addressed by other researchers (see Ogier 1982, and Runciman 1983) both on its own and in conjunction with other concepts. It is interesting that much work has been done in this area but still the practitioners find this particular aspect of their role the most difficult. Referring back to the stated relative importance of the three aspects of the charge nurse role the overall result was that of seeing practitioner as first, manager second and teacher third. In conjunction with this, the statement by some of the participants that they had found the teaching aspect the one area that could have been addressed more fully within the course, also helped to highlight the deficiencies perceived in this aspect of their role.

Whether this feeling of neglect in the area of teaching was as great as perceived by the participants, or whether it was because this was the area in which they felt the least confident, and therefore needed more support is difficult to be certain about. However, the fact that charge nurses
still saw this as a problem indicated that perhaps more attention was needed to this area. Understanding that teaching in the ward situation does not necessarily comprise of structured 'tutorials' or 'lectures' and understanding the needs of all levels of learners (qualified and unqualified) are issues that were mentioned. Also, the feeling that as nurses they had never been taught how to teach (which in itself produces anxiety in the teaching situation) contributed to the overall problem. These points mirrored the findings of Runciman (1983, pp.65-66) who observed and spoke to a group of nine ward sisters actually at work on their own wards.

Taking an overview of the three courses, it was interesting to note that throughout the results there were not any noticeable differences in the benefits accrued by the participants (point b). Each of the three colleges structured their own programme based on the guidelines of the NBS and inevitably differences in the day to day content occurred e.g. input relevant to the area the course was being held in. There were however no great discrepancies in the overall content and for any charge nurse, any one of the three courses was effective. This also appeared to be true for any charge nurse whatever their age, length of experience, speciality etc..

The issue of consolidation raised here (point c) refers to the overall course structure. The fact that the participants experienced three weeks in college, followed by eight weeks back in post, a further week in college and six months back in post before the final study day appeared to have an impact on course effectiveness (see page 34). Theory learned in the college situation was not given as a 'one off' experience. After the first three weeks of the module, the charge nurse had to go back to work and use any knowledge gained in relation to her job, in preparation for her action plan. More theoretical input was then received during the single week in college, followed by return to the work situation to use the knowledge (consciously or
unconsciously) and this time, actually undertake the action plan. Each time there was contact in the college following a period of work, there was not only continued learning, but also accountability generated for each participant. The accountability occurred in terms of having to share their experiences with the other charge nurses and the course leader (which in itself provides a learning forum) on return to the college, and meant that there was incentive during the time in post to utilise the information learned and carry out the action plan to the best of their ability.

The educational implications of this type of continuing education included:-

a) The need for continuing education per se

b) The translation of theory into practice

This module was the beginning of the continuing education initiative being implemented by the NBS and based on the recommendations of the Working Party report (Working Party, 1981). The perceived needs of the profession were outlined in this report and underlined by the NBS in their initial course planning. The other side to this equation however was the recipient of the continuing education, and the needs which they felt could be met by such an initiative.

Of the charge nurses interviewed in relation to this project both from the modules and also from area D, the needs specified are presented in tables 6 and 9 (see pages 98 and 113). These show the deficits of the participants in relation to their jobs, as perceived by themselves. There were two other aspects however, referred to by all members of area D when asked how they saw continuing education benefiting the profession as a whole. One related to nurses' own esteem and the other to the perception of nurses as professionals by others who work in the health service.
The first point was raised, as many of the respondents felt that nurses were not given as much support or recognition as they should be by their peers. If they were given such consideration, by being provided with a coherent and continuous programme of continuing education, this could make them feel more valued and worthwhile. It could also make them feel a part of the service, as time is being taken to consider their needs as individuals. In addition information is being provided about what is happening around them within the profession and the health service as a whole.

Part of the value in encouraging staff to feel worthwhile within the nursing structure, is that they are then less likely to leave the profession. Work has been carried out (Redfern, 1981) which suggests this link (see page 26 of this research). She suggested that differences occur in satisfaction between leavers and non-leavers in relation to contextual factors within their job (e.g. opportunities for advancement, supervision and recognition), rather than content factors (e.g. ability utilisation, responsibility, social service).

Taking this conclusion, it can be seen that this particular module (and indeed continuing education in general) addressed this notion. It is also beneficial in keeping the sister and her expertise within the profession so that her skills are used where they are most needed.

The second point raised here about the professionalism of nurses has already been discussed (see pp. 26-27). The thoughts of those in area D however, who saw continuing education as a way of raising the perception of others about the professionalism of nurses, fit in with this notion about needing education to continually feed the ever changing demands of a true profession and the associated knowledge base. Unconsciously, they too had equated the idea of education to enhance practice, with the concept of professionalism. This can be summed up as follows:-
"Knowledge, skills and attitudes together form the essentials of professional practice. The practitioner who is weak in one of these dimensions is less than a total professional - each, in its own way, is a vital constituent to practice." (Jarvis 1983, p.79)

The translation of theory into practice (point b), has also been discussed as an important element of continuing education (see pp.31-34). In this particular study, evidence existed that this transition had been made to a greater or lesser extent by the charge nurses attending the modules. Having had time to integrate the theory and practice during the course (due to course structure and the undertaking of an action plan), consolidation of the experience occurred before the charge nurse returned to her job after completion of the module. This concept was not followed up in terms of a longitudinal study of course outcomes (which would be the desirable action), due to the logistical impossibility of such an activity within this project. Indications existed however - from some of the statements made by participants (see table 8, page 102) and also the reported benefits from the action plans (see table 14, p.129) - that this was the case in the short term at least. Additionally, there was reporting from the charge nurses that indicative of the fact that theory learned had been translated into broader concepts such as greater awareness of their situation and an increase in confidence. These are factors which in themselves are less likely to be lost than a conglomeration of facts and theories. It also indicated that the learning experience underwent a transition within the individual from theoretical, into practical and applicable concepts.

3 - Beneficial Factors

This last section deals with the benefits of the module. Areas to be discussed include:-

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a) Opportunities presented by continuing education programmes

b) The three questions posed at the outset, namely:

i What changes in knowledge, skills and attitude are experienced by the course participants?

ii How is their role as a manager, practitioner and teacher affected by the course?

iii How has the course developed in the three colleges?

In deciding what opportunities are presented by continuing education programmes (point a), there is an important distinction to be made which must be considered. Opportunities and also effects of any type of course can be either intended or unintended (a point also made in discussing the differing evaluation strategies - see page 14). This means that when people attend a course there are certain intentions, stated in course aims and objectives, about what effect the course will have on any individual. These are the intended outcomes and represent the opportunities being offered by the educational input. In this case the intentions were stated by the NBS and the opportunities for the participants are presented in the course content of the three colleges.

The unintended effects are accrued in the informal contact gained with other members of the course, or anyone else that might come into contact with the participants. This can occur over coffee or lunch or even in discussions which take place in the classroom. It was this type of opportunity - meeting with others and learning their views, that as a single aspect of the course, was most frequently mentioned by the participants as being of great benefit (see tables 8 and 12, pages 102 and 119).
The location of the course in the college and therefore outwith the work place also facilitated this process. It meant that a cross-sectional group of charge nurses met together (away from the pressures of the work situation and the risk of still being accessible to their colleagues in the ward) and distanced themselves from their work. In this situation, they were able to see their job in a less emotive light and assess problems and ideas from a fresh perspective. This is an important point to consider because of the dichotomy created, when the use of distance or open learning is indicated.

Of the three questions posed at the start of the evaluation, the last one will be addressed first. The development of the courses over the pilot scheme was subtle and as such, indicative of the amount of planning that went into the implementation of the module. From the original NBS guidelines, through the course submissions and their acceptance by the NBS, to the actual delivery of the module, the correct content and level of aptitude appeared to be addressed. It has already been stated that the day to day content of the three courses differed, but it was interesting in terms of the type of guidelines sent out by the NBS (i.e. non-prescriptive) that all the modules had a positive effect on those involved.

Concerning any changes in knowledge, skills and attitudes and the possible effects on the role of the charge nurse as manager, practitioner and teacher, these two questions are at the heart of this continuing education strategy. Indeed, the main purpose of the evaluation has been to address them, in trying to find out the overall effectiveness of the courses.

In relation to changes in knowledge, skills and attitudes, all these categories were apparently influenced in some way by the module. Evidence to support this is available throughout the reported results e.g. benefits of the course, benefits from action plans and stated aim of the
module. In terms of the three aspects of the charge nurse role the first two, namely practitioner and manager were more affected than the third (teacher) and once again evidence for this was consistently found throughout the results.

It must be stressed however, that for any single individual the effects of the course were intrinsically different, and that although there were overall trends perceived, each charge nurse had a unique set of outcomes. It is perhaps this one factor that was the single most positive aspect of the course. Everyone who attended the module in some way benefited from the experience.

To summarise the discussion, the following tables represent the conclusions that were drawn from the sum of the evaluative activities carried out:-

1. Staff of all grades need more information about the new continuing education initiative and its implications
2. The need to target mental handicap nurses should be assessed (there were no representatives of this area on any of the modules)
3. Open and distance learning strategies could be considered, especially in geographically diverse areas
4. More active support during the six month action plan would be beneficial to participants to enable the work to be carried out and library and other facilities to be used
5. Some participants at least would benefit from an introduction to student centred learning techniques at the beginning of the module
6. The role of the charge nurse as a teacher needs to be addressed in greater depth
7. Having a cross-section of nurses from all disciplines is beneficial
8. The non-prescriptive guidelines issued by the NBS worked well in terms of local variations in course delivery

**TABLE 17 – Generic Outcomes of the ECNM**
Student centred learning was a success
There was no barrier to learning in terms of different age groups, length of experience, type of post held or qualification
The structure of the course promotes consolidation of learning before the module is completed
The action plan is a positive aspect of the course in promoting beneficial outcomes

TABLE 18 - Educational Outcomes of the ECNM

The analysis of costing of courses needs more development
Continuing education enhances the professional status of nurses
Benefits accrued by participants include increases in objectivity, awareness, knowledge, confidence, the ability to question and enthusiasm. These factors were noted not only by participants, but also the course leaders and nurse managers
There is evidence to suggest that the theory learned in the college situation is being translated into practice
Any participant is able to benefit from the course
Charge nurses do not necessarily make changes in the work situation over a nine month time span, which would suggest that the changes made by the course participants were a direct result of attending the course
Behavioural changes are noted to have occurred (either in the charge nurse herself, her staff or sometimes, her patients), especially as a result of the action plans undertaken

TABLE 19 - Professional Outcomes of the ECNM

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Background

Taking the preceding results, the pitfalls of the initial design became apparent. The strength of the qualitative approach was not being enhanced by the forced choice scales, some of the data execution procedures needed to be tightened up, and for a larger exercise, more flexibility needed to be introduced. To counter these problems, the design was re-examined and the flaws considered.

Returning to the literature, more consideration was given to the concepts of adult learning, the idea that andragogical rather than pedagogical forces might be in action, what impact this might have on the type of information that could be reasonably expected, and what it would mean in terms of data collection. Also, looking at the type of information that had been collected for the ECNM, it was felt that a higher level of data could be obtained, which could possibly have come through the quantitative scales, but had not. The extra data had to relate to the relevance of the course for the individual - in essence an indicator of outcomes at some level - since, this would help build the case for the inferential links that the data produced, to prove that attendance at a continuing education course could have some effect.

The use of the forced choice scales had been initiated in response to the fact that information was being sought about the knowledge, skills and attitudes of the individuals involved with the ECNM. This was taken in quite a literal sense so that the scales were supposed to provide the data on attitudes and behaviour. Self-appraisal had been chosen as the most practical method for collecting this data, but this did not prove to be as reliable or as sensitive as had been envisaged.
Some of this lack of utility was undoubtedly due to the design of the instruments. Although they had both been pre-tested, and the first of the two scales altered accordingly, there had not been enough thought put into their construction. Indeed it was only at the stage of analysis that it was realised that the frequency scale was not suitable for statistical application, due to the fact that a shift in score either way (i.e. higher or lower), could be seen as a positive result. Thus it was not showing anything useful at all in terms of the evaluation, although if used as a scale in a study concentrating on the role of the charge nurse, it would undoubtedly have some use.

The attitudinal scales were more of a problem since, having carried out a pre-test and item analysis, it was presumed that they would be beneficial to the study. The fact that there were no consistently significant results, did nothing to strengthen the findings from the rest of the evaluation. For this reason they were not of use to the overall picture of the ECNM. The decision not to pursue them into the evaluation of PSI&II therefore, was based largely on this fact. Also, on reflection it could be seen that this type of instrument had been chosen because classically, this was how to measure attitudes, and it involved some form of quantitative measure which had been thought to be desirable. Consideration was given to this fact, and it was decided that this need not necessarily be the case.

The problem that was being confronted at this stage was not limited to the measurement of attitudes. There was a large need, especially on behalf of the sponsoring body, to see some results that proved that continuing education was actually having a beneficial effect on the participants. They also wished to see some results as the project progressed, rather than waiting until the end of the allocated time. This is not an unusual situation by any means in evaluation work, and simply means combining some form of formative work, with an overall summative picture.
Alternative methods for collecting data therefore – in addition to the questionnaires and interviews – had to be considered.

To address this problem, a debate arose around the notion of constructing a competence indicator. If this were possible, then it would solve the problem of showing not only what processes were at work, but also what outcomes were present. To look at it another way, it was like looking at effectiveness compared with efficiency. After a review of the field however, it was realised that this was not possible within the remit of this type of project and in fact the development of just such a tool could be a complete thesis in itself. One step below competence would be performance and many performance indicators are already in existence e.g. MONITOR (Goldstone et al, 1983) and Qualpacs (Wandelt and Ager 1974, and Wainwright and Burnip 1983). These were examined, but it was felt that to incorporate them into an evaluation was neither practical nor relevant. Indicators that exist at present are for looking at whole wards or units and not individual performances. Also the indicators are purely a pointer towards actual performance, and not how the nurse feels about that performance, or what effect this might be having on patient care. Add to this the time and cost of trying to observe all participants prior to a course (for how long, with what sort of patients, when they have what degree of responsibility) and then again at some future point in time, plus the necessary involvement of a number of ethics committees, then the whole plan would become unmanagable.

The approach taken therefore was one of needs assessment for the individual. Current thinking in the adult and / or professional education debate advocates the concept of student centred learning (see Boud and Griffin 1987, Knapper and Cropley 1985, and Knowles 1984), with the emphasis on the needs of the individual and the experiences that they bring with them to the learning situation (see pp.27-31). Using needs assessment, individual information
could be gathered for each person attending a PSI module, setting up a situation whereby the content and outcome of the module could be judged against the stated needs of participants. Additional benefit of this type of data is that it reflects the situation as perceived by the individual, rather than being artificially identified by another person. This is similar to the difference pointed out by Knowles (1984, p.17) when he describes 'felt needs', compared with 'ascribed needs'. The former here are attributed to the individual and the latter to the dictates of organisation or society from which the individual originates. It was for the purpose of this needs assessment that the Nursing Log was developed (see page 66). For PSI, the Log was not considered useful, since participants were attending a specialised set of modules. Their needs were therefore content specific to the modules that they had chosen to undertake.

In conjunction with the decision to pursue needs assessment, there was the fact that a much larger scale innovation was to be considered which would mean that to make sense of the differing ideals and mechanisms in use, more background information would be needed. With the ECNM, the initiative had been well defined in terms of there being three colleges who were piloting the module, and a straightforward structure which charge nurses started at the beginning, and went right through the nine months to the end. This allowed a relatively leisurely pursuit of the modules to take place, with information being picked up over time about their development and implementation. Add to this the needs of the sponsoring body - also a relevant issue in the literature e.g. Kogan 1986 - and what level of information they could reasonably expect and when, the structure of the evaluation had to an extent, to be re-designed.

The considerations discussed above are reflective of the differences in design that need to occur depending on the scale of the evaluation. Fundamentally, the questions being
asked remain the same and the factors that need to be studied are consistent. The sheer difference in scale however, means that the larger the concern, the more attention needs to be paid to the structures supporting the initiative. In this case that meant that the amplification of monitoring activities, to ascertain the structures and processes involved in the planning and delivery of courses. In total all these factors put together meant the following changes to the previous design, when translated into the structure of the work for PSI&II:-

1  Time had to be spent assessing the level of knowledge about, and the viability of, modules.

2  This information then had to be used to assess the level of development and implementation of modules.

3  The new instrument known as the Nursing Log had to be incorporated into the evaluation.

The elements that remained constant, were those pertaining to the questionnaires and interviews for module participants, comparator groups, course leaders and service managers. These methods were satisfactory and translatable into the larger picture. The following pages report on the results of the work carried out to expand the previous structure and knowledge base i.e. the monitoring exercise of PSI&II that took place and also some preliminary results from the use of the Nursing Log.

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CHAPTER 15 - PSI&II EXPLORATORY INTERVIEWS

As detailed in the chapter on research design (see page 64), a semi-structured interview was used as the first information gathering instrument for PSI&II. This began the monitoring exercise and provided - along with other documentary information - the basic information that was needed to ensure that the evaluation was going to follow the important features of the initiative.

The exploratory interviews (see appendix 11) were carried out to try and get an informed picture of some of the important points relating to the development and running of PSI&II modules. A cross section of staff was taken from each of three health boards representing different stages in the development process, plus two members of the NBS. These stages were characterised as follows: courses up and running (area 1); submissions to the NBS, but no validation (area 2); no contact concerning PSI&II with the NBS (area 3). The different grades of staff were chosen based on the following categorisation of interested parties:-

1) NBS - the initiator
2) Service - the consumer
3) Education - the provider
4) Management - the facilitator (both nursing management and general health board management)

The total number of respondents were:-

5 Unit General Managers (UGM)
3 Directors of Nursing Services (DNS)
3 Directors of Nurse Education (DNE)
3 Continuing Education Tutors (CE)
2 Nursing Officers (NO)
2 Ward Sisters (WS)
3 Staff Nurses (SN)
2 Members of the National Board (NBS)
NB For each question the category of respondent is shown, followed by the response.

1) What do you know about PSI&II?
UGM - There was not much knowledge about the initiative from this group, except in one area where there had been particular staffing problems and Professional Studies had been an issue.
DNS/DNE/CE - All were well aware of the source and content of the initiative.
NO/WS/SN - At this level the differences in knowledge became apparent. Those that were involved in area 1 were well aware of the situation. In areas 2 and 3 knowledge was sparse, some saying that this was the first time that they had had an opportunity to find out specifically what it was all about (i.e. through the interview), though they had all at least heard of Professional Studies. In one case there was a little more knowledge because the individual had read a leaflet about it.
NBS - Both concerned with the initiation of Professional Studies, and therefore well informed.

2) How does this fit in with your current Health Board policies / practices?
UGM - None of the respondents knew of a specific continuing education policy for nurses. The only semi-positive response was that there was a policy for PSI&II in area 1, but it was felt that any health board policy should be multidisciplinary and not just for nursing.
DNS/DNE/CE - General agreement within and across all areas, that there is no specific health board policy concerning continuing education for nurses. It was seen that PSI&II would provide some sort of policy and in three cases it was pointed out that the appointment of a continuing education tutor would help with this issue.
NO/WS/SN - In area 1 the policy was seen to be Professional Studies. In the other areas, nothing was identified.
3) **Do you think that continuing education is necessary?**

**UGM** - There was a positive response to this question in that all the respondents consider it to be a necessity. Reasons given included the positive effect that this could have on staffing, but more specifically, if it is related to and therefore improves practice. Some concern was also expressed by one respondent that it should not put too much emphasis on specialities to the detriment of the general areas.

**DNS/DNE/CE** - Necessity was not questioned by this group, and all gave similar answers. It was recognised that the basic nurse training is only a beginning and that more preparation is needed to help with the responsibility of being qualified, as well as updating. This would then help in dealing with a more well-informed public. It was also felt that education should be provided in a more ordered way so that the individual has a more coherent career plan and does not do courses merely to collect certificates.

**NO/WS/SN** - Again everyone saw the necessity, but more specifically in this group the need to constantly update was recognised because of the need to stay informed and deal with raised public expectations.

**NBS** - The need for staff to recognise that continued learning is something that should happen throughout their career, and to keep people informed. The old courses were not doing this.

4) **Do you think that it is practical in terms of:**

- resourcing
- releasing staff
- cost implications?

**UGM** - This question brought some varied opinions. Two of those interviewed felt that the cost of releasing staff could be absorbed in a similar way to sickness and holidays (assuming that not too many people are away at any one time). The only cost then would be travelling expenses and these could be met. The other respondents, however, were quite negative about cost implications, saying that resources were short and that funding would need to be
available before anything could be considered. It was also suggested that money should not be made freely available, but that it should be targeted to those areas with greatest need and that the individual should justify the cost in their application to attend.

**DNS/DNE/CE** - Resourcing is a problem at two levels. One concerns the lack of identified staff within the colleges who work on continuing education and the concomitant teaching resources; the other is the release of staff by the service side. The latter is seen as being a possibility in areas that are adequately staffed and can therefore allow someone the time off, but only if there are not too many people released at the same time. If there was money for replacement staff and also for the colleges, things would be made a lot easier. Area 2 is not running approved modules at present due to a lack of resources. It was felt by one respondent that unless the courses become mandatory for employment purposes (e.g. like the Health Visiting certificate), then health boards will continue to be unwilling to provide additional resources. It was also pointed out that some funding is being used from old CCNS courses in areas that have in the past run approved post-basic courses, but this will run out in the near future (and even now this covers only a small number of areas).

**NO** - Because the modules are flexible and each one is in itself relatively short, area 3 felt that sending people away should be possible and that it is important that everyone gets a chance to go - bearing in mind that they have not really started seconding people as yet. In area 1 the mechanism is in place for seconding staff and the loss to the ward is now written into the staffing levels and places allocated well in advance. This serves two purposes a) the ward is well prepared for staff being absent to attend a module and b) individuals are aware of when they will be attending, and can see that they are actually going to get a turn at a specific point in the future.

**WS/SN** - Not much awareness at this level of the implications apart from the feeling in areas 2 and 3 that
staffing levels would present a problem if the courses were to be made available to them.

NBS - In theory the design of the diploma makes it achievable. It would help if the Board had funding for teaching staff, though this would not help with releasing staff. The problem is trying to discover the hidden costs that are taken for granted, and getting these put into the college budgets.

5) What benefits do you foresee coming from the implementation of a coherent strategy such as this?

UGM - This should help to produce a more able nurse, improving the quality of patient care with better professional training. A spin off in the area of management development, in terms of understanding of the day to day responsibility that nurses can have would also be useful. It should also have an effect on the retention of staff.

DNS/DNE/CE - Should have better prepared Charge Nurses with a more definite career plan. The college/ hospital/ service divide is a problem, so it would be good to have a continuing education department to rationalise the situation.

NBS - For the first time it will give nurses an educational background - this should then become a way of life and nurses will go on researching / searching for information themselves. It can only make better professional people.

6) How do you think that it will help nursing provision

- expertise
- efficiency
- morale
- patient care?

UGM - It should help in attracting staff to short staffed areas, especially the specialities. Morale should be affected which is another important factor in staff recruitment and retention. Provision of training vital to assist in good standards of patient care.

DNS/DNE/CE - There was a feeling that it would have positive effects on morale and the standard of care given.
Nurses should be encouraged by this to learn for themselves and continue to improve their own standard of care in light of the increased demands from the job. In addition, staff should be attracted to, and encouraged to stay in nursing, with the possibility of being able to broaden their horizons and decide what is best for them and for the service.

NO/WS/SN - Morale will be an important factor, largely influenced by the fact that courses are being provided for people i.e. somebody is taking notice of staff and staff needs. It should also help in giving confidence, indirectly affecting patient care provision. Staff should also gain knowledge to share with others on return from a course. Recruitment will be affected - already indications that staff are preferring areas that are offering modules.

NBS - It should help the educational background of nurses and therefore develop their confidence and the ability to pass on their information, all of which should improve the quality of patient care.

7) What criteria do you use to assess the success of such an initiative and do you carry out any form of in-house evaluation?

UGM - There is an inference that because a course is there it is good and for a while at least people are just sent along. A course needs to be running for at least 18 months to two years before it can be seriously looked at. Not sure how to evaluate it. Suggest that somebody needs to be put into post to assess the areas needs and judge the success of the available provision.

DNS - Do people want to attend the courses, is there any indication that staff have a greater professional commitment to accept more responsibility, are they more assured? Would need to ask those who have attended a module six months or a year after completion.

DNS/CE - This group saw evaluation relating to the modules provided rather than of the individual benefits. Area 1 stated that it was running end of module evaluations and
this was also suggested by area 2. There were no criteria suggested for success.

NBS - Each submission has its own external examiner as well as their own evaluation procedure. The NBS does not see the results of the evaluations, but maybe it should do.

8) What drawbacks do you envisage?
DNS - Anxious that the service won't be able to put enough people through i.e. release of staff. That too many modules are developed for one area and that the general areas are left without provision. Also that there will be a glut of people who have completed PSI and are waiting for PSII.
There may be problems in the practical element of the module if staff return to their own ward for the experience, since they will have to get their Charge Nurse and Nursing Officer to see that they are still on a course.
NO - In area I a system has been developed, whereby staff are allocated places in advance, so that planning for holidays or any other form of absence can be arranged. This happens up to 9 months in advance however, which is a long time for people to have to wait. The plus side to this is that everyone can see that they will be attending at some point in the future.
NBS - There is a possibility of duplication of problems and courses due to a lack of communication between colleges. Some of the guidelines may be a little unclear since there is some confusion around various issues e.g. that Professional Studies is a different concept from CCNS courses.

9) Is there a time limit on how long you are prepared to try this for?
UGM - After 2 years there should be some evidence about the efficacy of the proposals and at this point decisions should be made.
DNS - 5 years before the overall worth can be assessed.
NBS - There is no specific time limit set, though the guidelines will need constantly reviewing. The results of Project 2000 will need to be taken into account.
10a) What continuing education provision for nurses did you have before these modules were initiated / will be superseded by this strategy?

UGC - In-service courses offered, which have more immediate effect than longer courses. Area 3 had no provision for longer courses, but used Greater Glasgow's resources, though they do have provision for in-service courses.

DNS/DNE/CE - Areas 1 and 2 offered various CCNS courses and area 3 confirmed the use of GGHB. All three areas mentioned the provision of in-service courses as well.

WS/SN - There are the post-basic courses that you can apply for and some in-service study days, though it is not always easy to get time away from the ward to go to these. Other courses are not very common and are hard to get on to, it is left up to the individual to try and find courses to go to in many cases. Staff in area 3 would prefer to see courses being brought into their own health board instead of having to go elsewhere. Problems with attendance are perceived to be related to staffing and funding. The only other choice in the past has been to apply for a full time post-basic or post-registration course, thereby giving up a secure job.

10b) How do you think that the new provision compares with the previous continuing education offered?

NBS - There is no comparison with the CCNS courses. Specific courses were designed for specific situations - it would be good to see someone trying to take a course and put it into modular form with each module four or five months in length.

11) What strategy has been used to decide what modules should be developed - i.e. who is involved - service / education / management, and how do you design modules?

DNE/CE - In the two areas which previously ran post-basic courses, the first modules developed for PSII have been based on these. Subsequently, modules (including specific requests) have been considered in terms of practicability and college resources. In area 3 it is considered that it
should be a joint venture, with the college having some say and also local demands and initiative taken into account. It is important that all parts of the register are catered for if possible. All areas either use or propose to use working groups to prepare modules, consisting of both service and education staff to provide all the expertise needed. Being quite geographically widespread, area 3 is going to have to consider ways of making the courses available to all staff e.g. taking tutors to outlying hospitals as well as bringing people in. These are important considerations since, one of the problems that might be encountered is a target group that is too small to justify the development of a particular speciality unless other modes of delivery are considered. Even if this is done however, it may be that there are still too few staff for some options and in this case it may be necessary to second staff elsewhere.

NO/WS/SN - Generally very little was known at this level, though there was a feeling that suggestions could and indeed should come from the service side for new modules.

12) How does a nurse obtain continuing education?

UGM - All stated that the individual could ask to be sent on a course and that the decision would then be made by senior nursing staff. There is also the possibility that an individual could be asked to attend a course, if something specific came up that was particularly suitable for them. In one instance it was pointed out that staff appraisal should highlight needs.

DNS/DNE/CE - The individual should apply for whichever course it is that they want to attend. The nurse manager then has to agree to their secondment. Everyone who is eligible should be entitled to do PSI, but a more stringent selection procedure needs to be used for PSII. Possibility of using a joint education / service interview for this. The annual review should be used in helping people to decide to apply. Although the general opinion was that there is no problem in attracting applicants, it was
pointed out that some units are better than others for encouraging staff and being prepared to second them.  
**NO** – In area 1 there is a definite policy for giving out information in the first instance, followed by definite selection and attendance procedures (this is in a unit that seconds people to PSII modules as well as PSI). In the other areas it was suggested that the manager either has it in mind for an individual or the yearly assessment brings it forward.  
**WS/SN** – You definitely have to ask for things, since only very occasionally do you get offered anything. Even when in-service days are offered it is often difficult to attend as the ward is too busy and you cannot get away. Once having asked however there is no guarantee that you will be sent – suggestions were made that it may depend on factors such as how you are perceived as an individual or your status – and also that staffing levels will be the priority rather than the educational needs of the person involved.

13) **How do you find the procedure for design and validation of the modules?**  
**DNS/DNE** – The guidelines are adequate that the NBS have provided. There are problems however with the procedure involved in validation. Respondents went on to talk about the total length of the validation procedure and the number of different bodies involved. By the time a submission is made to the NBS it may have taken up to two years to develop the modules, so that a further year for validation is a long time to wait. It was also felt that at times, the 'goal-posts' were moved during the validation procedure which made it difficult to be sure that the original proposals were going to be acceptable. It would be useful to have more opportunity to discuss particular cases with preview groups or specialist panels.

14) **How did the procedure for validation come about and is it satisfactory?**  
**NBS** – It is partly historical based on the old CCNS system. The preview group was formed to take the pressure off the
post-basic committee. There are difficulties with the present system, some of which are being addressed by the preview group – there are proposals for amalgamating some members of the group with those of specialist panels to reduce the number of different groups who see the submissions, thereby reducing the length of time involved. Other problems stem from those making the submissions. Some people appear to be finding it difficult, having to go through the validation procedure per se. It may be because they have not had to justify their submissions in the past, but reaction to the feedback offered, is sometimes quite surprising.

15) Who are the courses aimed at, should they be open to all those who apply – what about charge nurses etc.?  
NBS – In the first instance the courses are meant for staff nurses with at least six months post-registration experience. Places can be given to others if there are any spare. This is one of the reasons that the ECNM was proposed in the first instance, to try and provide continuing education to the next grade. In theory however once the courses are established staff should be able to pick single modules to do if it is relevant to their place of work and it is of interest to them. This is one of the advantages of the proposed system. At present however, some colleges seem to be more rigid than this, expecting the modules to be done as a complete set. If the former system eventually prevails then we will truly have continuing education.

16) Do you see the development of modules in 'unpopular' areas as a useful way of attracting staff to these specialities – should this be allowed to happen?  
DNS – It is possible to use PSII in this way, though it would be better to develop courses which are applicable across a number of areas, then specific problem areas would not be highlighted. Modules should certainly be developed for other areas apart from the specialities addressed by the old CCNS courses. It is also apparent that if areas are
not provided with modules then staff will be less willing to go and work there.

NBS - This was talked about in relation to PSII particularly in areas such as psychiatry. For instance, prior to PSI&II virtually the only option would have been to do a post-registration RGN course which meant that some staff inevitably were lost to the area. This is not very satisfactory. Nothing has been specified in relation to this, but it would make sense if the people concerned in these areas made particular requests for modules to be mounted.

17) Do you think that there has been enough publicity about the strategy?

NBS - All possible publicity has been given, but there are still people around who have not heard of Professional Studies or who are misinformed. Some people may find the change threatening and therefore do not want to understand what it is about.

18) Do you think that all staff are aware of what is available for them?

NO/WS/SN - Area 1 reported that staff know what is available. In the other two areas however little was known about the whole initiative and staff felt that they could do with more information - maybe in the form of a study day run by the college. It was felt that students had more information than many of the trained staff, simply because of their links with the colleges. The charge nurses also felt that they would like some form of continuing education before their staff nurses went away and took part in any modules. Everyone reported that Professional Studies was a topic of conversation amongst staff to a greater or lesser extent, and it was reported that there was concern that it is going to affect promotion prospects. Even in area 1 where the courses are running, it is seen that because the staff attaining the Diploma are coming from intensive care only (at present), this would give them an unfair advantage for promotion.
19) Are you pleased with the response to the proposals - should there be more interest or is it proliferating at a reasonable pace?

NBS - The response has been varied, with some areas doing very well and being quite innovative. Others however are either not producing anything at all, or are not accepting that what they have produced is not appropriate. Good submissions are coming in from a variety of places, not all of which were to be expected and some of the poorer submissions are coming from areas that would have been expected to be better. Part of the problem in the spread of the modules is related to resourcing.

20) What questions would you like to see addressed by the evaluation?
- UGM/DNS/DNE/CE/NO/WS/SN/NBS
See table 20, below and overleaf

Patient Care
What effect is this having on patient care - can performance indicators be used to find out?
Is it going to help the individual or the patient?
Is the quality of care being improved?
Can we prove an increase in standard of patient care and not just relate care to staffing levels?

Nursing
Will it cause nurses to stay in nursing?
Do we equip people to work in specific areas?
Does it have an effect on career patterns - do these people go on to do advanced course or do they opt out?
Do nurses consider PSI really useful and valuable ("it is more theoretical rather than being related directly to practical skills which is what nursing is all about")?
Will SN's be able to see themselves as skilled leaders?
Are they getting more confidence and professional development - will the development continue even after the course has finished?
Does it prepare better leaders?
What is it providing for the profession - a better specialist or a better nurse generally?
Does it improve the professional status of nurses?
How do you get advice for post-registration career decisions?

TABLE 20 - Stated Questions Relating to PSI&II
Funding
How much (money) is allocated for it?
Cost-effectiveness?
Can funding for this come from the NBS to ensure that everyone has the opportunity to develop and participate?
What is the cost and what is the effect? - if nobody knows this then there is no motivation to find money for it
These things are not finite in terms of cost - the NHS is broader than a hospital or college etc. - is this being appreciated?

Courses
Is there a need for the courses?
Does it make people value education in the wards more - do they question things more?
What effect are the courses having on the colleges?
Is the addition of post-basic courses to some colleges having a positive effect on teaching staff?
Do PSII come in the right order?
Should we be looking at more generic type PSII modules?
When can we give up PSI - and if we do can PSII be done straight from basic?
What are the practicalities of service coping with the release of staff?
How can you ensure a fair and equitable distribution of PS modules throughout Scotland - what controls are there on the numbers and types of courses?
Does the fact that each health board has a different approach matter in terms of the individuals' ability to move - will they have to make up a shortfall?
How much repetition is there going to be - is everyone just looking to themselves - in terms of courses developed?
See if the development of courses relates to any national initiatives e.g. the review of cardiac surgery?
Is there in-house evaluation?
Are there enough places for everyone?
How long will this remain the way to obtain continuing education - will it be superseded soon?

TABLE 20 (CONT.) - Stated Questions Relating to PSI&II
CHAPTER 16 - PSI&II MAILSHOT QUESTIONNAIRES

Taking the results from the previous interviews, there were areas of concern that were becoming apparent as well as the generic questions posed at the outset of this evaluation (see table 3, page 59). The questions in table 20 begin to show the broad outlines of the categories into which future information would fall, and using these, a questionnaire and follow up interview were devised, called 'Mailshot'. The broad categories to be addressed through the questionnaire, were the same as those used in table 20, i.e. patient care, courses, nursing and funding. A slight change in emphasis occurred however, since the audience that was about to be targeted was educational staff. Main areas of concern were development and running of courses, including funding, and their perceived views about patient and nursing outcomes. The overall aim of the questionnaire therefore was to collect information - still at the monitoring level - which would enhance the understanding of the picture of PSI&II development and implementation in Scotland. The results of these questionnaires are presented next.

Four versions of the questionnaire were distributed to all Colleges of Nursing and Midwifery, CI's and Universities within Scotland that had any capacity for nurse education (see appendices 12 to 15). The version sent to each was dependent upon the status of the courses that were being offered by the institution (as specified in the NBS list of validated Professional Studies modules, August 1988) i.e.:-

1 College of Nursing and Midwifery with PSI and/or PSII modules validated - MAILSHOT
2 College of Nursing and Midwifery without PSI or PSII modules validated - MAILSHOT 1
3 Central Institution / University with PSI and/or PSII modules validated - MAILSHOT 2
4 Central Institution / University without PSI and/or PSII modules validated - MAILSHOT 3
The baseline of information collected in this way, could be updated in the future to see whether some of the earlier problems (if any) were being solved and if any further ones were being encountered. The results from each of the four versions of the questionnaire have been described separately, and are presented in this format here.

Total numbers involved in this exercise (representing a 100% response rate) were as follows:-

Mailshot 13 colleges
Mailshot 1 8 colleges
Mailshot 2 1 CI
Mailshot 3 8 CI's / Universities

Mailshot

Question 1
The total numbers of validated modules within the 13 colleges in August 1988 were 48 PSI and 17 PSII. All colleges confirmed that the information given was accurate although four centres indicated that they had not as yet commenced provision of the modules. Two of these stated that they had no definite start date as yet, one specified January 1989 and one October 1988. Modules that are being run occur one to four times per year, with PSI being more frequent than PSII. Average PSI attendance is 15 participants per module and PSII 10 per module. In theory this means that there are between 1500 and 1700 places on PSI modules in any one year and over 320 PSII places.

Question 2
Grades of staff attending modules:-
PSI 8 put SN's first; 3 stated only SN's; 5 will take WS's and one has taken an Occupational Health Nurse.
PSII 2 put SN's first and one put SN's second; 1 put WS's first and 1 put WS second. Two included NO's as a third
priority and other categories included Health Visitors and a Macmillan Nurse.

As can be seen from these results SN's form the major uptake group for both PSI and PSII, but WS's and NO's are also involved particularly at the level of PSII. Staff mentioned that work outside the ward environment e.g community or clinic nurses, are being accepted onto modules specific to their particular area of work.

Question 3
Questions about funding meet with a particular difficulty due to the lack of information that some colleges have. The responses to this question therefore were so diverse, that in their current form they have little meaning, certainly not in relation to each other. However, in response to the question about whether funds were sufficient to meet continuing education needs all but one college said that they were not. The remaining college was unable to say whether it was sufficient or not.

Question 4
This question produced the anticipated variety of answers, confirming the problem highlighted by the answer to the previous question. Two colleges did not offer any information about how their courses were funded, one stated that funding had been sufficient so far, but other answers were:-

Occasional 'one-off' allocation of funds from CANO's office, usually at the end of the financial year, also one DNS seconds a member of staff from time to time
Application for permission to run courses is made to the CANO and money released
Money comes from the basic education budget
1 nurse teacher and participants costs from the Health Board
Health Board provides funds for 2 members of staff and some books and equipment. The rest is shared with the basic courses and NBS funded staff are 'seconded' on a rotation basis to the team
From the contributions of a number of members of staff
In part from income generation from evening classes
and advanced midwifery courses
From in-service budget

Question 5
6 colleges said that time had been built into service
staffing figures to allow for continuing education. One
stated that the Telford system operated, allowing 1% of
total time, and another that 1 - 2% of time was allowed. 6
other colleges stated no time was allowed and one did not
know.

Question 6
3 colleges did not answer this question. Of the remaining
10, 7 stated that they had had no problems in running
validated modules, and of the 3 who had, one stipulated
that lack of funding had caused an overall delay in the
start up of the modules. Another of these three stated that
they had not commenced their modules as yet and could
therefore not say what problems there might be. Finally,
the third college stated that a lack of staff was providing
a problem, added to the delay caused by the unavailability
of PSII modules whilst old post-basic courses were being
phased out.

Question 7
8 out of the 13 colleges run consolidation courses with 6
of them following the NBS guidelines. Of these 6, 5 require
candidates for PS to have attended consolidation. One
further college requires consolidation as a pre-requisite
though they have extended the length of the course beyond
the time recommended by the NBS.

Question 8
Out of the 13 respondents, one area felt that all three
modules should be taken consecutively and one did not
answer. The other 11 all replied that modules could be
taken one or two at a time.
Question 9
Staff involvement – see table 21

<table>
<thead>
<tr>
<th>SUBJECT AREA</th>
<th>DEVELOPMENT</th>
<th>CO-ORDINATION</th>
<th>TEACHING</th>
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<tbody>
<tr>
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<td>PSI PSII PSII PSI PSII PSI PSII PSI PSII</td>
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<td>STAFF NURSE</td>
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<td>EXT. LECTURER</td>
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TABLE 21 - Staff Involvement with PS Modules

6 colleges had no particular time allocation built into staffing figures for the planning and development of modules. 6 colleges do allocate time, 3 as part of the tutor with responsibility for CE's time, with one other only allocating time until modules are developed. There was one non-respondent.

Question 10
All areas had an identified CE team consisting of some combination from:

senior tutor  charge nurse
nurse tutor    ADNE
clinical teacher

The number and amount of involvement varied considerably, with the bulk of the posts being Health Board funded. Only $3^{1/2}$ posts were NBS funded, these being one and $^{1/2}$ nurse teachers and two clinical teachers.
Question 11
Of the options offered for mode of delivery in this question all 13 replied that classroom contact would be used. In 3 cases this was the only method mentioned. Of the other 10, 7 stated the use of open learning; 1 distance learning and workshops; 1 guided learning packages and 1 self learning Open University packages on or between study days.

In identifying these alternative forms of delivery the next step is to ask the respondents what exactly they mean by 'open' or 'distance' learning, because there are many definitions in existence.

Question 12
Access to modules was in the mainly through the line manager who sent in the name of the candidate to the college. One centre had access directly via the college and another discriminated between PSI and PSII. In this case, access to PSI was through the line manager and PSII via the college.

Question 13
5 colleges have participants attending PSI modules who are not from within their designated area. The reason being that some areas do not yet have PSI available locally. Priority is being given however to those from within the colleges own catchment area, stated specifically by one centre:-

'Modules are open to non-health board and non-NHS staff, but local staff will be given priority.'

For PSII there are 6 colleges taking participants from other Health Boards and this will continue since, different areas of expertise will be available in different colleges, unlike PSI which should ultimately be available to all, on a local basis.
Question 14
Only one out of the 13 respondents suggested that there were any problems with recruitment and this was stated as a perceived difficulty in giving definite commitment to PS, due to the current political and economic situation. One other college whilst saying that recruitment was not a problem stated that:

'...however, this is complicated by the secondment system and the absence of replacement staff in the service area.'

Question 15
6 colleges had no particular modules that were attracting more applicants than others. A further centre also had no particular bias but stated that this was probably due to the fact that, although in theory applicants could apply for single modules, in reality they tended to be seconded on a three module basis. 3 areas not yet running validated modules were unable to answer this question and one only college specified that one of their optional modules (research based) was not proving to be popular as yet.

Question 16
Selection procedures for PSI were specified by 5 of the colleges. 2 said that the application should be supported by the line manager; 1 required an interview with the college and service staff; another specified the minimum entry requirements (NBS) in their answer as well as referees and an interview; finally one asked for applications supported by a written application to, and successful interview with their DNS, in conjunction with the completion of a satisfactory project from the consolidation course. 8 colleges did not specify any selection procedure.

For PSII all 5 colleges with validated modules required an interview with college and service staff and one also asked for references.
Question 17
5 colleges work with waiting lists, 6 do not and 2 gave no reply (not yet running modules).

Question 18
From the 11 colleges that answered this question the overriding response was that there was no special provision for night or part-time staff. This was then elaborated to say that staff could join the ordinary programmes, 2 centres implying that night staff only had to go on to days to do the theory (the others made no specific comment) and another 2 centres saying that part-time staff could have the modules lengthened (presumably the practice component) pro rata according to the number of hours that they normally worked. This was in contrast to 5 other areas who said that they should go full time for the duration of the course. 2 colleges did not reply.

Question 19
Apart from one non-response and a college who were reviewing the available information all other centres had documents informing staff of what continuing education they offer. Of these 11, 3 offered information only on request and the rest offered a combination of request and routine circulation. Those that circulate routinely tended to do this through the service managers, thereby sending information into all clinical areas as far as they are aware. Whether this information actually reaches all the staff who are interested will be a useful point to follow up, since from the interviews carried out at the end of 1987, it would appear that this is not necessarily the case. Another source for routinely given information in 3 colleges is module 8 basic students who are provided with the information before they actually qualify.

Question 20
In response to the question of a Health Board policy for continuing education 6 colleges said that they had one and 7 did not. The interesting point to note here, is that
within one of the Health Boards that has more than one college, there was not universal agreement over the existence of such a policy i.e. 2 colleges recognise a policy and 2 do not.

Question 21
The policy stated by four out of the five colleges was that of the Auld report and PS. Only one had a completely separate polic, that in fact had been written by a member of the college staff and adopted by the Health Board. Within one of the Health Board's with multiple colleges, it was noted that the policy was to allow each college to develop the two core PSI modules and for each of them then to develop different optional PSI, and PSII modules. This information was given out only on request apart from one college which gave it to module 8 basic students.

Question 22
Of those who did not have (or know of) a policy, 5 colleges felt that there were a number of problems created by this situation. These were:-

1. Difficult to set priorities and obtain adequate funding
2. Difficult to determine which modules to develop
3. It doesn't help us to convince nurses of the importance of continuing education with any degree of credibility
4. Release of staff by service managers
5. No specific funding of PSI

Question 23
The range of proposed modules for development in each of the time scales shown, over all 13 colleges was as follows:-

<table>
<thead>
<tr>
<th>PSI</th>
<th>12 Months</th>
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<tbody>
<tr>
<td>Quality Assurance &amp; Standards</td>
<td></td>
</tr>
<tr>
<td>Selection &amp; Interviewing</td>
<td></td>
</tr>
<tr>
<td>Patient Education</td>
<td></td>
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<tr>
<td>Models of Care</td>
<td></td>
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</tbody>
</table>

192
PSII

12 Months
Care of the Elderly
Orthopaedic
Operating Room nursing
A&E nursing
Neuromedicine and neurosurgery
Plastic surgery / burns

Oncology
Child psychiatry
Peri-operative surgery
Ophthalmology
Psychosocial issues
in infection control

24 Months
Community Mental Health
Rehabilitation
Control of aggression
Peri-operative nursing
Patients with cancer
Patients with HIV / AIDS
Neonatal surgery
Alcohol dependency

ENT
Cardiac nursing
Renal nursing
Understanding aggression
Orthopaedic
Ophthalmic
Surgical

36 months
Care of the elderly
General medical/surgical

As can be seen from this list, longer term planning is mainly in the PSII area. This is because each college will have the two core, and at least one optional, PSI modules within the next twelve months. It is also apparent that within the foreseeable future planned modules are still in the more specialist areas rather than within the more generic areas where a high proportion of staff work (whatever the branch of nursing).

Question 24
There was one non-response to this question, but the other 12 all stated that all modules would be evaluated. 7 said that their methods of evaluation were proving to be satisfactory, the other 5 having no information available as yet. Only 2 colleges had made any alterations according to their findings, one to re-word some questions and the other to redesign an assessment. No-one had made any changes to their evaluation format (as submitted to the NBS).

Question 25
In terms of identifying suitable training areas for PS participants, there was general agreement that areas for
PSI were not strictly identified since each candidate returned to their own ward for the placement. For PSII however, there were more criteria cited since the experience has to be related to the area covered by the module in the first instance, and the right skill mix, level of experience and clinical agreement were also necessary. Placements for PSII are also visited by the NBS and there are criteria specified by them which must be met including adequate staffing levels and adequate provision for obtaining experience. One final factor that was mentioned in 3 areas was the degree of commitment to PS in the area.

**Question 26**

7 of the colleges specified a number of criteria for identification PS placement supervisors. Each of them included two or three of the following:

- Motivation; appropriate knowledge and experience;
- consult with the nurse manager who nominates a WS who then agrees; WS who has received appropriate in-service education; someone with the appropriate qualifications.

One college in particular however stated 'preceptorship' as the criteria for clinical supervision. This involves 'clinical teaching, supervision, counselling and assessment of the performance of qualified nurses undertaking educational programmes', with relevant preparation for the individual.

Of the other 5 colleges there was one non-response, two stated that criteria were being developed and the others merely said that a Charge Nurse is identified as a suitable supervisor.

**Question 27**

Preparation of supervisors was specified in 11 colleges, the other 2 did not reply. Of the 11, 2 merely said that it would be required. Another simply specified 'in-service training', another 4 said that anything from $\frac{1}{2}$ to 2 study
days would be given (this includes the college using the concept of preceptorship). The remaining 4 colleges stated something a little more specific, which included 1 - 2 day workshops for each module; a one week course prior to a PSII candidate being present on the ward plus a study day for PSI; in-service training on supervision and assessment of students; 3 day workshops for each module consisting of preparation of a teaching programme, criteria for assessing competence and identification of learning opportunities.

Question 28
3 colleges were not prepared to be involved in a possible longitudinal survey, one college did not respond and the other 9 answered positively.

Question 29
Only 2 colleges were not prepared to be followed up at interview.

Mailshot 1

For a list of questions, see appendix 13.

Question 1
Courses offered by six out of the eight colleges included in-service offerings as well as some post-basic and post-registration courses. Apart from the bridging course (available in two areas) designed for enrolled nurses, all the rest were offered to staff nurses or ward sisters.

Question 2
All eight colleges plan to offer some form of PS input.

Question 3
1 college intends offering only PSI, another 3 will offer only PSII and the other 4 will offer both. The module subjects proposed include:
PSI
Core modules
Optional modules -
Management roles for nurses
Supervising clinical experience
Standards in nursing care
Systematic approach to nursing
Infection control
Continence
Computer use
Resource management
Teaching and assessing in clinical practice

PSII
Mental handicap modules
Intensive care of the psychiatric patient
Nursing care of the dying patient, and support for the carers
Advanced psychiatric skills
Care of the elderly
Neonatal paediatrics
Alcohol dependency
Orthopaedic nursing

The first three PSII modules listed were put forward by specialised hospitals and represent the three areas wishing to mount only PSII modules. They have each teamed up with a college of nursing in their area to help with the preparation and submission of documents to the NBS.

Question 4
The stage of development of the modules varied quite considerably amongst the 8 colleges. 4 had submissions that were already lodged with the NBS, a further 3 had modules that were still in the planning stage and 1 had no development underway. In addition to this, one of the colleges who was still in the planning stage was pre-testing their modules in situ, prior to submission to the NBS, representing yet another stage of development for PS.

Question 5
Staff involvement with modules was the same as for the Mailshot respondents (refer back to table 21, page 188).

Question 6
4 colleges had a continuing education team (one of which was part-time), but not NBS funded. The other 4 had no
identifiable continuing education team, although one of these did state that they had a continuing education tutor funded by the NBS. This - interestingly - was also the college where no development had as yet taken place on PS modules. Of the other 3 without a team, one used the introductory / management module staff, two others stated that it was impossible without Health Board funding and the other one stated that negotiations were underway with the Health Board.

**Question 7**
In terms of modes of delivery, one college was unsure what was to be employed at this stage of its thinking. 6 others mentioned classroom contact, 2 envisaging this as the sole delivery mode, 2 proposing open learning as well, and the other two proposing a mixed experiential format in conjunction with classroom contact. The other college specified a mixed approach with the foundation being distance learning based.

**Question 8**
In relation to whether the modules should be taken consecutively or not, one college reported being uncertain at this stage since it was dependent upon the collaborating establishment. Of the others, 2 (geographically linked within one Health Board), stated that they would want PSII modules taken as a group of three, but PSII could be taken separately. Another stated the opposite i.e. that PSI could be taken separately, but PSII should be taken as a unit. The rest all said that all modules should be available as separate entities.

**Question 9**
Asking colleges to produce their budgets again proved to be a problem. 4 colleges did not answer and of the 4 that did, the figures varied greatly, indicating that all were not using the same type of information to produce the data. These figures were also compared with those that were
obtained from the NBS, but it still proved difficult to obtain any uniformity or comparability amongst colleges.

In answer to whether there might be sufficient funds for running modules in the future, 2 colleges answered positively, whilst the other two felt that they would not have enough. Of these two, one suggested that the CANO could allocate part of the training budget to this end.

**Question 10**
The application processes were similar to those from the first group of respondents i.e. either through the line manager or by application to the college, or a combination of the two. The one variation was in one of the hospital based colleges where it was suggested that places would be advertised in the press, with applicants then applying through their line manager.

**Question 11**
As these colleges were not at the stage of offering modules the plans for selection of candidates were not specific, except in one case, where only PSII is being offered. They suggested that a selection committee will be established and that 18 months post-registration experience would be required from applicants. 6 of the other respondents stated that they would have some form of selection.

**Question 12**
For the three colleges offering only PSII, they each suggested that the training areas would be those that best met the objectives of the modules. One college did not respond and another suggested joint consultation with the course planning team. 2 offered PSI wards as those that the participant came from and PSII areas as those approved for the modules. Finally, the other college offered a concept of placement based on known areas of 'good practice'. These areas are defined by the excellence of the staff *in situ*.
Question 13
This question elicited a response from 6 colleges. 2 identified potential clinical supervisors as those with motivation and willingness to teach, and one identified experts in the field (for PSII) who are already practising the appropriate skills and have skills in supporting and assisting students. 2 more mentioned areas where staff with appropriate expertise would be available and the final one mentioned staff who will have attended the planned supervisors module.

Question 14
The preparation of supervisors was unsure as yet in 5 of the colleges. One area mentioned study days on request, combined with involvement in the planning team for the module. The area providing a supervisors module would see this as preparation for future PS supervisors. The answers that each college gave reflected the level which they had reached in the planning of their proposed modules.

Question 15
6 replies specified that there is time built into service staffing figures to allow for continuing education. Of the two that said no, one stated that this may change as the needs of the staff change.

Question 16
In relation to part-time and night staff, the availability of continuing education varied. 2 areas offer in-service education; 2 release staff at the discretion of the managers; 2 suggested that they had equal priority with other full time staff; 1 was re-planning provision and 1 released night staff for teaching, with part-time staff having the same priority in selection procedures as full time staff. These replies again suggest that provision for these staff depends on local conditions rather than there being firm policies.
Question 17
There was one non-response to this question, but of the rest, information is available routinely in 5 colleges and on request in one. They each have their own form of dissemination whether through managers or circulars sent to the clinical areas. 2 colleges are reviewing the information that is available at present.

Question 18
Of the (five) colleges of nursing and midwifery who answered this questionnaire 4 stated that their Health Board had a strategy concerning continuing education and only one answered negatively. The three hospital attached colleges were all unaware of a policy, though one did have ratification from the parent Health Board to offer the proposed modules.

Question 19
3 colleges that answered the previous question positively stated that their Health Board policy was still being developed, and that it would be available on request when completed. In the fourth college, there were no documents available but there is a strategy built on the provision of in-service training by staff outwith the college.

Questions 20 and 21
One college did not wish to participate in a longitudinal survey, but all colleges were prepared to be interviewed.

Mailshot 3 and 4
These were the two questionnaires that were sent to the Central Institutions and Universities associated in some way with nurse education. The one college to receive mailshot 3 is running both PSI&II, but the modules are designed to lead to the Community Mental Health Certificate as well as the PS Diploma (i.e. they are run for a very specific purpose). For this reason, and also because the
background logistics concerning funding, recruitment and attendance are quite distinct from the experience of the Colleges of Nursing, it will not be included in the generic statements made concerning PSI&II.

Mailshot 4 elicited responses from the other 8 centres, 7 of which stated that they had no current plans for the development of modules. The one that is planning some modules is still in the very early stages and as such was not able to respond to many of the questions about how this would develop.

**Conclusion**

This set of questionnaires provided a useful body of information. Certain issues emerged, including the economics of running modules, the amount of time that is allowed for planning and developing modules, and preparation of supervisors. The other striking point is the overwhelming diversity of responses from Colleges of Nursing about the questions that have been asked. These issues will be followed up in the Mailshot interviews.

- o - o - o - o -
These interviews were carried out as a follow up to the mailshot questionnaires, in colleges of nursing and midwifery that had, or were proposing to have any PS modules. All DNE's and their continuing education tutors (where included by the college) who had indicated that they would be willing to be interviewed, were included in the study. In addition, a sample of NBS representatives was taken, in order that a balanced picture could be provided of the overall pattern and problems of PS module preparation and provision. In total, this meant the following numbers were involved:

16 colleges of nursing and midwifery
3 hospital based colleges of nursing
5 representatives of the NBS

The interviews were semi-structured, based around a set of core questions (see appendix 16) for each of the groups, but this was not rigidly adhered to if there were salient points that any respondent wished to discuss. This means that the responses are not presented according to what question was asked, but according to which one of six categories the answer relates to. The six categories that were found to be generated by the data thus received were:

1  Budgets / Funding
2  Validation Procedures
3  Production of Modules
4  Running of Modules
5  Professional Studies Effects
6  Other - clinical grading and Project 2000 (P2000)
DNE's

In relation to funding of continuing education, this has provided one of the largest problem areas for the DNE's. Money for continuing education staff is meant to come from the health boards, but this has been translated into between one and a maximum of three teaching posts for any one college. Further funding for back up support or other resources has not been forthcoming. If participant salaries are included in costings, then these become prohibitive. If however, there is no provision for participant salaries, then there is no replacement cost to the service side. This in turn puts pressure on the already short staffed wards and departments who cannot then release staff as they would wish to. A combination of these facts has led to more than one college postponing the start of their modules because there was no funding available. It also means that there is a shortage of staff in the colleges to service the modules and future development is thwarted due to lack of time:-

"The stumbling block is getting agreement locally with health boards to fund continuing education."

"The problem isn't in fighting for funds because we have absolutely no structures open to us to fight for funds."

"For some of our modules, we have excellent lecturers coming in and obviously they have to be paid. But nowhere do I have an identified budget for that. A claim goes in and presumably they do get paid, but nobody has said how much do you need."

"We have other modules developed that we can't run because of lack of staff."

Some colleges that have in the past run post-basic courses, have developed PS using this money but that is not guaranteed for the future, and they do not appear to be any better off than other colleges in terms of resources. The suggestion that a standardised method of costing might help in these matters met with a modicum of approval, though for
those areas that do not actually have the budget in their hands, it was suggested that this would not make any difference.

The most frequent suggestion was that the NBS should take responsibility for funding. This had been raised as a future possibility when the modules were first proposed. All education would then be under the same direction, which would make the whole issue more manageable. The NBS monies would be used for staff and college resources, and it was suggested that the health boards should continue to be responsible for the salaries of participants. There is currently, use of college resources that are technically there for the basic courses, but are used on a 'grace and favour' principle for continuing education:-

"If the NBS supplied the tutorial and clerical support, then the health board could pay the students."

"Unless the funding is taken on by the NBS, I can't see us getting what we want in this financial climate."

"It would be helpful if the NBS held the money for continuing education, because it would then be more professionally and educationally driven."

There were no positive comments about funding from any source.

NBS

The problem of funding was well recognised by the NBS representatives, with it being drawn to their attention mainly with respect to employment of more teaching staff and ability to develop more modules. This information tends to be picked up incidentally however. In theory by the time modules are submitted to the NBS, they have the signature of the Local Training Committee which should mean that adequate funding is available. Also, they find evidence contained within the diversity of responses in the submissions, relating to the estimated cost of modules. These vary from the sublime to the ridiculous, and from
this point of view, some more standardised method would be useful for producing the figures. One problem attached to this, is that in some cases the health boards require a different type of costing from the NBS, so that the colleges would still have no standard procedure to follow:-

"Some costings were incredibly cheap and some expensive, and we as a Preview Group didn't know which was correct."

"If you see different costs, then the general manager will ask why one is so expensive compared with another."

"Funding in colleges tends to depend on who is convincing who at the time."

The fact that colleges have found it difficult to get money to run modules appears to have produced differing responses. Some started running modules, determined to get the money from somewhere and others 'felt as if they were locked in combat' with their health board, and would not start their modules until they had funding.

The issue of taking the funding into the NBS, was advocated by the respondents, but it was recognised that there had been problems with this proposal. The use of basic education resources, although not strictly proper was known to occur and from this point of view, a centralisation of funding would stop the conflict of interest and provide a more cohesive picture.

The initial proposal at the beginning of the continuing education development had been for the NBS to take over the responsibility for finance. This in turn may have generated one of the problems that is now apparent, since this impression was passed on to the colleges, who are still waiting for it to happen. The reasons behind the failure of the NBS to be given the funding are not precisely clear and relate to various factors, including the introduction of general managers, other health service changes and perceived changes in priorities at the NBS itself. It is
possible that this position might still alter with future changes in the health service and more particularly with changes in nursing education.

The shortage of funding also affects the NBS in terms of continuing education. Initially there was only one full time officer working on the developments. This changed however at the beginning of 1988, when an additional professional adviser was seconded to the Board, for a two year period (with a specific remit to deal with PS). There has always been a case for making the job a permanent post, and plans for this are still being pursued. There were also a certain amount of study days / workshops mounted for education staff. This exercise was limited however, by financial and more specifically, resource constraints, although it was recognised that they provided a useful forum for dissemination of information.

2 - Validation Procedures

DNE's
Of those who had been through validation, two comments that came up frequently were a) that the process takes too long, and b) that the rules seem to change all the time. These comments were being made for the most part in relation to PSII. The length of time taken that was quoted most frequently, was two years for a PSII module and it was felt that this was too long. Problems associated with this were related to turnover of staff that may occur between submission and validation - therefore making the teaching team less viable, and the fact that funding agreements made in relation to a particular financial year were no longer valid.

The specialist panels were mentioned as being a particular problem in the PSII process for various reasons. The fact that they could not always meet with any regularity; that any one panel could have a number of members, not all of
whom would meet on consecutive occasions, thus making it difficult for a consensus of opinion to be reached; members came from different health boards and they each put their perception of their own health boards needs into their appraisal of the submission in hand. These did not then necessarily coincide; there is too much individual interpretation. It was even suggested in one place that the panels were looking for repeats of the post-basic courses.

"Too slow. It's not nearly responsive enough to the needs of health boards. Even if it's nine months, that virtually always puts you into a new financial year."

"Interpretation of the guidelines in a different way by different people seems to be a problem in validation, especially for PSII."

The fact that rules had apparently changed, were partly acknowledged as being due to the NBS learning what processes were going to be the most effective. Others though, merely saw this as being unfair, and creating a situation that was not strictly uniform across the colleges. It was also felt that if you made changes that were requested at one meeting, then when you re-submitted other problems were highlighted. The suggestion was made that the NBS should be more prescriptive, especially in relation to PSII modules:--

"The goalposts seem to move. For instance everyone knows that nine weeks is the average length of module and a specialist panel has suggested lengthening one set, and service are very angry because of the implications for the release of staff."

"The rules have changed which was not always beneficial to those submitting early. Other colleges are now allowed to move with proposals not allowed initially."

"Getting things through the CNAA doesn't seem to be half as bad as it is to get through the NBS."

All these negative points were counteracted slightly by some colleges that had had no particular problems, though this seemed to be related to having consulted the Board
during the preparation of the submission. Some colleges also felt that validation for five years was a good length of time.

One suggestion for a remedy to some of the seemingly insurmountable problems was that a forum for all those involved in PS development would be beneficial. This could promote discussion and learning between staff who had had successful submissions, and those who were still having problems or were just about to start:

"It's a shame there's no forum for people who are involved in these modules, to learn from each other and look at each other's submissions. It may save the NBS time in the long run."

**NBS**

The validation procedures had their origins in a combination of two systems, brought together when the NBS was formed. One was that of the old post-basic courses and the other was one that the Board proposed. It was hoped that a generic system of validation for all levels of courses within the Board's domain could be produced and there had to be some negotiation to try and find the most suitable for PS. There were some conflicting interests at this stage, but from within this the present system evolved.

"It is educationally sound that someone should be looking at the structure of modules and seeing that it fits in with the agreed parameters and guidelines."

All modules come to the preview group, and PSI is dealt with at this level. For PSII, the modules are referred on to the specialist panels at this stage, unless there are major problems picked up. If there is not enough information, then a lengthy correspondence can ensue. The lack of information can either be due to the fact colleges simply have not written in enough of their rationale - rather than it being a lack of planning, or due to information being missed out that is requested in the guidelines. The progression of the module then becomes very
dependent on the written communications that occur in both
directions. The college may be invited to a meeting at the
Board if there are major problems, but this does not always
get things sorted out:-

"Sometimes documents come in short of vital
information that is outlined in the guidelines, and
just hasn't been included."

"Liaison needs to be fostered more closely between
the NBS and planning groups at an early stage -
though this is dependent on time and resources
etc.""

In the final instance modules are recommended to the Post-
Basic committee for validation, rather than having to wait
for a meeting of the full Board which was the original
arrangement. This has saved some time on the overall length
of the process.

3 - Production of Modules

DNE's
The production of modules within colleges elicited a wide
cross-section of responses, dealing with issues ranging
from staff and resource difficulties, to the apparent lack
of modules for psychiatry and mental handicap nursing.

Resourcing is obviously linked up with funding, and again
mention was made of the use of basic resources - from staff
to overhead projectors, although this should not strictly
happen. It was not seen to be satisfactory, and was felt to
be an added pressure on module production and delivery. The
usage stems from the fact that there is a shortage of
resources dedicated to continuing education. The fact that
every area had produced the core modules for PSI met with
query from one college, due to the duplication that this
engendered throughout Scotland. This duplication leads to a
large demand on staff time and resources, which could be
utilised more effectively. This comment was made however,
in the face of the fact that, that particular college and
others too, mentioned that the NBS guidelines had been good in promoting flexibility and local variations:--

"We have to turn down requests for modules, because there is no staff time to deal with them, let alone run them."

"There is a heavy use of resources and they really belong to basic, therefore they get first shout."

"People seem to have made adaptations to meet local needs."

"If we run the modules and then review the situation, it may be that we'll be able to continue and may be that we won't. I feel then that we will be able to say why we can't and make a case for it."

In relation to the provision of modules as separate entities, some colleges programmed potential participants on a one module basis unless told otherwise, whilst others organised participants to do sets of three. The choice was based on the perceived needs of service colleagues. The service / education liaison was mentioned as a positive facet of this initiative, although two comments pertaining to service involvement were interesting. The first concerned the lack of dissemination of information through the managers to staff, and the second related to some areas of service that had not as yet realised the potential of PS. These were isolated comments about specific situations, but revealed that there are some areas still to be resolved between service and education staff:--

"Where someone directly indicates to me that they wish a nurse programmed for three modules then I'll do it. Otherwise I will assume that the manager wishes to do it on a one module basis."

"Service would rather have 20 people with the PS Diploma than 60 people who had done isolated modules."

"There are still some areas who haven't latched on to PS."

The subject of modules was the final area of concern for colleges. Dividing up some PSII subjects and creating discreet modules was not always easy. The suggestion of
having one core module for an essential theoretical component, with two optional 'satellite' modules was offered as a possible solution. Choice of areas for future module production related to general medical and surgical wards, as well as psychiatry and mental handicap, as these had not been addressed as yet. The subject areas served by PSII to date, are nearly all within the domain of previously existing post-basic courses. Geographically isolated colleges also felt the need to be self sufficient in modules due to the difficulties in sending staff to other health boards.

"We are concerned with basic medical and surgical areas so that they don't feel sort of neglected, left out and stuck, and perhaps lose out in things like gradings, promotion and so on."

"It can take just one whizz-kid consultant to hit town and suddenly you've got a whole area of speciality that we hadn't thought of before."

NBS

The main areas of concern for the NBS were the use of the guidelines, the service / education liaison, and resourcing.

The guidelines for modules were produced out of a service / education based set of discussions through the post-basic committee. Some colleges have had no problems in following them, whilst others are still not able to use them well. Some of the biggest problems come from areas with old post-basic courses. At times, colleges appear to try and cut up existing courses into three parts, instead of creating modules. The desire of some colleges to have more prescriptive guidelines is also recognised, but this is set against those who see them as a basis for flexibility. The opportunity for this type of continuing education was particularly welcomed by areas without existing CCNS courses, as this would give them a chance to develop local provision to some degree. Modules submitted to the NBS for possible validation sometimes show obvious signs of misinterpretation of the guidelines. Others arrive as a
'bulk' submission. If a flaw is found in one, then this means that all the modules contain the same difficulty. This becomes expensive on everybody's time and resource:-

"You often get the same lack of explanation, but it is in the document although maybe not as a set of specific instructions."

"Some colleges had no problems following them [the guidelines] and are producing marvellous, innovative and exciting modules."

"They wanted to cut the course into three rather than modularise it. It was like a bereavement to them."

To help the education staff with the understanding and acceptance of the new guidelines, a series of workshops were held at the NBS for discussion to take place. This effort however was strongly affected by the resource implications, as it was time away from work for a number of people, plus travelling costs. This same problem also affected the Board in relation to providing any other support, which it is recognised could have been beneficial. In addition, there was only one Professional Adviser in the beginning for whom there was too much work in relation to all the development across the colleges. Also, the committee members all had other full time jobs, which meant that the time available for getting the system running smoothly was short. It is argued, that there should perhaps have been more time spent in the initial stages on the acquisition of adequate resourcing for this initiative, but a lot of work was done on the understanding that if the demand was proven then support would be forthcoming. This has not happened as was hoped, and with P2000 on the horizon, the problem is not a priority at present:-

"It's possible that it's been a mistake to battle on and get things going, because now some things are working, then it's easier to ignore the problems."

"Looking at the numbers of modules developed and the amount of both NBS and college staff to deal with them, then we may have gone too far too fast."
"More support could have been offered by the NBS to colleges but it didn't happen because of the shortage of resources."

Liaison between service and education staff in module development, is recognised as being a problem in some areas by the NBS. The extent of the liaison is apparent through the submission, and if there are perceived problems, then these are confirmed when visits are made to an area. Sometimes, service staff do not have the knowledge that they should have, or ask questions which belie an understanding of what has been presented. Apart from the problems that this can create in relation to commitment and understanding of PS, it shows that the choice of module subject has not necessarily been because of a service led demand. This can then lead to problems:

"There needs to be more dialogue about the perceived need of service providers and the educationalists, not just education for the sake of it."

"There isn't always a wide staff involvement - you can tell when you do visits that there has been a quick briefing beforehand."

4 - Running of Courses

DNE's

Major factors in the running of modules are the numbers of students from the service areas and their release from the wards; the supervision of students; and the development of open or distance learning.

Starting with the promotion of the modules in service areas, information is passed on through the managers and also module 8 basic students in an official way, although word of mouth has helped to inform a large number of people. This seemed to help at the start of running modules, as some people attended and then went back and told others about what it was like. Applications to attend modules have to be supported by the nurses' manager, and
then comes the problem of being released from the ward or department (see above). Waiting lists are used in some areas to alleviate the uncertainty of knowing when staff will be able to attend. Although most of the applicants and participants are staff nurses, there are some ward sisters who are interested in doing PS — both I and II. Staffing levels are obviously critical in the release of staff, and the number of modules offered by colleges in any one year are governed (certainly the maximum number) by what capacity the hospitals have for staff release, in conjunction with the resources available at the colleges. Concern was expressed by one college that the possibility of a member of staff being released to do PS, was to an extent dependent on the relationship that the nurse has with their manager:—

"We work out attendance for PSI in conjunction with the service side for any individual."

"Word of mouth helps to fill courses, especially options that maybe didn't appeal to start with."

"PS should be open to all qualified nurses."

Supervision of participants was recognised as being a problem, more so for PSI, since this covers a much larger and more diffuse amount of the clinical areas. Comments about how difficult it is for college staff to visit all students whilst on placement, and having to convince supervisors not to feel threatened by the participants just because they are on a course were not uncommon. Mention was made on a number of occasions of the ECNM which (depending on whether the area was running it or not) was either used in the preparation of supervisors, or was being considered for this reason. It is interesting that the value of this particular course is just coming to be recognised now.

The problem with providing continuing education for all staff prompted a lot of comment about open and distance learning. There was also a lot of misinterpretation of the use of the phrase open learning, in that it was used to describe the way that activities were carried out in the
classroom i.e. student centred learning activities. Use is being made of already existing distance learning packages, incorporated into some modules held in college, but the development of materials by colleges themselves was seen to be impossible within the resource and knowledge constraints that obtain. Without some kind of open or distance learning in geographically diffuse areas, continuing education could never really be available to everyone:-

"We are using an open learning pack in one module but we would like to develop our own if we had the resources."

"One problem with distance learning and others who practice in their own area is that people may forget that you're actually on a course."

NBS

The recognition of the problem about the preparation of supervisors has been addressed by the NBS. Although the report of the ECNM (Whiteley and Broomfield, 1987) highlighted the fact that not all charge nurses are properly prepared to meet the demands of supervision, additional information was requested and this is currently being sought. Until the information is at hand however, the problem remains that supervisors feel threatened by somebody on a course - even though they may have years and years of experience:-

"Most supervisors have a lot of experience, but as everybody does, they feel threatened by somebody with a wider theoretical knowledge."

"You need to build on what you have and the evaluation [of the ECNM] says that the course meets a need."

Other comments relating to the running of courses were about specific issues. Mention was made of the length of modules and the fact that there was no set maximum time. Also, even though seven weeks for a placement is quite short, in the specialities people will have been working there for a while anyway, and the module should be providing a 'top up'. The release of staff onto modules was recognised as being an individual process, dependent
upon the needs and constraints of the service. The practice of doing modules ended on was questioned however, in that some time for consolidation between modules was felt to be beneficial. This was based on the fact that there had been some observations that an individuals' competence at the end of a module was dependent on their previous experience, and initially (on completion) competence could be quite basic. It was noted however that managers sometimes seemed more able to let one person go for 27 weeks, rather than three people go, each for 9 weeks.

Finally, the NBS would like to see the development of open and distance learning, though they recognise that neither they, nor the colleges have enough resources to do this. There is a concerted effort in one college to develop open learning, but money for packaging and promotion is a problem. Plans are being discussed however, for a link to be established between the college and one of the Scottish Central Institutions who are interested in, and willing to provide support for, the scheme.

5 - PS Effects

DNE's
Delivery of continuing education using PS as a vehicle was recognised as being a good method, especially if there were enough resources and staffing to service it. This does not mean that it is necessarily the best method, but it is the best that is available at present. Reasons for this included the fact that if it was left to each individual area, then everyone would be going in different directions, and it provides opportunity for all staff, instead of just those who could afford time and money to do the Diploma or open university courses. The provision of PS by a college is seen as important, based on demand coming from staff. In those areas that are not providing modules yet, there is the fear that staff will move elsewhere if their needs cannot be met locally. One problem with this at present is
the inability of staff to pick and choose modules across health boards. Not only are there not enough modules available yet, but secondment between health boards is not really established. Another drawback was deemed to be the lack of recognition of the PS Diploma within the general education system. A lot of respondents talked about the possibility of getting some form of accreditation and using credit accumulation to acknowledge the value of PS in the wider field.

"If we don't offer something like that - or any area that doesn't - they are going to have staff who will walk."

"At the moment it is the only method and we are trying to make the best of it. It's much, much better than the old courses."

The use of the annual staff appraisal was mentioned as being valuable to put forward people with the potential to develop. This links in with a comment made about PS being a platform for promotion for those who have the Diploma.

"It's value in the long term will be in the preparation of the staff nurse for promotion."

"It won't affect them at all if there is no improvement in the assessment of those people by their managers."

Concerning any effects that the modules might have had on participants, there had been some feedback about this, a lot of which related (not surprisingly) to PSI. Comments centred around issues such as greater confidence, greater perception of others needs and a greater ability to cope. Positive comments had also been made about PSII some of which were in relation to the increased knowledge of the individuals. It was noted that if there are no improvements in the staff and therefore hopefully in patient care, then there is no point in pursuing the exercise. One slightly more cautious comment pointed out that feedback about the modules was tending towards the positive, because of the dissatisfaction with what was available before:-
"If the quality of the courses is high enough I can't think that it would be anything other than beneficial academically and professionally for the person."

"I have had spontaneous comments from the ward staff that they had noticed that the S/N's were more willing and able to communicate with patients and things like this."

NBS

Effects on participants are harder for the NBS to pick up because they do not have a close connection with participants. However, from feedback that they had received, the impression given was that there is a positive response by participants in terms of motivation to undertake the modules leading to an opportunity to develop their careers. This motivation was thought to be a good investment for the future as well, since it should promote a degree of self-reliance in the individual for pursuing further continuing or self education. One problem that was perceived however, was the effect that the shortage of resources could have on staff motivation. If requests for attendance were being denied because there is no funding or someone else is already away, then motivation will fade in the face of constant denial:

"It's very difficult to measure the effect that it's having on patient care, but there's a feeling of change for the better."

"If there is no increase in patient care then we would have to ask what we were spending our money on."

The other issue mentioned in this section related to the prospect of credit accumulation. This was recognised by the NBS in the same way as the colleges, and was felt to be an important point. The awarding of the Diploma in PS at present was seen to be a good thing however, because it is important to have some form of recognition for this type of education. If a strategy for credit accumulation were to develop, then this would leave the capacity for a flexible approach in PS content to occur, whilst the overall strategy remained constant.
6 - Other: clinical grading and P2000

DNE's

Comments about P2000 - a national plan for nursing provision in future years (UKCC 1986) - merely said that only preparatory work, if any, had been carried out as yet because it is difficult to know what to do when the national policy has not yet been publicised fully. There was one comment that said that it would be good to see PSI disappear into basic training within P2000, because then they could just concentrate on PSII.

"We're just beginning to look at what it might mean. We'll get on with it once we know what the parameters are."

Clinical grading refers to a new type of nursing pay scale (designated from A to I), introduced by the Government in 1988. It concerns the grading of all clinical posts (from nursing assistant to clinical nurse specialist) which nurses then occupy, and for which they are paid according to the 'value' of the post, not according to what qualifications or experience they may have (though certain qualifications and experience may be required for a specific post e.g. a ward sister in an intensive care unit). In terms of the responses from the colleges, the whole issue proved to be a fraught area. The overall impression is that people see a link between PS and grading, though there are two sides to the issue. The positive side is that PS I or II could help individuals gain a more highly graded post in promotional or specialist terms. The negative side though is that because of the mode of introduction of the whole system, there are many people who think that just because they have an additional qualification - be it PS or any other - then that should automatically qualify them for a higher grading. This is the situation where, the fact that it is the post and not the person who is graded, is not being appreciated. Two other comments, one positive and one negative highlighted other important issues. The negative point was about the
possible difficulty with supervision in the clinical areas. It was seen that if charge nurses were graded at F (the lowest charge nurse grade), then they may not be willing to act as supervisors. There is no hard evidence to suggest this at present, but it is worth noting. The positive issue was that if you do need qualifications for a post — and you do not already have them — then it should be easier to get them through this modular system, compared with having to take a 52 week course.

"It is important not to give nurses the impression that a bit of paper is the be all and end all — it qualifies them to do the job they are employed for and doesn't automatically qualify them for a higher grade."

"The whole area is fraught with difficulty and managers are scared stiff to identify any qualification as a pre-requisite for a job, because it might mean that they have to put the job at a higher grading."

NBS

PS in relation to enabling P2000 was seen potentially to have great significance in Scotland. It was thought that the timing of PS had been fortuitous, although continual development is still necessary. The preparation that staff nurses are getting with these modules was seen as being beneficial when it comes to supervision of the proposed new style of learner, in addition to the fact that nurses in the future will still continue to need post-basic provision. The other issue concerned finance, and the possibility that continuing education might benefit in relation to this, from the introduction of P2000 (whether in the form of PS or not).

Clinical grading met with the broad comment that it was not the Board's domain and the two areas i.e. continuing education and clinical grading should not be linked. It was recognised though that there will be certain times when a post demands a specific qualification, but this is based on a particular service demand, and not on the fact that
someone has a qualification therefore they should be graded accordingly. These are the same two arguments that the DNE's had:–

"What grade you put people on is a service management decision, nothing to do with the preparation of education courses."

"There will be situations where a post demands certain knowledge, skill and accountability etc. and this will then demand a qualification and then you make sure the person gets appropriate training, not you have the training so we'll pay you more."

"I can't think of any other profession where they train people and then they stop and don't think that they are on the first rung of the career ladder."

Conclusion

In presenting these results, it is hoped that an illumination of both sides of this continuing education initiative will have been achieved. There are obviously several ongoing problems, most of which – though not all – stem from a shortage of funding and resources. Both parties i.e. the colleges and the NBS have their own difficulties, and it would seem that the NBS is aware of most of the difficulties that the colleges have. This is to be commended, though there are apparently some areas where the colleges still do not feel that the Board is providing enough information or support.

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At the time of reporting, the number of pre-course Logs (see appendix 17) that have been returned is twenty four, from two groups of the sample for PSI (there are no post-course Logs as yet). There will be a third set of Logs from a PSI group in the future, plus a fourth set from one half of the PS comparator group. Development work in this area is therefore ongoing. The results received thus far however, are positive and have provided a useful baseline of information of the type predicted for this instrument.

Of the Logs received, fifteen are from one area, and nine from the other. The total numbers involved in each group were nineteen and twenty seven respectively. The small response rate from the second area was partly due to the mismatch of names supplied, compared with the actual participants on the module. This was an unavoidable occurrence, but is indicative of the type of logistical error that can occur in this particular mode of enquiry.

The calibre of response was high in the Logs returned, in that the situations described were the everyday occurrences that happen in the ward situation, and not just unusual occurrences that the respondents as staff nurses, would not be expected to be able to cope with on first encounter. In terms of the Log acting as a needs assessment instrument at the level of PSI, the types of problems indicated are consistent with the input that the staff are about to receive. One of the striking things about the reported observations was the amount of insight that the respondents had as to the possible solution to the situation. They had been asked to provide a possible solution to see if they had an understanding of their situation beyond the factual content of the events. This seemed to be the case in most instances, the solutions offered being a translation of the
factual component of the situation into a more conceptual framework e.g. of communication problems, or lack of assertiveness. There were one or two instances where this was not the case and it will be interesting to note if there is any shift of emphasis in this area from the follow up Log.

The examples that were reported included:- encounters between the respondents and student nurses or other junior members of staff, where they felt unable to deal effectively with what they saw as inappropriate behaviour; miscommunication with medical staff; problems in dealing with relatives; and the inability to answer questions from patients either due to lack of knowledge about a specific condition or because they did not know if they were 'allowed' to give them certain information. Some of the situations described were out of the control of the individual, in that they were due to larger concerns, such as shortage of staff, lack of communication from another source, or shortage of resources.

Of the responses received, one problem that was cited in every case, relating to a variety of situations, was a lack of sufficient communication and counselling skills. This comment was made in relation to other members of the nursing staff, relatives, patients and other hospital staff. Instances were cited where the individual felt unhappy with the outcome of a situation, either because they had not handled it at as they would have wished, or because they were put into a situation not of their making, that they tried unsatisfactorily to deal with. Two examples are shown in table 22 overleaf. Neither example represents an uncommon occurrence, although they are situations that are never easily dealt with. Given that the staff who reported them were about to receive some PSI input however, they are indicative of the type of situation that could be addressed.
1 A nurse was continually arriving late for shifts. Although the staff nurse took her aside to speak to her about the situation, she did not feel that she made any inroads into the problem.

2 A patient on the way to theatre was questioning the meaning of the procedure he was about to undergo. The nurse felt that these issues should have been addressed before this point either by the medical or nursing staff, but given that they had not, felt inadequate in dealing with the situation satisfactorily.

**TABLE 22 - Nursing Log Examples (1)**

It was also recognised by some of the respondents that more experience would help in dealing with these difficult or uncomfortable situations. This is an interesting point, since it was found during the ECNM evaluation, that the members of the comparator group felt that they had achieved their ability to practice in a competent manner mostly through experience. The need for continuing education in any area was not specified, and they could not think of things that could be helped by an educative process (see page 114).

The next most common problem related to knowledge about medical conditions / situations and specific policies for dealing with certain occurrences. Sometimes, this then linked in with the counselling issue mentioned above, but at other times was seen as a learning situation for the individual. Possible solutions that were suggested included looking up the answer to factual problems, or becoming more assertive when the situation arises in finding someone in situ who does have the relevant knowledge. For example:-

1 Students asking questions in a tutorial that the respondent could not answer, thus creating a need to go and read about the subject a little more.

2 Being confronted with the death of a patient whose relatives lived a long way away, and therefore having to deal with the immediate issue of registering the death, but having no knowledge of how to do this.

**TABLE 23 - Nursing Log Examples (2)**
The reverse situation was also quoted in one situation, where the individual felt that she had the knowledge, but was afraid to say anything, as it was a doctor who was having difficulty in dealing with the situation.

Finally, issues that were mentioned less frequently included a generic need to be able to deal more ably with the medical staff, more support for staff working in the wards, stress reduction techniques, a better understanding of professionalism and there was one mention of an ethical dilemma. The bulk of the problems therefore lay in the communication and counselling side of the job, rather than with specific needs in relation to specialist knowledge. It remains to be seen whether the input from PSI will help with these.
PART FOUR:

THE PRODUCT
CHAPTER 19 - THE PRODUCT

Introduction

This chapter is entitled 'The Product', to describe the fact that the structure of the proposed model of evaluation will be presented here. Unlike the course of a positivistic report, there is no 'discussion' to follow the presentation of the 'results'. More fitting to this phenomenological type of study, is a conclusion to the continuous dialogue that has occurred throughout the preceding chapters.

Many issues have been raised, including reasons for evaluation, the different aims of continuing education, the lack of straightforward methodology for evaluation and most importantly, the need for a conceptual framework to structure evaluation. It is now necessary therefore, to put various pieces of data together, and explain the overall picture that has emerged in the course of this research.

The proposed aim of this study has been to produce a model of evaluation for use with continuing education courses in nursing. At this point, the groundwork has been described, through the presentation of relevant themes in the literature, followed by a description of the methodological design and approach, and concluding with a set of results obtained by putting this theory into practice. To put this process into perspective, the following comment made by Gosnell (1984, p.9), sums up the situation:-

"Evaluation of continuing education is a very complex issue. What is to be evaluated - participants, curriculum, or climate? How? Why? When? By whom?"

Or, put even more simply by Abrahamson (1984, p.19):-

"Evaluation is a simple concept, but a complex process."
The point that is being made here is that even with a model for evaluation, there are no easy ways for it to be put into practice. This means that the framework provided by the model has to be explicit whilst providing flexibility, and structured without being prescriptive. If this can be achieved, then a framework is provided within which to answer the type of question broadly addressed by Gosnell, or more explicitly posed by Kogan (1984 – see chapter 5, page 45).

Evolution of a Model

In beginning this study, the only frame of reference available was the literature that has already been reviewed (see chapters 2 – 5), plus the evaluation reports of work that had been carried out on other nursing courses (see page 6). None of this literature was seen to be specific enough to dictate how the current evaluations should be carried out, and for this reason new work had to be formulated.

For the evaluation of the ECNM, a methodology was devised that closely followed the principles of Illuminative Evaluation as suggested by Parlett and Hamilton (1972). Through studying their paper, the principles that underpinned the concept seemed to be apt (because of their flexibility) for the continuing education setting, and also provided a fresh outlook on evaluation that would allow for the 'human component' to be taken into account. What is meant here by the human component, is the concept that where a process is occurring that has as an integral part of it human participation, then this fundamentally affects how it can proceed and succeed. Indeed, the whole ethos of the nursing profession is based in this component, both in the delivery of and the receipt of care. Continuing education in nursing therefore, has a particular interest in this concept, since both the undertaking of continuing education and also what happens with the results of that
education are dependent on the 'human component'. In evaluation terms therefore, there was the utmost need to take this into account. Qualitative techniques and a non-prescriptive research approach had to be the answer, rather than rigorous measurement and testing of potentially spurious objectives. An interesting comment about what could happen if too much emphasis is placed on performance testing comes from Kogan (1986, p.143):-

"The extreme possibility is that knowledge of what is will anaesthetise our powers to distinguish from what ought to or could be."

On the other side of the argument generated by this choice of approach, was the need to ensure that what was being reported through the evaluation did not merely become what Abrahamson (1984, p.6) called a "happiness index". He used this term basically to describe participant satisfaction questionnaires that are, more often than not, given out without much thought at the end of a programme, for participants to complete. Whilst more instruments were to be used than just a post-course questionnaire for this study, it is important to remember that information needs to be gathered that can be analysed and not just fed back in a purely descriptive form as 'proof' or otherwise of the worth of a programme. As stated by Wolf (1987, p.8):-

"The mere collection of evidence does not, by itself, constitute evaluation work. Yet uninterpreted evidence is often presented to indicate the presence (or absence) of quality in an educational venture."

The example given by Wolf of how misunderstanding can arise through uninterpreted evidence, is one where high school dropout rates are used as a straight index of programme failure. If taken at face value, this is not an unreasonable assumption to make, but with other supporting evidence to put the figures into perspective, there can be alternative explanations. It may be that students dropped out because they successfully found employment, or moved on to higher education, either of which could be due to
positive teaching already provided, in the programme that they have 'dropped out' of. Both of these alternative explanations are very positive indicators about programme success and not, as was assumed in the first instance, evidence of failure.

Keeping these points in mind, the methodology for the ECNM was designed and executed in order to answer the questions defined at the outset. The questions posed were not highly specific in relation to particular outcomes, and were certainly not behaviourally orientated, although behaviour was one of the areas of interest. Thus there were pre-determined guidelines for the evaluation, which merely served to guide the work rather than dictate it. Certainly, Scriven's Goal-Free Evaluation (1972 - see chapter 2, page 18) was not being attempted, but the point being made is that it is possible to set broad objectives for an evaluation without being prescriptive about the programme of work, or what is to be included.

Having developed particular instruments to be used in the first evaluation, this facilitated the move to the second more complex set of modules. The results gained through the use of the procedures on the ECNM, were satisfactory enough to allow the same type of thinking to be used again for PSI&II. It became apparent however during this transition, that there were more issues to be considered than had been foreseen at the very beginning of the research. In planning the second evaluation the methodological basis to be used was still that of Illuminative Evaluation, but it was becoming obvious by this stage that other issues were arising that would need to be incorporated into a model.

With the expansion of the work to encompass the larger initiative of PSI&II, there was a lot more monitoring work to be considered. This was not an entirely unexpected situation. In terms of the large scale of the PS programme across Scotland, monitoring represented a more systematic
look at the context of the modules. This was not only in terms of the instructional system as outlined by Parlett and Hamilton (1972, p.14), but also for the wider field of programme initiation and implementation. Monitoring was a new step forward, and if it was to be synthesised with the evaluative strand of the work, then a suitable framework was needed to make sense of the whole.

The framework that presented itself as being valid and applicable in terms of synthesising the differing facets of this complex compendium of data sources and progressive focusing, is one that is also being used in the field of quality assurance. Its origins are attributed to Avedis Donabedian (1966), who proposed that in evaluating the quality of medical care there were three categories of information to consider. These were:-

1 Structures
2 Processes
3 Outcomes

In discussing the quality of medical care and how it could be assessed, Donabedian suggested that the most widely recognised indicator of good or bad performance was the outcome e.g. the restoration of an individual back to the quality of life that they enjoyed prior to illness, or as an extreme case of bad practice, surgical fatality. He went on to consider however, that not all outcomes lend themselves to straightforward assessment or measurement. Another approach therefore could be the consideration of the process of care - what is actually done in the practice of medicine and not just what the results are. He recognised that the two were interlinked, especially as the outcomes would be dependent on what processes had been used to achieve them.

Finally, Donabedian (1966, p.189) suggested that a third approach to the assessment of medical care would to be to:-
"...study not the process of care itself, but the settings in which it takes place and the instrumentalities of which it is the product. This may be roughly designated as the assessment of structure."

These three categories have been used in quality assurance, to promote the setting of standards, by which the level of practice can be monitored and assessed (see for instance Kitson 1987 or Baskett 1987). In setting a standard, a particular aspect of practice is chosen for the care group under consideration, and then the optimal way to achieve this is defined by the practitioners concerned. The topic is defined within the three categories of structure, process and outcome so that everyone involved knows what is required for that situation. Structure represents the physical conditions that are needed to support the care e.g. building space, numbers of staff, and knowledge base. Processes are the methods by which the care is given, and outcomes represent the desired effects which these processes should have. The model is symbiotically linear, in that each component is dependent on the preceding characteristic. Improvements in either of the first two categories should lead to an improvement in the third.

In relation to the evaluation of continuing education courses, the almost alarming clarity that this framework gave to the comprehension of how all the different facets under study had been chosen was startling. Any continuing education initiative will have elements of all three categories, and information can be collected for each of them, which ultimately when put together should illuminate the complexities of the whole. There is one major difference in the application of this process to evaluation however. In evaluation, it is standard definition and not standard setting that is happening. Through data collection and analysis, the elements of the three categories are described and the standard deduced. It is a process of investigation and not affirmation. The evaluator must use the framework proposed to discover what exactly is occurring in the field, and then apply this knowledge to
answer the questions that are being asked. A diagrammatic representation of the Structure-Process-Outcome Model that embodies this framework is shown in figure 26.

![Diagram of the Structure-Process-Outcome Model]

**FIGURE 26 - The Structure-Process-Outcome Model of Evaluation**

In proposing a model there are three distinct stages to be considered if it is to be used successfully to facilitate an evaluation. In preparing to begin an evaluation, there is the first stage of deciding where to start in terms of what questions need to be asked and therefore what information to collect. No model can ask the specific questions about a particular project, but it can outline the broad areas for concern. Once these have been defined, the second stage is to use the model to provide the framework within which to answer the questions. The third stage concerns the methodology of application. It is no use having a structure without knowing how to implement it. An analogous situation would be acquiring a game of chess and
setting out all the pieces, but not being able to play because there is no knowledge of how the pieces should move. If you have a plan for an evaluation, you must be able to action it. These three processes will be described now, using the context of the evaluations previously described as an exemplar.

The Model in Action

To recap, the first thing to do in starting an evaluation is to consider the who, what, how and why of the situation:—

1. Why is the programme to be evaluated?
2. Who is to carry it out?
3. Who is to set the criteria for evaluation?
4. What are the criteria?
5. Who is the evaluation for i.e. what audience(s)?
6. How is the data to be collected?
7. How long is it to take?
8. What form will it take?

TABLE 24 - Questions Preceding an Evaluation

In terms of PSI&II, these questions were answered as follows:—

1. The NBS as the sponsoring body wished to know the effectiveness and value of PSI&II
2. An independent nurse researcher was contracted to carry the evaluation
3. Criteria were set partly by the NBS through their desire to have the programme evaluated and partly by the researcher
4. The criteria were the questions posed at the outset (see chapter 6, page 59)
5. The evaluation was primarily for the NBS, but also for managers and educators associated with nursing in Scotland, and the programme participants
6 The data was to be collected through the use of predominantly qualitative methodology, from a variety of appropriate sources associated with the initiative.
7 Three years were allocated for the study.
8 The work was to be illuminative.

With this prescription, the application of the Structure-Process-Outcome Model becomes self-evident. The structure and some of the processes, relate to the provision of the programme by the educators - facilitated by the NBS and the service managers - and the rest of the processes and the outcomes relate to the receipt and application of the programme by the participants. In the case of the research completed, the evaluation of the ECNM concentrated on the latter stages of this process i.e. the processes and outcomes from the participants viewpoint, with backup from other sources. For PSI&II however, the first stages were added i.e. structure and processes concerning people other than just the participants.

Starting with structure therefore, within PSI&II the initial information gathering exercise carried out within three health boards, provided knowledge of the questions that were required to be asked of all the colleges. The culmination of this being the mailshot written questionnaire, with the follow up semi-structured interviews. Looking at the results of these latter interviews, six categories were identified in relation to the data, four of which encompassed the range of important issues that affected the planning and delivery of PSI&II - namely budgets / funding; validation; production of modules; other - clinical grading and P2000. The two categories which did not relate to this area were those of running of modules and PS effects. These have relevance to other aspects of the evaluation and as such provide the raw data to guide the direction of the progressive focusing at a later stage.
Within the specified categories, tangible structural components such as building space, staffing, library facilities, adequate funding were identified. There were also however, some intangible structural components, determined by items such as programme rationale, guidelines for modules and validation protocol. Having identified the structural criteria, questions could then be asked to elicit problems, practicalities or positive aspects related to any of these points.

Broadly this process could be translated into the following questions of the provider:

1. What is the rationale behind the programme?
2. Who decides the rationale?
3. What resources are needed and are there enough - physical and human?
4. Who provides these resources?
5. Where is the course to be run?

**TABLE 25 - Structural Questions for the Provider**

The next step is to look at the processes that are being used in order to utilise the structures to the best advantage, in the provision of modules. Here the category 'running of modules' from the interviews gives the broad information concerning module development, teaching approaches, student assessment, student supervision and release of staff. This information is then followed up in sample colleges with the teaching staff, to provide more specific data. Questions that could be used to summarise this process include:

1. How is the course planned and developed?
2. How are these plans implemented?
3. What teaching methods are involved?
4. How is assessment carried out?
5. How is the student given support?
6. How are staff released onto modules?

**TABLE 26 - Process Questions for the Provider**

At this point, the emphasis changes and the participants become involved, by providing answers to the process
questions that relate to them, in terms of receiving the
course. It is also the point where the exercise moves
beyond straight data gathering and presentation, into the
evaluative phase which involves much more triangulation of
data and a wider cross-section of respondents. Data
collected that would fit into this category has been
presented from the ECNM in earlier chapters (see pages 88–
136) and will be duplicated for PSI&II. It involves some of
the information taken from the pre and post course
questionnaires and some of the interview data. In relation
to the participants, it is necessary to know what teaching
methods they have experienced, whether they have found them
effective or not, whether they have received adequate
supervision, how the practice placements were utilised and
how easy or difficult it is to be released for and actually
attend a college based input:-

1. How effective were the teaching methods?
2. How useful was the content?
3. Was there enough support?
4. Were the practice placements effective?
5. How practical is attendance at a college based
   module?
6. How were you involved in the course?

TABLE 27 - Process Questions for the Participants

Finally, it is necessary to determine the outcomes of the
situation, in terms of the participants. While there are no
specific outcome measures (see chapter 14, page 167) causal
interpretation has to be made of the information gathered
through the interviews and questionnaires from
participants, as well as from comparator group members,
nurse managers and course leaders. Having undertaken a
module that has been provided in a specific way, through
the use of the various methods and facilities that will
have been described through the processes, the outcomes and
how they articulate with these processes are collected.
Overall effectiveness, changes in knowledge, attitudes or
behaviour, and whether needs were met are all outcomes for
the participants. These can be summarised by the following
questions:-

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None of these sets of questions are designed to be totally exhaustive, since they only serve as guidelines for enquiry. In most evaluation situations there would be concerns that could not be predicted within a generic model. It can be seen that more of the provider questions are factual and represent what has been called the monitoring exercise - who, what and where. The latter questions of the participants are more evaluative by nature - how and why, the two sides of the equation interacting through the process of teaching / receiving instruction. Both sides need to be considered together to provide the total picture.

Finally, the application of the methodologies previously described has shown that they provide the widest scope for data acquisition in following this Structure-Process-Outcome Model. To facilitate the ability that an evaluator has in searching for and acquiring data, it is advantageous to have an awareness and understanding of how the system operates that is under study. This not only helps in being receptive to issues that are raised (Cleave-Hogg and Byrne 1988, p.267) and the comprehension of their significance or otherwise (a very important point if progressive focusing is used, in order that spurious leads are not followed), but also in the 'trustworthiness' of the data as a whole (see chapter 7, page 72). It is also important where possible that the evaluator should be outwith the programme under study, in order to promote a more objective stance.

By beginning the data search for PSI&II with a broad cross-section of respondents, the important issues from all perspectives were highlighted. These were then taken as the basis of the progressive focusing and selective sampling
that allowed for more information to be collected, using the questionnaire and semi-structured interview format. The division of the work into monitoring and evaluation, meant that that the sponsoring body could receive results halfway through – in formative style – whilst allowing for the larger and more complex data collection about participant processes and outcomes to move forward in the second phase. The approach therefore remains firmly based in the phenomenological field, with progressive focusing allowing for the inter-relatedness of the categories to be pursued and highlighted.

**Discussion**

This is not the first time that the quality assurance categories have been considered in nursing education and evaluation terms (Zettinig and Lang 1981, Strauss 1978), neither is it the first time that an illuminative evaluation approach has been used (Lathlean and Farnish, 1984). It is however, the first time that a merging of the two processes has occurred, to order the evaluative process into a flexible and adaptable model.

A recent paper by Crotty and Bignell (1988) referred to and used an instrument proposed by Zettinig and Lang (1981) based on the structure, process and outcome categories. The instrument was originally developed specifically for completion by course participants to provide immediate feedback to the educators, to facilitate changes and improvements in a given programme. The three categories merely provided a framework in which to put data, rather than offering a conceptual model with an associated research base.

Zettinig and Lang suggested the use of the three categories, and offered highly detailed checklists through which data was collected. This process was used, since they based their proposals on the ANA criteria for quality
assurance, which specifies the use and measurement of predetermined criteria (American Nurses' Association 1976).

The research that has been carried out through the evaluations of the ECNM and PSI&II has sought to bring order through the development of the Structure-Process-Outcome Model, providing a sound epistemological basis and the knowledge of how to adapt an evaluation to a particular setting. The flexibility of this model, is the fact that it is adaptable for both macro and micro evaluations. In this particular study, evaluation has been carried out on a macro level of a single programme of continuing education. The emphasis has therefore been on the complete through process, from planning and implementation to delivery and effects - structure, process and outcome for both provider and participant. At the micro - or local - level however, it may be that the evaluation needs to be carried out more in relation to the provision of a programme. In this case, the structures and processes will become more specific than at the macro level, and all three categories will be considered in terms of the provider. This is the flexibility. After the initial questions have been answered, the emphasis of the evaluation becomes apparent and the direction of enquiry - whilst starting with structures and moving linearly through the categories - progresses along the model using appropriately selected groups of respondents.

**Endpoint**

The last, and possibly the most important consideration in educational evaluation - although ironically, the one over which the evaluator has least control - relates to the application of the evaluators findings to the situation in hand. At first glance, this point may seem to be a spurious concern - surely if the work was commissioned, then it is going to be used in some way? This need not necessarily be the case for a variety of reasons, some of which can be
addressed by the evaluator and some which are beyond her / his control. It is not the place of an evaluation model to suggest how this issue can be overcome, but it is important to be aware of the problem.

Last year in the quarterly journal 'Evaluation Practice' (Sage Publications), a heated debate was carried out between two respected practising evaluators namely Carol Weiss (1988a and 1988b) and Michael Patton (1988a and 1988b), which has since been followed up by an overview from Smith and Chircop (1989). The importance of this debate (prompted by a keynote address given by Weiss), is that it represents seemingly contradictory views about the utilisation of evaluation findings. Patton is a great exponent of this area of evaluation research (see Patton 1986) and holds the belief that there are certain methods that an evaluator can use, to influence the stakeholders and thus promote the utilisation of results. Against this optimistic picture, Weiss adds a greater touch of reality in describing some of the factors that can inhibit the outcome of evaluation utilisation, bringing some of the realities of the political arena into play. Table 29 sums up the standpoint of each protagonist:-

**WEISS**
There is no single 'correct' decision. Information that supports negotiation is needed. Evaluation is never comprehensive or convincing enough to supply the 'correct' answer. Many programme decisions do not come about through rational decision making processes. People do not always know what information they need to know. Many people are wary of moving from the status quo that obtains.

**PATTON**
Overcome staff fear of being evaluated at the outset. Ask the right questions of the stakeholder to ensure each side really understands the other. Be situationally responsive in evaluation. Reflect and evaluate your own practice to ensure continued high standards. Be an advocate for evaluation so that stakeholders believe in the 'product' that they are getting.

**TABLE 29 - Conflicting Views of Evaluation Utilisation**

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Some of the discussion around these points suggest that the difference in viewpoint is based in the level at which the evaluation is carried out. This relates back to the macro and micro level debate again. It is more difficult for the evaluator to initiate action based on evaluation results at the macro level than it is at the micro - or local - level (Smith and Chircop 1989, p.6). Two other authors (Shapiro 1985, and Shadish 1986) who have recognised this position in previous papers, take on the more realistic approach adopted by Weiss. They suggest that:-

"People have been making decisions long before, and without the aid of, evaluative data. Thus, the utilization question must not be phrased 'How can I induce the decisionmaker (sic) to utilize my information?', but rather, 'How can evaluation data be plugged into the existing decision process, in a manner compatible with the demands of that process, such that the results are likely to be utilized?'" (Shapiro 1985, p.247)

It can only be hoped that if an evaluation is well researched and presented, then this will encourage the use of the findings. To have a model to guide the work must be of help in this matter and it is for this reason that the work described here was carried out.

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CHAPTER 20 - CRITICAL OVERVIEW

Evaluation Considered

In the first two sentences of this thesis, the questions why evaluate – why not maintain the status quo; and, who needs evaluation anyway – or more specifically, why do you need a model of evaluation (see page 1), were posed?

Through the critical pathway that the research has taken, the answers to these questions have become clear. To evaluate is to gather information, whereby the merits or drawbacks of a programme can be judged. The model of evaluation is needed to facilitate the collection and presentation of this information, in a constructive and comprehensive manner. The former relates to the programme planners (at all levels), and the latter to the evaluator.

In deciding to adopt a qualitative approach to addressing these points, the most positive but also the most frustrating aspect of the research is generated:– Doing this type of work demands a clarity of thought, and discipline, that many do not appreciate.

Collecting such a lot of data means that many fascinating issues are raised. The grounded, progressive focusing approach allows these to be explored until the nature of the information is clarified. Thus, there is the scope to follow each point, and decide not only if it fits into the jigsaw, but also where – if it does fit – its right place is. This is the very essence of this approach.

The frustrating side however, is that boundaries have to be drawn somewhere. In terms of the enquiring mind, and the quest for knowledge, this can be difficult. A good example of this occurs in the evaluation of the ECNM. Respondents from area D stated at interview, that they had learned
their job almost 100% through experience; they also stated that continuing education was a necessity. If, however, you learn your job through experience, what do you need continuing education for? On one level both of these responses could have been predicted, but it would be fascinating to explore this dichotomy further, to see what relationship exists between the two concepts. This was neither possible, nor desirable, within the remit of this evaluation, and the example given represents only one of many such potentially diverting instances.

Conclusion

In conclusion to this thesis, an analogy to describe the execution of qualitative research compared with quantitative research is proposed:

Quantitative research is like following a recipe, where the ingredients and what to do with them, are specified according to set procedures. An order must be followed in preparing the food, but if combined in the right way a dependable result can be guaranteed. Qualitative research on the contrary, provides the ingredients, but leaves no clue as to how they should be combined, or indeed what the product will look like! Indeed, there may be many different options for combining, cooking and presentation. Informed and intelligent decisions have to be made at each step of the process, but consistent and often creative results can be obtained through this method. This fact is often not appreciated – both methods can produce a palatable end result – and it is only through thorough, well argued and well presented qualitative studies that this attitude will ever change.

In real terms, this means that when applied to evaluation, the qualitative approach although optimal, is not cheap when time and resources are considered. It therefore needs a lot of commitment on behalf of the sponsoring body. It
also means that in smaller situations, there may be a need to consider a more prescriptive and less time consuming approach.

With the flexibility of the Structure-Process-Outcome Model of evaluation however, the use of data, time and resources is maximised. In terms of one of Abrahamson's (1984, p.6) 'happiness indices', both sponsor and evaluator should score highly!

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REFERENCES


HAMILTON David et al - eds. (1977) Beyond the Numbers Game: A Reader in Educational Evaluation. Macmillan Education


JARVIS Peter (1983) Professional Education. Croom Helm


KNAPPER Christopher K and CROPLEY Arthur J (1985) Lifelong Learning and Higher Education. Croom Helm


LATHLEAN Judith et al (1986) Post-Registration Development Schemes Evaluation. NERU report no.4. Nursing Education Research Unit, King's College, University of London


248

LEVINE Harold G (1985) Quality of Care: Relationship to Quality of Education. Evaluation and the Health Professionals. Vol.8, No.4, pp.429-437


NEILL A S (1968) Summerhill. Pelican Books


REDFERN S J (1981) Hospital Sisters: Their Job Attitudes and Occupational Stability. RCN


250


STRAUSS Mary Beth (1978) Quality Assurance and Nursing Education. Nurse Educator. March-April, pp.19-21


BIBLIOGRAPHY


HUFF Darell (1973) How to Lie with Statistics. Pelican Books


253


TOWELL D and HARRIES C - eds. (1979) Innovation in Patient Care. Crown Copyright, Croom Helm Ltd.

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APPENDICES
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<tr>
<th>STUDIES</th>
<th>Staff Nurses and Charge Nurses</th>
<th>Qualification</th>
<th>Requirements</th>
<th>Modules of equal length at least 60 hours in each must be used for theoretical activities</th>
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<tr>
<td>PROFESSIONAL STUDIES 1</td>
<td>4. To provide the nurse with increased knowledge and competence in broad aspects of nursing practice</td>
<td>Requirements: 1. Interpersonal relationships 2. Learning, teaching and counselling</td>
<td>Option (Examples): models of patient care research related to nursing practice, moral and legal issues in nursing, health care policies and social change, decision making in the health service</td>
<td>Three modules</td>
</tr>
<tr>
<td>PROFESSIONAL STUDIES 2</td>
<td>5. To provide the nurse with increased knowledge and competence in specific aspects of nursing practice</td>
<td>Complementary Modules in a Specific Area of Practice (Examples): Accident and emergency nursing, behavioural therapy, nursing, critical care nursing, community psychiatric nursing, ear, nose and throat nursing, neonatal and paediatric nursing, neurosurgical/neurosurgical nursing, nursing of elderly people, nursing people with cancer, operating department nursing, orthopaedic nursing, plastic and maxillo-facial surgery and burns nursing</td>
<td>Two required, one optional module</td>
<td>Three modules</td>
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(See: The National Board for Nursing, Midwifery and Health Visiting for Scotland)
APPENDIX 2:

PRE-COURSE QUESTIONNAIRE
ECNM PARTICIPANTS
INSTRUCTIONS

In this handout you will find seven sheets of paper, making up three separate sections. Part 1 relates to a set of biographical details, which are quite straightforward. I would be grateful if you would complete all the questions. You will only be asked to give this information once, and when it has been returned to me you will be allocated a code number. This means, that any information given in this or either of the other two sections then becomes strictly confidential.

Parts two and three are two separate questionnaires. You are asked to work your way through both, filling in each item by inserting a tick in the appropriate column. The columns for part two range from ‘always’ to ‘never’ (A, N), the intermediate categories being ‘often, sometimes and rarely’ (O, S, and R). These responses refer to how frequently you would say that you carry out each statement. In part three the columns range from ‘strongly agree’ to ‘strongly disagree’ (SA to SD), also encompassing ‘agree, undecided and disagree’ (A,U,D). These responses refer to how you feel about each statement.

There are no right or wrong answers, all answers reflect your own knowledge, attitudes and opinions. Please insert a tick in the column which most accurately reflects your view. e.g. if you think that you always use the nursing process, then put a tick in the left hand column marked ‘A’. Please try to avoid using the ‘undecided’ column in part three unless absolutely necessary.

Once again I would like to emphasise the strict confidentiality of this project.

Thank you for your help.

Sara Whiteley
Research Nurse
MODULE FOR EXPERIENCED CHARGE NURSES PRE-COURSE QUESTIONNAIRE

PART 1
1) Name

2) Location of course

3) Date course commenced

4) Age (please circle)  21-30  31-40  41-50  51-60

5a) Post and base (Hospital/Clinic/Health Centre etc.)

5b) Current clinical area (Type of ward/department and name/number)

5c) No. of years in this post

5d) Total no. of years spent as a Sister/Charge Nurse

5e) If you are qualified to work in more than one area e.g. general and psychiatry or sick children's and district nursing, and have worked as a qualified nurse in both (or all) areas, please state for how long and at what grade you worked.

6) Qualifications (please delete where not appropriate):
   a) Educational - O grades/levels (number)

   Higher/A levels (number)

   Further education e.g. Degree, HND, Diploma etc. (please specify)

   b) Nursing (including date of qualifying)

   i) Basic

   ii) Further registration(s)/qualification(s) (please tick):
       General
       Sick Children's
       Midwifery
       Health Visiting

       Psychiatry
       Mental Handicap
       District Nursing
       Other (please specify)

7) No. of whole years that you have practised nursing (exclusive of time out for any reason)

8) Name and location of nurse manager who is your immediate superior.
9) How did you come to attend this course? (please tick all relevant responses):-

a) Put name forward for any continuing education available ___
b) Asked specifically to come on this course ___
c) Were asked to but given the option to refuse ___
d) Were told to ___

If you answered (d), given the option, would you have refused? YES/NO

10) Courses attended - please tick all relevant responses:-

First line management ___ Oncological nursing ___
Middle management ___ General intensive care nursing ___
Accident and emergency nursing ___ Care of the dying patient and family ___
Infectious diseases ___ Neonatal paediatric nursing ___
Tropical diseases ___ Renal nursing ___
Family planning course ___ Ophthalmic nursing ___
Research methodology ___ Operating department nursing ___
Stoma care ___ Special/Intensive care of the newborn ___
Nursing elderly people ___

Refresher course(s) (please specify)______________________________________

Other(s) (please specify)________________________________________________

11) Please note briefly your expectations of this course e.g. educational, of benefit to your work, of benefit to others etc..

12) Please write a brief account (no more than 200 words) of your perception of the role of the Charge Nurse (using attached sheet)
Question 12 answer sheet
A: Always, O: Often, S: Sometimes, R: Rarely, N: Never

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<tbody>
<tr>
<td>1</td>
<td>Use the nursing process</td>
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<tr>
<td>2</td>
<td>Plan admissions</td>
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<tr>
<td>3</td>
<td>Assess learners at end of placement</td>
<td></td>
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<tr>
<td>4</td>
<td>Interview learners half way through placement</td>
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<td>41) Set priorities for a day</td>
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<td>42) Liaise with other members of team</td>
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<td>43) Carry out administration of necessary paperwork</td>
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<td>44) Use knowledge of disciplinary procedures if appropriate</td>
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<td>45) Ensure nursing records are kept accurately</td>
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<td>46) Report to nursing management</td>
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<td>47) Organise resources</td>
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<td>48) Communicate with patients</td>
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<td>49) Attend hospital meetings (unit etc.)</td>
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<td>50) Provide co-ordination with other departments</td>
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<td>51) Have an awareness of ethical and legal implications involved with care</td>
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<td>52) Attend ward rounds personally</td>
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<td>2) I spend too much time on ward management</td>
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<td>3) Ward management is something I have been trained to do</td>
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<td>4) I feel my knowledge is used to its full extent</td>
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<td>5) Ward management is an enjoyable part of my job</td>
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<td>6) I find teaching stressful</td>
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<td>7) I like learners to ask me questions</td>
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<td>8) Continuing education takes you away from your job for long periods</td>
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<td>9) Ward management is the basis of ward activity</td>
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<td>10) The role of the Charge Nurse is supervisory in clinical practice</td>
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<td>11) Continuing education is necessary for my job</td>
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<td>12) I do not feel there is enough time to spend with patients</td>
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<td>13) Teaching is a necessary part of my job</td>
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<td>14) Continuing education can be provided by single study days alone</td>
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<td>15) I do not find teaching rewarding</td>
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<td>16) Other non-nursing professionals can provide input into continuing education</td>
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<td>17) Knowledge of the job comes only from practising it</td>
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<td>18) Ward management is very time consuming</td>
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<td>19) I know how to teach</td>
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<td>20) Teaching is enjoyable</td>
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<td>21) Ward management helps to run the ward more efficiently</td>
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<td>22) I spend a lot of my time on patient care</td>
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<td>23) The Charge Nurse should not be expected to be involved in direct care giving</td>
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<td>24) I miss direct patient contact</td>
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<td>25) Continuing education should be compulsory</td>
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<td>26) I think all trained staff should teach</td>
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<td>27) The Charge Nurse should be involved in technical rather than basic nursing care</td>
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<td>28) It is difficult to find time to teach</td>
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<td>29) Continuing education should be taught away from the place of work</td>
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<td>30) Continuing education does not require formal taught input</td>
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<td>31) Clinical practice is the most important role of the Charge Nurse</td>
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<td>32) I do not get enough support with ward management</td>
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APPENDIX 3:

PRE-COURSE QUESTIONNAIRE
AREA D
INSTRUCTIONS

In this handout you will find six sheets of paper, making up three separate sections. The first part contains four questions about your work over the past nine months (since you completed the first questionnaire), and you are asked to complete any or all of the questions which are relevant. Parts two and three should be filled in in the same way as before, placing a tick in the column which most accurately reflects your attitude or opinion corresponding to the question asked. Just to remind you, the questions in section two relate to how often you carry out each statement listed, and the questions in section three relate to whether you agree or disagree with each statement.

I would also like to remind you once again that there are no right or wrong answers, and that all information received is taken in the strictest confidence.

Thank you for your help

Sara Whiteley
Research Nurse
MODULE FOR EXPERIENCED CHARGE NURSES PRE-COURSE QUESTIONNAIRE

PART 1
1) Name______________________________________

3) Date______________________________________

4) Age (please circle) 21-30  31-40  41-50  51-60

5a) Post and base (Name of Hospital/Clinic/Health Centre etc.)__________________________

5b) Current clinical area (Type of ward/department and name/number)

5c) No. of years in this post__________________________________________________________

5d) Total no. of years spent as a Sister/Charge Nurse_________________________ 

5e) If you are qualified to work in more than one area e.g. general and psychiatry or sick children’s and district nursing, and have worked as a qualified nurse in both (or all) areas, please state for how long and at what grade you worked.__________________________________________________________

6) Qualifications (please delete where not appropriate):-

a) Educational - O grades/levels(number)______________________________

Highers/A levels(number)______________________________

Further education e.g. Degree, HND, Diploma etc.(please specify)__________________________

b) Nursing (including date of qualifying)

i) Basic______________________________________

ii) Further registration(s)/qualification(s) (please tick):-

General (RGN)      ___ Psychiatry (RMN) ___

Sick Children’s (RSCN)      ___ Mental Handicap(RMND/RMNH) ___

Midwifery(SCM/RM) ___ District Nursing certificate ___

Health Visiting certificate ___ Other(please specify)__________________________

7) No. of whole years that you have practised nursing (exclusive of time out for any reason) ____________________________

8) Name and location of nurse manager who is your immediate superior.
9) Courses attended - please tick all relevant responses:

- First line management
- Middle management
- Accident and emergency nursing
- Infectious diseases
- Tropical diseases
- Family planning course
- Research methodology
- Stoma care
- Nursing elderly people

Refresher course(s) (please specify)

Other(s) (please specify)

10) Please write a brief account (no more than 200 words) of your perception of the role of the Charge Nurse.
PART 2

A: Always, O:Often, S:Sometimes, R:Rarely, N:Never

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<td>41</td>
<td>Set priorities for a day</td>
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<td>42</td>
<td>Liaise with other members of team</td>
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<td>43</td>
<td>Carry out administration of necessary paperwork</td>
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<td>44</td>
<td>Use knowledge of disciplinary procedures if appropriate</td>
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<td>45</td>
<td>Ensure nursing records are kept accurately</td>
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<td>46</td>
<td>Report to nursing management</td>
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<td>47</td>
<td>Organise resources</td>
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<tr>
<td>48</td>
<td>Communicate with patients</td>
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<td>49</td>
<td>Attend hospital meetings (unit etc.)</td>
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<td>50</td>
<td>Provide co-ordination with other departments</td>
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<td>51</td>
<td>Have an awareness of ethical and legal implications involved with care</td>
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<td>52</td>
<td>Attend ward rounds personally</td>
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</tbody>
</table>
1) Ward management is my sole responsibility

2) I spend too much time on ward management

3) Ward management is something I have been trained to do

4) I feel my knowledge is used to its full extent

5) Ward management is an enjoyable part of my job

6) I find teaching stressful

7) I like learners to ask me questions

8) Continuing education takes you away from your job for long periods

9) Ward management is the basis of ward activity

10) The role of the Charge Nurse is supervisory in clinical practice

11) Continuing education is necessary for my job

12) I do not feel there is enough time to spend with patients

13) Teaching is a necessary part of my job

14) Continuing education can be provided by single study days alone

15) I do not find teaching rewarding

16) Other non-nursing professionals can provide input into continuing education

17) Knowledge of the job comes only from practising it

18) Ward management is very time consuming

19) I know how to teach

20) Teaching is enjoyable

21) Ward management helps to run the ward more efficiently

22) I spend a lot of my time on patient care

23) The Charge Nurse should not be expected to be involved in direct care giving
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<td>24) I miss direct patient contact</td>
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<td>25) Continuing education should be compulsory</td>
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<td>26) I think all trained staff should teach</td>
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<td>27) The Charge Nurse should be involved in technical rather than basic nursing care</td>
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<td>28) It is difficult to find time to teach</td>
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<td>29) Continuing education should be taught away from the place of work</td>
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<td>30) Continuing education does not require formal taught input</td>
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<td>31) Clinical practice is the most important role of the Charge Nurse</td>
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<td>32) I do not get enough support with ward management</td>
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APPENDIX 4:

SEMI-STRUCTURED INTERVIEW
ECNM PARTICIPANTS
This interview is part of the evaluation package which has been put together for the purposes of evaluating the module for experienced Charge Nurses. You have already filled out a questionnaire and I would now like to explore further some of the issues introduced there, as well as exploring some new areas.

Broadly, the new areas fall into three categories. They all relate to your own thoughts about the course, but try and look at these from different perspectives. The first perspective is the teaching which you have received in college. The second is what you see as being your own needs, and the third concerns your own thoughts about the whole module and how this affects you.

So, on the subject of teaching:-

1) Have you found it difficult to study again?

2) Have you found it hard to adapt to being in college again? 
   If yes, then:- a) What was difficult about it and how do you think that this could have been prevented or helped?

3) Do you think that the course is too long?

4) Have you found the teaching well structured?

5) What teaching methods have you experienced eg. lectures, tutorials, self-learning etc?

6) Which of these methods have you found the most effective, and conversely, which have you found the least effective?

7) Have you any suggestions about the structure of the course - that is, do you find the distribution of the college time and the overall length satisfactory, and if not what would you suggest as a possible alternative?

Moving on to the second section, here are some questions about your own needs:-

8) Do you see continuing education as a necessity?

9) What would you say was the best way for this to be carried out?

10) Generally, do you think that this particular course has taken into account and catered for individual needs?

11) On the basis of what you have received in college as formal teaching, was this adequate to meet your needs?
    If yes, then:- a) What were your needs?
    If no, then:- b) What needs were not met and what else would you like to have had included?

12) How prepared do you feel for your action plan?
13) How much support have you had from the college in preparing it?
   a) Is this enough?
   b) Do you feel confident enough to carry it out?

14) If you think at any point that you will need more support for
     this, who will you contact?

15) Has support been pre-arranged from the college?

Finally, this last set of questions relates to what thoughts you
have about the module.

16) In your questionnaire you said that your expectations of the
     course were (see attached sheet). Would you now say whether these
     have been met or not and explain your reasons for saying this.

17) What practical applications has the course had in terms of:-
     a) the staff you work with?
     b) patient care?
     c) your own development?

18) Also in your questionnaire you wrote about your perception of
     the role of the Charge Nurse (see attached sheet).
     a) Has this changed in any way since you came on the course?

19) If your role is defined in terms of manager/practitioner/teacher in
     what order of preference would you place these three
     categories?
     (If no preference defined, prompt to identify which role is most
     identified with).

20a) Do you feel that you have benefited from the course so far?
     If yes, then:- a) In what ways would you say that you have
     benefited?
     If no, then:- b) Why not?
20b) The following benefits have been suggested by some other
     people, would you agree or disagree with them?:-
     (give interviewee separate sheet)

21) What criticisms and/or recommendations do you have about the
     course?

22a) Finally, if you were asked to speak to someone who was about
     to come on the course what would you say to them?
22b) Would you agree or disagree with the following statements:-
     i) No-one is too old to attend
     ii) Be open minded
     iii) Be prepared to take and make constructive criticism
     iv) It is necessary to be an "experienced" Charge Nurse in
         order to gain most benefit from the course
     If yes, a) Why?
     If no, b) Why not?

23) Have you any other comments that you would like to add?
a) Thought-provoking
b) Stimulating
c) Learned a lot
d) Useful to have people from different fields e.g. district and general/ psychiatry etc.
e) Increased objectivity and awareness
f) Feeling of involvement in the planning of the course being attended
g) Renewed enthusiasm for the job
h) Useful to be able to discuss individual problems with a variety of people with different experience
APPENDIX 5:

SEMI-STRUCTURED INTERVIEW
AREA D
SEMI-STRUCTURED INTERVIEW FOR AREA D

This interview is part of the evaluation package which has been put together for the purposes of evaluating the module for experienced Charge Nurses. You have already filled out a questionnaire and I would now like to explore further some of the issues introduced there as well as exploring some new areas.

Broadly, these new areas fall into three categories. They will relate to your own opinions, and as in the questionnaire, there are no right or wrong answers. The first category relates to the general subject of continuing education. The second, to how you might feel about the experienced Charge Nurses module and the third to your work situation.

So, on the subject of continuing education:-

1) What do you think of the need for structuring continuing education in nursing?

2) Do you see continuing education as a necessity?

3) What would you say was the best way for this to be carried out?

4) Do you think that there is enough continuing education offered at present?

5) Whose responsibility do you think it is to carry out continuing education?

6) What benefits to the following people do you see continuing education having?
   a) Staff you work with
   b) Patients / clients
   c) Yourself

7) How do you think that this will benefit the profession as a whole?

8) How do you keep yourself up to date with nursing issues at present?

This set of questions relates to the experienced Charge Nurses module:-

9) What needs do you have that could be met by an experienced Charge Nurse’s course?

10) How would you feel if you were offered a nine month continuing education course of the form:-
    3 weeks in college
    8 weeks in post
    1 week in college
    6 months in post
    1 study day
    - and would you be willing to attend?
11) How do you think that this would affect your work situation?

12) How would you feel about being asked to carry out a project of your own choice related to your work situation over a six month time span?

13) Do you think that courses which take Charge Nurses from different fields of nursing would be beneficial?
   If yes:- a) Why?
   If no:- b) Why not?

This last section relates to your work situation:-

14) Do you think that natural changes occur in your working style over a nine month period?
   If yes:- a) Could you say how you see these changes occurring and what form they take?
   If no:- b) Do you think that changes occur over a longer time span, or do you not think that they occur at all?

15) In your questionnaire you wrote about your perception of the role of the Charge Nurse. Has this changed in any way since you first took up your post?
   If yes:- a) Has this been a natural progression or has it been helped by any form of continuing education?

16) If your role is defined in terms of manager / practitioner / teacher, in what order of importance would you place these three categories?
   (If reluctant or finding it difficult to answer, please prompt so that at least one is specified as being most or least important)

17) How do you think that a Charge Nurse decides how to act in their professional capacity i.e. what factors have influenced how you do your job?
   (eg Based on previous role models / intuition / experience / things that have been taught etc)

18) Have you any other comments that you would like to add?
APPENDIX 6:

POST-COURSE QUESTIONNAIRE
ECNM PARTICIPANTS
INSTRUCTIONS

In this handout you will find eight sheets of paper, making up three separate sections. The first part contains a set of questions which are all self-explanatory (apart from number three) and require either a short description or a straightforward choice from the stated answers. Parts two and three should be filled in in the same way as before, placing a tick in the column which most accurately reflects your attitude or opinion corresponding to the question asked. You are reminded once again that there are no right or wrong answers, and that all information received is taken in the strictest confidence.

Question three in part one is similar to the questions that occur in parts two and three. You are asked to work your way through all the objectives, inserting a tick in the column which most accurately reflects your own opinion. The columns are labelled 1, 2, 3, 4, and N/A or UNNEC, and the question asks the extent to which you feel that you have been helped in the stated aspects of your job by coming on the course. The scale 1 - 4 represents the opinions from a ‘lot’ (1), to ‘not at all’ (4), the intermediate categories being ‘a moderate amount’ (2) and ‘a little’ (3). The last column should be used if the stated objective is not applicable to your job (N/A), or if you feel that your work was satisfactory and did not need help in this area (UNNEC).

eg If you think that you have been helped a moderate amount in the planning and organising of your work, then insert a tick in the column marked ‘2’. Alternatively, if you think that you did not need help in this area as your planning and organising were satisfactory, then insert a tick in the right hand column marked ‘N/A or UNNEC’.

Thank you for your help

Sara Whiteley
Research Nurse
PART 1 - Section A

1a) NAME ____________________________________________

1b) LOCATION OF COURSE __________________________________

2) DATE ____________________________________________

3) To what extent do you think that the following aspects of your job have been helped by coming on the course:

<table>
<thead>
<tr>
<th>Planning and organising work</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>N/A or UNNEC.</th>
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<tr>
<td>Understanding your role</td>
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<td>Teaching junior staff</td>
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<td>Having ideas about how to carry out your work</td>
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<td>Understanding of ethical issues</td>
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<td>Improving standards of care</td>
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<td>Being able to identify your strengths</td>
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<td>Being able to identify your weaknesses</td>
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<td>Carrying out evaluation of care given</td>
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<td>Determining your sphere of control</td>
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<td>Communication with your colleagues</td>
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<td>Communication with your patients/clients</td>
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<td>Responsibility for your own learning</td>
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<td>Utilisation of counselling skills</td>
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<td>Research appreciation</td>
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<td>Increase in enthusiasm for your job</td>
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<td>Being able to question the way things are done</td>
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<td>Managerial skills</td>
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</table>
4) What have you found the single most positive aspect of the course?

5) What have you found the single most negative aspect of the course?

Section B

6) ACTION PLAN

a) Please list briefly the goals and/or aims that you set out to achieve during the six months back in post

b) Overall to what extent do you think that these have been achieved? (please circle one)

FULLY  PARTIALLY  NOT AT ALL

c) If partially or not at all, please indicate reasons why, if known.
d) What benefits eg in terms of improved performance (in self or staff), patient comfort or cost and/or labour savings do you think have occurred, or are likely to occur, due to the implementation of your action plan?


e) Did you receive support from any or all of the following to carry out your action plan? (please circle where appropriate)

   COLLEAGUES  LINE MANAGERS  COURSE STAFF  OTHER

f) If you circled any of the above alternatives, was this support enough, and if not how could this have been improved?


g) If you did not receive support from any of these alternatives please explain why.
h) Would you say, in terms of achieving your given aims, that the time allocated to the action plan (ie six months) was adequate? If not please suggest what a suitable alternative would be and why.

7) Having come to the end of this nine month course, which of the following would you say applied to the overall length?
(please circle appropriate answer)

   TOO LONG   TOO SHORT   SATISFACTORY

8) Finally, the stated aim of the course is:-
"To enhance the ability of a Charge Nurse to fulfill her/his composite role as a practitioner, manager and teacher."
To what extent do you feel that for yourself, this aim has been met?

9) Any other comments
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<th></th>
<th>Always (A)</th>
<th>Often (O)</th>
<th>Sometimes (S)</th>
<th>Rarely (R)</th>
<th>Never (N)</th>
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<tbody>
<tr>
<td>1</td>
<td>Organise nursing staff on duty</td>
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<td>2</td>
<td>Teach implications of illness to patients</td>
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<td>3</td>
<td>Work in conjunction with Clinical Teachers if present</td>
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<td>4</td>
<td>Use knowledge of Health and Safety at Work. Act if appropriate</td>
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<td>5</td>
<td>Report to nursing management</td>
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<td>6</td>
<td>Use task allocation</td>
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<td>Develop good working relationships</td>
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<td>Provide teaching for untrained, permanent members of staff</td>
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<td>9</td>
<td>Develop personal leadership skills where possible</td>
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<td>10</td>
<td>Keep up to date with new nursing trends</td>
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<td>11</td>
<td>Interview learners half way through placement</td>
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<td>12</td>
<td>Provide teaching for trained members of staff</td>
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<td>Co-ordinate patient care</td>
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<td>Carry out administration of necessary paperwork</td>
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<td>Ensure nursing records are kept accurately</td>
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<td>Have an awareness of ethical and legal implications involved with care</td>
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<td>17</td>
<td>Teach implications of illness to relatives</td>
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<td>18</td>
<td>Delegate work where possible</td>
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<td>Behave as a role model</td>
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<td>Sort out nursing staff problems when they occur</td>
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<td>Plan admissions</td>
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<td>Assess learners at end of placement</td>
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<td>Be available in case of emergency when on duty</td>
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<td>24</td>
<td>Identify teaching needs for individuals</td>
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<td>Provide health education to patients</td>
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<td>Liaise with relatives and friends</td>
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<td>Attend hospital meetings (unit etc.)</td>
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<td>Use the nursing process</td>
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<td>Plan staff holidays</td>
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<td>Plan off duty</td>
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<td>31</td>
<td>Counsel permanent staff if necessary</td>
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<td>Use patient allocation</td>
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<td>Interview learners at beginning of placement</td>
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<td>Teach patients about their illness</td>
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<td>35</td>
<td>Set priorities for a day</td>
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<td>Ward management is the basis of ward activity</td>
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<td>I miss direct patient contact</td>
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<td>22) Clinical practice is the most important role of the Charge Nurse</td>
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<td>23) Ward management is an enjoyable part of my job</td>
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<td>24) Continuing education can be provided by single study days alone</td>
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<td>25) I do not find teaching rewarding</td>
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<td>26) Ward management helps to run the ward more efficiently</td>
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<td>27) I like learners to ask me questions</td>
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<td>28) I spend too much time on ward management</td>
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<td>29) Knowledge of the job comes only from practising it</td>
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<td>30) Teaching is enjoyable</td>
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<td>31) The role of the Charge Nurse is supervisory in clinical practice</td>
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<td>32) Continuing education should be compulsory</td>
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APPENDIX 7:

POST-COURSE QUESTIONNAIRE
AREA D
INSTRUCTIONS

In this handout you will find six sheets of paper, making up three separate sections. The first part contains four questions about your work over the past nine months (since you completed the first questionnaire), and you are asked to complete any or all of the questions which are relevant. Parts two and three should be filled in in the same way as before, placing a tick in the column which most accurately reflects your attitude or opinion corresponding to the question asked. Just to remind you, the questions in section two relate to how often you carry out each statement listed, and the questions in section three relate to whether you agree or disagree with each statement.

I would also like to remind you once again that there are no right or wrong answers, and that all information received is taken in the strictest confidence.

Thank you for your help

Sara Whiteley
Research Nurse
FOLLOW UP QUESTIONNAIRE: AREA D

PART 1

1) NAME_________________________________________________________

2) HOSPITAL_____________________________________________________

3) DATE________________________________________________________

4) Have you implemented any changes in your work situation over the past nine months, and if so why?

5) What benefits eg in terms of improved performance (in yourself or your staff), patient comfort or cost and/or labour savings do you think have occurred or are likely to occur due to these changes?
6) Have you attended any courses or study days during the past nine months, and if so what were they?

7) Any other comments
## PART 2

A: Always, O: Often, S: Sometimes, R: Rarely, N: Never

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<td>Organise nursing staff on duty</td>
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<td>Teach implications of illness to patients</td>
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<td>Work in conjunction with Clinical Teachers if present</td>
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<td>Develop good working relationships</td>
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<td>Develop personal leadership skills where possible</td>
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<td>Keep up to date with new nursing trends</td>
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<td>Interview learners half way through placement</td>
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<td>Co-ordinate patient care</td>
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<td>Carry out administration of necessary paperwork</td>
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<td>Ensure nursing records are kept accurately</td>
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<td>Have an awareness of ethical and legal implications involved with care</td>
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<td>Delegate work where possible</td>
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<td>Behave as a role model</td>
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<td>Sort out nursing staff problems when they occur</td>
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<td>Plan admissions</td>
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<td>Assess learners at end of placement</td>
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<td>Be available in case of emergency when on duty</td>
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<td>Identify teaching needs for individuals</td>
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<td>Attend hospital meetings (unit etc.)</td>
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<td>Plan staff holidays</td>
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<td>Plan off duty</td>
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<td>Counsel permanent staff if necessary</td>
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<td>Set priorities for a day</td>
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<td>16) Teaching is a necessary part of my job</td>
<td></td>
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<tr>
<td>17) Ward management is the basis of ward activity</td>
<td></td>
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<tr>
<td>18) I miss direct patient contact</td>
<td></td>
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<tr>
<td>19) Ward management is my sole responsibility</td>
<td></td>
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<tr>
<td>20) Continuing education should be taught away from the place of work</td>
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<tr>
<td>21) I find teaching stressful</td>
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<td>SA</td>
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<td>U</td>
<td>D</td>
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<tr>
<td>22)</td>
<td>Clinical practice is the most important role of the Charge Nurse</td>
<td></td>
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<tr>
<td>23)</td>
<td>Ward management is an enjoyable part of my job</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>24)</td>
<td>Continuing education can be provided by single study days alone</td>
<td></td>
<td></td>
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<tr>
<td>25)</td>
<td>I do not find teaching rewarding</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>26)</td>
<td>Ward management helps to run the ward more efficiently</td>
<td></td>
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<tr>
<td>27)</td>
<td>I like learners to ask me questions</td>
<td></td>
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<td>28)</td>
<td>I spend too much time on ward management</td>
<td></td>
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<tr>
<td>29)</td>
<td>Knowledge of the job comes only from practising it</td>
<td></td>
<td></td>
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<tr>
<td>30)</td>
<td>Teaching is enjoyable</td>
<td></td>
<td></td>
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<tr>
<td>31)</td>
<td>The role of the Charge Nurse is supervisory in clinical practice</td>
<td></td>
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<tr>
<td>32)</td>
<td>Continuing education should be compulsory</td>
<td></td>
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</tbody>
</table>
APPENDIX B - COURSE LEADERS’ PROCESS RECORDING FORMS

A) What changes have you made to the following items, since the last module?

1) Content

2) Teaching style

3) Materials used

4) Programme structure

B) Why did you see these as being necessary? (p.t.o. for more space)

Signed:

College:

Date:

Date of next module:
APPENDIX 9 - COURSE LEADERS SEMI-STRUCTURED INTERVIEW

1) Were the NBS guidelines adequate for the planning of the module?

2) What considerations did you then make when planning it and deciding upon the course content?

3) What were your expectations of the course prior to commencement?

4) Have these been met, and if not why not?

5) How did/do you spread the information about the start of the courses and also its continuation?

6) How do you see the course having developed over the past two years?

7) How have your expectations changed over the period of time you have been running the module?

8) How do you see the C/N’s benefitting from the course?

9) Have you had any feedback from the following about any aspects of the course?
   a) participants
   b) NO’s / service side
   c) DNE’s/DNS’s etc

10) What has this feedback consisted of?

11) What support have you had from within the college for the running and planning of the module?

12) What support (if any) have you had from the service side?

13) How do you invite application and select the participants for each module?

14) Do you/your college propose to continue with the course?

15) Do you think that this offers the best continuing education for C/N’s, or can you suggest any alternatives which might be more effective (or would you rather revert to the system which you had before its innovation)?

16) Any other comments?
APPENDIX 10:

NURSE MANAGERS' QUESTIONNAIRE
INSTRUCTIONS

In this handout you will find three sheets of paper, which form a questionnaire relating to the Module for experienced Charge Nurses. Please fill in all the questions asked to the best of your knowledge, and if you are responsible for more than one Charge Nurse who has attended the course, please fill in a separate questionnaire for each of them. There are no right or wrong answers to any of these questions, they merely reflect your own opinions, and as such are valuable to the evaluation work being carried out. This is the reason for asking you to carry out this procedure, and if you have any reservations or enquiries about doing so, then do not hesitate to get in touch with me.

All the questions are self explanatory, apart from number three, and require either a short description or a straightforward choice from the stated answers. For number three however you are asked to work your way through all the objectives, inserting a tick in the column which most accurately reflects your own opinion. The columns are labelled 1, 2, 3, 4, and N/A or UNNEC, and the question asks the extent to which you feel that the Charge Nurse has been helped in the stated aspects of her job by coming on the course. The scale 1 - 4 represents the opinions from a 'lot' (1), to 'not at all' (4), the intermediate categories being 'a moderate amount' (2) and 'a little' (3). The last column should be used if the stated objective is not applicable to her job (N/A), or if her work was satisfactory and did not need help in this area (UNNEC).

Eg If you think that she has been helped a moderate amount in the planning and organising of her work, then insert a tick in the column marked '2'. Alternatively, if you think that she did not need help in this area as her planning and organising were satisfactory, then insert a tick in the right hand column marked 'N/A or UNNEC'.

Once you have completed the questionnaire, I would be grateful if you would return it to me in the envelope provided. I would like to emphasise that any information that you send to me will be treated in the strictest confidence, and will be coded on arrival, so that individuals cannot be identified in the results.

Thank you very much for your help.

SARA WHITELEY (MS.),
RESEARCH NURSE,
QUEEN MARGARET COLLEGE,
CLERWOOD TERRACE,
EDINBURGH
EH12 8TS
031-339 8111 ext. 262

The female gender is used in this document for ease of reading; it also applies however to male nurses.
3) To what extent do you think that the following aspects of this Charge Nurse's job have been helped by attending the course:

<table>
<thead>
<tr>
<th>Planning and organising work</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>N/A or UNNEC.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding her role</td>
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<tr>
<td>Teaching junior staff</td>
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<td>Having ideas about how to carry out her work</td>
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<tr>
<td>Understanding of ethical issues</td>
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<tr>
<td>Improving standards of care</td>
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<tr>
<td>Being able to identify her strengths</td>
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<td></td>
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</tr>
<tr>
<td>Being able to identify her weaknesses</td>
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<tr>
<td>Carrying out evaluation of care given</td>
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<tr>
<td>Determining her sphere of control</td>
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<tr>
<td>Communication with colleagues</td>
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<tr>
<td>Communication with patients/clients</td>
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<tr>
<td>Responsibility for her own learning</td>
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<td>Utilisation of counselling skills</td>
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<tr>
<td>Research appreciation</td>
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<tr>
<td>Increase in enthusiasm for her job</td>
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<tr>
<td>Being able to question the way things are done</td>
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<tr>
<td>Managerial skills</td>
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</table>
4a) Were you consulted, prior to commencement, about her attendance on the course? (please circle appropriate answer)

YES    NO

b) If yes, please tick which of the following apply:
   i) It was your suggestion that they attend____
   ii) It was not your suggestion, but you were happy for them to attend____
   iii) It was not your suggestion, and you would rather they had not attended____

c) If no, please tick which of the following apply:
   i) It would have been useful if you had been consulted____
   ii) It does not make any difference that you were not consulted____

5) What benefits eg in terms of improved performance (in herself or her staff), patient comfort or cost and/or labour savings do you think have occurred, due to her attendance?

6) Please describe the contact that you have had with this Charge Nurse relating to the course throughout the past nine months (eg once a week or once a month etc), and indicate the form this contact took, and why it occurred.
7) Do you feel that you were given enough information about the course, and if not what kind of additional information would you have found useful?

8) On the basis of your knowledge of this Charge Nurse module, would you have an interest in attending a course of this kind if the opportunity arose? (please circle appropriate answer)

YES       NO

9) Finally, the aim of the course is:-
"To enhance the ability of a Charge Nurse to fulfill her composite role as a practitioner, manager and teacher"
To what extent do you feel that this aim has been met for this Charge Nurse?

10) Any other comments
APPENDIX 11:

EXPLORATORY INTERVIEW PSI&II
EXPLORATORY INTERVIEWS; PSI&II

1) What do you know about PSI&II?

2) How does this fit in with your current Health Board policies / practices?

3) Do you think that continuing education is necessary?

4) Do you think that it is practical in terms of:-
   - resourcing
   - releasing staff
   - cost implications?

5) What benefits do you foresee coming from the implementation of a coherent strategy such as this?

6) How do you think that it will help nursing provision
   - expertise
   - efficiency
   - morale
   - patient care?

7) What criteria do you use to assess the success of such an initiative and do you carry out any form of in-house evaluation?

8) What drawbacks do you envisage?

9) Is there a time limit on how long you are prepared to try this for?

10a) What continuing education provision for nurses did you have before these modules were initiated / will be superseded by this strategy?

10b) How do you think that the new provision compares with the previous continuing education offered?

11) What strategy has been used to decide what modules should be developed - i.e. who is involved - service / education / management, and how do you design modules?

12) How does a nurse obtain continuing education?

13) How do you find the procedure for design and validation of the modules?

14) How did the procedure for validation come about and is it satisfactory?

15) Who are the courses aimed at, should they be open to all those who apply - what about charge nurses etc.?

16) Do you see the development of modules in 'unpopular' areas as a useful way of attracting staff to these Specialities - should this be allowed to happen?
17) Do you think that there has been enough publicity about the strategy?

18) Do you think that all staff are aware of what is available for them?

19) Are you pleased with the response to the proposals - should there be more interest or is it proliferating at a reasonable pace?

20) What questions would you like to see addressed by the evaluation?
APPENDIX 12:

MAILSHOT
DIRECTOR OF NURSE EDUCATION / HEAD OF DEPARTMENT
PROFESSIONAL STUDIES QUESTIONNAIRE

The following questionnaire requires a variety of responses, according to the type of question asked. Where there are options offered e.g. Yes or No; Classroom Contact / Distance Learning / Open Learning etc., please indicate with a tick(s) whichever is appropriate.

Alternatively, where the question says please state or specify an answer, a space has been left for you to elaborate with as much information as you think is necessary. If the space provided is not large enough, please use the blank sheets attached to the end of the questionnaire to extend your answer.

NAME __________________________________________

COLLEGE ______________________________________

Please enter the date when you have completed the questionnaire:

DATE ______________________________________
1) According to the NBS database you are running the following Professional Studies modules:-

Please confirm this information, and indicate by each module how often it is run and how many people on average attend it. Alternatively, if the information is inaccurate, please amend where appropriate and then add the above details.

2) What grade(s) of staff are attending the modules? Please number your answers in descending order, according to the number of participants provided by each group e.g. if Staff Nurses are the most prevalent put 1; if Charge Nurses are second put 2 etc.

<table>
<thead>
<tr>
<th>Staff Nurse</th>
<th>PSI</th>
<th>PSII</th>
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</thead>
<tbody>
<tr>
<td>Ward Sister</td>
<td></td>
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<tr>
<td>District Nurse</td>
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</tr>
<tr>
<td>Health Visitor</td>
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<tr>
<td>Nursing Officer</td>
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<tr>
<td>Other - please specify</td>
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</tbody>
</table>

3a) What is your annual education budget?

________________________

3b) Approximately what percentage of this is given to:-

| Basic education |   |
| Post-basic education |   |
| Continuing education |   |
| In-service education |   |
| Other - please specify |   |

3c) Is the above figure for continuing education sufficient?

YES _____ - please go to question 5
NO _____ - please go to question 4
4) If this figure is insufficient, please state how you fund your continuing education modules.

5) Is any time built into service staffing figures to allow for continuing education?

   YES _____
   NO _____

6) Have you been unable to run any of the validated modules for any reason?

   YES _____ - please say why this was
   NO _____

7a) Do you run Consolidation courses?

   YES _____ - please go to question 8
   NO _____

7b) Do these follow the NBS guidelines?

   YES _____
   NO _____ - please state why not

7c) Do candidates need to have completed this before attending Professional Studies I modules?

   YES _____
   NO _____
8) Do candidates have to do three modules consecutively or is it possible for interested parties to undertake only one or two at any one time?

<table>
<thead>
<tr>
<th>ALL 3</th>
<th>PSI</th>
<th>PSII</th>
</tr>
</thead>
<tbody>
<tr>
<td>ONE OR TWO AT A TIME</td>
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</table>

9a) It is important to know what staff are involved with the development and running of modules. Please specify by each of the following items what type and grade of staff are responsible for the activity:

a) CHOICE OF SUBJECT AREA

PSI

PSII

b) DEVELOPMENT

PSI

PSII

c) CO-ORDINATION

PSI

PSII

d) TEACHING

PSI

PSII

9b) Is any time built into education staff figures to allow for the planning and development of modules?

YES ____
NO ____
10a) Do you have an identified continuing education team?

YES_____ - please specify its composition (stating whether this is a full or part time responsibility) and go to question 10b

NO _____ - please state why not and go to question 11

10b) Are any or all of these posts funded by the National Board and if so please state which?

YES _____

NO _____

11) What modes of delivery do you employ in providing the modules?

Classroom contact _____
Distance learning _____
Open learning _____
Mixed approach - please specify _____

Other - please specify _____

12) How do staff gain access to the modules?

Make request for attendance directly to the College_____ Make request for attendance to line manager _____ Name put forward by manager _____ Other - please specify
13a) Are people attending Professional Studies I modules from outwith your College's designated area?

YES ____ - please state why this is

NO ____

13b) Are people attending Professional Studies II modules from outwith your Health Board?

YES ____ - please state why this is

NO ____

14) Do you have any problems with recruitment?

PSI PSII

YES ____ ____ - please specify

NO ____ ____

15) Are some modules attracting more applicants than others?

PSI PSII

YES ____ ____ - please specify

NO ____ ____
16) Do applicants to modules go through a selection procedure?

<table>
<thead>
<tr>
<th>PSI</th>
<th>PSII</th>
<th>YES</th>
<th>NO</th>
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<td></td>
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</table>

- please specify

17) Do you have waiting lists for modules?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

18) What continuing education provision do you have for night staff and part-time staff?

- NIGHT STAFF

- PART-TIME STAFF

19a) What information do you give to staff about the continuing education that is available to them? - If you have any documents or leaflets that are made available, please include examples with the questionnaire.
19b) Is this information given routinely to all staff, or only at the request of individual members of staff?

ROUTINELY

ON REQUEST

20) Does your Health Board have a policy and strategy concerning the provision of continuing education for nurses?

YES

NO

- please go to question 21

- please go to question 22

21a) Please state what this policy and strategy is and include with the questionnaire any documents or leaflets that are available.

21b) Is this information given routinely to all staff, or only at the request of individual members of staff?

ROUTINELY

ON REQUEST

22) If your Health Board has no policy or strategy, is this a problem to the provision of continuing education in your area?

YES

NO

- please state why
23) Do you have any plans to increase your provision of modules over the next 12 / 24 / 36 months? If so, please state what modules are planned.

PSI PSII

12 MONTHS

24 MONTHS

36 MONTHS

24) In the document that you submitted to the NBS for validation, information was contained about the methods that you proposed to use to evaluate modules. Based on this information would you now answer the following questions:-

a) Are evaluations being carried out on:-

   i - All modules ___

   ii - Some modules ___

   iii - No modules ___ - please state why
24b) Are the methods proposed proving satisfactory?

YES _____
NO _____ - please state why not

24c) Have the methods been changed?

YES _____ - please state how

NO _____

25) How do you identify suitable training areas for Professional Studies modules? - please state the criteria used in this process

26) How do you identify suitable clinical supervisors for staff on Professional Studies placement? - please state the criteria used in this process
27) Is there any preparation and training for these supervisors?

   YES ___ - please state what this involves

   NO ___ - has any been requested ___________________

28) Would you as a College, be prepared to develop and implement (with the aid of the researchers) a longitudinal survey into the effects of continuing education on staff development.

   YES ___

   NO ___

29) A sample of the respondents to this questionnaire will be followed up by interview in order to gather more in depth information about Professional Studies I and II. Would you be prepared to take part in an interview if selected?

   YES ___

   NO ___
APPENDIX 13:

MAILSHOT 1
The following questionnaire requires a variety of responses, according to the type of question asked. Where there are options offered e.g. Yes or No; Classroom Contact / Distance Learning / Open Learning etc., please indicate with a tick(s) whichever is appropriate.

Alternatively, where the question says please state or specify an answer, a space has been left for you to elaborate with as much information as you think is necessary. If the space provided is not large enough, please use the blank sheets attached to the end of the questionnaire to extend your answer.

NAME

________________________________________

COLLEGE

________________________________________

Please enter the date when you have completed the questionnaire:

DATE

________________________________________
1) At present, according to the NBS database you do not have any Professional Studies modules validated. Please could you state therefore what post-basic or continuing education courses you offer at present and what grades of staff these are offered to:-

2) Do you envisage offering Professional Studies modules (either I or II) in the future?

   YES    ______ - please complete Sections 2 and 3
   NO     ______ - please state why not and then complete Section 3

SECTION 2

3) What modules are you planning to offer?

4) At what stage of development are these modules?
5) It is important to know what staff will be involved with the development and running of modules. Please specify by each of the following items what type and grade of staff are proposed for each activity:

a) CHOICE OF SUBJECT AREA
   PSI
   PSII

b) DEVELOPMENT
   PSI
   PSII

c) CO-ORDINATION
   PSI
   PSII

d) TEACHING
   PSI
   PSII

6a) Do you have an identified continuing education team?

   YES——— please specify its composition (stating whether this is a full or part time responsibility) and go to question 6b

   NO——— please state why not and go to question 7
6b) Are any or all of these posts funded by the National Board and if so please state which?

YES ______

NO ______

7) What modes of delivery will you employ in providing the modules?

    Classroom contact ______
    Distance learning ______
    Open learning ______
    Mixed approach - please specify ______

    Other - please specify ______

8) Will staff have to do three modules consecutively or will it be possible for interested parties to undertake only one or two at any one time?

    All 3 PSI PSI-II
    One or two at a time ______   ______
    Don't know ______   ______

9a) What is your annual education budget? ______

9b) Approximately what percentage of this is given to:-

    Basic education ______
    Post-basic education ______
    Continuing education ______
    In-service education ______
    Other - please specify ______
9c) Do you think that your current funding will be sufficient in the future to run modules? If not, please state how you envisage funding them.

YES _____ NO _____

10) How will staff gain access to the modules?

Make request for attendance directly to the College _____
Make request for attendance to line manager _____
Name put forward by manager _____
Other - please specify _____

Don't know _____

11) Will applicants to modules go through a selection procedure?

PSI PSII

YES _____ _____ - please specify

NO _____ DON'T KNOW _____

12) How will you identify suitable training areas for Professional Studies modules? - please state the criteria used in this process

13) How will you identify suitable clinical supervisors for staff on Professional Studies placement? - please state the criteria used in this process
14) Is there any preparation and training for these supervisors?

YES _____ - please state what this involves

NO _____ - has any been requested __________________

SECTION 3

15) Is any time built into service staffing figures to allow for continuing education?

YES_____  
NO _____

16) What continuing education provision do you have for night staff and part-time staff?

NIGHT STAFF

PART-TIME STAFF

17a) What information do you give to staff about the post-basic / continuing education that is available to them? - if you have any documents or leaflets that are made available, please include examples with the questionnaire.
17b) Is this information given routinely to all staff, or only at the request of individual members of staff?

ROUTINELY _____

ON REQUEST _____

18) Does your Health Board have a policy and strategy concerning the provision of continuing education for nurses?

YES _____ - please go to question 19

NO _____ - please go to question 20

19a) Please state what this policy and strategy is and include with the questionnaire any documents or leaflets that are available.

19b) Is this information given routinely to all staff, or only at the request of individual members of staff?

ROUTINELY _____

ON REQUEST _____

20) If your Health Board has no policy or strategy, is this a problem to the provision of continuing education in your area?

YES _____ - please state why

NO _____
21) Would you as a College, be prepared to develop and implement (with the aid of the researchers) a longitudinal survey into the effects of continuing education on staff development.

   YES  
   NO   

22) A sample of the respondents to this questionnaire will be followed up by interview in order to gather more in depth information about Professional Studies I and II. Would you be prepared to take part in an interview if selected?

   YES  
   NO   

APPENDIX 14:

MAILSHOT 2
The following questionnaire requires a variety of responses, according to the type of question asked. Where there are options offered e.g. Yes or No; Classroom Contact / Distance Learning / Open Learning etc., please indicate with a tick(s) whichever is appropriate.

Alternatively, where the question says please state or specify an answer, a space has been left for you to elaborate with as much information as you think is necessary. If the space provided is not large enough, please use the blank sheets attached to the end of the questionnaire to extend your answer.

NAME

COLLEGE / UNIVERSITY

Please enter the date when you have completed the questionnaire:

DATE
1) According to the NBS database you are running the following modules:-

Please confirm this information, and indicate by each module how often it is run and how many people on average attend it. Alternatively, if the information is inaccurate, please amend where appropriate and then add the above details.

2) What grade(s) of staff are attending the modules? Please number your answers in descending order, according to the number of participants provided by each group e.g. if Staff Nurses are the most prevalent put 1; if Charge Nurses are second put 2 etc..

<table>
<thead>
<tr>
<th>Staff Nurse</th>
<th>PSI</th>
<th>PSII</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward Sister</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td>District Nurse</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Health Visitor</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Nursing Officer</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Other - please specify</td>
<td>___</td>
<td>___</td>
</tr>
</tbody>
</table>

3a) What are the resource implications in the running of these modules?

3b) Who provides the resources to cover these?
4) Have you been unable to run any of the validated modules for any reason?

YES_____ - please state why this was

NO _____

5) Do people have to do three modules consecutively or is it possible for interested parties to undertake only one or two at any one time?

<table>
<thead>
<tr>
<th>ALL 3</th>
<th>PSI</th>
<th>PSII</th>
</tr>
</thead>
<tbody>
<tr>
<td>ONE OR TWO AT A TIME</td>
<td>_____</td>
<td>_____</td>
</tr>
</tbody>
</table>

6a) It is important to know what staff are involved with the development and running of modules. Please specify by each of the following items what type and grade of staff are responsible for the activity:–

a) CHOICE OF SUBJECT AREA

PSI

PSII

b) DEVELOPMENT

PSI

PSII

c) CO-ORDINATION

PSI

PSII

d) TEACHING

PSI

PSII
6b) Is any time built in to education staff figures to allow for the planning and development of modules?

YES _____
NO _____

7) Do you have an identified continuing education team?

YES_____ - please specify its composition and state whether this is a full time responsibility.

NO _____ - please state why not

8) What modes of delivery do you employ in providing the modules?

Classroom contact _____
Distance learning _____
Open learning _____
Mixed approach - please specify _____

Other - please specify _____

9) How do potential students apply for a place on the modules?
10) Do you have any problems with recruitment?

   PSI     PSII
   YES ___  ___  - please specify

   NO  ___  ___

11) Are some modules attracting more applicants than others?

   PSI     PSII
   YES ___  ___  - please specify

   NO  ___  ___

12) Do applicants to modules go through a selection procedure?

   PSI     PSII
   YES ___  ___  - please specify

   NO  ___  ___

13) Do you have waiting lists for modules?

   YES___
   NO ___
14) Are the modules full time only?

   YES ____ - please state why

   NO _____

15a) What information do you provide about the continuing education that you offer? - if you have any documents or leaflets that are made available, please include examples with the questionnaire.

15b) How is this publicised?

16) Do you have any plans to increase your provision of modules over the next 12/24/36 months? If so, please state what modules are planned.

   PSI                        PSII

   12 months
24 months

36 months

17) In the document that you submitted to the NBS for validation, information was contained about the methods that you proposed to use to evaluate modules. Based on this information would you now answer the following questions:-

a) Are evaluations being carried out on:-
   
i - All modules ______
   ii - Some modules ______
   iii - No modules ______ - please state why

b) Are the methods proposed proving satisfactory?
   YES ______ - please state why not
   NO ______

c) Have the methods been changed?
   YES ______ - please state how
   NO ______
18) How do you identify suitable training areas for Professional Studies modules? - please state the criteria used in this process

19) How do you identify suitable clinical supervisors for staff on Professional Studies placement? - please state the criteria used in this process

20) Is there any preparation and training for these supervisors?

YES _____ - please state what this involves

NO _____ - has any been requested ______________

21) Would you as a College, be prepared to develop and implement (with the aid of the researchers) a longitudinal survey into the effects of continuing education on staff development.

YES ____

NO ____

22) A sample of the respondents to this questionnaire will be followed up by interview in order to gather more in depth information about Professional Studies I and II. Would you be prepared to take part in an interview if selected?

YES ____

NO ____
APPENDIX 15:

MAILSHOT 3
DIRECTOR OF NURSE EDUCATION / HEAD OF DEPARTMENT
PROFESSIONAL STUDIES QUESTIONNAIRE

The following questionnaire requires a variety of responses, according to the type of question asked. Where there are options offered e.g. Yes or No; Classroom Contact / Distance Learning / Open Learning etc., please indicate with a tick(s) whichever is appropriate.

Alternatively, where the question says please state or specify an answer, a space has been left for you to elaborate with as much information as you think is necessary. If the space provided is not large enough, please use the blank sheets attached to the end of the questionnaire to extend your answer.

NAME

__________________________________________

COLLEGE / UNIVERSITY

__________________________________________

Please enter the date when you have completed the questionnaire:

DATE

__________________________________________
1) At present, according to the NBS database you do not have any Professional Studies modules validated. Please could you state therefore what post-basic or continuing education courses you offer at present and what grades of staff these are offered to:

2) Do you envisage offering Professional Studies modules (either I or II) in the future?

YES _____ - please complete Sections 2 and 3

NO _____ - please state why not and then complete Section 3

SECTION 2

3) What modules are you planning to offer?

4) At what stage of development are these modules?
5) It is important to know what staff will be involved with the development and running of modules. Please specify by each of the following items what type and grade of staff are proposed for each activity:

a) CHOICE OF SUBJECT AREA

PSI

PSII

b) DEVELOPMENT

PSI

PSII

c) CO-ORDINATION

PSI

PSII

d) TEACHING

PSI

PSII

6) Do you have an identified continuing education team?

YES____ - please specify its composition and state whether this is a full time responsibility

NO ____ - please state why not
7) What modes of delivery will you employ in providing the modules?

   Classroom contact
   Distance learning
   Open learning
   Mixed approach - please specify

   Other - please specify

8) Will staff have to do three modules consecutively or will it be possible for interested parties to undertake only one or two at any one time?

   ALL 3
   ONE OR TWO AT A TIME
   DON'T KNOW

   PSI
   PSII

9a) What will be the resource implications in the running of these modules?

9b) Who will provide the resources to cover these?

10) How will potential students apply for places on the modules?
11) Will applicants to modules go through a selection procedure?

| PSI | PSII | YES |                     | please specify
<table>
<thead>
<tr>
<th></th>
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<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NO</th>
<th>DON'T KNOW</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

12) How will you identify suitable training areas for Professional Studies modules? - please state the criteria used in this process

13) How will you identify suitable clinical supervisors for staff on Professional Studies placement? - please state the criteria used in this process

14) Is there any preparation and training for these supervisors?

| YES |  | - please state what this involves |
|-----| |----------------------------------|
|     | |                                  |

| NO |  | - has any been requested |
|----| |--------------------------|
|    | |--------------------------|
SECTION 3

15a) What information do you provide about the post-basic / continuing education that you offer? - if you have any documents or leaflets that are made available, please include examples with the questionnaire.

15b) How is this publicised?

16) Would you as a Department, be prepared to take part in a longitudinal survey into the effects of continuing education on staff development?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

17) A sample of the respondents to this questionnaire will be followed up by interview, in order to gather more in depth information about Professional Studies I and II. Would you be prepared to take part in an interview if selected?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 16:

MAILSHOT
SEMI-STRUCTURED INTERVIEWS
DNE SEMI-STRUCTURED INTERVIEW SCHEDULE

1. How long have your courses been running?

2. Funding is obviously an important issue in the provision of CE, can you explain how your funding is obtained and what you feel would be helpful in easing the situation – eg do you think that if you had a standardised method for costing modules that this would help, or is it merely a matter of injecting more resources into the initiative.

2. What funding is necessary for each individual participant – do they bring funding with them; are they seconded or funded (PSII).

2. What effect is running these courses having on your resource situation

3. What do you think of the NBS guidelines for producing PS modules

3. How do you find the validation procedure

3. Although the NBS states that the modules for both PSI and II should be available as separate entities is this

   A) Viable
   B) Desirable
   C) Practical
   D) Reality

4. What post-basic courses did you offer in the past and have modules been developed from these/this

4. Are you still running any of these post-basic courses

4. Is the development of modules based on service demand or is it related to the expertise that is available within the College

4. Did you take account of what modules were being offered by other colleges

5. Do you think that PS is the best method for providing CE to qualified nurses

5. How do you think it will effect the professional development of individual nurses who undertake the modules

5. Do you see your courses as being aimed specifically at S/N's or is it that this is simply the major uptake group

5. How do you see this fitting into the clinical grading that is being introduced
Would it be / is it important to have time built in to the service staffing quota to enable the effective provision of CE and why. Is this also true for education staff figures.

Does having a wide staff involvement in the development and running of the modules facilitate :-

a) dissemination of information
b) service / education liaison
c) the provision of modules

You said in your questionnaire that you would be using open learning methods - could you explain exactly what you mean by this

Has there as yet been any improvement in patient care which could be perceived as related to the PS initiative

a) Specifically in those wards/departments which have been identified as training areas
b) In general

Have you started any preparation for P2000 and will this have any bearing on the type of continuing education provision that you offer

Should there be some standardisation of entry requirements or should each college continue to set its own

What has the feedback been like from students regarding PS modules

Do they feel that they are adequately informed regarding continuing education

NBS Semi-Structured Interview

1. How long have the NBS been promoting PS?

2. What is the current position at the board re. funding? How do they see the funding issue with regard to the colleges? Do you think a standardised method of costing would be helpful? How do the board see the funding issue being resolved?

3. How were the guidelines developed? Do you think they've been effective? Is the NBS satisfied with the identification and preparation of clinical supervisors?

4. How was the validation procedure developed? What amendments have been made to it and why?
(for both PSI&II)
How is it working?
Have people always offered modules as separate entities or have there been cases of 2-3 modules constituting a programme?
Can you identify the NBS policy on validation? What are your views on this?

Do you feel that the development of modules is based on service demand?
Is the NBS satisfied with the amount of modules which have been developed?
Is the NBS satisfied with the type of PSI module developed, or are there areas not yet addressed that should be emphasised in the future.

Is PS the best method for providing continuing education to staff?
How would the NBS like to see it affecting the professional development of individual nurses?
Should the courses be aimed specifically at SN's?
What are the major problems that the NBS has come across in terms of instigating and promoting PSI&II?

How does the NBS see this pattern of CE fitting in with the new clinical grading structure?
Does it think it necessary to have time built into service and education staff figures to facilitate the provision of CE?
Is it the Board's impression that that there is a wide staff involvement in the development and running of modules; does this help with:-

a) Dissemination of information
b) Service / education liaison
c) The provision of modules?

Is the NBS keen to see open and / or distance learning promoted and is it actively involved in this area?
What improvements is it hoped that there might be in patient care coming from PS continuing education?
Will P2000 have any bearing on the type of continuing education offered in the future?
What feedback have you had from the colleges - or others - about in relation to PS?
Finally, does the NBS feel that they have provided enough information and support to the colleges involved in the provision of PS?
APPENDIX 17:

NURSING LOG
NURSING LOG - INSTRUCTIONS

The purpose of the Log is to record those working situations that you are involved in during the course of a shift, where the knowledge and experience that you have are not adequate to meet the demands that you feel are being made on you. The top sheet of the Log is a sample form which has been filled in with some very broad examples, to give you an indication of how it should be completed. The other five sheets are blank forms for you to use. I have included this number to make sure that you do not run out of space. Please do not feel obliged to fill them all in! The headings at the top of the four columns describe the type of information that is required i.e.:-

<table>
<thead>
<tr>
<th>SITUATION</th>
<th>- What you were doing</th>
</tr>
</thead>
<tbody>
<tr>
<td>EVENT</td>
<td>- What actually happened</td>
</tr>
<tr>
<td>ACTION TAKEN</td>
<td>- Your response to the event</td>
</tr>
<tr>
<td>POSSIBLE SOLUTION</td>
<td>- What (if any) remedy you can suggest</td>
</tr>
</tbody>
</table>

You are asked to add your own information as and when a situation occurs. You do not have to produce pages of writing. All that is required is a set of explanatory notes. You are asked to do this for the five shifts that you work in the week prior to your commencement of the module on August 28th (if you are on holiday that week, but still have some shifts to work before then, please complete the Log at this time).

To make it easier, it is suggested that you fill in the Log twice during any one shift e.g. if on an early shift you come across a situation at 8am and another at 10.30am, make a mental note of these and write them both in just before lunch. Similarly in the afternoon try and remember anything appropriate and make notes at the end of the afternoon. It is appreciated that this will not always be possible, but take this as a working guide.

ALL INFORMATION THAT YOU WRITE IN THE LOG IS CONFIDENTIAL

Unless you choose to show what you have written to someone else, no-one apart from myself and my assistant will see the contents. This does not form any part of your assessment for PSI.

Please bring all forms that you have used with you to the first day of your PSI module, where they will be collected in.

Thank you for your help,

Sara Whiteley,
August 1989
<table>
<thead>
<tr>
<th>SITUATION</th>
<th>EVENT</th>
<th>ACTION TAKEN</th>
<th>POSSIBLE SOLUTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Making a bed</td>
<td>Couldn't fold corners</td>
<td>Left bed in a mess</td>
<td>More practice needed</td>
</tr>
<tr>
<td>Taking a BP</td>
<td>Patient asked difficult question about his illness</td>
<td>Changed the subject and told him his BP was fine</td>
<td>Learn about counselling skills</td>
</tr>
<tr>
<td>Helping an elderly confused patient</td>
<td>Patient refused to cooperate and became aggressive</td>
<td>Asked for assistance from another staff member</td>
<td>Increase knowledge of patient and learn more about coping with aggression</td>
</tr>
<tr>
<td>Student arrived late for a shift - again</td>
<td>She made no attempt to explain why</td>
<td>Tried to find out why so that her time keeping could be improved</td>
<td>More experience with and knowledge of counselling</td>
</tr>
<tr>
<td>NURSING LOG</td>
<td>POSSIBLE SOLUTION</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------</td>
<td>------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EVENT</td>
<td>ACTION TAKEN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SITUATION</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## APPENDIX 18 - FIELDS USED IN ECNM DATABASE

<table>
<thead>
<tr>
<th>TITLE</th>
<th>CONTENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME</td>
<td>CODE NUMBER OF RESPONDENT</td>
</tr>
<tr>
<td>LOCATION</td>
<td>COLLEGE OR AREA</td>
</tr>
<tr>
<td>DATE</td>
<td>START OF COURSE OR NINE MONTHS</td>
</tr>
<tr>
<td>AGE</td>
<td>CHOICE OF FOUR CATEGORIES</td>
</tr>
<tr>
<td>POST</td>
<td>TYPE OF POST HELD</td>
</tr>
<tr>
<td>AREA</td>
<td>DESCRIPTION OF WORKPLACE</td>
</tr>
<tr>
<td>IN POST</td>
<td>NUMBER OF YEARS</td>
</tr>
<tr>
<td>IN JOB</td>
<td>NUMBER OF YEARS</td>
</tr>
<tr>
<td>PAST EXPERIENCE</td>
<td>TYPE OF POST(S) AND YEARS EXPERIENCE</td>
</tr>
<tr>
<td>QUALIFICATIONS 'O'</td>
<td>NUMBER OF 'O' GRADES/LEVELS</td>
</tr>
<tr>
<td>QUALIFICATIONS 'H'</td>
<td>NUMBER OF HIGHERS/A LEVELS</td>
</tr>
<tr>
<td>FURTHER EDUCATION</td>
<td>ANY DIPLOMA / DEGREE ETC.</td>
</tr>
<tr>
<td>NURSING QUALIFICATION</td>
<td>NAME AND YEAR OF BASIC NURSING REGISTRATION</td>
</tr>
<tr>
<td>FURTHER REG.</td>
<td>ANY FURTHER NURSING REGISTRATION</td>
</tr>
<tr>
<td>YEARS PRACTICE</td>
<td>TOTAL NUMBER OF YEARS SPENT NURSING</td>
</tr>
<tr>
<td>ATTENDANCE</td>
<td>ROUTE OF ENTRY TO COURSE</td>
</tr>
<tr>
<td>FURTHER COURSES</td>
<td>NUMBER OF COURSES ATTENDED</td>
</tr>
</tbody>
</table>
APPENDIX 19

SELF-REPORTED STATEMENTS DEPICTING THE CHARGE NURSES’ PERCEPTION OF THEIR ROLE

Manager at ward level
Delegate work appropriately
Liaise with medical, paramedical and nursing staff and other departments
Teach all grades of staff
Be approachable
Lead a team of colleagues in the care of patients
Provide a good standard of care
Co-ordinator in ward management and patient care
Be an example to the staff
Good communication
Keep up to date with nursing topics
Teach and counsel students where necessary
Keep relatives and patients informed
Part of a multidisciplinary team
Liaison between ward and management
Create a happy atmosphere
Be aware of problems arising and deal with them
Involve staff in ward decisions
Make sure staff achieve their potential
Listen to others and after discussion put things into action
Give the patient the full use of the NHS resources
Provide total nursing care and treat patients as individuals
Supervise the work of others
Show leadership qualities while on the job
Ensure health board policies are carried out
Have a sense of humour
Counsel where necessary
Ensure good health and safety in working conditions
Inform relatives
Should be competent
Be responsible for running the ward
Be available to staff and patients for help
Assess patients for care on the community
Most important person on the ward
Aware of legal and ethical implications all the time
Responsible for the care of the patient
Administration
Maintain discipline
Health education
Act as catalyst regarding information, advice and guidance
Aware of cost
APPENDIX 20:

AIMS AND OBJECTIVES OF
ECNM ACTION PLANS
To motivate self and improve management and teaching methods.
Better communication; more skilled teacher of learners and trained staff; to have more awareness and become better educated and more skilled.
To evolve a plan for individualised patient care by looking at the patient as a consumer.
To improve clinical condition and reduce dressing change.
More effective screening.
Start quality circles and always put problems in writing to management.
Increase staff awareness of teaching responsibilities and develop systematic teaching plans to help nurses teach patients.
Set up quality circle on social skills. Introduce student induction programme.
Survey cost of incontinence, try new aid and assess benefit and cost.
Be more conscious of the need to question actions taken on the ward and develop quality circle meetings amongst nurses.
Educate patients prior to confinement and research the need for pre-conceptual care.
Study the effect of a particular drug in induction from a nursing point of view and teach the student midwives.
Evaluate the differences between open and closed urinary drainage systems.
Set up a special counselling service for psychiatric patients with church connections.
Use MONITOR on own ward
Improve the reception of, communication with and role of relatives.
Set up quality circles; replan teaching of learners; patient education.
Make a reference guide to benefit other members of staff, especially if they haven't worked in the ward before.
Plan and reorganise the working of the department and research other similar departments.
Prevent unnecessary admission of patients at term by performing a CTG, and if all is well then send patient home.
Have a written policy for certain aspects of care; meet more regularly with colleagues.
Better communication with bereaved relatives. Monthly meetings with night staff and day sister.
Patient and relative education; staff discussions.
Create a plan to assist new trained staff with ward routine and possible difficulties.
Re-site the charge nurse office; have patio door access from day room to garden; more time to speak to patients.
Develop a programme of teaching for learners through aims and objectives, and evaluate what they have achieved.
Look at and improve information and communication given to surgical day patients.
Improve communications. Reduce incontinence in long stay patients using the systematic approach to incontinence.
Staff development; improved patient care; improved communication.
Rehabilitate and reorientate long term care patients.
Improve relations and communication between nursing and medical staff.
Improve on planning for discharge; improve induction for learners and newly qualified staff; initiate quality circles.
Keep up to date with district nursing material and strive for perfection and kindness in all aspects of care.
Better communication among staff; teaching and orientation of new staff; use existing room for distressed relatives.
Look at job as manager - delegating projects to staff, looking at pharmacy costs, store costs, overlap of staff.
Costing exercise of nursing time and change a nursing practice with a view to cost saving.
Look at workings of department both workload and staffing.
Gather material together for a resource pack on geriatric agencies involved in community care. Interview those concerned.
Ward teaching plan, setting up quality circles.
Communication; kardex writing; identify particular area of conflict and deal with it; keep up to date; invite comments from and encourage staff to keep up to date and discuss things.

Improve patient education; increase staff morale by giving them more responsibility and implementing nursing process. Implement a programme for night nursing auxiliaries concerning all aspects of their job description.

Assess the needs of the elderly in the community referring as necessary to other services available; plan routine visiting of elderly giving health education as necessary and highlight shortfalls in service available - tell other colleagues plans.

Produce research proposal as first step to forming a service to support relatives, using extension of role into community. Development of written philosophy on carer / relatives problems.

Enhance performance as a charge nurse and understand role more fully.

Run a quality circle.

Identify physical illnesses suffered by psychiatric patients and develop a means of dealing with these through GP's and staff.

Improve communications and staff attitudes to relatives; senior staff eventually and reluctantly admitting problems exist and attempting to identify and solve them.

Move staff around to give more experience whilst finding out their wishes through counselling sessions. Set up a quality circle.

Interest staff in ongoing self education. Implement new discharge prescription sheet and get greater involvement from relatives with medication compliance through education.

Greater awareness of needs of long term patients; motivation of team members; improve patient care.

Be a more able teacher; having confidence and knowledge in work without the need to be supervised.

Improve teaching of learners and the care of patients and their education on the ward.
Explore the cost-effectiveness of midwifery activities within a labour suite and identify areas of waste.
Initiate a quality circle to improve all aspects of ward work.
Create more time in the afternoons for staff to talk to patients and relatives.
Achieve the use of patient allocation; organise the night duty rota to give efficient cover satisfactory to staff.
Put together information on basic theatre technique to benefit newcomers to theatre.
Quality circles; involve staff in all aspects of patient care; delegation.
Plan individual rehabilitation programmes for patients and increase standards of nursing care. Pioneer a rehabilitation system.
Identify problem areas; improve communication and patient care and act as advocate for the elderly in decision making.
APPENDIX 21

DIVISIONS USED FOR ATTITUINAL SCALE ANALYSIS

1  Total group of course participants
2  Total group of area D participants
3  Courses 1 and 2, College A
4  Courses 1 and 2, College B
5  Courses 1 and 2, College C
6  Age 21 - 30
7  Age 31 - 40
8  Age 41 - 50
9  Age 51 - 60
10 Area = general
11 Area = psychiatry
12 Area = hospital
13 Area = community
14 In position <= 5 years
15 In position 6 - 10 years
16 In position 11 - 15 years
17 In position >=16 years
18 Years practice = 5 - 15 years
19 Years practice = 16 - 25 years
20 Years practice >= 26 years
21 Qualifications 'O' >=5
22 Qualifications 'H' >=1
23 Attendance = A
24 Attendance = B
25 Attendance = C
26 Attendance = D
27 Courses = 1 - 2
28 Courses = 3 - 4
29 Courses = >=5
30 Course 1, College A
31 Course 2, College A
32 Course 1, College B
33 Course 2, College B
34 Course 1, College C
35 Course 2, College C
APPENDIX 22

On completion of the ECNM evaluation a report was prepared for the NBS. This was reproduced by the NBS, and is still available from them (Whiteley and Broomfield, 1987). Some work from the report (all completed by the author) has been used in this thesis, in relation to the reporting of the ECNM, but as it is not an official publication, the whole report has not been included.