A Participatory Action Research Study on Continual Professional Development with Nurses in Grenada West Indies

This thesis is submitted at Cardiff University for the award of Doctor of Philosophy

October 2018

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ABSTRACT

Background: In Grenada, the process of revalidation requires 60 hours of continuous professional development (CPD) to be carried out over a three year period. This requirement highlights the value of CPD to the Grenada nursing council (GNC) to maintain, improve and broaden nurses' knowledge, expertise and competence. However, there is a lack of a CPD framework, guidelines and policies to guide nurses to enable engagement with CPD and compliance for revalidation. In the international context participation in CPD is expected as a means to provide quality care, but there is a wide variation of engagement. Additionally, internationally there has been a movement to reform and implement contextual frameworks to strengthen CPD for lifelong learning and improvement.

Literature review: The body of knowledge on continuous professional development, including theoretical perspectives, voluntary or mandatory CPD, standards, consensus and evidence linking CPD to competencies and competency provide the foundation of this research.

Aim: The primary intention has been to involve the active participation of Grenadian nurses concerned in working towards identifying the issues and explore the concepts of CPD. Additionally, to identify the organizational and personal issues surrounding CPD in

Grenada. With the aim to identify structures required to propose an effective framework for CPD in Grenada.

Methodology and methods: A participatory action research (PAR) paradigm guided this research. The theoretical framework underpinning this research was critical theory. The participatory action research team (PART) steered the decisions on the methods to be used. Three cycles of planning, action, analysis and reflection were carried out over a year. Data from the PART's meetings and experiences were analysed along with a national survey which informed 24 semi structured interviews to investigate the issues surrounding CPD in Grenada. Differing analysis dependent on the data was used; descriptive statistical analysis for the questionnaire and thematic analysis for the qualitative portions created the results.

Findings: Significant findings from the quantitative and qualitative data analysis informed the PART to create a comprehensive CPD framework. It found that CPD is a complex process, context based and involves formal and informal activities. There is a strong concept that CPD is integral to professional identity, however there was no uniform concept of what CPD is. This study discovered that a framework was viewed essential for CPD engagement and guidance. The acceptance of both formal and informal activities supports current knowledge. Similarly, the need to embed learning theories not only enables the framework to measure CPD but leads to CPD as well. Additionally

the needs and commitment of the individual, profession and institution must combine to ensure development and life-long learning are achieved. As a methodology, due to its characteristics, there is evidence that action research is well suited to post-colonial countries.

Discussion: The research adds new insight into CPD for Grenadian nurses; namely that context based, progressive multidimensional frameworks are needed to capture the processes of CPD and ensure sustainability. The key findings show what constitutes CPD and highlights the issues surrounding availability and accessibility of CPD. This study supports those who advocate for a comprehensive framework to aid engagement. It adds to the literature that mandated activities are viewed positively as evidence of support from the institution. Additionally, engaging with meaningful CPD has complex internal and external factors. The framework proposed is supported by learning theories that encourage autonomy and self-reflection as a means to embed CPD in the culture whilst mandating certain institutional requirements to address patient safety concerns. Critical theory provided a suitable explanatory approach to the findings. Lastly, utilizing PAR supports current knowledge that research findings are applied into practice thus increasing the relevance and clarifying the context and issues at hand. This new knowledge can be transferred to the region and beyond.

Conclusion and recommendations: This research adds to the knowledge on CPD. Acknowledging CPD as a dynamic complex process taking into consideration the needs of the individual, the profession and the institution offers promising potential as future frameworks are evaluated. The conceptual framework is offered as a recommendation for a change in practice, additionally wider implications and recommendations in terms of a change in leadership culture to a more transformative and transparent are presented.

Dedication

This thesis is dedicated to my family, my husband Mark for his unstinting support and belief in me and what I wanted to achieve. Also my children Dylan, Molly and Lily who despite missing many events encouraged and cheered me on. I could not have done this without you all.

Acknowledgments

Undertaking this study over the past four years has been a privilege and I would like to acknowledge and thank the following in their part in the completion of this thesis:

- My supervisors, Dr. Heather Waterman and Dr. Tina Gambling for their experience, wise advice and thought provoking questions, timely feedback and perpetual encouragement.

- Dr. Geraldine Lyte as a critical friend.

- Those colleagues who became co-researchers, for their knowledge, guidance and faith in the process.

- The support staff at Cardiff University, especially in HCARE and library for their advice, guidance and assistance as I navigated the nuanced world of academia.

Contents

List of Tables

List of Diagrams

CHAPTER ONE – INTRODUCTION

1.1 Introduction

The provision, teaching and assessment of clinical competence through continuing professional development (CPD) is essential in order to support nurses (RCN, 2016). CPD ensures that the qualified nurse continues to practice safe, efficient and effective care against the backdrop of rising expectations and with a more autonomous role (Levett-Jones 2005; Benner et al. 2010). In Grenada, where this study takes place, prior to 2009 there was no requirement for nurses to engage in CPD and there are currently still no guidelines or framework in place to assist nurses to undertake CPD. This study will explore the concept of CPD in the Grenadian context. By using a participatory action research (PAR) methodology this study will actively involve nurses in the research and change process to develop a framework for CPD in Grenada.

It is accepted that future practitioners will require the skills and knowledge to base care on best evidence, to use critical thinking and demonstrate advanced leadership and decision-making skills. This will develop and enhance services in a more complex and diverse healthcare environment (Levett-Jones 2005). There is evidence that the practitioner's ability to keep up to date in order to meet patient needs is reaching a critical point (Graham et al. 2006, Majid et al. 2011). As nurses develop, promote new

roles and take on prominent leadership positions, professional development will be required to enable them to meet these challenges (Casey and Clarke, 2009). Furthermore, expectations of clinical skills and competencies of the modern nurse are changing rapidly, with nurses assuming greater responsibility for a more diverse population (Robbins and Hoke 2008; Rouse, 2010; Jefferies et al. 2011; Oranye et al. 2012; Clarke et al. 2015).

Historically what might have been adequate maintenance for the practice of nursing is insufficient for modern times, nurses are faced with increasing demand to remain both professionally up-to-date and personally capable of coping with change and the stresses of nursing (Levett-Jones, 2005; Majid et al. 2011).

1.2 Continuing Professional Development (CPD), definition and associated terminology

1.2.1 Continuing Professional Development definition:

Acknowledging that a nursing career can last for more than 40 years, coupled with the concept that healthcare is a dynamic and changing environment, leads to the conclusion that learning and development evolves over time. As Lliffe (2011) points out, there are numerous definitions, emphasis and pathways for CPD, these include continuous professional education and lifelong learning. These terms are used somewhat interchangeably, but clear distinctions should be made due to their varying abilities to

both promote and confine learning and this will be explored deeper in the thesis (Finkelman and Kenner 2009).

As an illustration of the multiple definitions, two from CPD from Australia and the USA are described. This is followed by the International Council of Nurses definition which is used in this study.

1.2.3 Differing definitions of CPD

As stated by the RCN, while there is no universally agreed term for CPD, there is however a generally accepted understanding of its purpose (RCN, 2016). The Nursing and Midwifery Board of Australia define CPD as the way in which members of the "professions maintain, improve and broaden their knowledge, expertise and competence, and develop the personal and professional qualities required throughout their professional lives" (NMBA 2009). However, only maintenance is mentioned by the RCN stating CPD will help nurses 'maintain' an updated skills set so that they are able to care for patients safely and competently (RCN, 2016). Likewise, within the ICN code of conduct, continual learning is emphasized as a means to maintain competence (ICN, 2012). In contrast the American Nurses Association (ANA) and Health Care and Professionals Council (HCPC) include the concept of career development describing CPD as "a lifelong process of active participation by nurses in learning activities that assist in developing and maintaining their continuing competence, enhance their professional

practice and support achievement of their career goals" (ANA 2000) and "a range of learning activities through which health and care professionals maintain and develop throughout their career to ensure that they retain their capacity to practice safely, effectively and legally within their evolving scope of practice"(HCPC 2005).

1.2.4 Definition for CPD in this context

For this study the term CPD is defined by the International Council of Nurses (ICN) as 'a lifelong process of maintaining and enhancing the competencies of the nurse' (ICN, 2010). Four reasons for using this definition are as follows: firstly the ICN represents nurses on an international platform being globally representational. Secondly, this definition focuses on a more holistic 'lifelong process' rather than the ANA and HCPC definitions emphasising a narrower perspective of only 'learning activities'. Thirdly, in agreement with ANA and HCPC although not explicit the addition of 'lifelong' suggests CPD is on a continuum to include career and differing interests by the individual (ANA, 2000; HCPC, 2005). Lastly, the simplicity of the definition is encompassing, focusing on competencies and acceptance of the lifelong nature of development.

1.2.5 Competency:

There is debate in the literature on the definition of competency, and this will be further explored in Chapter Three. However as defined by Roach (1984, p.54), as 'competency having the knowledge, judgment, skills, energy, experience and motivation required to

respond adequately to the demands of one's professional responsibilities'. In addition, Khan and Ramachandran (2012) state that competency is a skill and competence is the attribute of the person. The concept of a continuum is suggested with competence on a point on the spectrum of improving skills, knowledge attitudes, values and abilities which affect performance (Lliffe, 2011).

1.2.6 Continuing education:

Continuing education is an instructional programme for adults, consisting of nursing courses to increase the learner's knowledge and skills. The aim is to provide quality patient care (Govranos and Newton, 2013). The purpose of continuing education in nursing is to enhance knowledge, skills, and confidence of professional nurses so that they are able to provide high-quality, competent, and safe patient care (Smith et al. 2015). Continuing education can contribute, but is not exclusive as an activity for professional development.

1.2.7 Lifelong learning:

It is accepted, that the ability to learn does not peak at adolescence but develops throughout life (Maslow, 1943; Knowles, 1970). This has resulted in the advocacy of increased public participation in lifelong learning to enable individual development and fulfilment of potential (PARN, 2013). The concept is that lifelong learning can assist with the rapidly changing environment within which nurses work (Clinton et al. 2001).

Another characteristic is that it must be self-directed and active (Clinton et al. 2001). Lifelong learning is defined by Davies and Longworth (2003, p. 22) as the "development of human potential through a continuously supportive process which stimulates and empowers individuals to acquire all the knowledge, values, skills, and understanding they will require throughout their lifetimes and to apply them with confidence, creativity and enjoyment in all roles, circumstances and environments".

The World Health Organization (WHO) recommended that the link between lifelong learning and CPD would enable nurse and midwives to work efficiently and effectively and to realize their full potential as professionals but falls short of specifics (WHO, 2000).

In conclusion, lifelong learning is a dynamic process and involves both formal and informal activities. It encourages and requires critical reflection to gain a new perspective as well as questioning one's environment, knowledge, skills and interactions. The individual, through curiosity, seeks learning to translate knowledge into the capacity to deliver high quality nursing care and this is viewed as being integral to the profession.

1.3 Background

1.3.1 Significance of the Problem

Relative to CPD, there are conflicts within nursing. It is apparent that professional bodies globally have not reached a consensus for proof of development and hours required, with wide variation and formatting (Lliffe, 2011; McCarthy et al. 2013). Within the Caribbean, where this study takes place, miscellany is apparent. For instance, Grenada stipulates 60 hours CPD every three years, whereas Trinidad and Tobago a neighbouring country does not mandate CPD for registration, conversely St Lucia requires 15 hours of CPD activities each year (Onuoha et al. 2013, General Nursing Council of St Lucia, 2015).

Furthermore, encompassing a wider context in 2016, the Nursing and Midwifery Council (NMC) of the UK reviewed its CPD policy, increasing hours and stipulating certain activities such as participation with colleagues and reflective writing (NMC, 2015). To add to the multiplicity many individual institutions in the United States, UK, Europe and Australia demand activities to maintain employment which may or not constitute CPD, such as health and safety mandates. This finding is at odds with the Institute of Medicine (IOM) call for planning and reorganization in US health care institutions and the International Council of Nurses (ICN) for convergence and standardisation of competencies and regulatory frameworks (IOM., 2010; Barry and Ghebrehiwet, 2012).

There also appears to be some conflict regarding what constitutes CPD and who it is intended for. This lack of consensus is evident in the titles of recent articles focusing on CPD. Authors have asked whether CPD in the UK is a 'friend or foe' (Lucas, 2012), in Australia a 'necessity or nicety' (Levett-Jones, 2005), or simply in Canada, 'lost in translation' (Graham et al, 2006). In the medical field, the question of how much and what form continuing education and development should take has inconsistency stating "there is no single correct way to do CPD", this serves to underline the variances and policies in other health disciplines (General Medical Council 2012 pg. 13).

Nursing in Grenada is at a critical juncture, as the introduction of mandatory CPD hours, without organizational or policy recommendations, could create confusion and concern amongst nurses. This is evident as they try to adhere to the requirements to maintain their registration, as regional documentation reflects (Onuoha et al. 2013). Furthermore, levels of migration and 'brain drain' are increasing, motivation and levels of confidence are low as nurses struggle to maintain standards (Salmon et al. 2007). Despite the lack of organization there are spontaneous continuing development opportunities (Onuoha et al. 2013., Xuereb et al. 2014; Gaspard and Yang, 2016). However, many Caribbean nurses do not participate due to ignorance or not being afforded the opportunities for CPD (Onuoha et al. 2013). Nevertheless there is one area for consensus, barriers including financial considerations and lack of institutional support, time constraints, and family commitments transcend geographical and cultural boundaries. The matter of CPD

is urgent in the Caribbean with a call by the Caribbean Community (CARICOM) to conduct a comprehensive evaluation of nursing education and agree on a regional plan for nursing (CARICOM, 2015).

1.4 Personal involvement

I became personally involved with the Grenadian nurses as part of an unofficial continuing education and development resource through volunteering at the Grenada General Hospital. Through this personal connection and observation there is a need for an organized approach to CPD in Grenada.

Underpinning this concept is the belief in and promotion of lifelong learning that enables nurses to learn continually, utilizing all the professional teaching and learning opportunities available to them to facilitate their development and thus enhance competency.

As a result of personal experience and my investigation in this area, I was keen to answer the practical need of bringing theory and practice together to find a solution to this crucial issue.

1.5 Research aim and objectives

This study will explore the concept of CPD in Grenada and propose a framework of CPD that meets the needs of nurses independent of their speciality. This study is underpinned

by the premise that CPD is a necessary activity for nurses at all levels and disciplines and should be supported.

1.6 The research aim:

1. Utilize PAR to identify the organizational and personal issues surrounding CPD and the changes required in Grenada in order to develop and propose an effective framework for CPD in Grenada.

1.7 Objectives and research questions

1. How can Grenadian nurses engage in meaningful CPD?

2. What is the Grenadian nurses understanding of CPD?

3. What are the internal and external issues surrounding CPD in Grenada?

4. How does the use of PAR contribute to achieving the development and proposal of a CPD framework in Grenada?

1.8 Order of Thesis

This thesis is presented in ten chapters. It describes a study undertaken using PAR to explore the issues surrounding CPD and engagement in the Grenadian context. The aim is to inform a framework that would be affective for the nurses in Grenada who need to ensure that their registration is current. Acknowledging the differences in the reporting required for a PAR study , this thesis utilizes the PAR cycles of planning, action, observation and reflection with an analysis of the data at the end of each cycle informing successive chapters (Herr and Anderson, 2005; Stringer, 2007).

Chapter One commences with an introduction to the study and provides the background, it also describes the significance of CPD to nursing practice.

Chapter Two begins with a critical discussion on Grenada in order to familiarize the reader, it provides an overview in terms of social makeup and geographical location. The research aim and objectives are identified along with the research questions.

Chapter Three provides a critical analysis of the background and current literature in the context of CPD and factors influencing engagement. It begins with the theoretical underpinnings which lead to the development of three questions which informed the literature search. The literature reviewed focuses on differing CPD frameworks evidence linking competence, competency and lastly factors that influence CPD.The literature also illustrates how CPD is at the forefront and focus of nursing regulatory or advisory bodies.

The fourth chapter outlines the methodology of PAR. A critical analysis of the theoretical underpinnings and accepted definitions associated with PAR are examined. The research paradigms are discussed, this leads to the explanation of the use of critical theory. Personal epistemology and ontology is described as it relates to the research process and shaping the study. Also, the use of this methodology in healthcare research and its suitability for this study is argued. A full description of the different cycles and their components is presented. In conclusion, unique challenges and evaluation processes are analysed.

The method is described in Chapter Five it gives a broad overview of the methods used in this study, specifically mixed methods. A visual model of the cycles is presented. Finally, the process of gaining ethical approval.

Having established the congruence of PAR to the study aims, Chapter Six, Seven and Eight follow the chronological order of the three cycles involved in creating a CPD framework. An explanation of the data collection and analysis procedures is given and the results are outlined within these cycles. The framework synonymous with PAR of planning, action, observation and reflection are addressed in each cycle, with the analysis of the data informing subsequent chapters.

Chapter Six describes the first action cycle in the study, focusing on 'beginning the journey' it describes the sampling and recruitment of the co-researchers. It outlines the

research decisions made by us and the establishment of the role, scope and responsibilities. The data is analysed and reflected upon, which leads to the start of the next cycle.

Chapter Seven begins with the planning of the action namely a national survey and in-depth semi structured interviews. The second cycle focuses on data gathering from the nursing population in Grenada to fully understand the issues surrounding CPD in the local context. This helps address and answer the following research questions, what is Grenadian nurses' understanding of CPD and what are the internal and external issues surrounding CPD in Grenada? A critical description of the process and analysis of the data for both methods is presented. Finally the discussion and reflection leads to the final cycle in Chapter Eight.

The third and final cycle is outlined in Chapter Eight. This is a synthesis of the findings from the previous cycles and culminates in a conceptualized framework for CPD that could be used by Grenadian nurses. The framework driven by the data includes the organizational culture and support necessary, format and documentation required, and finally the constituents of CPD. The framework is illustrated as a model to facilitate use in context. Subsequently action research in action and reflection on the process is described.

Chapter Nine reflects on the third research question 'how does the use of PAR contribute to achieving the aims of the study?' It reflects on the study design. Additionally a discussion and critique of the proposed framework is presented. This is to show the strengths and limitations of the framework relevant to the literature.

Chapter Ten reviews the work undertaken and summarizes the contribution this study has made to the literature. Implications for further research are outlined including a final reflection.

1.9 Conclusion

In this chapter, an introduction and the background to the research problem and its significance for research is presented; this is followed by definitions that are pertinent to the study. My personal involvement in such a study is described; essentially the purpose of my commitment was to improve practice by investigating the issues surrounding CPD and to develop a framework for CPD using PAR in collaboration with Grenadian nurses. Lastly the order of the thesis was delineated with special focus on the atypical nature as it utilizes the PAR cycles with the analysis of the data at the end of each cycle informing successive chapters.

So, beginning with Chapter Two, a description of the study location and its background is presented. This includes geographical location, the health system and the governing

body related to nursing. Lastly some unique challenges pertaining to nursing and working

in Grenada are outlined.

CHAPTER TWO - BACKGROUND

2.1 Local Grenadian context

This chapter will include a presentation of the historical and cultural background to the studies. This will include an account of the general issues faced by nurses including working conditions. The Caribbean island of Grenada is a tri-island state comprising of Grenada, Carriacou and Petit Martinique with a total land area of 133 sq. miles. Known as the 'spice isle' for its nutmeg and cinnamon production, it is one of the most southerly islands in the Caribbean. The majority of the 100,000-person population live on Grenada itself. Originally it was settled by Arawaks around 4000 BC and was a peaceful farming population which became disturbed between the 15th and 18th centuries, as the island changed hands many times between the French, Dutch and finally the British. African slaves, brought to work on the sugar and nutmeg plantations, replaced the indigenous population continuing until abolition in 1834 (Steele, 2003).

Diagram 1 Map of Grenada (Steele, 2003).

Grenada is a member of the British Commonwealth, it gained independence from the United Kingdom in 1974. Of note in recent history was a popular coup in 1979. The People Revolutionary Government took control, this ended in an invasion from the USA. This popular invasion was seen as a tool for the US to halt Cuban involvement in the

region (Steele, 2003). A national holiday 'thanksgiving' is celebrated each October to recognise the USA's role in re-establishing democracy.

Grenada currently has a stable democratic political environment with a Westminster-style parliament. There is cultural tolerance and heterogeneity due to constant racial and cultural mixing over centuries, the island has significant Indian, Syrian and European populations. However there is a process of cultural reclamation, in the post-colonial era, as ideals based on European models are replaced by Caribbean custom and culture. For instance in Carriacou the yearly Maroon festival celebrates dialect, local stories, music and food.

The main industries are tourism and agriculture; however, statistics reveal that 35.3 percent of the population is classified as poor (UNICEF, 2010). The poverty line is estimated at a daily rate of US$ 3.37 per adult (UNICEF, 2010). The impact of poverty and health in Grenada is of concern in terms of gaining access to care and in responding to health needs.

2.1.1 Health System

The health of the nation is based on the UK 'Beveridge' model, taxes being collected to provide care (Wallace, 2013). However charges are made for certain investigations, prescriptions and 'services,' such as laundry. These 'out of pocket' expenses are a concern for the vulnerable and poor (CCHD, 2006). Shortages in medicines, disposable

items and human resources are common as the health service cope with increased

demand and complexity of care (NOW Grenada, 2017). It appears there is an

institutionalization of a three-tiered system in which the wealthy opt for overseas care

for all but the most minor issues, the upper middle income groups have health insurance

and opt primarily for local private care, and the low middle income groups and the poor

utilize the publicly supported health care services. There are ongoing discussions

regarding a regional insurance scheme for the smaller islands such as Grenada to access

specialized health care in the wealthier islands, namely Trinidad, Barbados and Jamaica

but this has not become a reality (Grenada Broadcast, 2011).

2.1.2 Workforce and conditions

The General Hospital and two tertiary hospitals have 200, 44 and 32 beds respectively.

In addition, the Mt. Gay Psychiatric Hospital and Richmond Home for the Elderly have

100 beds apiece. Currently there are 520 nurses employed in the system. Although data

is not available for Grenada, a recent survey in Trinidad showed that of those who

participated in their study there is a male-to-female ratio of 1:16 (Onuoha et al. 2013).

Remuneration on the island is significantly lower with an experienced staff nurse being

expected to earn £6,500 per year whereas in Trinidad 100 miles away the salary is £9,500

(Government of Grenada, 2017). For comparison, a teacher in Grenada can expect to

earn £7,500. There has been a shift from hospital based care out into the community to

address the change in health care needs, namely an increase in the incidence of non-communicable-diseases such as cardiovascular disease, diabetes and hypertension. This shift results in extended hours for community nurses, increased home visits and development of outreach programmes, as a result there is a move to integrate services into the community (GOG, 2017).

However, as in the UK, despite the challenges Grenadian's are proud of their health service and nurses enjoy a high stature and respect (Grenada Informer, 2016).

2.1.3 Grenada Nursing Council

The semi-autonomous governing body, the Grenada Nursing Council (GNC), is responsible for all nurses including midwives, students and aides. It forms part of the Regional Nursing Council. This advises and regulates the nurses within the Caribbean region. The Caribbean formed the West Indies Federal Nursing in 1959 which in 1972 became the Regional National Board, of which the GNC still forms part (Gittens-Scott, 2008). The Caribbean Nurses and Midwifery Act for registration came into effect in 1966 (Gittens-Scott, 2008).

Nursing students are admitted on to the register after completing an Associate degree at the local Community College and passing the regional exam which allows nurses the freedom to practice throughout the Caribbean. Continuing registration by the GNC was introduced in 2009, with requirements for payment and 60 hours of CPD every three

years. As shown in Appendix A, there are variations within the Caribbean and wider for CPD requirements, though this will be explored further in the following chapter. In conclusion the influence and guidance of the GNC is universal and considered throughout the study.

To further aid understanding of the way in which the relationship and influence of the UK played a part in the development of CPD in Grenada, the two countries are discussed below. The UK and Grenada's historical links serve to answer how CPD has changed over the years in these two countries.

2.2 An historical perspective of CPD in Grenada and the UK

To situate CPD and its evolving nature within nursing, a review of the historical landscape is required. As a narrative both the development of CPD in Grenada and the UK is explored. This island, once a colony until independence in 1974, remains part of the British Commonwealth. The late 1950's and early 1960's saw political agitation with many of the colonial countries calling for and gaining independence from the UK (Palmié and Scarano, 2013). Healthcare in the islands relied on training from the UK, and supplementary colonial staffing. Moreover, unlike the male doctors, nurse training was locally provided in colonial hospitals. Racial tensions were also documented as colonial white nurses became the senior managers (Barros et al. 2009). Nurse education was hampered by insufficient nurse tutors and general staffing shortages. This was

highlighted in the Trinidadian report of 1957. It suggested that staff shortages were due to poor utilization of trained staff, absence of development programmes, and the frustration of committed personnel (Walt et al. 2002; Barros et al. 2009).

In the UK the need for organized training and courses was met in 1979 with the formation of the English National Board (ENB) along with the United Kingdom Central Council (UKCC). Their role was to oversee courses for nurses at both pre-and post-registration levels and thus professional development in the UK gained traction. The UK passed statutory recognition for post-registration education in 1983, at the same time the University of the West Indies began awarding a BScN acknowledging the need for a degree programme for nursing.

The UKCC developed Post Registration Education and Practice (PREP) from their professional code of conduct, the consultation document was published in October 1990 (Hallett and Cooke, 2011). This finally officially recognized a need for CPD in relation to the maintenance of registration. However, fears of the financial impact led to new guidelines which stated that nurses would be expected to demonstrate 'equivalent' learning in their professional profile but that this did not have to involve any formal training (Hallett and Cooke 2011). Within the Caribbean region, a need for standardized pre-registration examinations led to the Regional Examination Nurse Registration in 1993. Ratified by the regional national board the standardization of practice, education

and guaranteed reciprocity within the Caribbean community allowed free movement to practice within the region.

2.2.1 Contemporary issues

Within England, due to scandals in nursing practice, discipline decisions, organizational and financial criticism by government and nurses, the Nursing and Midwifery Council (NMC) replaced the UKCC in 2002 (Hallett and Cooke, 2011). In the Caribbean, the region reviewed policy regarding re-licensure during the period 1999 – 2002, organizational and communication issues were cited as the reason that the policy review took so long (N. Edwards 2016, personal communication, 19 Nov). The GNC having looked at trends and policy Caribbean-wide, made the decision that re-licensure for nurses should be issued every three years, requiring 60 hours of professional development. Due to organizational issues and the desire for the Caribbean to have a harmonious policy, it took an additional seven years to implement re -licensure for nurses. In 2009 CPD requirements and policy was applied in Grenada. However, despite aspirations, re-licensure is not standardized and Caribbean countries have adopted individual policies.

A list of nurses who hold current license in Grenada is published in the Government Gazette yearly. There are presently 520 registered nurses, it should be noted the GNC does not differentiate between midwives or nurses. Guidelines regarding what constitute continuing education and development, the means for providing evidence of

such and computerized record keeping for documentation for Grenadian nurses are not established. These challenges are thought to be due to organizational and budgetary issues (N. Edwards 2016, personal communication, 19 Nov).

The UK's governing nursing council introduced a new framework in 2015 replacing PREP intended to fulfil a key recommendation from the Francis report (Francis, 2010; NMC, 2013). The aim is to empower the profession through demonstrating nurses and midwives ability to deliver care in a safe, effective and professional way. This multi-faceted approach stipulates differing CPD requirements, namely a description of the topic and how it relates to the individual's practice and the code. Additionally, evidence of professional development through reflective essays, feedback and confirmation from a third party is required. This is seen as an improvement with an emphasis on participatory learning activities which involves interaction with one or more other professionals such as workshops, mentoring or conferences.

In conclusion, similarities regarding nursing education can be drawn in the UK and the region as reforms and improvements involving change and challenges are shown. Also the historical perspectives within the region highlight the struggle to formalize education, training and autonomy as it emerged from colonial rule.

2.2.2 Factors that influence migration of workforce

Unique to the region are the migratory characteristics of the nurses (Salmon et al. 2007). Nurses have traditionally migrated from the islands seeking better working conditions and opportunities (Hewitt, 2004; Salmon et al. 2007). The challenges for nurses in Grenada are numerous and this results in many seeking relocation overseas (Hewitt, 2004; CCHD, 2006). The main reasons cited for migration are known as 'push and pull' factors. Push includes, low pay, poor working conditions, limited career structures, restricted employment opportunities and unstable economic conditions (Hewitt, 2004; CCHD 2006). Pull factors are those offered by countries and institutions as a way of addressing these issues to fulfil staffing shortages. Although not unique, the impact on a developing country such as Grenada is significant in economic and institutional terms. The Government presently has a co-operational agreement with Trinidad for the hiring of Grenadian nurses, with 6% of the workforce leaving last year, as political and budget pressures highlight the inability to hire local nurses to work in Grenada (Today, 2015). The requirements of international recruitment and the demand for transferable skills necessitates that nurses who wish to migrate must keep up to date.

In conclusion, in relation to the importance of this study and the background there are a number of issues that have been highlighted. Grenada has limited resources as a country and consequently nurses' income is low, thus any framework would have to be economical and practical for sustainability and uptake. Secondly the changing healthcare

needs of its population mirrors other 'western' countries highlighting the need for

mechanisms where nurses can engage in lifelong learning in order to maintain skills and

knowledge. However in this context as the nursing population is small, they have the

ability to make a large impact on the country's health. Furthermore, in Grenada the issue

of migration is impacted by restricted career structures and constrained employment

prospects both of which could be negated by CPD. Lastly as there is no regional

consensus, the role and influence of the GNC on the Regional Nursing Council could assist

in creating a framework for the Caribbean region.

CHAPTER THREE – LITERATURE REVIEW

3.1 Introduction

This chapter provides a detailed appraisal of CPD in the literature. The main focus will be in geographical areas which are undergoing review, change or introduction of CPD. On initial investigation it was apparent that the literature related to CPD is extensive. Therefore, in order to hone the search and to look for themes that would inform a CPD framework was employed. The aim of the review is to develop an understanding of the existing literature and the objectives are to:

- Gain a critical perspective of frameworks of CPD in use currently.

- Examine evidence linking CPD, patient outcomes and competency.

- Discuss factors influencing engagement with CPD.

Lastly, the key gaps identified in the evidence will be highlighted and discussed that could relate to a potential Grenadian CPD framework.

The organization of this chapter is as follows. Firstly presentation of three predominant theories associated with continuing professional development and life-long learning namely, experiential learning, adult learning theory and novice to expert theory . This informs an initial broad search and development of three questions to guide the literature review.

Each area, namely frameworks of CPD, evidence linking CPD to patient outcomes and competency and factors influencing engagement with CPD is taken separately to then create three themes and a cohesive synthesis of the literature relevant to a CPD framework. Each search has its own flow diagram utilizing Prisma to illustrate the literature searches results (Liberati et al., 2009). A table of the literature is presented covering the three themes that includes a critique of the evidence.

3.2. Theoretical perspectives surrounding CPD.

A critical discussion of the theoretical perspectives relating to CPD follows. The use of theory to underpin the interventions and resources required for a CPD framework is crucial (Mack et al. 2017, Moetsana-Poka et al., 2014). Although acknowledging the many ways in which adults learn (Merriam et al., 2007), these theories are particular to the field of continuing professional development and clinical learning. These theories support lifelong learning which is an element associated with professionalism. The three theories also represent the acquisition of the various dimensions involved with clinical and professional learning; knowledge, skills and attitudes.

It will be demonstrated that these theories complement and overlap with one another and that there is considerable complexity surrounding continuous professional development. In brief, in the case of experiential learning the focus is on the individual's experience. Alternatively adult learning theory is concerned with the individual

development and self-directed learning whereas with 'novice to expert' the development is embedded through 'on the job' practice and experience. Subsequently the theories will be critically analysed within the context of professional development. The three theories are presented in chronological order illustrating the development of thought in the field of 'learning'. This provides a theoretical foundation for a CPD framework.

3.2.1 Adult learning theory

Knowles (1913 – 1997) from the field of education developed an adult learning theory (andragogy). He was influenced by the works of educational pioneers John Dewey and Eduard Lindeman. He also believed that adult education was a force for constructive social action. Knowles (1970) suggested there were five characteristics that defined adult learners:

- **Self-concept**: As a person matures their self-concept moves from one of being a dependent person towards one of being a self-directed human being.

- **Experience**: Through accumulating varied experiences this becomes an increasing resource for learning.

- **Readiness to learn**. Person's readiness to learn becomes oriented increasingly to the developmental tasks of his/her social roles.

- **Orientation to learning**. Learning shifts from one of subject-centredness to one of problem centredness. Focus on the application of knowledge to the immediacy of application.

- **Motivation to learn**: The motivation to learn is internal.

In relation to training and education, the literature noted these characteristics (Clarke et al. 2015, Gaspard and Yang, 2016, Cleary, 2011). In the literature, CPD is recognized as being self-directed towards activities to increase competence, for instance, taking the initiative to ask senior colleagues or reading on a certain topic (Pool et al. 2016). Additionally the self-directed and relevancy characteristics of adult learning theory has alignment with the ICN code of ethics where nurses must maintain competence by continual learning (ICN, 2012). In this context, the competence is applied and is situational based. Eraut (2007) found relevance to adult learning theory as well, finding the majority of the learning being informal and within the workplace itself. He also suggested that this learning is triggered by the challenge of the work itself, emphasizing the orientation to learning in the workplace. However, the assumption by Knowles that just by being adults these characteristics manifested themselves is criticized for being idealistic (Merriam, 2001). Furthermore, learners may be unable or unwilling to take initiatives, or lack the knowledge to create developmental tasks. Viewing learning on a continuum or by the learning situation rather than the learner, may be more useful

(Merriam, 2001). In relation to the implementation and adherence to adult learning, within the area of further education or formal continual professional development often evaluation or assessment is by means of examinations or testing. However as Rachal (2002) points out andragogy eschews paper-pencil testing, yet this remains the most common form of determining whether the learner has mastered content. Its main limitation is the exclusion of context and the social mechanism of constructing meaning and knowledge (Taylor and Hamdy, 2013).

In comparison experiential learning focuses on experience and reflection rather than individual development and self-directed learning.

3.2.3 Experiential learning

Although learning through experience has its roots in Aristotle, the theory is associated with Kolb, (1984) a social psychologist. Influenced by John Dewey, Kurt Lewin and Jean Piaget he was concerned with the more concrete issues related to the learner and the learning context.

Experiential learning or 'learning by doing' considers the individual learner and it is associated with other concepts such as service learning theory, action learning, situated learning and workplace learning. Berings et al., (2008) found that on-the-job learners have more opportunities to choose their own learning activities and were actively involved in the experience. Furthermore the focus is on the individual's understanding

or making sense of events. In the context of work placed learning and professional development, learning occurs without an instructor, or utilizing peer support or mentoring. In Haiti, Clarke et al. (2015) recommended these strategies in areas that were resource poor. Similarly, Hosey et al., (2016) in Africa suggested the use of incorporating CPD related activities into other ongoing or existing nursing activities. Berings et al., (2008) felt it could be described as "what" a person learns, rather than "how" a person learns. Kolb (1984) develops the idea whereby the process of 'meaning making' is reaffirming or revising. This essential piece revolves around the utilization of a phase of reflective observation as part of the four-step model. Kolb (1984) states that to gain genuine knowledge from an experience, the learner must have four abilities:

- The learner must be willing to be actively involved in the experience

- The learner must be able to reflect on the experience

- The learner must possess and use analytical skills to conceptualize the experience

- The learner must possess decision making and problem solving skills to use the new ideas gained from the experience through transference and execution.

However, Kolb does not clarify to what extent learning can occur or is inhibited if these attributes are not present (Quay, 2003). Many of the constructivist models such as Kolb's define experiential learning as a psychological, stepwise process, thus it offers only limited insights into a complex practice including dynamic physical and social interactions

(Seaman, 2007; Quay, 2003). Additionally Michelson (1996) critiques the phases as too linear, with equal depiction and order being a misrepresentation. Michelson goes on to state that the absence of tacit knowledge through experience is unaccounted for. Berings et al., (2008) also discuss reflection seeking clarification surrounding the amount, content, depth and timing of reflection. It could be suggested that too much reflection may lead to indecisiveness and inertia. Moreover, enabling reflection is also a complex process, in a critical analysis of data based studies and implications for nursing education common themes were identified, these amongst others were, being motivated, availability of time to reflect and the need for guidance (Ruth-Sahd, 2003). Another concern is that one may only reflect on what one is consciously aware of, so reflective practice cannot consider learning that occurs outside one's conscious awareness. Lastly in the Grenadian context there is criticism that the theory ignores the ways perceptions and actions are culturally determined (Miettinen, 2000).

In conclusion, Kolb's theory has been used successfully and extensively in nursing education especially in the clinical and simulation fields (Lisko and O'Dell, 2010; Pool et al., 2014). In this model Kolb emphasized the role that experience plays in the learning process. This offers a method for nurses to develop and adapt knowledge, skills and attitudes in the clinical area which relates to the achievement of CPD.

Unlike Kolb (1984) context is central to Benner's (1984) novice to expert theory along with situational learning over time. Additionally, intuition or tacit knowledge is accepted and clarified.

3.2.4 Novice to Expert

Benner's work is applied specifically to the nursing profession and is adapted from the Dreyfus Model of Skill Acquisition (Dreyfus and Dreyfus, 1980). The Dreyfus brothers were from the fields of education and operations research and proposed five developmental stages for training. Benner (1984) proposed that nurses grow in their chosen career as they gain experience within the context of their work setting. Additionally, that professionals move through a five level continuum in which they progress from a novice to an expert. At the centre of Benner's theory is the premise that nurses develop skills and understanding of their profession over time through exposure to education and experience (Benner, 1984). This is evidenced in the literature emphasizing the lifelong nature of CPD and the continuum of learning which is dependent on the nurse's experience and needs (Cleary et al., 2011; Pool et al., 2013; Gaspard and Yang, 2016). Additionally, learning strategies also differed with novices preferring formal learning, whilst in contrast the expert can learn by assimilating new information with their past experiences or by differentiating their experiences from the new information (Benner, 1984). Experts primarily learned through a process of dialogue

and sharing, this process moves towards a constructivist approach. Benner (1984) characterized the stages of clinical competence as follows;

- **Novice**: Limited ability to predict, needs direction and correction.

- **Advanced Beginner**: Can recognize and respond to situations, needs direction

- **Competent**: Able to engage in planning and organizational skills.

- **Proficient**: Utilize and learn from experience and can modify plans in response to different events.

- **Expert**: Apply an intuitive grasp of the situation based on their deep knowledge and experience

Benner (1984) advocates learning through observance and emulating role models, this is problematic in areas lacking in experienced nurses who are able to act as mentors or instructors. Benner's work echo's Schon (1983) who describes the use of reflection as an aid improvement. He explores the concept of 'thinking on one's feet', and that through a feedback loop of experience, learning and practice, there is the possibility to improve performance and become a reflective practitioner. The work of both Schön and Benner reveal the multi-faceted character of knowledge for professional practice. For Schon, (1983) there was a divide between 'knowing that', taught in universities, and 'knowing how', as Benner has suggested, relying on intuition without the need for articulation. Additionally, the required level of competencies that should be possessed by an expert

is open to consideration and subjectivity. English (1992, p. 389) critique of Benner's model focused on the ambiguity of how one moves from novice to expert, stating at what point does "enlightenment and cognitive reorganization suddenly befall the 'proficient' nurse and she is transformed into an 'expert' is not clear, nor what catalyst brings about the conversion". Surprisingly, Aiken et al., (2003) study appears to show that the level of education, not level of experience has the greater influence on patient outcomes. The view that experience is a great teacher has merit from both Kolb and Benner, but the learning is only as in-depth or broad as the individual understands and may be limited by resources, culture, individual values and judgments.

In summary the theories put forward support the interrelations and complexity between nursing and CPD. It also supports the premise that CPD does not happen by accident, nor does it happen solely through formal educational processes, although these are part of the acquisition of new knowledge and skills to inform our practice. The main ways in which we develop professionally, however, are through the practice of our profession itself, and the stimulation from the practice world. This makes us continually build on our existing knowledge, seek out new knowledge and skills, make connections between our knowledge base and the challenges we encounter in practice. Thus utilizing reflection we can learn from our experiences. These theories have clear implications as the conceptual framework is developed. It is proposed these will inform the framework to guide its development for nurses in Grenada.

This concludes the theoretical perspectives related to CPD and life-long learning. The review of these theories support the subsequent themes by exploring how nurses engage with CPD and develop professionally. These theories are embedded in existing frameworks which can sign post possible options in this context. Additionally linking CPD with competency as nurses develop on a continuum from novice to expert through experiential and formal learning needs to be established to justify the time and expense of CPD. Lastly the theoretical underpinnings illustrate how complex and multifactorial CPD is thus exploring the factors which influence this is required for a new framework to be implemented successfully. Next is a description of the literature search, including the methods, search questions and critical appraisal of the literature related to CPD.

3.3 The literature search – Aims

A literature review enables the researcher to critically summarize the current knowledge in the area under investigation by identifying any strengths and weaknesses in previous work. In addition, it can provide the context within which to place the study (Aveyard, 2014.

Accordingly, literature reviews are key as they fulfill three main aims: firstly to summarize the literature that is available and its significance to the study. Secondly, to make sense of a body of research by searching for themes or patterns including an overview of the

methodologies used, and lastly to present an analysis of the literature searched in order to bring new insights (Aveyard, 2014).

A comprehensive overview of the literature was produced, papers were selected that most closely represented contemporary understanding of CPD, and were related in this context.

3.4 Search strategy - Methods

A systematic approach as suggested by Jeon et al. (2010) was adapted to examine the research publications; firstly an initial broad search using relevant key words illustrated the vast landscape of this topic. Once aware it was possible to focus the search using three differing questions to explore the subject. Each PICo question was applied which identified the broad literature, next an initial level of screening through reading the abstracts and applying limiters narrowed the results, then the full articles were read to assess eligibility this led to the final selection.

Using a tool to assist in a literature search ensures that relevant studies are selected and helps to determine the inclusion and exclusion criteria. Three tools were considered; population, intervention, comparison and phenomenon (PICO) population, phenomenon of interest and context (PICo) and sample, phenomenon of interest, design evaluation and research type (SPIDER). As this study required a depth and breadth across all domains, it was appropriate to use PICo headings to help identify the key concepts

(Creswell and Clark, 2007). The rationale for using PICo as an organizing framework was that it was considered superior for this purpose. This is compared to the more quantitative focused, PICO as these may have limited the evidence found. Alternatively the use of SPIDER was rejected as both Cooke et al. (2012) and Methley et al. (2014) found it reduced the initial number of articles identified on a given search. This approach was used for the three areas of interest within CPD and the search terms used are listed in each relevant section of the literature review.

Using PICo facilitated the exploration of the multidimensional aspects of this study, in terms of established frameworks in use as well as the theoretical basis for CPD. Also being able to understand the factors which influence engagement and uptake of CPD along with an understanding of the influence of context was also seen as key in a framework creation. Although perhaps not in the Grenadian context, this would establish the current knowledge and identify any gaps this study may address. Gaining an appreciation of the evidence that links the utility of CPD with competency and competence (See Chapter One, paragraph 1.2.5) was also important as this would indicate the efficacy for introduction of a framework at a policy level. To observe what was implemented in developing or resource poor countries, these were included in the search terms giving a broader landscape. In summary the review showed little in the Caribbean; however the aim was to get a sense of what informs the Caribbean such as the UK and USA.

Database searches of Cumulative Index to Nursing and Allied Health Literature (CINAHL), OVID Emcare, Ovid Embase, Education Resource Information Center (ERIC), and Medline were carried out to identify literature relevant for each theme of the literature review. Limits were placed on the searches including 'peer review', 'English text' and date limit 1993 – 2018 to ensure a wide breadth of literature. The date limit was set to reflect the historical evolution and awareness for post registration education as discussed in Chapter Two, section 2.2; for instance in the UK the introduction of PREP (Hallett and Cooke, 2011). The reference lists of the articles were also hand searched systematically to locate more relevant studies. The search terms were applied in various combinations and notes taken at each stage. Some combinations revealed zero hits. Duplications and those not relevant were removed. Studies included qualitative, quantitative, case, observational and discursive, additionally policy documents and position papers were reviewed. Each objective will be taken separately and described below.

The initial literature search was carried out between March 2015 and June 2015. However, a second search for current literature was conducted, using the same search strategy, between September 16 and December 2017. This was then integrated into the original review. This reflects the dynamic interest of CPD as this subsequent search identified two relevant articles from St Lucia and Haiti (Clarke et al., 2016; Gaspard and Yang, 2016). The literature had an iterative quality as the databases produced a broad range of literature, for instance CPD within allied healthcare professionals or physicians.

Essentially to have a more focused literature review of the phenomena, three literature searches were undertaken relative to the area below and will be synthesised distinctly.

Frameworks of CPD in use currently	Frameworks in use and examples to illustrate developments •Frameworks for registration or revalidation
Evidence linking competence, competency and CPD.	•Evidence linking CPD to outcomes and improved practice •Evidence linking competence, competency and CPD
Factors which influence CPD	• Influences - Individual, institutional and organizational •Motives and activities undertaken by individuals •Allignment and congruity with differing priorities

Diagram 2 Overview literature review

Critical appraisal serves different purposes for different researchers, but it is to facilitate the formation of opinions regarding the quality, flaws, and strengths within the methodologies. Several tools were considered for instance GRADE (Grading of Recommendations, Assessment, Development and Evaluations) which is a framework for developing and presenting summaries of evidence and provides a systematic approach for making clinical practice recommendations (Ryan and Hill, 2016). Its focus is randomised control trials and systematic reviews. Alternatively the GRADE-CERQual (Confidence in Evidence from Reviews of Qualitative research) approach has been

developed by the GRADE Working Group (Lewin et al., 2015). The approach has been developed to support the use of findings from qualitative evidence syntheses in decision-making, including guideline development and policy formulation.

Specific to this study due to familiarity the literature was reviewed using the critical appraisal skills programme checklist (CASP), this is a simple tool to assist in the appraisal of the literature (CASP, 2015). The CASP checklists cover three main areas: validity, results and clinical relevance. The validity questions vary according to the type of study being appraised, and provide a method to check that the biases to which that particular study design is prone have been minimised. There was a need for an overall synthesis and commentary on both the certainty and hierarchy of evidence. Facilitated by CASP, the review focused on quality of reporting, methodological rigour and conceptual depth and breadth of studies as suggested by Massod et al. (2011). The relevant CASP qualitative, quantitative, review and case study tools were used to appraise the studies. Qualitative and quantitative studies, theoretical articles, and government and non-government reports allowed for different types of evidence in the review. Non-research publications provided a background for the research studies of the review period. Examination of all publications for their relevance to the present study, for the depth of information, and for the robustness of the research findings in terms of their validity and reliability, took place. The 25 studies comprised of six literature reviews, five quantitative, four qualitative, four case, two mixed methods studies and four reports. To

provide an overview of the knowledge to identify themes a synthesis matrix was constructed for each of the areas identified. Tabulation enabled the exploration of relationships, heterogeneity and commonalities. This facilitated the organization of sources in the literature review and integrate them for interpretation. From these tables, exploration and comparisons of the findings to identify emerging patterns and themes was possible. Due to the lack of studies that established high levels of evidence, this literature review is a comprehensive review rather than a systematic review of studies that demonstrate high levels of evidence. Presentation of the literature in this way emphasises the complexity of the issue and the difficulty that nurses have in drawing conclusions about their practice of CPD.

The following table summarises the studies in terms of the three searches methodologies, population studied, phenomenon of interest, main findings and critical comments

Table 1 literature review

Theme One -Frameworks of CPD			Theme two – Evidence linking CPD, patient outcomes and competencies or competence		Theme three - Factors influencing engagement with CPD	
Article Title	**Main Author Country Year of publication**	**Research instrument**	**Population**	**Phenomenon of Interest**	**Main Findings**	**Critical comments**
Developing a framework to measure health profession regulation and strengthening	MCarthy et al. Sub-Saharan Africa 2014	Case study	Nurses and Midwives from 5 African countries	A collaborative was formed to bolster the capacity of nursing and midwifery regulatory bodies and the creation of structures to develop or strengthen CPD regulation in the region.	The paper describes the framework developed to evaluate the impact of the project. Using an adapted 'capability maturity model' to measure the progress of five countries that received assistance to strengthen regulations and CPD frameworks. The resultant regulatory function framework included; registration and legislation, scope of practice and CPD	In the study design a participatory process was used however the level of collaboration or participation is not explicit beyond 'feedback provided'. The framework akin to a rubric requires self-assessment which could be open to bias and subjectivity. The framework is simplistic which aids ease of use; however this could overlook certain criteria and does not take into account the complex nature of implementing or strengthening CPD or legislation. Lastly the framework has not been

						validated or formally endorsed by the countries it was designed for.
A comparison of international systems for nurse revalidation – lessons for the UK	RCN 2014 UK	Policy briefing	UK nurses who have to undergo revalidation	A review of five countries revalidation frameworks (Australia, Canada, Ireland, Italy and Slovakia).	Four key themes are explored through a case study on each country related to the proposed changes in the UK, namely; use of third-party confirmation, use of patient feedback, minimum CPD requirements and systems of audit and quality control. Lastly observations for the UK which puts each country in the UK context.	The briefing does not draw any conclusions or specific recommendations. Although a rationale was provided for the countries chosen the sample is limited and perhaps could have included countries with similar or larger numbers of nurses such as China.
Models for implementing continuing professional development programs in low-resource countries	Mack et al. International 2017	Narrative literature review	Physicians and healthcare workers in developing countries.	A review that identifies five models for implementing CPD programs in low resource settings namely; twinning, greenfield, formal programmes guided by international bodies, directed by regulators,	General principles are set out with specific recommendations and models offered for resource scarce countries. These models are illustrated with examples from countries such as Cambodia and Bangladesh. The advantages and	The majority of the examples used are illustrations from the field of medicine which may have limited relevance to Nursing. The paper does not make any recommendations as to which model may be best suited to low-resource countries. Additionally the issues surrounding sustainability

				informal prgrammes guided by international bodies	disadvantages are identified with each model.	or collaboration are not addressed.
Developing a continuing professional development programme to improve nursing practice in Lesotho	Moetsana-Poka et al. Lesotho 2014	Case study	Nurses, Midwives and Nursing Assistants	The Lesotho Nursing Council sought to develop a national CPD programme which would be linked to licensure.	Through outside assistance and collaboration with stakeholders the nursing council developed a CPD programme based on a 'points system' recorded in a log book. The development started in July'11 and ended in Oct'12 with an official launch	The study discusses the use of stakeholders which were consulted and created a group of 'experts' for the CPD advisory committee. However as acknowledged in the paper these persons 'had no pre-existing knowledge or experience with CPD' also the selection criteria is absent (pg 12). Also the level of collaboration is not described only in terms of obtaining buy in. Additionally the development of the national CPD programme was only over a period of four days, with an additional day for a stakeholder consultation meeting. However the paper states that nursing cadres were engaged in all the stages of the process. Although described in broad details there is an absence how certain

						decisions were made to develop the framework.
Establishing an online continuing and professional development library for nurses and midwives in east, central and southern Africa	Hosey et al. 17 member countries in African region 2016	Mixed methods using participatory action research	37 Nursing and midwifery leaders from member countries completed a survey. 46 modules were reviewed this was followed by participatory meetings with stakeholders to finalize content and relevancy to the region	The purpose of the study was to develop an online CPD library on the East, Central and Southern Africa College of Nursing website to reach 3000,000 African nurses and midwives	The survey assessed the components, successes and challenges of CPD efforts already in place. A list of resources available from the 17 members were evaluated. A cost effective and feasible mode of delivery were evaluated. Seven common topics were identified for learning modules to be piloted for the library.	The participatory action research methodology is not clearly defined or explained. There is reference to feedback being sought or participatory observation but the extent and level of collaboration is not outlined. There is no criteria included or described on how the modules were evaluated. Other challenges with the methods were highlighted by the author such a language barrier and need for a translator. Challenges such as expertise, competing priorities and gaining participation from nurse leaders were also sited compounding delays and momentum.
Keeping up to date: Continuing professional development for health	Giri et al. Intrahealth International	Technical brief summarizing the literature concerning current best practice in	Healthcare workers in developing countries	Healthcare workers and those who advise or run CPD programmes	Identified the key components of CPD specifically; content should be evidenced based and relevant. Learning outcomes should be clear.	There is a lack of practical solutions or a blueprint on how to implement best practice. The implementation of CPD in developing and rural areas

workers in developing countries.	(32 developing countries) 2012	CPD targeted towards developing countries.			Incorporate learning theories for effective learning. CPD systems should be multifaceted and provide formal and informal learning opportunities. There is a need to incorporate strategies to transfer learning to the bedside.	maybe more complex than the paper suggests.
Strengthening healthcare delivery in Haiti through nursing continuing professional education (CPE)	Clark et al. Haiti 2015	Case study presented as an example of how CPE is used to strengthen health care delivery in a low-resource setting	Registered Haitian nurses at one hospital	The introduction and evaluation of a continuing education proramme in a developing country	Conclusions were drawn from the experiences of those involved in the introduction of the programme including, collaboration with stakeholders, relevancy to local context, use of participatory teaching methods and tailor content to level and care of participating nurses.	The paper states that evaluation and monitoring are crucial aspects of a programme, however this had not been carried out. The authors state the program will be evaluated by third party but no detail is given. It goes on to state that the programme implementation is incomplete and premature to take their recommendations without an evaluation. Additionally the number of nurses receiving this training is unclear.
Developing a national continuing	Liffe Lesotho	Literature review	Nurses and Midwives	Key features of a number of CPD frameworks across the	Many variations in CPD related to their definition, principle, scope,	The article concludes without making recommendations. The varying standards and

professional development framework	2011		undertaking CPD	African continent namely; Lesotho, South Africa, Malawi in contrast to Australia, the UK and New Zealand	requirement and monitoring. There is no perfect model of CPD.	consensus across Africa had not be evaluated for effectiveness or efficiency.
Redesigning continuing education in the health professions	Institute of Medicine USA 2009	Report	Healthcare workers in the USA	The report, examines CE for all health professionals, it explores development of a national continuing education institute, and offers guidance on the establishment and operation of such an institute.	The report states that there are major flaws in the way CE is conducted, financed, regulated, and evaluated. Health professionals and their employers tend to focus on meeting regulatory requirements rather than identifying personal knowledge gaps and finding programs to address them. Many of the regulatory organizations that oversee CE also tend not to look beyond setting and enforcing minimal, narrowly defined competencies. The recommendation is to create a CPD system to broaden the focus that will ultimately lead to	The recommendations are ambitious requiring federal government to develop a public private institute to regulate across states and national CPD providers. Also to finance CPD and develop a scientific basis for the practice of CPD across all healthcare providers.

					improvements in patient health and safety.	
Impact of a program to improve quality of diabetes care in the Caribbean	Xuereb et al. Jamaica 2014	Quantitative: Audit of 1140 patients charts to assess practice change following workshop 133 healthcare professionals	Healthcare professionals from five Caribbean countries; Belize, Guyana, Jamaica, St Vincent, Suriname	Evaluation of a CPD activity to improve the standards of care for diabetics in the Caribbean region. The two and half day training overviewed the non-communicable diseases and the role of nutrition management, assessment and management process for diabetics, hypertension and obesity. The main goals were to improve the standards of care for patient with Type 2 Diabetes.	Charts were evaluated if the 16 measurements or actions which should have been carried out, measured or completed and recorded in the medical charts in accordance with the training were carried out A statistical improvement in the quality of care following CPD was found through the chart audit.	The lack of laboratory facilities for Some of the post intervention countries Limited the results. Similarly the dietician markers were not conclusive due to a lack of personnel. Alternatively as the participants were aware the charts maybe audited there may have been bias. Also the time between the training and data collection is not stated so retention Is not measured.
Educational levels of hospital nurses and surgical patient mortality	Aiken et al. USA 2003	Quantitative Cross-sectional analyses of outcomes date for 232342 patients	Nurses working in hospital settings	The study was to identify if hospitals with higher proportions of direct care RNS educated at the baccalaureate level or above have lower risk adjusted mortality rates.	The empirical evidence clearly indicated a 10% increase in the proportion of nurses holding a degree was associated with a 5% decrease the likelihood of patients dying within 30 days of admission. Also	The authors suggest repeating the study in other areas to ensure generalizability. This study centers on only one area of professional development namely bachelor degree prepared nurses so the

		discharged linked to nursing survey data providing information on education levels.		Also to offer insights into the potential benefits for a more highly educated nursing workforce.	nurse's years of experience were not found to a significant predictor of mortality.	implications for this study is limited.
A systematic review to appraise the evidence relating to the impact and effect of formal CPE on professional practice	Sykes and Temple International 2012	Narrative literature review 21 papers	Registered nurses who had completed modules or further education.	A literature review was to investigate what the impact and effects of CPE on the professional practice and development of registered nurses. This was delineated into *what* knowledge skills and attitudes were obtained and then *how* they applied in practice.	Nurses who had further their studies were able to transpose knowledge into practical skills. However due to a number of barriers implementing newfound knowledge and skills was a challenge.	The review did not include literature regarding workshops or informal CPD. Although professional development was discussed this review focused on continuing education.
The impact of short-term professional development on participant outcomes: a	Lauer et al. International 2014	Narrative literature review 23 papers	Professionals who undertake short professional development courses	The literature review was to identify the design features of effective short term professional development sessions. Design features which	Many of the courses used adult learning theory concepts. The findings suggested that short courses had positive impacts which could be measured in terms of	Most of the studies utilized qualitative methods such as measured perceptions of the participants or perceived changes in knowledge, skills or attitudes. This kind of self-reporting could be biased. Lastly

review of the literature				proved most successful were; use of learning objectives, alignment with participants needs, demonstrations and hands on practice, group discussion, pre and post work or follow up support to promote transference.	transfer of learning. It concludes that the focus should be on what happens during short CPD courses rather than focus on the time allotment.	some of the literature reviewed did not comprehensively describe the CPD design rendering classification problematic.
The effects of focused nursing education on 3F Groshong PICC Occulsion rates: the experience of one tertiary pediatric care facility	Holt et al. America 2010	Quantitative A pre (n= 101) and posttest (n = 53) design. Direct observation (n= 39) and retrospective chart review (n=55)	Pediatric nurses working on medical and surgical units in one hospital facility	To evaluate if a focused nursing education intervention would reduce the incidence of catheter occlusion. The PICO question was 'in patients with PICC lines, does implementing a focused nursing education as compared to basic orientation and the availability of policy and procedures decrease catheter occlusion rates?'	Focused nursing education contributed to significantly reducing occlusion rates, also increased knowledge was observed in the pre and posttest scores. Through observation psychomotor skills were also seen to be improved through adherence to protocols.	As the units were aware the study was being conducted there is a possibility that a 'Hawthorne effect' where behavior is changed due to being observed. Additionally the posttest was not taken by 50% of the nurses so the data may be compromised, also the integrity of the posttest could have been compromised as it was conducted over a period of time. Lastly variables such as cross-contamination amongst nursing staff may have influenced the results.

Effectiveness of continuing education programmes in nursing: literature review	Griscti & Jacono International 2006	Narrative literature review 40 papers	Nurses, Midwives and Health visitors	The review examined the effectiveness and impact of continuing education on practice. This review covers formal, informal, short and long courses. Mandatory vs voluntary and challenges with evaluating outcomes are covered.	There is a concern that focusing on structured courses is overlooking a large part of how nurses learn. There needs to be investigations into why some do not participate in CPD. To address accessibility and sustainability it is recommended that nurses, institutions and professional bodies collaborate.	There is not a clear distinction between professional development and continuing education. The literature failed to provide a unified picture in terms of the effectiveness of continuing education.
Training needs assessment of health care professionals in a developing country: the example of St Lucia	Gaspard & Yang 2016 St Lucia	Quantitative questionnaire training needs analysis questionnaire. 208 Questionnaires were distributed with a response rate of 68%.	Healthcare professionals from St Lucia Caribbean	A needs assessment of continuing education to ensure training needs preferred approaches and effectiveness in St Lucia.	The need for CPD was rated the highest priority followed by research and audit activities. Training needs centered on communication and management skills and research methodology. These activities were seen as the best way to increase quality patient care.	The questionnaire addressed the needs of the nurses in St Lucia so generalizability could not be assured. As the opinions questioning only the employees it did not account for the needs of the institution or other stakeholders in the needs assessment.

A survey of the participation of nursing in continuing professional education in Trinidad and Tobago: A case for chronic research self-management education for patients	Onuoha et al. Trinidad and Tobago 2013	Quantitative questionnaire 1,032 nurse completed the questionnaire 70% response rate	All qualified nurses employed in the Regional health authorities in Trinidad and Tobago	To assess nurses participation in continuing education (CE)	The main barriers were; awareness, accessibility, finances and time. Nurses appeared ignorant of CE opportunities (55.4%) of the 44.4% that knew of CE only 25.9% had attending CE activities. There was an overall interest in attending CE if given the opportunity (86.7%)	The questionnaire was unable to Illuminate why certain answers were given, therefore analysis was open to conjecture and interpretation. This survey focused on continuing education rather than CPD so may not be transferable.
Factors influencing continuing professional development	Brekelmans et al. Netherlands 2012	Mixed method Questionnaire and discussion Delphi study 38 Dutch nursing experts	Nursing experts: Nurse educators, employees, managers and Professional Institutions.	To present an inventory of expert opinions on the factors that influence the participation of registered nurses in CPD	Main influencing factors were: a CPD registration system, attractiveness of the profession, identification with the profession, workplace opportunities, role modeling and attractive educational programs.	The use of 'experts' to evaluate 'regular' nurses feelings and influences towards CPD could bias the results. Not including the nursing workforce does not create a full account of the factors which influence professional development.
Strengthening professional	Chilomo et al. Malawi	Case study Conducted 20 supportive	Nurses and Midwives in Malawi and those who	A situational analysis of the factors that influence engagement	Challenges noted were; facilitators did not fully understand the concept of CPD, managers were not	The CPD taskforce is not fully described in terms of sampling recruitment or details as to scope or data gathering

development in Malawi	2014	visits to gain insight into the current challenges and successes of CPD	manage or facilitate CPD	with CPD. Focusing on the rural areas in Malawi	adequately supportive, inaccessibility due to rural settings, knowledge deficits on documentation CPD activities lack of standardization of training materials and workforce resistance.	methodology. Methods of the study are not explained nor how statistical data was achieved is missing. The 20 supportive visits are not described fully.
Exploring ward nurses perceptions of continuing education in clinical settings	Govranos and Newton Australia 2014	Qualitative 23 members in 4 focus groups 6 individual interviews	Nurses from Med/Surg unit in a major teaching hospital	Exploration of clinical nurses values and perceptions towards continuing education and professional development.	Multiple factors influence nurses' ability and motivation to incorporate lifelong learning. Three themes were identified, culture and attitudes, what is learning, being seen regarding opportunities and challenges to CE. Overall nurses felt CE was perceived as important.	The interview size is considered small, utilizing only one ward in one hospital. Therefor the results are not as generalizable. Also the views on the Clinical nurse educator are unclear if they are referring to one person assigned to the ward or educators in general.
Motives and activities for CPD: An exploration of their relationships by integrating	Pool et al. Netherlands 2016	Qualitative Using semi-structured interviews 21 nurses interviewed	Full and Part time registered nurses from two metropolitan hospitals	Nurses were selected via purposive and maximum variation sampling. Data was analyzed using the framework on CPD motives and activities	Nine motives and four categories of learning activities for CPD were delineated. Increasing competence was the primary motive that stimulated nurses to engage in self-directing learning during work and	Using interview data from a previous study could have biased the results, as the previous data was on career pathways favoring formal pursuits. As the interviews used a retrospective narrative there

					in formal learning activities. To comply with requirements mandatory courses were done, to deepen knowledge conferences were attended, to develop careers post graduate education was taken.	could also be bias in the participant's memories. The data may not be applicable as it was originally collected in 2013, this study was published in 2016
literature and interview data						
continuing professional development in nursing in Australia: Current awareness, practice and future directions	Katiskits et al. Australia 2013	Quantitativeq uestionnair 289 responses 39% Response rate	Public and private hospital nurses from Queensland Australia. EN, RN and RM participated	To determine current understanding practice and needs of nurses for CPD. Also to ascertain perceived barriers or incentives to participate CPD. This is hoped to improve CPD engagement.	Results showed that understanding of the new CPD requirements were high. Most valued ongoing learning. The majority preferred work based learning within the working day. Barriers included understaffing and time constraints conflicting with home life. The need for institutional and managerial support was highlighted.	The data was collected from one geographical locale. The survey was previously used to measure adaptability for change for substance abuse and organizational change however how it was adapted or application was not described fully. The wording from the original survey was also changed, this was not fully described.
Mandatory continuing professional development requirements:	Ross et al. Australia 2013	Narrative Literature review 29 articles	Nurses and Midwives in Australia.	An examination of how CPD requirements have evolved and the impact	Nurses make a variety of choices in order to fulfill legislative requirements. Effective CPD is complex and should incorporate	A full description of the literature search methods was lacking.

what does this mean for Australian nurses				of mandatory CPD requirements	different situations and accommodate learning styles.	
The views of mental health nurses on continuing professional development	Cleary et al. Australia 2011	Qualitative Semi-structured interviews	50 nurse participants Large mental health center in Sydney Australia	To ascertain clinical nurses views and preferences regarding CPD and their employment intentions	CPD is highly valued across all that participated. In house sessions were preferred. Patient related clinical skill was most desired. Work based flexibility, appeal of courses available, and time for study leave where seen as contributing to engagement. The main focus of engagement in CPD was to further tertiary studies.	The sample population was concentrated from one large mental Health center. Additionally as the interviews were structured with prepared questions thus the expansion and exploration of views was limited.
Illuminating the process: Enhancing the impact of continual professional education on practice	Clark et al. 2015 UK	Qualitative Two rounds of interviews the first n=35 and a second six months later n=31	Nurses four stakeholders: Students Managers Educators Governing Board	To explore the processes that key stakeholders believe are the most important in facilitating a positive impact on CPE on practice.	Four themes showed the views about the issues affecting the process of CPE; organizational culture, partnership working, supportive learning environment, changing practice. These themes developed three key issues to enhance the	The study relied on telephone interviews which may have affected the answers, observational cues and therefore the data. The split of the stakeholders numbers are not described, there would be differing perspectives but this is not described on how the stakeholders views differed or

					impact of CPE on practice; organizational culture, learning environment and partnerships between the four stakeholders.	how this is incorporated into the study findings.

This next section begins with a critically analyses of the frameworks of CPD is presented as per the first literature objective. Starting with, three frameworks in use from the literature are offered. Then the evidence related to competency, competencies and efficacy of CPD is critically discussed. Lastly the factors which influence engagement with CPD are detailed.

3.5 Frameworks of CPD in use currently

The PICo approach was followed to identify literature that facilitated understanding and assisted in describing the varying frameworks that are used by individuals, institutions and organizations to facilitate, support, document and prove CPD for nurses. The question centered on 'what continuous professional development frameworks for registered nurses are currently used in developing countries'. Key search terms for Population (P) were 'Nurs*'. Key terms for the phenomenon of Interest (I) were 'CPD', 'continu* professional development', 'mandatory or voluntary', 'revalidation', 'continu* education', 'practice theor*', 'continu* education* theor*', 'learning theor*', 'CPD model', 'CPD design', 'policy', 'framework*', 'frame work*'. Context (C) key words included 'commonwealth', 'Caribbean', 'developing countries' 'low resource'. The results within the databases are; Eric (58 citations, 4 utilized), Cinahl (84 citations 3

utilized), Ovid Emcare (79 citations 4 utilized), Ovid Embase (32 citations 0 utilized) and Medline (18 citations 0 utilized).

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│  Records Identified through data bases   │
│               (n=136,075)                │
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│  Abstracts screened after keyword search │
│                and limiters              │
│                 (n= 271)                 │
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│       Full text assessed for eligibility │
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│             Exclusion            │
│  Desgin not consistant with aim -7│
│  Research methodology not clear - 17│
│     Data analysis not clear- 18  │
│     Relative to this study - 30  │
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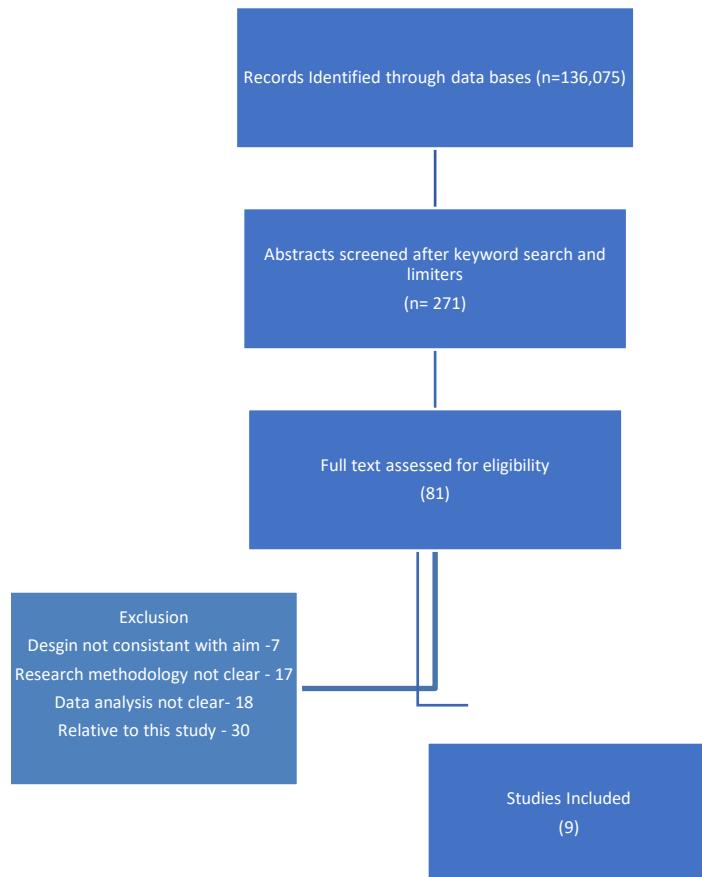
Diagram 3 Result of question one literature search

3.5.1 Examples of frameworks in UK, Australia and Malawi

This section starts with a brief overview of three frameworks as they are indicative of others in the literature including Lesotho, South Africa, New Zealand, Ireland, Jamaica,

Canada, (RCN, 2014, NMBI, 2017.,NCJ, 2017., Lliffe, 2011., Moetsana-Poka et al., 2010, Gross et al., 2015). This section will analyze three particular frameworks in use from the UK, Malawi and Australia taken from the literature. These represent the differing landscapes of CPD and how there is a necessity for context to meet the needs of the individual, profession and institution. In the literature the Institute of Medicine (2010) conducted a review on the issues related to continuing education of health professionals, recommending the US move from fragmented continuing education offerings to focus on a broader concept of CPD. In suggesting a comprehensive CPD system the goal would be to have an improved professional performance and identity, one that is independent of specialty and encompasses lifelong learning. However, the evaluation of CPD for re-registration is diverse, in the United States and South Africa evidence of attendance at certified events is required, whilst in the UK and Australia, random audits of portfolios is currently in place (HPSA, 2011, NMC 2015, ANMC, 2009, ANA, 2000, Lliffe, 2011, Griscti and Jacono, 2006). This is further illustrated by Lliffe and McCarthy (2013) who proposed a toolkit for the African region stating each country should develop its own policy and framework.

The three frameworks represent the development of CPD across the globe, both Malawi and Australia are developing frameworks but in different ways, the UK has re-evaluated and introduced a multifaceted approach after extensive research which could serve as an indicator for the future. Of interest in this study are frameworks where resources are

limited, the literature included several studies undertaken in Africa as a major initiative had been instigated. Within the Caribbean, Jamaica did have online documentation regarding mandatory CPD, specifically 30 hours every two years with 25 hours related nursing/midwifery hours and five (5) non-nursing hours, although useful, it did not offer the detail or rationale required for assessment or to inform.

Mack et al., (2017) conducted a review and identified five differing models of CPD for developing countries, of the five discussed they favoured programmes which are directed by regulators or governing bodies, as they felt this increased the legitimacy and organizational capacity. Regrettably in Mack et al., (2017) study, the search strategy employed for the review was not stated and the scope centered on physician CPD. Having a regulatory body involved is the case in the three frameworks explored. However, involving such a body requires a certain level of infrastructure and may become bureaucratic. The frameworks examined will help contextualize both the learning theories which were discussed in this section and the core concepts from the literature.

These three studies from the literature are indicative of the progress along with the diversity of CPD frameworks. Although some countries such as Sweden, Malta and China have voluntary systems in place, these were not highlighted. These CPD frameworks did not have the detail or defined recommendations to inform this study (EAHC, 2013).

These voluntary CPD frameworks are based on an ethical obligation by the professional to participate in CPD not requiring assessment. The frameworks below are discussed in terms of purpose, process, challenges, evidence for CPD, and theoretical links.

3.5.2 Purpose

The frameworks examined for CPD are linked with standards, safety and competence (Lliffe, 2011; Ross et al., 2013; McCarthy et al., 2014). In Malawi the purpose for developing a CPD framework was to enable nurses to stay current and respond quickly to rapid changes in healthcare (ARC, 2013).

In contrast, as described earlier, in both the UK and Australia the revision of CPD and frameworks for revalidation were a direct result of enquiries into standards of nursing practice (Francis, 2010; Garling, 2008, Ipsos Mori, 2017). It was specified in the NMC's response to the Francis report to develop a new revalidation and CPD system along with a new code and proficiency standards (NMC, 2013; Ipsos Mori, 2017). The purpose of both frameworks is to enhance public protection and improve nursing standards to encourage and support a culture of individual professional responsibility and ongoing learning and reflection (NMC, 2013; NMBA, 2017).

Furthermore in the UK, Australia and Malawi the frameworks can be used as a tool for showing that CPD activities undertaken are appropriate for supporting and enhancing professional practice for re-registration by governing bodies.

3.5.3 Process

In the UK the revalidation framework is multifaceted, including reflective essays, feedback and confirmation from a third party with an emphasis on participatory learning activities such as training courses and mentoring (NMC, 2015). Specific to CPD, 35 hours are required, with 20 hours of 'participatory' learning; this is an activity that involves interaction with one or more other professionals. Additionally detailed records are required to include; the CPD method, a description of the topic and how it relates to individual practice, the dates on which the activity was undertaken, the number of hours, identification of which part in the code the activity relates to and evidence that the CPD activity was actually completed. A reflective account must be written referring to either CPD, practice-related feedback or an experience related to professional practice.

In Australia a federal system was introduced to support revalidation as a means to ensure quality in nursing. Specifically, minimal hours of CPD (20 hours) and documentation of an identified learning need, a learning plan, participation in the learning activity, and the outcome achieved form the evidence of CPD via a professional portfolio for audit and approval. This criteria for ongoing registration was introduced in June, 2016 (NMBA, 20117; Katsikitis et al., 2013).

The study carried out by Lliffe (2011) in Malawi in 2011, describes a CPD framework with limited resources, this included a CPD log book, with a 'points' system (25 per year) and

a self-assessment process. These points are offered for varying activities, reflection garnering one point, whilst being involved in a research project offers three. This reflects many of the initiatives undertaken by African countries such as Swaziland, Kenya and Botswana following the African health profession regulatory collaborative (Gross et al., 2015, Hosey et al., 2015, Lliffe, and McCarthy, 2013). Lliffe, as part of the commonwealth nurse federation, also established the CPD 'toolkit' to act as a guide for the region (Lliffe and McCarthy, 2013). In their recommendations it was suggested that CPD should be relevant, current, available, accessible and affordable.

It is interesting to note that all these frameworks have been introduced recently, indicating a shift in priorities, emphasis and requirements from governing bodies

3.5.4 Challenges

There has been criticism of structures that reward or focus on simply meeting regulatory requirements rather than identifying personal knowledge gaps (IOM, 2010, Boud and Hager, 2011). Having systems which require self-appraisal could address this (IOM, 2010). Using these three as examples it can be concluded that these mandatory programmes were adopted to answer the need and responsibility of regulatory authorities to ensure patient safety. Across these frameworks there is evidence that mandated CPD, whilst powerful in maintaining an oversight of the profession through the standardization of training opportunities, should not negate the need for

professionals to be proactive in identifying and meeting their own development needs (Brekelmans et al., 2013). This will be expanded on in section 3.6 when discussing competency and competence. Moreover, differences are stark, for instance, standards in the hours of practice are varied. The UK requires 450 hours of practice over three years, Canada requires 1,125 hours in five years and the US requirements are 960 hours over five years (NMC, 2015, CRNBC, 2015). As well as supporting the contextual nature of nursing as discussed earlier, these variations exemplify the differing resources, geographical challenges and infrastructure available in these countries (see Appendix A).

All three frameworks have a mandatory quality, and are related to re-registration. In two of the frameworks, namely Australia and Malawi, there is an emphasis on formal learning activities rather than informal. This is perhaps due to a pressure to 'measure' learning and focus on obtaining credit hours or points rather than outcomes (IOM, 2010). Malawi's, and others in the African region, point system is evidence of this; relying on a structure that rewards attendance that is easy to count and register. Whilst suiting the novice, the lack of structures to encourage internal motivation and problem solving skills are incongruent with learning theories such as Benner (1984). In conclusion the simplistic points system and reliance on classroom based CPD in Malawi may inadvertently promote thinking that does not identify and challenge assumptions but passively accepts an established method.

The UK's multidimensional system goes some way to address this need with a focus on the individual or micro and the professional or macro perspective. It has a multi-layered approach, however it may be an intimidating process requiring extensive infrastructure. It should also be noted that introduction and implementation of any national programme has challenges. Chilomo et al., (2014) described how monitoring and evaluation visits by the Nursing and Midwifery Council of Malawi revealed that nurses and midwives, as well as CPD facilitators, did not fully understand the concept of CPD and had knowledge deficits on the documentation process for CPD. It does not go on to fully describe the methods or analysis which led to these conclusions, however the council did receive grant monies to bolster the programme, suggesting rigour was in place.

In summary all three frameworks are new initiatives which aim to address the wider issues of safety and revalidation. All three support a mandated framework stipulating certain requirements and activities to document CPD and thus revalidation. However, within all the frameworks there is a lack of evidence as to why a certain requirement is made. For instance, the UKs' framework requiring five reflective essays appears an arbitrary number, in Malawi a nurse can gain only 3 points for 'contributing' to a textbook or publishing an article whilst attending a workshop offers 1 point. Moreover hours of documented CPD vary across these highlighted frameworks. Lliffe (2011) adds to this stating that the lack of consensus indicates there is a lack of agreement on what level of CPD constitutes a minimum requirement for safety. Moreover, the evaluation process to

demonstrate benefit to the individual, profession and institution is not explicit in any of the frameworks.

A binding characteristic of all three frameworks is that they support an individual's professional perspective. All three recognize situations where professionals learn in ways that shape their practice and so can be defined as professional development. The allowance in the three frameworks of informal education programmes, through interaction with colleagues, or from experiences outside work is progressive and consistent with learning theories which were discussed (Schatzki, 2012; Webster-Wright, 2009). Boud and Hager (2011) explore this further suggesting the futility of isolating activities offered by educationalists independent of practice and context. In the Australian and Malawi frameworks, the inclusion of self-assessment and goal setting is congruent with a self-directed approach in line with adult learning theory and novice to expert (Knowles, 1970; Benner 1984). Additionally, in the UK the inclusion of reflection supports experiential learning (Kolb, 1994). Similarly, all the frameworks accept the premise, to differing degrees, that the activities that constitute CPD should be varied linking all three theories earlier discussed. It is acknowledged that this diversity focuses on flexibility and thus compliance is facilitated. In conclusion it should be rejected that 'one size fits all' and that CPD should be focused on the individual's developmental goals.

This next section will critically discuss mandated and voluntary CPD and how this can influence a CPD framework for re-registration. The focus is to identify structures required to propose an effective framework for CPD in Grenada, it is necessary to understand the relationship between these two models in order to create an effective Grenadian CPD framework.

3.5.5 Mandated CPD

The concept of having mandated CPD is to acknowledge the dynamic nature of the nursing profession and the need to maintain skills to retain the capacity to practice safely and effectively (Lliffe, 2011). However, this is criticized by Kennedy (2005 and 2015) as having too much focus on institutional requirements, being too prescriptive, and unable to identify an individual's needs for development. Additionally, Lawton and Wimpenny (2003) show concern because emphasis is drawn away from lifelong learning as it is not self-motivated. This was especially evident in the papers produced from Australia, as the introduction of mandatory CPD is a departure from before (Cleary et al. 2011; Katiskits et al., 2013; Ross et al., 2013; Govranos and Newton, 2014). Furthermore, it is argued that mandating certain requirements has shifted the focus and placed emphasis on the content and activities rather than professional development (Kennedy, 2005; Boud and Hager, 2012). Similarly, passive learning or conventional workshops may not translate into a change in practice or promote procedural practices thus reducing the nature of development and critical thinking (Boud and Hager, 2012; Ross et al., 2013). In the review

on Australia, Ross et al., (2013) cautioned against nurses simply fulfilling hourly requirements.

A Delphi study exploring mandated CPD in Holland was conducted by Brekelmans et al., (2013), this consisted of three rounds of interviews amongst 38 nurse experts. The experts consisted of managers, professors in education and representatives from professional institutions. The findings suggested that a mandatory system was preferred and called for a strategic policy to ensure compliance. However, although supporting mandated CPD the study cautions against overly prescriptive control preferring autonomy and an empowering process, however, how this would be achieved was not clarified. The study was critical of nurses who, in the expert's opinion, did not take responsibility for their own professional development. How the experts came to this opinion is not clear, appearing subjective, as the views of the general nurses were not sought. Furthermore the strategic policy which was used to ensure compliance was not identified. Further investigation was recommended to seek clarification of the nurses' understanding of the CPD process. Related, Giri et al. (2012) conducted a technical brief to summarize the literature concerning current best practices and innovative ideas for CPD specifically in developing countries, suggesting mandating CPD would lend legitimacy and enforce investment. However Giri et al. (2012) acknowledged that the expenditure involved could be prohibitive.

In contrast, two studies by Lee et al., (2005) and Cleary et al., (2011) refute the suggestion that nurses would not take responsibility for their own CPD. In Cleary et al., study (2011) a series of semi structured interviews with 50 Australian mental health nurses found the respondents actively sought out diverse courses, without any mandates. Of those interviewed 40% (n=50) expressed the view that CPD was key to their future, seeking more courses than those classed as mandatory (Cleary et al., 2011). This is confirmed by Lee et al., (2005) whose quantitative survey in Hong Kong showed that 59% of those surveyed (n=142) had completed more than the mandated requirements in order to enhance their practice.

This is supported by the quantitative research carried out by Katsikitis et al., (2013). The survey sought to ascertain the current understanding of practice and future CPD needs of nurses in a region of Queensland. Of the 289 responses, 92% agreed that CPD was important to their nursing practice. Although the response rate to the survey was only 39%, the survey methods included a validated questionnaire to create data. Evidence that mandated hours was not a motivator was apparent, as only 17% admitted that they participated in CPD to keep their hours up. Motivation was also explored in Lee et al., (2005) only 13% (n=33) saw CPD as pre-requisite for license renewal as a motivating factor. This contrasts with overwhelming support for CPD, as 92% (n=234) agreed that CPD was important to their nursing practice. Also of interest is that 85% (n=284) of nurses used CPD to remain engaged and interested in their profession (Katsikitis et al., 2013).

27

The level of burden the institution should carry in terms of financial assistance, enabling

attendance or hosting CPD was called for but not clarified (Ross et al., 2013). However in

the Francis and Garling reports on care failings, both the institution and individuals were

seen as key contributing factors in safety and patient outcomes. This suggests that

mandatory CPD could form part of the solution (Francis, 2010; Garling, 2008).

This concludes a summary of mandated CPD. The literature suggests mandating CPD

would ensure compliance by the individual, but may reduce the activity to mere

attendance (Brekelmans et al., 2013). Comparatively, on the side of the institution

mandating activities could enforce investment and convey validity but prove too

prescriptive (Giri et al. 2012). However, the literature showed that individuals often 'go

above and beyond' the mandated requirements as CPD is highly regarded as a means to

stay engaged with the profession and key to nursing practice (Katsikitis et al., 2013; Lee

et al., 2005). This voluntary CPD will be discussed next.

3.5.6 Voluntary CPD

As suggested by the literature, voluntary CPD is aligned with life-long learning (Lawton

and Wimpenny, 2003). Also this is supported by educational theories surrounding CPD,

namely that learning is self-directed and internally motivated (Knowles, 1970). In

Australia, many nurses already complete significant hours of CPD without any

recommended or mandated hours (Katsilitis et al., 2013). This could be as a result of the

overwhelming acceptance that CPD is important to nursing practice. Lee et al., (2005) noted that the overall motivation for enrolling in formal CPD activities was a personal interest with the majority 37.5% (n=96) currently studying using personal funding. Additionally, in Australia, the Nursing and Midwifery Federation states that accountability and responsibility for CPD belongs with the individual nurse. This suggests that it supports voluntary CPD activities (James and Francis, 2011). Comparably, within the European Union there is evidence that self-declaration and accountability is acceptable as only 12 of the 28 member states (including the UK) require that nurses be revalidated and show evidence of any kind of CPD (RCN, 2014).

Voluntary engagement enhances the outcome of the learning experience and the impact on individual practice related to individual needs, by focusing on reflection and self-evaluation (Kolb, 1984). In this, results are implicit, and professional development is a part of the culture, demonstrating commitment to that profession (Mulvey, 2013). However, this culture is institutionally based as well, within an institution knowledge is not individualized. The way an entire organization learns can be instrumental in its innovation and culture, requiring certain control by that institution (IOM, 2015). This makes a strong case for mandated activities which could change and develop an organization positively.

In relation to spontaneous and work placed learning (Eraut, 2007, 2009), in the developing and resource scarce context, it should be considered that a health worker in a remote, rural clinic with no other professional colleagues nearby will not have the same opportunities for spontaneous professional dialogue as a peer working in an urban environment (Giri et al., 2012). Lastly, it must be acknowledged that not all nurses are concerned, are aware of, or can access professional development (Brekelmans et al., 2013, Griscti and Jacono, 2006; Onuoha et al., 2013).

Within the context of independent learning this is an emergent process and bound in the concept of the meaning and identity of professionalism, this cannot be mandated or forced (Brekelmans et al., 2013). In addition, the concept is built on the accepted notion that critical reflection and autonomy aid CPD and the profession (Friedman and Phillips, 2004).

The issues surrounding documentation and mandatory and voluntary CPD activities, show the complexity and conflict created as it tries to be 'all things to all people' (Cleary et al., 2011; Lliffe, 2011; Brekelmans et al., 2013; Katsikitis et al., 2013). Additionally the distinction is not so clear, agreeing with Billett (2006) that formal learning may occur in the more informal work environment and mandated activities may yield high engagement and involvement. In conclusion, there is a clear need to balance the

developmental needs of the individual, whilst taking into account the overall goals of the institution to the benefit of the patient.

3.5.7 Learning theory, relating to voluntary or mandated CPD

Using the information within the literature it was clear that there were tensions between mandated CPD and CPD which was undertaken freely. This will be further discussed in relation to frameworks in the next section. The critical analysis of the two, mandated and voluntary activities, will help shape the basis on which a Grenadian CPD framework can be formed.

In relation to learning theories described earlier, mandatory CPD initially appears incongruent to the principles of adult and lifelong learning (Knowles, 1975; Lawton and Wimpenny, 2003). This criticism would be rebuffed by those involved with these activities, stating that teaching style and methods such as simulation can create an environment for critical thinking and relevance to the individual (Dickerson et al., 2014, Schubert, 2012).

As analysed previously, Benner's (1984) theory supports the belief that learning and development occurs in, for instance, interaction with colleague and peer mentorship (Lawton and Wimpenny, 2003; Benner, 1984). This argument is expanded on by Eraut (2000) who states that learning is situated in a context which comprises not only a location but is socially constructed and thus encourages critical discourse. The

individual's experience described in Kolb's experiential theory is supported via reflection and can aid change and learning (Kolb, 1984). However only the UK framework, which is discussed shortly, requires evidence of a reflective discussion.

Nevertheless there is support that mandated CPD whilst powerful in maintaining an oversight of the profession, through the standardization of training opportunities, should also encourage professionals to be proactive in identifying and meeting their own development needs to support the essence of professionalism (Brekelmans et al., 2013).

By contrast, voluntary CPD emphasizes the outcome of the learning experience and the impact on individual practice related to individual needs, by focusing on reflection and self-evaluation. In this, results are implicit, and professional development is a part of the culture, demonstrating commitment to that profession (Mulvey, 2013). The model draws upon Kolb's reflection cycle of planning, action, learning and finally reflection, to develop and change practice (Kolb, 1984). It is seen as an emergent process and bound in the concept of the meaning and identity of professionalism (Brekelmans et al., 2013). In addition, this concept is built on the accepted notion of reflection aiding learning and CPD (Friedman and Phillips, 2004).

Lawton and Wimpenny (2003) propose there is a dichotomy between CPD that is a professional commitment to lifelong learning and development and CPD for re-registration. They go on to suggest this illustrates tension as to who decides CPD

priorities. This could be viewed as over simplification and polarizing the arguments surrounding mandating or voluntary CPD activities. To suggest that nurses fall into an 'either or' category cannot articulate the complex nature of CPD and associated frameworks. With mandatory CPD hours set, many go above and beyond these as the drive to evolve and develop is a characteristic easily recognised within the profession. As discussed earlier the work by Billett (2006) suggests people learn by using the methods that suit their interests and goals and choose how to engage in what is available, this can be both voluntary and mandatory activities. Both activities could support learning and professional development. Depending on the country's policies this can be documented and exposed to an audit. Although as discussed earlier some countries, such as Ireland, do not require any documentation to re-register.

To refute Lawton and Wimpenny's (2003) dichotomy, the model below demonstrates the interrelatedness between mandated and voluntary activities. On the outer ring are the core competencies that contribute to the profession, on the next and inner rings are the various mandatory and voluntary activities which can be undertaken. Lastly in the centre is personal professional development through a cycle of identifying knowledge gaps, plan of action to address those gaps, action and finally review and reflection on development. The rings are not continuous which represents how the voluntary and mandated activities interdepend, one influencing the other and ultimately the profession. As an example basic life support may be mandated, however this may lead

to an individual wishing to expand their knowledge and experience voluntarily to advanced or paediatric life support. In relation to a CPD framework design, it should consider the type of understanding unique to the profession as well as the context in which this knowledge is to be obtained (Herbert and Rainford, 2014). Evidently a balance is required; a record of activities, without regard to the quality or impact of those activities does not constitute learning or change in behaviours (Ross et al., 2013).

Diagram 4 interrelatedness between mandated and voluntary activities to CPD

PROFESSIONALISM

Mandatory Activities

Voluntary Activities

Identify

PERSONAL

Review and Reflect

PROFESSIONAL

Plan

DEVELOPMENT

Act

ATTITUDES

KNOWLEDGE

SKILLS
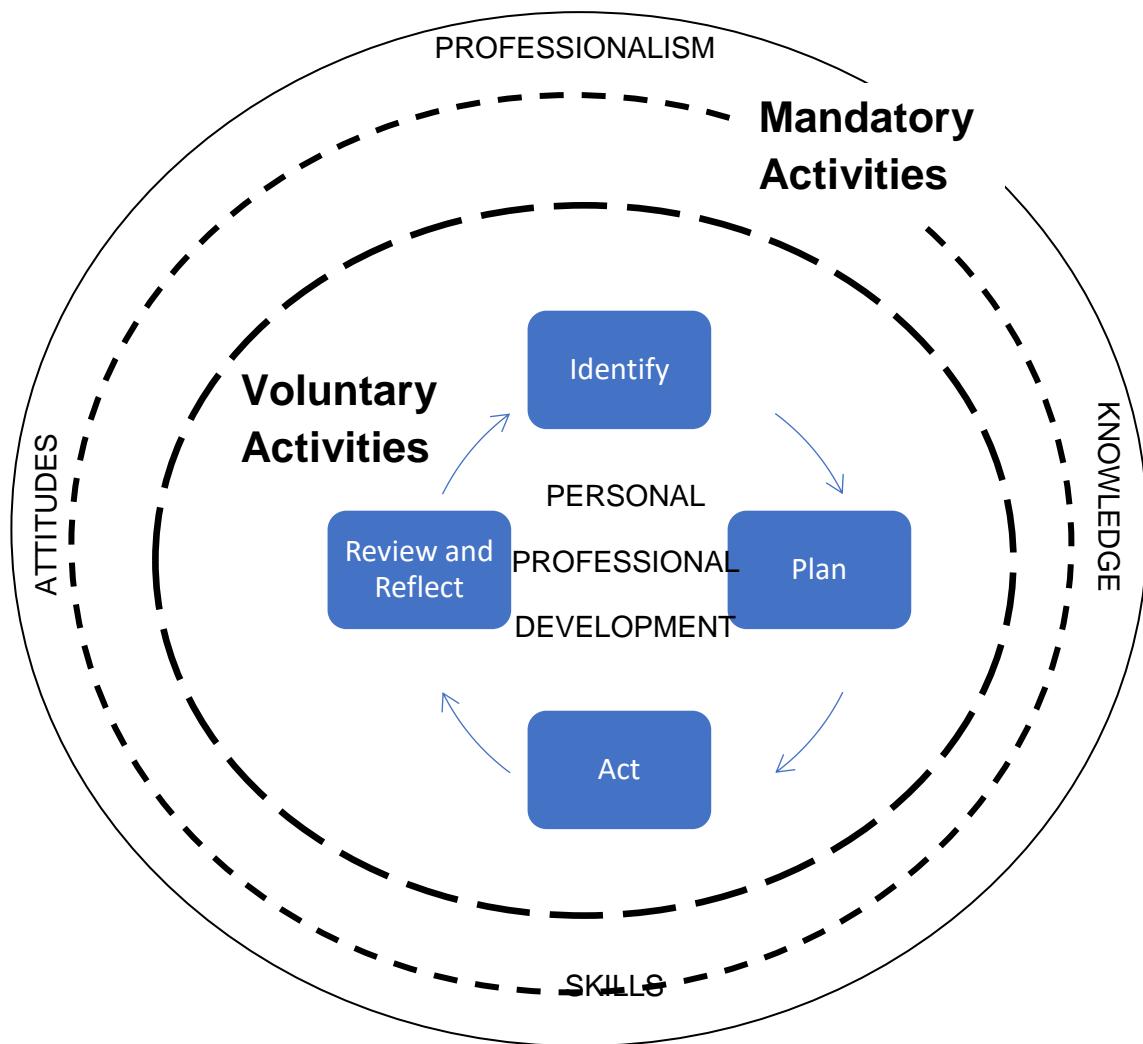
In conclusion, it is evident that there are tensions between the theoretical perspectives

and the 'how' of continuous professional development. Returning to the ICN's definition

of CPD, the emphasis is on the individual, however, not all nurses are interested in, or

perceive benefits through professional development engagement (Griscti and Jacono, 2006; Onuoha et al., 2013).

In this next section the issues regarding the evidence of outcomes and CPD are critically analysed as considerable funds, time and infrastructure are required both institutionally and personally to complete and document CPD activities. It will be shown that there is growing evidence linking CPD with patient outcomes, however this is not without controversy (IOM, 2010; Lauer et al., 2014). Similarly there is skepticism as to how much continuing education is needed to maintain competence or professional development and to support learning or affect performance (IOM, 2010).

3.6 Evidence Linking Competence, Competency and CPD.

The PICo approach was taken again to identify literature that facilitated understanding and evidence that supports efficacy of CPD, acknowledging the significant investment that CPD demands. The question focused on 'what is the evidence linking continuous professional development in nursing to improved patient outcomes, nursing competency and competence?'. The need for evidence to link CPD with outcomes is required and although emerging is not explicit. Studies included case, observational and discursive, additionally policy documents and position papers were reviewed. Key search terms for Population (P) remained the same. Key terms for the phenomenon of Interest (I) were 'CPD', 'continu*professional development' 'patient outcomes', 'competency',

'competence'. Context (C) remained the same. The search terms produced the following; Cinahl (77 citations 0 utilized), Ovid Emcare (40 citations 1 utilized), Ovid Embase (80 citations 1 utilized) and Medline (188 citations 7 utilized). As with the previous searches different permutations of the search terms were used to ensure all possible combinations and, to avoid duplication, notes were made each time a specific combination was used.

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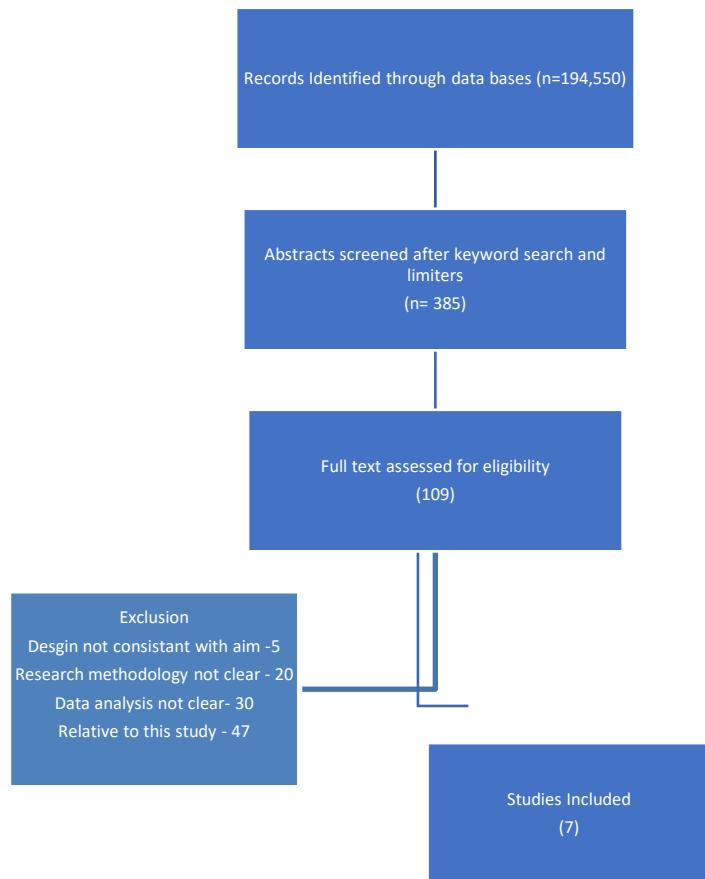
Diagram Five Result of literature search question two

The following section addresses the evidence surrounding competence, competency and CPD. Discussed are the differentials between competence and competency and the issues with correlation and CPD.

As described in the introduction, difficulties in defining competence and competency make their measurement problematic (Watson et al., 2002). Studies including both definitions but not clearly delineating them was evident during the literature review (Oranye et al., 2012; Zamora et al., 2011). However, there is agreement that clinical competency is an essential requirement to carry out safe and effective nursing care (Clarke et al., 2012; Oranye et al., 2012; Rouse, 2010; Zamora et al., 2011, Bradshaw and Merriman, 2007). Furthermore, the Royal College of Nursing (RCN) acknowledges this by stating that CPD is "the mechanism through which high quality patient and client care is identified, maintained and developed" (RCN, 2007, p.2).

To help clarify this polemic, Khan and Ramachandran (2012) state that competency is a skill or set of skills, whilst competence is the attributes of the person. It can also be viewed that competence is a point on the spectrum where improving skills, knowledge and attitudes, values and abilities which affect performance can be found (Lliffe, 2011).

In the literature it is acknowledged to varying degrees, that nurses who have engaged in CPD activities have positive patient outcomes (Lliffe, 2011; Lauer et al. 2014; Beaumont and Stainton, 2016). This develops the idea that CPD, along with clinical practice, contributes to competency and that both are essential for safe practice (Giri et al., 2012; Moetsana-Poka et al., 2014). As described earlier, in both the UK and Australia it appears revision of CPD and frameworks for revalidation were as a direct result of enquiries into

standards of nursing practice (Francis, 2010; Garling, 2008). As discussed earlier, it was the NMC's response to the Francis report to develop a new revalidation and CPD system along with a new code and proficiency standards (NMC, 2013). Both countries allude that these frameworks will help to improve nursing standards and will encourage and support a culture of individual professional responsibility and ongoing learning and reflection.

However, even when meaningful learning occurs, this does not necessarily result in an improvement in performance; transfer of learning is affected by several factors, including institutional support, self-motivation and culture (Schostak et al., 2010., Sykes and Temple, 2012., Ross et al., 2013; Brekelmans et al., 2013).

In the UK, the independent review of the new revalidation process suggests there is a lack of robust evidence to link the individual elements of revalidation, such as the practice hours, CPD and confirmation to the ultimate outcomes that revalidation seeks to propagate (Ipsos MORI, 2017). It also states there was 'no evidence' linking practice hours to fitness to practice or only limited evidence to link CPD hours to fitness to practice (Ipsos MORI, 2017 p. 15). However this study relies on self-reporting and participants were unable to generalize the extent of the behaviour change in question.

In the systematic review by Sykes and Temple (2012) to appraise the evidence relating to the impact and effects of continuing education on professional practice, the authors suggested there was abundant but inconclusive studies. This appraisal had a narrow

scope of methodology, of the 21 studies reviewed, 13 consisted of personal perspectives through interviews and eight were self-reporting questionnaires. These were measuring a change in attitudes and behaviour, if personal development occurred and whether practice was affected. All of the studies reported a change in attitudes through increased confidence, self-esteem or empowerment, equally all reported that personal development occurred but did not give details. Lastly, only ten studies noted a change in practice although the review did not go into details as to what changed or how it was measured.

There appears to be a lack of validated outcomes measurements, perhaps as the purpose is unclear or diffuse. There was a lack of defined outcomes to measure. Additionally the methodology is poor, none reviewed by Sykes and Temple (2012), utilized observational studies for instance. As with the review carried out by (Griscti and Jacono, 2006) the studies rely on the health professionals' perceptions of change, which does not necessarily equate to improvement in patient care. Sykes and Temple (2012) also suggested the possibility of recall bias, as the conclusions relied on many retrospective qualitative studies. Similarly, in the field of education, Lauer (2014) reviewed 23 studies with activities of 30 hours or less. This review relied on studies measuring participants' perceptions. As previously discussed these studies had positive outcomes related to knowledge or improved skills. For instance, there was reported increased efficacy related

to their ability to improve asthma care or improved post-intervention scoring. However they acknowledged limitations with regard to the rigour and methodology.

There is limited quantitative evidence in the literature using controlled before and after testing to ascertain changes in outcomes (IOM, 2010). Two articles examined focused on educational interventions (Holt et al., 2010; Xuereb et al., 2014). The quantitative study carried out by Xuereb et al., (2014) evaluated whether there was an improvement in the standards of care for diabetics following a CPD activity. Focusing on five Caribbean countries, 133 participants were recruited, and 1140 medical charts were audited to measure a statistical improvement in the quality of care. The results showed that CPD did improve practice in the management of diabetes, adherence to evidence based practice and protocols were significantly superior. However significantly, the time between the training and audit was not stated and a follow up audit had not been planned to assess knowledge and protocol retention. It could also be surmised that if participants were aware that their charts would be audited this might have resulted in unrealistic compliance and consequently had an influence on the results.

A similar study investigated the skills and knowledge of central line catheters focusing on care, maintenance and flushing to prevent occlusions. A pre and post-test design, observation and a retrospective chart review to determine the rate of occlusion were measured. The intervention focused on an educational programme utilizing adult

learning theory on the correct technique for flushing the catheters. The results showed that the educational intervention enhanced post-test written scores, observation of psychomotor skills showed improved techniques and occlusion rates reduced from 21.11/1000 catheter days to 15.49/1000 catheter days. Similar to the previous study the post-test, observation and chart review occurred relatively soon (one month) after the intervention without any planned long term follow up, thus unable to show the long term effects of the intervention and knowledge retention. Additionally, although thoroughly described there were some issues with the methods, the direct observations did not occur in the same environment with some having to be assessed in the simulation laboratory. As previously discussed, participants were aware that their performance was being observed so this may have been influential. Lastly, although 101 nurses took the pre-test and educational intervention only 53 concluded the post-test potentially biasing the results as those who felt confident may have self-selected to take the test. However the implications for practice and outcomes are encouraging through these two studies. Nevertheless there is clearly more to be done to justify the burden and expense of undertaking CPD and similarly those who offer, regulate and evaluate CPD.

One important study in a related field may indicate a methodology choice for further research into CPD. This was in the field of education by Aiken et al., (2003). This study, which was part of a larger investigation, examined whether the proportion of hospital nurses educated at the bachelors level or higher is associated with lower mortality rates.

The study analysed patient outcome data derived from hospital discharge abstracts that were merged with information on the characteristics of the hospital nurses. The data was collected from 168 hospitals in Pennsylvania, this included, 10,184 and 232,342 patient charts who underwent general surgery. The study provided the first empirical evidence that hospitals who employed a higher proportion of degree nurses have improved patient outcomes.

Qualitatively, nurses have described several personal reasons for undertaking CPD linked but not conclusively to patient outcomes. In Australia, Katsikitis et al., (2013) showed the majority of nurses thought that CPD was important for nursing practice and that it helped sustain interest in the profession. Related to outcomes, nurses also reported increased confidence, personal satisfaction, keeping up to date and career development (Katsikitis et al., 2013; Onuoha et al., 2013; Gould et al., 2006). The training needs assessment carried out in St Lucia in the Caribbean showed nurses wanted continuous professional education with communication and clinical skills being cited specifically (Gaspard and Yang, 2016). These activities have been linked with improved patient outcomes, suggesting the nurses are trying to 'fill gaps' in their knowledge that would directly affect patient care (Draper and Rogers, 2015; Cleary et al., 2011). This is echoed by Cleary (2011) whose semi-structured interviews again highlighted the overwhelming request by nurses to broaden their clinical practice expertise.

The consensus in the literature appears to be that nurses value and express a desire to develop and engage in CPD as a means of delivering quality care (Majid et al., 2011; Katsikitis et al., 2013; Onuoha et al., 2013; Govranos and Newton, 2014). Moreover, the observation that autonomy and empowerment through knowing one's practice and having control and the ability to act on that practice is supported by CPD is important. However, the link between these characteristics and patient outcomes remains unclear (Manojiovich, 2007). These studies relying on personal accounts are problematic as there are several variables such as the institution's culture to embrace change or allow new found knowledge or skills to be applied (Sykes and Temple, 2012). Similarly Draper and Rogers (2015) semi-structured interviews illustrated how the process of CPD planning, delivery and engagement were influencing factors on the overall impact of CPD on practice. They go on to suggest that a positive organizational culture, effective partnerships between stakeholders and a supportive learning environment are essential for CPD to be influential at the bedside (Draper and Rogers, 2015).

In summary with several regulatory authorities requiring specific skills and minimum practice the underlying argument that patient outcomes and competency is linked to CPD is suggested (NMC, 2015; CRNBC, 2015). However, just how much practice, over how long and the contribution to competency and positive outcomes remains unclear. It appears there is a difficulty in defining the right outcomes to be measured as it relates to CPD.

Furthermore there are concerns surrounding, efficacy, accreditation and quality as the commercial interests grow, with the CPD industry estimated at a $180m per year in Australia (Ross et al. 2013).

It is accepted that CPD interventions are complex, measuring various outcomes on multiple levels (IOM, 2010; Katsikis et al., 2013). There are several interacting components and variability within the nursing population. It is also evident from the literature that there is a need for institutional and professional bodies to support CPD (Levett-Jones, 2005, Warden et al., 2009, IOM, 2010, Katsikis et al., 2013). Additionally, as there are multiple methods of CPD delivery and a variety of content, it appears the central questions of what matters the most remains uncertain. Craig et al., (2008) for the Medical Research Council offers guidance which is relevant to a CPD intervention suggesting there is a need to consider; the complexity of understanding how each element works and influences the outcomes, to appreciate what causal mechanisms are at play and how the range of effects can vary amongst the recipients (age, geographical location, time etc). Similarly many of the studies in this literature review have not stated which outcomes are most important, which are secondary, and how these multiple outcomes are dealt with in the analysis. It may be the inherent characteristics of CPD, the flexibility and variety is the challenge of standardizing and measuring the delivery and outcomes in a way that shows the efficacy.

This concludes the evidence from the literature linking competence, competency and CPD.

3.7 Factors Influencing CPD

Lastly the third theme, factors influencing CPD, is explored this question 'what are the main factors that influences nurses in developing countries from engaging in continuous professional development?. This was needed because in developing a framework, an understanding of how nurses can engage and complete certain requirements is essential. Again the PICo approach was used to identify literature that illustrated motivating factors and conversely barriers, challenges or issues surrounding nurses undertaking CPD. Key search terms for Population remained the same. Key terms for the phenomenon of Interest (I) were 'CPD', 'continu*professional development, motivation or motives, barriers or challenges. Context (C) was not changed. The search terms applied created the following hits; Cinahl (142 citations 1 utilized), Ovid Emcare (344 citations 3 utilized), Ovid Embase (172 citations 0 utilized) and Medline (195 citations 1 utilized). As with the previous searches different permutations of the search terms were used with notes taken at every stage.

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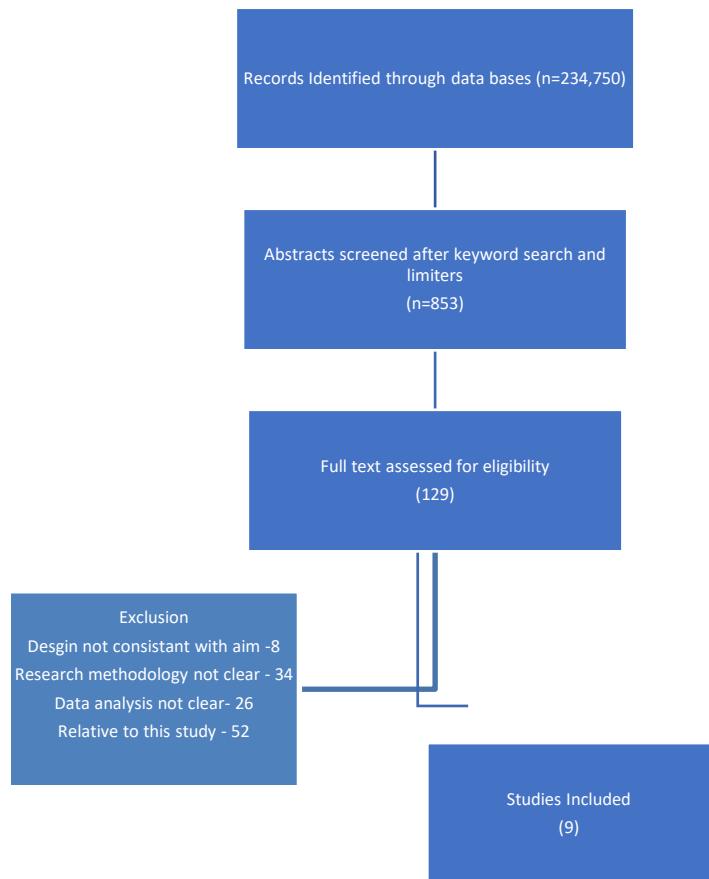
Diagram six Result of literature search question three

Beginning this section, the concept of individual and organizational factors which influence engagement with CPD is analysed.

Several factors influence the structure, delivery and engagement with CPD, the following will draw from the literature. As previously discussed the importance of CPD is widely

supported (Friedman and Phillips, 2004; Schostak et al., 2010; Cleary et al., 2011; Brekelmans et al., 2013; Friedman, 2013). However, a nurse's decision to participate in CPD can be influenced by several factors which can be roughly categorized as "individual" and "organizational". Themes such as time, institutional support and finances reoccur throughout the literature; this suggests commonalities are facing the profession irrespective of resources or geographical location.

Individual factors identified in the literature review fell into the following categories, access, awareness, funding, time, and motivation (Schostak et al., 2010; Cleary et al., 2011; Hosey et al., 2012; Brekelmans et al., 2013; Onuoha et al., 2013; Ross et al., 2013).

Two studies focus on the factors that influence the undertaking of CPD, a quantitative survey from Trinidad, and the other from Australia (Onuoha et al., 2013, Ross et al., 2013). The study by Trinidadian, Onuoha et al., (2013) assessed participation and awareness of continuing educational activities. In response to a national survey of 1,032 participants with a 70% response rate, Onuoha et al., (2013) found that although highly motivated to take part in CPD, awareness and ability to gain access were the main factors for participation. Awareness was cited as a factor in this study with 48.9% (n= 492) of respondents stating they had never heard of continuing medical education. However this result could be questionable as the terminology was not defined in the survey and could be construed in the field of medicine rather than nursing or professional development.

Financial constraints were also seen as a barrier to attending CPD programmes with only 5.7% (n=16) being able to participate outside the Caribbean. This contrasts with the 87% (n=871) who expressed an interest in participating, the recommendation by the author of financial sponsorship in a developing country such as Trinidad may be ambitious whereas other creative solutions could be more realistic and sustainable (Giri et al., 2012; Hosey et al., 2016). For instance Namibia and Malawi are working towards shared resources such as online courses and training materials (Hosey et al., 2016).

In Australia, Ross et al., (2013) systematic review of 29 articles and two theses suggest the challenges are geographically sensitive. In the authors view there was a need for programmes to offer equitable access and to consider the needs of rural nurses, part-time or night workers to increase involvement. This is echoed in Malawi where additional challenges to the uptake of CPD was contingent on those working in rural posts (Chilomo et al., 2014). Online and technical assistance could negate some of these concerns, although as suggested by Hosey et al., (2016) slow or limited internet access or limited computer technology across the African region is an issue. In addition, both studies cited financial constraints as an issue with many nurses self-funding their own CPD (Ross et al., 2013; Hosey et al., 2016). Time limitations, both personal with domestic obligations, and institutional with lack of staff coverage are also highlighted as a challenge.

Organizational factors affecting CPD opportunities were identified as, commitment and organizational support, giving ability to participate through protected study time, and internal infrastructure (Brekelmans et al., 2013; Ross et al., 2013). Furthermore both Katsikitis et al., (2013) and Onuoha et al., (2013) advocate for institutional support and the responsibility for enabling attendance, thus acknowledgment by the institution of the link to patient outcomes. Support is highlighted by Chilomo et al., (2014) who, a year after a CPD programme was implemented in Malawi, suggested failings were in part due to the nurse managers not adequately supporting staff to fulfil CPD requirements. However neither of these studies consulted the institution to establish what support could be given or to offer solutions. Similarly, Levertt-Jones (2005) supports this, asserting that managers or administrators must support CPD for it to become part of the institutional culture, however, again, there are no suggestions on ways this could be implemented or evaluated.

Three studies in the literature echoed the need for institutional provision and a culture of support for lifelong learning and development, but again stop short of articulating specifics (Cleary et al., 2011; Govranos and Newton, 2013; Pool et al., 2016). Moreover, according to the experts, in Brekelmans et al., (2013) study the greatest factor for participation was mandating CPD by regulatory authorities, which is at odds with Onuoha's study which showed a strong internal desire to engage in CPD (Onuoha et al. 2013). It is clear that organizational support is only one factor to consider. It could be

argued that Brekelmans et al., (2013) study over simplifies the issues simply by offering mandated CPD. In contrast, in three studies the participants cited varied reasons for undertaking CPD including increasing skills, support for careers and improving patient outcomes, highlighting the internal forces and commitment to lifelong learning (Govranos and Newton, 2013; Cleary et al., 2011; Pool et al., 2016).

Individual motivation to undertake CPD is also seen as a factor, as discussed earlier a desire to impact patient care or career benefits can influence CPD choices (Cleary et al., 2011; Govranos and Newton, 2013). Intentions were explored by Pool et al., (2016), they carried out 21 semi-structured interviews with hospital based nurses to explore differing motives related to varying CPD activities. In the interviews four motives for engagement with CPD were most frequently cited; to increase competence or deepen knowledge, to enhance career development and compliance to mandated activities. The activities included formal activities such as short courses or workshops, conferences and post-graduate education or more informal such as discussions, new clinical experiences or conferring with other team members or the internet. It was evident that these nurses selected various activities to fulfil varying motives and that there was an organized, thoughtful and deliberate choice to CPD. In this study the acceptance and choice of mandated or formal activities indicates how the nurses viewed their professional development and uniqueness of what it meant to be a nurse. However as a limitation Pool et al., (2016) felt retrospective narratives could have biased the results as people

could focus on formal activities or those where a specific skill was learnt. As discussed, individual motivation was suggested as the most significant reason for participation (Brekelmans et al., (2013). Similarly, the integration of CPD and the identity of the profession were highlighted by Brekelmans et al., (2013). However this was an undefined concept and would require further exploration to fully understand this phenomenon. Lastly Brekelmans et al., (2013) assert that teamwork, role modelling, and embracing professional development as the cultural norm would enhance participation. However in this study, details and guidelines on ways of developing this culture are not included.

3.8 Review of Literature Summary

In summary of the three themes; frameworks in use, evidence linking competence, competency and CPD and lastly factors which influence CPD were discussed in the literature. It is clear there are complexities around all three. The issue of individual and institutional support, complexity and requirements are differing, evidence of improved patient outcomes are scarce. There appears to be strong support and a need for organizational endorsement, however articulation and concrete recommendations are lacking. Individual factors which influenced engagement in CPD included expense, time to attend, and motivation, however suitable solutions were not forthcoming in the literature.

This review of the literature provided a detailed examination of three perspectives of CPD, beginning with

- Frameworks of CPD in use currently

- Evidence linking competency, competence and CPD

- Factors which influence CPD

The issues were illustrated by drawing on healthcare and educational theories in addition to frameworks worldwide within the nursing profession. Utilizing PICo to undertake the literature reviews, both theoretical perspectives and the empirical knowledge on CPD showed varied methodologies added to the narrative, it is clear there is much on the subject. The literature illustrated that globally, nurses face many of the same CPD issues. The papers identified the issues as well as some gaps in the literature. Whilst there is a significant amount written on CPD, there appears to be nominal evidence regarding rationale and theory behind these policies and models evidenced by a lack of consistency.

3.8.1 Grenadian context

Given that the literature states that there is no single or correct way of doing CPD. this study will explore the concept of CPD to further investigate these three themes.

A priority is the content, context and processes chosen, depending upon spheres of practice, learning styles and personal preferences (Kennedy 2005). In St Lucia that

congruency between the needs of the individual and institution is put forward, adding to the complexity and challenges surrounding CPD (Gaspard and Yang, 2016). This acknowledges the need and influence of alignment and the possible conflicts of offering CPD where there is perceived irrelevance to the individual. In this practical example the framework links healthcare priorities with education echoing the needs of the individual and institution to be in balance (Gaspard and Yang, 2016).

The request that the burden of CPD cost and access should be shared by the institution was voiced in the literature. (Katsikits et al., 2013). In the Grenadian context this would have to be innovative to help facilitate nurses' access as resources are limited (Giri et al., 2012, Ross et al., 2013).

In this context, with the absence of any guidance or framework in Grenada compared with international developments, it is imperative that this issue is addressed. The published literature on CPD in Grenada is non-existent and there is limited research in the Caribbean. Furthermore as international developments are at a pace, the time is right for Grenada to use the evidence and add to this knowledge, to implement a strategy and to develop a CPD framework.

The issues remain as to how to develop a CPD framework in the given context of this study. While the evidence from the literature review provides a comprehensive picture of differing perspectives in CPD and frameworks, there is little information on how these

perspectives can translate into an understanding of the issues surrounding CPD in Grenada. Without such an understanding it would be challenging to develop a CPD framework in this study. In the context of this research, nurses have not been required to provide documentation, or to provide any evidence of CPD. Therefore the landscape and culture will need to be investigated. However, the allure of increased retention, improved patient outcomes, increased empowerment and self-determination leading to a better working environment, as highlighted in the literature, is promising and may provide opportunities to shape the profession in Grenada.

Furthermore based on the urgent need to implement CPD in this context, it is unclear how GNC will accept and embrace the policy and a change of this magnitude without thorough investigation. It is envisioned that, along with infrastructural changes, there would need to be a shift in attitudes and perspectives towards CPD and an acceptance that nursing as a profession is dynamic and lifelong learning should be integral.

In conclusion, the literature clearly guided the stages required for this study. A Grenadian framework would have to include discussion and agreement on the following items.

- What constitutes CPD, documentation and review procedures.

- A standard or consensus and a theoretical foundation will be decided.

- Investigation into the factors influencing CPD in Grenada is required.

In closing, the nursing profession in Grenada demands that practitioners possess the skills, knowledge and attitudes to deliver safe and effective care. CPD can contribute to this, however guidelines, policy and a framework will need to be created to facilitate this.

Chapter Four describes the methodology for this research study. The justification and explanation of PAR is followed by ontological and epistemological perspectives, then critical theory is introduced as the theoretical framework guiding this study. Within this the methods are discussed leading to a mixed methods approach. The penultimate section seats this study against the backdrop of other variants of action research. This is followed by an analysis on establishing rigour in this study.

CHAPTER 4 METHODOLOGY

4.1 Introduction

The purpose of this study was to explore the concept of CPD in Grenada. Rather than explore current practice as a snap shot through quantitative or qualitative focused methodologies, a PAR approach was used to provide a vehicle to collaboratively and critically review current practices and thus improve engagement in CPD. It was expected that the issues surrounding CPD and registration would be explored making recommendations to ultimately develop and improve practice. This chapter will present a justification for the choice of PAR methodology, followed by a discussion on PAR through differing interests, lenses, characteristics and benefits. These will be described, justified and linked to this study. The establishment of validity and rigour in PAR will be discussed and the limitations of the methodology acknowledged. Additionally, as it relates to methodological choice the need to contextualize this study within the post-colonial perspective and draw parallels between this and critical theory and PAR are discussed.

4.2 Justification of the methodological choice

I considered that this study required a participatory approach in order to provide a collaborative effort which would ensure engagement and ownership, thus allowing and enabling the research and outcomes to translate into action.

As Kemmis, McTaggart and Nixon (2014) suggest, the aim in this study is to have participants experience a sense of development and evolution in their practices and an understanding of their practice, ultimately leading to change. The development of a CPD framework will enable this sense of evolution through its creation. The question of whether action research could answer the needs of Grenadian nurses was central to the research design. In this case this study's emphasis is on a change which is necessary and will benefit a community, whilst the knowledge produced from the participation and process would stand up to scrutiny (Kemmis et al., 2014).

In summary it was essential that the need for improvement and change was recognised in relation to nurses' engagement in CPD in Grenada. Inherent was a desire to raise mine and Grenadian nurses' consciousness of CPD. It was necessary to create an awareness that current research on CPD was not being translated into practice so that this would precipitate action. Additionally due to its application in organizational development and its ability to facilitate, self-examination or reflection was advantageous (Lewin, 1948; Reason and Bradbury, 2008). It is for the reasons described that the utilization of action research was decided upon as the best methodology. As described by Jones and Gelling (2013), the focus is on improving practitioner and user engagement including myself in the change process in order to develop a CPD framework. Through an investigation of alternative methodologies, such as case-studies, PAR offered the characteristics and outcomes which I considered would help address the research question. The limitations

of this methodology will be acknowledged later in the chapter, namely differing expectations, levels of participation and power differentials, also the ways in which this study will take action to mitigate these.

4.3 Ontological and Epistemological perspective.

When analysing and conducting research it is important to consider personal position along with philosophical assumptions or paradigms, concerning beliefs, values, or world view. Research is a disciplined and systematic enquiry with the aim of generating knowledge (Koshy et al., 2011). A world view is an orientation or framework of ideas and beliefs of an individual forming a global description through which an individual interprets the world and interacts with it. This is affected by many factors, historical, cultural life experiences and situations. These world views vary from one person to another (Creswell and Clark, 2007). The researcher may determine different approaches in an attempt to find answers for a particular research problem (Kincheloe, et al., 2006). In this section, research paradigms and approaches to the current research are discussed. In acknowledging these assumptions and choosing a stance the practical implications for designing and conducting the research follow on (Creswell and Clark, 2007). Therefore, the philosophical underpinning can be crucial for both designing the research and for explaining the approaches taken to support credibility.

The ontological and epistemological perspectives shape how we see the world, our assumptions and orientation to research and theory (Jackson, 2013). Ontology is the philosophical study of the nature of reality, or more colloquially, our perceptions, beliefs, and attitudes toward reality (Creswell, 2013; Jackson, 2013). Epistemology is the study of knowledge; it questions what knowledge is and how it can be acquired, and the extent to which knowledge can be acquired. Or as Carper (1978, p. 13) described "what it means to know and what kinds of knowledge are held to be of most value." The difference can be summarized: ontology concerns what there is to know in the world, whereas epistemology concerns what it is possible to know.

4.4 Methodological paradigms

The term methodological paradigm refers to the methods and techniques used by the social science researchers and the underlying principles and assumptions regarding their use. The methodological paradigms that have dominated in recent social research are the post-positivist paradigm, which is linked to interpretivism, and a qualitative approach (Merriman, 2002; Creswell, 2013). Traditionally, quantitative and qualitative research approaches have been viewed as incompatible, although recently researchers are more cognizant of all available research techniques, able to select methods with respect to their value for addressing the underlying research questions, rather than a particular approach (Onwuegbuzie and Leech, 2005). Both have generated new knowledge in the

field of nursing and CPD. A short discussion on interpretivism and positivism in relation to the suitability of this study follows.

Due to its precise nature and its desire for objectivity, positivism focuses on the quantification of concepts and their relationships via statistical, mathematical or computational techniques. It is founded upon objectivity through the testing of hypotheses and the prediction and control of the variables. In terms of ontology, it is concerned with an objective reality, which can be explained, controlled and predicted by means of natural laws of cause-effect (Creswell and Clark, 2007). Within this study there is a need to understand more than quantities to inform a complex CPD framework in Grenada.

By contrast, interpretivism tries to understand human behaviour through inquiry and interpretation, and the researcher believes reality is socially constructed. The researcher aims to understand reality by discovering the meanings that people in a specific setting attach to it. To them, behaviour is intentional and creative and it can be explained but not predicted. Within the field of social sciences and nursing, this is accepted as a means to explore the social, cultural and personal dimensions of disease, it can uncover motivations, values and experiences of the effects of pain and illness that quantitative is not suited for (Holloway and Galvin, 2016). However, it is limited to offering a snap shot, singularly articulating what it is, not what it ought to be. Although valuable, this type of

exploration does not ask for praxis or the ability for the participants to shape the framework that is in the Grenadian context.

4.4.1 Role of the researcher within these paradigms

The second key philosophical question I considered was in relation to the epistemological stance of this study. In other words, what would be the relationship between myself as the researcher and the participants being researched and how would the nature of the knowledge be developed and justified (Reason and Bradbury, 2008). In terms of epistemology, the researcher approaching with a positivism perspective sees themself as detached from the object being studied. The researcher studies objectively, signifying that the researcher does not influence the subject or the participants in the study nor is the researcher influenced by them. Conversely, an interpretivism approach engages in face-to face interactions where knowledge is created when the researcher and the participant interact, and their world is discovered and interpreted (Creswell and Clark, 2007). Within this context, involvement and participation was necessary to facilitate change; a clear aim of this study. I was not a neutral player in my approach to the study (Reason and Bradbury, 2008). I brought to it my background, knowledge and beliefs of working with Grenadian nurses and a prior interest in CPD both from the UK and as a naturalized Grenadian (Creswell 2007). The construction of knowledge was thus developed through the process of interaction, collaboration and critical reflection.

Finally, situated within this study is the acceptance that I was a participant as well as working as a facilitator to support the Grenadian nurses.

Considering my own ontological and epistemological position in relation to this study then led me to consider how these philosophical assumptions influenced my choice of theoretical paradigm and subsequent research methodology and methods. In conclusion, the deductive nature of positivism through developing specific predictions implies a selective approach, in contrast to interpretivism which deploys an inductive, exploratory approach (Lincoln and Guba, 1985). There is an alternative, within the paradigm of critical theory there is the ability to incorporate both qualitative and quantitative approaches, and this is discussed subsequently.

4.4.2 Personal world view

During the early planning stage of this study I spent some time considering what my personal and professional philosophical beliefs and position were regarding the nature and construction of knowledge. This was important to consider in light of the research methods I ultimately used in the study to ensure that these were congruent with my own philosophical stance (Reason and Bradbury, 2008). In addition, it was also important for me to recognise how my own beliefs about knowledge construction influenced the design and direction that the study took (Creswell, 2007).

Within the realm of my professional and personal experiences, there are multiple truths. Working as a nurse in collaboration with the individual to understand the meaning underpinning the experience of their illness, is a fundamental element of patient centred care. As a novice researcher I am aware of subjectivity and my suppositions. These truths are formed through interactions within a given social, cultural, and historical situation as well as placed in the social, cultural and historical context experienced. People construct their own understanding and knowledge of the world, through experience and reflecting on those experiences.

I believe that it is through the individual's ability to critically reflect on these experiences that learning and development transpires. In addition it is through collective critical dialogue that consciousness is raised and social change occurs. I use a pragmatic approach to research, using real world problems to inform the research aim. In this regard, there are multiple suitable approaches that are available to best answer the phenomena detailed in this study.

I regard myself as someone who conducts research amongst other people, learning with them rather than conducting research on them. Similarly I agree with the work of Reason and Bradbury (2008) who value and recognize the knowledge from 'ordinary people' without a hierarchy, acknowledging everyone's contribution to understanding. I

acknowledge that research should reach valuable conclusions, but these are always partial and cyclical, situated within a certain historical, cultural context.

In the context of this study participation is chosen as this emphasis ensures all co-researchers, including myself, will have the opportunity to contribute to and participate in all stages of the study. The studies I read from the region showed an overall commitment to collaboration and the need for all invested persons to have a voice, this is especially illustrated in Haiti and St Lucia, where stakeholder collaboration is explicitly described as an aim to listen and include the participants needs (Clark et al., 2015; Gaspard and Yang, 2016).

Next is a discussion on two philosophical frameworks associated with PAR; qualitative and participative. Following this a deeper account of critical theory as the chosen framework for this study.

4.5 Philosophical frameworks

Waterman et al., (2001) in their systematic review outlined three philosophical frameworks of action research – qualitative, participative and critical. However this delineation was argued as artificial by the authors as there are similarities across all three. Also, in the review they noted that authors did not draw exclusively on "any one framework to understand or to justify their approach to action research" suggesting a fluidity associated with PAR (Waterman et al., 2001 p. 14). These three philosophical

frameworks have been substantiated and supported by philosophical traditions such as phenomenology and hermeneutics.

4.5.1 Qualitative framework of action research

Exponents of the qualitative framework within action research, argue against a social science with a scientific (positivist) paradigm as it is seen as unhelpful in solving the complex interrelations of the practical or social problems in an organization or community (Coughlan and Brydon-Miller, 2014). The association with action research and a qualitative framework is strong, because PAR is based on localized studies that focus on the need to understand *how* things are happening, rather than merely on *what* is happening, and to understand the ways that those affected perceive, interpret, and respond to events related to the issue investigated (Waterman et al., 2001). Moreover, Reason and Bradbury (2008 p. 165) are critical of the distance taken by the positivist researcher from the subject and advocates "active engagement". Susmand and Evered (1978) and Stringer (2007) support this asserting the legitimacy of action research as a science, is justified in philosophical traditions such as phenomenology and hermeneutics. They point out that the knowledge of one's subjectivity is of crucial importance to action researchers when trying to understand the behaviour of group members. Within PAR and phenomenology both are focused in the everyday and embrace subjective or 'felt' experience as a means to gain knowledge (Stringer, 2007). It can be concluded that there is a connection between phenomenology and PAR; one offering a philosophical footing,

the other a method of research through which knowledge developed in the real-world can be achieved (Coughlan and Brydon-Miller, 2014). In support, hermeneutics strengthens the position of the action researcher within the cyclic processes of action and reflection by focusing on interpretation thus revealing knowledge about the social context in which they were formed. Further understanding is gained as hermeneutics illuminates the play between researchers' questions to and from the world and the narrative. In summary this is clarified by Stringer (2007) stating PAR, in its most effective forms, is phenomenological by focusing on people's actual lived experience or reality and hermeneutic as it incorporates the meaning people make of events in their lives.

4.5.2 Participatory framework of action research

Waterman et al., (2001) delineate the participative philosophical framework of action research as setting a priority on the search for the experiential, spiritual and practical knowledge of groups of enquirers. It also stresses the deep engagement of groups in experience and practice to create a 'better world'. Part of the characteristics which resonate with PAR as described by a participative worldview is that it is self-reflexive (Heron and Reason, 1997). A participatory approach as described above has been critiqued for being too introspective and consequently too uncritical (Waterman et al., 2001). However, a participatory approach has a focus and presupposes participation, through meeting and dialogue, in a culture of shared art and shared language, values, norms and beliefs. Heron and Reason (1997) describes how the knowledge generated

can be experiential, presentational, propositional, and practical, with practical knowledge having primacy over the other forms of knowledge. Experiential knowing is based on an experiential presence compared to ideas, for instance. This presence is understood in relation to other persons, places or things as a way of knowing that is mainly implicit, pre-verbal, and elusive. Similar presentational knowing is not expressed in academic verbal accounts but rather in images that articulate experiential knowing. These images are often narratives but can also take the form of pictures or music symbolizing experiences. Propositional knowing is expressed in ideas and theories, reified as knowledge. Lastly, practical knowing, which is knowing how to do, as compared to knowing about the theory of a subject matter. Practical knowing comprises of demonstrating a skill or competence as a culmination of the previous three forms of knowing, echoing the premise that we learn more when we are interested in enhancing or changing than simple learning about something.

4.5.3 Critical theory.

The philosophical framework of action research is commonly associated with critical theory, particularly by the writing of Habermas. The critical paradigm proposes that once injustice and inequity are exposed, people are able to participate in activities to make change for improvement. Critical theory, is social theory oriented toward critiquing and changing society as a whole. Generally, critical methodologies focus on change, rather than observation or description (Tyson, 2006). Methodologies that are congruent with

the critical paradigm involve collaboration with research participants, challenge the status quo, and enable change. They have emerged in connection with the many social movements, such as feminism that identify varied dimensions of the domination of human beings in modern societies. Critical theory provides the descriptive and normative bases for social inquiry aimed at decreasing domination and increasing freedom in all their forms. In the post- colonial context discussed 4.10.3 this influenced the philosophical framework. Advantageously, the critical paradigm incorporates action methodologies that use both qualitative and quantitative methods to create knowledge that leads to change (Whitehead, 2007). Habermas provides a theoretical basis for a view of action that emphasizes widespread public participation, sharing of information with the public, and reaching consensus through public dialogue rather than exercise of power. In Habermas' (2002, p.137) view, that through "interactive competence" the individual can reach mutual understanding to redress conflict, and "reciprocal recognition" to negate the power relations and promote cooperation. Similarly, Horkheimer stated that a theory can only be considered a true critical theory if it is explanatory, practical, and normative, meaning that the theory must adequately explain the social problems that exist, it must offer practical solutions for how to respond to them and make change, and it must clearly abide by the norms of criticism established by the field (Held, 1980). In relation to this study, the promise of a practical solution was appealing

PAR moves towards equity by reducing inequalities and power differences in access to resources. Power itself is an elusive concept about which there has been considerable discussion. Foucault's (1980) position is particularly relevant to PAR because he sees power as something that results from the interactions between people, from the practices of institutions, and from the exercise of different forms of knowledge. This approach aimed to propagate research, bringing it into the realm of the ordinary person, demystifying and creating inclusion and challenging the status quo (Waterman et al., 2001).

However, action researchers have used other theoretical frameworks, Waterman et al., (2001) in their systematic review stated that dialectics, hermeneutics, praxis and phenomenology along with critical theory are utilized. For instance phenomenology was used by MacDonald (2006) to gain an understanding of the life experiences of eight individuals who are hard of hearing, then utilizing PAR to identify opportunities for improvements in their lives. As described by Coghlan and Brydon-Miller (2014) appreciating the link between PAR and phenomenology enables people to value their experience of a phenomenon in their everyday lives. Thus putting the participant in the centre for knowledge creation. It could be argued that gaining an understanding of the life experiences requires a reflective and critical element in order to move a study from the observation to the action. However if too introspective it may call to question the rigour of a study (Waterman et al., 2001).

This concept of putting the participant in the centre is continued with hermeneutics, as this focuses the interpreter's relation to the interpreted and the understanding that arises out of that relation (Coghlan and Brydon-Miller, 2014). This is succinctly illustrated within a youth PAR project by using hermeneutics to identify and manage bias by visiting prior assumptions and creating understanding through the analysis, although just how subjective this new understanding is, is open to debate (Kirshner, 2011). Another similarity is hermeneutical inquiry requires questioning and reflection, however it can fall short of offering a platform for change (Coghlan and Brydon-Miller, 2014). Through a critical lens, hermeneutics can be employed as a means of penetrating false consciousness, discovering the nature of belief systems, promoting distortion-free communication, as well as accomplishing a liberating consensus (Agrey, 2014).

Critical theory was chosen for the framework within this study with the knowledge that like the other perspectives there is not a prescriptive but more 'orientations' depending on the circumstances and the aim of the study.

4.5.4 Historical perspective

Critical theory began with a group of Marxist-orientated German scholars in the 1920's, collectively known as the Frankfurt School (Polit and Beck, 2012). Those from the Frankfurt School, contributed to the development of critical theory, these included; Marcuse, Adorno and Horkheimer. Critical theory sought to develop a critical perspective

in the discussion of all social practices. The term critical theory can be applied to a set of paradigms, including Marxism, feminism, materialism and participatory inquiry. Inspired by the writings of Marx that synthesised philosophy, history and economics, they further developed Marx's foundational ideas that advocated approaches to social existence which are freer of domination, power inequities and oppression.

After the initial work with critical social theory up until about 1950 there was a period of dormancy that lasted until the late 1960's and into the 1970's when the theory was revised by other German philosophers, the best known being Habermas. He further developed critical theory. He describes the perspective and cognitive strategies on which human beings base their knowledge of reality. His perspective indicates that knowledge and power relationships are fundamental reasons why people control other people using notions of class, gender and age as discriminators (Habermas, 1984; Kemmis, 2006). Another key concept proposed by Habermas is that of 'communicative action', which is action directed towards understanding, and based on definitions regarding situations dependent upon the mutual recognition of ones' perceptions of the environment, social norms and the identities of individuals (Habermas, 1984; Kemmis, 2006). According to Kemmis (2006), the aspirations of communicative action could be written into or alongside the practices of reflection and discussion characteristic of action research. This is expanded on subsequently in relation to public spheres for dialogue.

Although not exclusive, the use of critical theory and action research are linked through Kurt Lewin (1890 – 1947). Lewin, underlined the congruence between critical social theory and action methodology with the perspective that theory and practice can form a symbiotic relationship. Furthermore collaboration between researchers and participants can bring about social change. He worked within the critical social theory framework to develop action methodology and in particular action research strategies. His work in the industry led to the belief that decisions for improvement, if made democratically, were more likely to be acted upon. Lewin articulated the characteristics of the cyclical problem solving approach and the inclusion of participants as co-researchers. The perception is that injustice and domination shapes the world in which we live (Lincoln and Guba, 1985).

Action research continued to evolve, in education a more democratic and inclusive philosophy championed by Stenhouse. Lawrence Stenhouse, (1926 – 1982) an educationist, attempted to demystify and democratize research by encouraging all practitioners to take a research role in the classroom to improve personally (McNiff, 2013). This is continued in Australia, with Carr, Kemmis and Mc Taggert developing the link between action research and critical theory (Kindon et al., 2007). Whilst Stenhouse used action research to focus on the personal, Carr, Kemmis and McTaggert promoted a collective form of action research, believing that groups have greater potential for effecting change than individuals (Waterman et al., 2001).

Meanwhile, in the developing world, PAR emerged as a result of social movements and a commitment to social justice and political activism with the aim of liberation and equality. The main actors Paulo Freire (1921- 1997), Orlando Fals Borda (1925 – 2008) and Frantz Fanon (1925 – 1961) aimed for liberation and equality. As an educationalist, Freire believed education could not be divorced from politics and could enable social change. In working amongst the illiterate poor he positioned himself to illuminate those who were oppressed and the oppressors, and that through education and a raising of critical consciousness the oppressed can regain their sense of humanity and regain emancipation. Freire defined this connection as a main tenet of critical pedagogy. Similarly, Fals Borda believed that it was the duty of a researcher not just to examine the social reality of the country, but to try to remedy the grave injustices that research uncovered (Borda, 2006).

The theory is said to be evolving, avoiding rigid epistemological beliefs as different mediums, such as media, exert power and domination (Kincheloe and Mclaren, 2002). Today action research has a focus on the following specific fields of inquiry: organization development (Bradbury et al., 2008; Friedman and Rogers, 2008; Coghlan and Brannick, 2009), education (Stringer, 2007; Somekh and Zeichner, 2009), health care, in particular nursing (Koshy et al., 2011), and community development worldwide (Cahill, 2004). Furthermore, the aim is to integrate theory and practice such that people become aware of inconsistencies and disparities in their beliefs and social practice. This leads to

inspiration and change (Mezirow, 1981). However this awareness and conscious raising is disquieting for some. Cahill (2004, 2007) describes in her action research study that it was the anger and indignation of participants on reading a stereotyped study that created the catalyst for this conscious raising and subsequent actions. Similarly, referring back to Friere, it would be myopic to only view the oppression of the poor, failing to deal realistically with oppression as it is found at all levels of society. In contrast, Fanton views the oppressed not as the poor but of colonized peoples, documenting the legacy left behind of being colonized. He refers to how being surrounded by the colonizer's culture and especially language creates an insecurity in the blacks' consciousness and subsequent tensions (Gordon, 2015b). His work is further elaborated subsequently in paragraph 4.10.4.

What is accepted as custom is critically assessed for injustice and disparities. Critical theory acknowledges that those who control knowledge creation, wield considerable power. However, this can be addressed by the principal investigator through an awareness of this power and redressing these imbalances can facilitate transformation (Mezirow, 1981).

4.5.5 Public spheres for meaningful dialogue
The public sphere allows individuals to come together to freely discuss and identify problems, that discussion and reflection results in action being taken, this sphere can

also include social media (Castells, 2008). The central issue is an insistence upon reciprocity and equality in the public sphere, augmenting a positive movement toward greater autonomy and self-determination. Reason and Bradbury (2008) suggest that critical theory involves a connection between philosophical reflection and a social scientific knowing; making it both critical and practical about society and requiring action. Moreover, Kincheloe and Mclaren (2002) address the complexity of this evolving theory, stating it avoids specificity or fixed characteristics. To some this allows for flexibility, whilst for others a lack of framework raises concern (Checkland and Holwell, 2007).

As discussed in terms of the ontological perspective, reality, is shaped by social, political, cultural, economic, or ethnic and gender factors. These are formed over time, solidifying into truth and reality by virtue of their historical placement (Guba and Lincoln, 1995). Thus, to acknowledge and encourage the interaction between the researcher and participants aids understanding and knowledge creation. This allows connections to influence what is to be studied, which in turn shapes the nature of understanding and creates many valid interpretations (Kincheloe and Mclaren, 2002).

To summarize, it is this purposeful combination of theory, practice and action that connects with the study in question. It has to do with the relationship between people involved in the inquiry and the decisions that affect them. It is hoped that this study will

go some way to honour the work carried out by Paulo Freire's work in Brazil (Freire, 2000). Freire argued that teaching and research should be based on dialogue with people instead of domination by experts. As discussed earlier, Freire and Habermas share an important premise that through dialogue and collective action, people can develop critical consciousness and act to liberate themselves. In the process, they acquire the confidence, skills, and knowledge that they need to improve their situation.

4.5.6 PAR and Praxis

The relevance of praxis to PAR lies with the understanding of practical knowing. The link of praxis and PAR is that the knowledge gained is through action with an explicit understanding that the point of gaining knowledge and interpreting the world is to change it (Reason and Bradbury, 2008). Similarly, Paul Freire believed praxis was essential; praxis is the act of action and reflection to bring about change (Freire, 2000). Freire argued that dialogue was not enough to gain knowledge of social reality, it is action along with critical reflection that can lead to transformation (Freire, 2000). This action or praxis is about reducing the theory – practice gap, going back to its origins with the Greek notion of praxis meaning 'informed committed action'. It is through the theory creation that the informed action can take place (Jonsson et al., 2014). However, what type of action and who is involved within the landscape of praxis, can be challenging. Reason and Bradbury (2008) for instance, advocate all participants should engage in praxis.

However this may not be wanted by the participants who should be at liberty to exert their own autonomy.

As with PAR, for this study, critical theory guides the study, as it promotes empowerment allowing persons to take control and change their situation for the better. In agreement with Conger and Kanungo (1998), using the definition of empowerment meaning 'enabling' through enhancing personal efficacy also examining through critical reflection areas where powerlessness exist, in order to effect personal change. Within this study the ability to empower myself and Grenadian nurses, through involvement in the subject, the research undertaken and the development of a framework, is anticipated. Through the act of investigating how Grenadian nurses can participate in CPD, a level of enablement and proactive engagement will be present.

Next, to further appreciate PAR, varying definitions, common characteristics and how PAR has been used in the health care setting is presented.

4.6 Definitions of PAR

There is considerable debate in the literature as to an authoritative definition of action research, and the inclusion of the term 'participatory' action research within the definitions (McNiff et al., 1996; Kemmis and McTaggart, 2000; Meyer, 2000; Greenwood and Levin, 2007; Lingard et al., 2008; Reason and Bradbury, 2008).

As defined by Koshy et al., (2011, p.9) "action research is an approach employed by practitioners for improving practice as part of the process of change. The research is context-bound and participative. It is a continuous learning process in which the researcher learns and shares the newly generated knowledge with those who may benefit from it"

4.6.1 Common Characteristics

Despite the differences in the definitions of action research, there are common characteristics which highlight the uniqueness of action research and distinguish it from other methodologies. These are: the construction of knowledge leading to action, the participation of research subjects, a desire to improve practice, and a cyclical process including critical reflection (Waterman, 2007; Koshy et al., 2011).

Bergold and Thomas (2012) stress that mere participation is not enough but involves the joint process of the research on equal terms. This could be viewed as a goal but in reality is too simplistic. Also, in practical terms this can be challenging due to prior experiences, confidence and time constraints (Kelly and Simpson, 2001; Conder et al., 2011). Furthermore, this equality suggests that all participants are seen and feel on a par, and have an opportunity to offer their unique knowledge throughout the project.

Additionally the supposition that understanding and action emerge in a constant cycle is ubiquitous. The cycle involves a spiral of planning, action observation and reflection in

phases, as illustrated below (Langlois et al., 2014). The spiralling concept in PAR is representational of the dynamic nature of the research design in response to the researcher and participant's reflection and analysis of the issues and data produced (Kemmis and McTaggart, 2000). The cycle also reflects the ontological acceptance of the existence of multiple truths, as discussed in Chapter Three, with knowledge arising from varying sources such as practice, experimentation and experiences.

4.6.2 Action research models in use - why a spiral

Within action research the process is usually depicted as a series of spirals. However, just as nurses are familiar with the ordered cycle of the nursing process and industrialists the plan-do-study-act where iterations inform and build on each other; there is also a realization that they have little relation to reality. Similarly, action research is rarely predictable spirals of self-contained cycles (Kemmis et al., 2014). Often the stages overlap, or return to a previous phase, initial plans becoming obsolete in the light of learning from experience, participants change the emphasis or alternatively a tangential issue shifts focus. By characteristic it is iterative and evolving, requiring sensitivity and reflexive practice in order to respond appropriately (Koshy et al., 2011; Kemmis et al., 2014). There are other models in use, showing derivations and tangents or how the cycles can converge (McNiff and Whitehead, 2010; Koshy et al., 2011). However in this study, the advantage of the spiral assists the novice in visualizing the unique stages of inquiry.

Diagram 7 PAR cycle http://www.movelearning.com/en/22-models-gallery/66-action-research
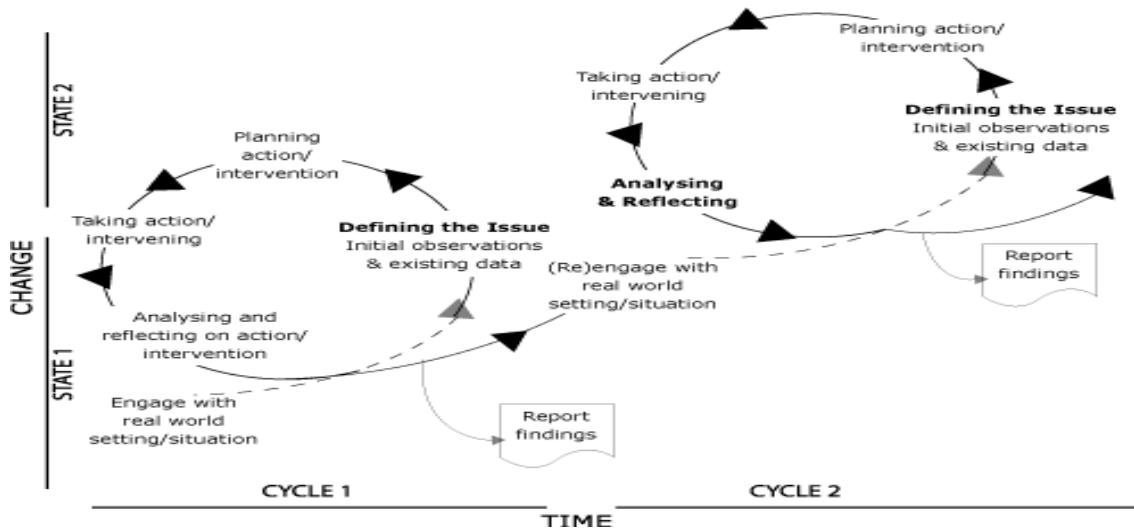
4.6.3 Model used in this study

Within the sphere of PAR, action is an integral part of the process, unlike traditional research where action occurs after the research and the data has been analysed (Reason and Bradbury, 2008). Below is a descriptive account of the model used in this study.

This model illustrates the continuous spirals to examine action in order to plan, analyse and evaluate the action while allowing for reflection on the action taken to inform the next cycle. As seen above the spirals follow the same pattern, these provide a framework to follow. Additionally it offers the opportunity to evaluate the process and direction as the study is in progress. The advantage of this is that participants can either cease action if there are problems or modify the next cycle dependent on the previous cycle's analysis

82

(Kemmis et al., 2014). The action phases of identification of a problem, planning action, data collection, analysis and reflection will be discussed in the methods chapter that follows.

In conclusion, the unique characteristics, phases and iterant nature are captured in the use of a spiral to illustrate the phases of PAR.

Practitioners have a central role as co-subjects; action research is concerned with the closing of power and knowledge gaps between practitioners and academics (Kemmis et al., (2014). However although this 'all inclusive' participation is desired by many, it can create tensions as power differences, research ownership and hidden agendas can arise (Makaroff et al., 2010). Key persons can respond negatively, acting as a 'gatekeeper' to access or limiting the scope and impact or by dominance. In conducting action research, excellent reflexive, social and communication skills are needed and should be incorporated (Glasson et al., 2008; Conder et al., 2011).

Participants can express anxiety at the change process; they may find the new dynamic unsettling due to loss of routine. To reduce these, careful pre-planning must take place, allowing ownership of the change to be dispersed, encouraging good team communication and the acceptance of negative feelings if required. Another challenge can arise as participants, on recognizing the injustices of their situation, become overwhelmed by the past, needing support as the sense of loss dissipates (Freire, 2000).

This disquiet can become more profound if the PAR is unable to create the change envisioned, either through lack of time, funding, expertise or other unforeseen issues. An ethical approach, ensuring the aims and objectives are realistic and achievable and an honest dialogue ensuring participants are aware of progress, would reduce the impact. Further limitations of PAR are outlined later in this chapter.

Some of the characteristics of PAR have been analysed; within these some challenges have been identified. This will be further discussed by using examples of those in the field (Makaroff et al., 2010; Condor et al., 2011).

4.6.4 PAR in healthcare

The methodology of PAR has been widely used and accepted in healthcare, viewed as a way of generating solutions to practical problems (Hughes, 2008; Munten, 2010; Koshy et al., 2011; Nitsch et al., 2013). As well as providing resolution, PAR is ideally suited to health promotion programmes where 'end users,' the patients, form part of the collaborative team (Teram et al., 2005; Lee, 2009; Bainbridge et al., 2013; Ward and Bailey, 2013). Collaboration amongst disciplines has also been successful utilizing PAR (Thistlethwaite, 2012; Langlois et al., 2014). Furthermore this methodology has successfully demonstrated improved practice on specific units (Glasson et al., 2008; Bamford-Wade and Moss, 2010; Froggatt and Hockley, 2011; Kenny et al., 2011; Harrington et al., 2013). PAR has had appeal and has been successful in both nursing and

other professions for several reasons. Firstly it is a vehicle to bridge the practice and theory gap, it has flexibility in its approach and it provides participation with others in a collaborative manner across disciplines (Abad-Corpa et al., 2010; Munten et al., 2010).

This concludes common definitions of PAR, binding characteristics and how PAR has been carried out in the health care setting. Next to further familiarise the reader with PAR the differing interests and lenses which can be applied are investigated with justifications for this study outlined.

4.7 Different interests of PAR

Beyond the characteristics of PAR, Carr and Kemmis (2003) describe three varying interests or emphases based on Habermas's theory of knowledge; these are; interest in the technical, the practical and the critical. These will be taken individually.

4.7.1 Technical

The technical interest aims to improve the outcomes of practice. The results are regarded at the end, with the aim being to ensure the practice change is effective or efficient. The focus is on the practitioner, typically external to the field of investigation. The principal researcher generally decides the direction and aim of the study and what needs to be changed to facilitate improvement. For example, Makaroff et al., (2010) were engaged as researchers by a service provider, their remit was to investigate the effectiveness of an intervention for the end users. As illustrated by the example, the

notion of transformation, political agitation or consciousness raising through critical reflection is absent. It is recognized as the most 'conventional' form of action research (Coghlan and Brydon-Miller, 2014).

There is an asymmetric relationship between the researcher and others involved, causing concern for those who advocate for a more collaborative and reciprocal study. However, as the expert facilitates the participants to achieve the goals of the project there is efficiency (Kemmis et al., 2014). This efficiency and efficacy is the focus of the study, contrasting to the more lengthy and complex critical interest or participant transformation.

The application of technical interest is broad; clearly if outcomes are a priority this interest is valid and pertinent. However caution should be exercised and steps taken to avoid conventional studies of researching on or for people rather than with. For this reason this approach was rejected. However, this can be avoided by adherence to the cycles which require critical reflection, ensuring the approach is bottom up and facilitated by the researcher rather than led.

4.7.2 Practical

Conversely, in practical action research, the emphasis is on participants affected in order to contribute and add to the study. The practitioner may still be the primary source of leadership but remains open to the views and responses of others. The emphasis is on

collaboration, fostering a symmetrical reciprocal relationship between the practitioner and the others involved (Carr and Kemmis, 2003). In contrast to technical interest there is a hope and facilitation for transformation in both the participants and facilitator. With the focus on partnership, the facilitator recognizes and accepts the plurality of knowledge and the different perspectives and worldviews to enhance the study (Coghlan and Brydon-Miller, 2014; Kemmis et al., 2014).

Beringer and Julier (2009), utilized this approach when they wished to reduce the amount of time nurses spent accompanying children to the X-ray department. The principal investigator from a nearby university led the study, however the nurses involved undertook and analysed the initial and subsequent audit to gather data. In addition, a description of a joint exercise to create a process map identifying hold ups and other problem areas was undertaken. This type of collaboration was deemed successful and indicated levels of transformation. The authors describe the facilitator as being able to keep the momentum going, whilst the collaborators learnt new skills and presented their findings at an international conference (Beringer and Julier, 2009).

As described, the issue of combining a clinical improvement project with research can be problematic as the aims, cycles and demonstration of reciprocity are needed for authenticity (Herr and Anderson, 2005). Additionally just how much participation, when and by whom, has to be negotiated and agreed. The positive effects of learning auditing

was highlighted by Beringer and Julier's case (2009), however the expectation is that levels of participation vary by levels of ownership and interest. The facilitator's role is to enable participants to be able to and to have the opportunity to participate equitably; this is critically analysed further in the criteria for rigour below.

Within this study, this approach was taken as the participants were able to fully contribute and add to the study. Moreover, their knowledge and perspectives were sought and reflected upon as a component to ensure the success of the project and authenticity.

4.7.3 Emancipatory

Lastly, emancipatory action is guided by emancipating people and communities from injustice. To explain, Kemmis et al., (2014) describe how the transformation in emancipatory action research not only involves the activities and their immediate outcomes as in technical, or the persons as in practical, but the social context where the practice occurs thus resulting in liberation. It departs from the others because there is an acceptance of emotions, power and politics in knowledge production. Furthermore the involvement, parity and collaboration suggested in the previous interests are amplified and expected (Kemmis et al., 2014). Emancipatory action creates an awareness of what is taken for granted, whether injustice or inequality, followed by galvanizing those involved into action, empowerment and having self-determination

(Mezirow, 1981). Continuing on from this, Cohglan and Brydon-Miller (2014) ask that the emancipatory interests connect learning and daily work experiences to identify assumptions and to create alternatives to those assumptions. However, the cause and effect of the action research study has temporal considerations with enablement and liberation occurring later due to alignment or a change in circumstances (Cohglan and Brydon-Miller, 2014). In summary it may not be apparent that the emancipatory interest is achieved until a later date.

In conclude a historical account, evaluation of antecedents and tracing events may well provide the evidence of the origins of a study with critical interest having such a powerful effect.

4.7.4 Different interests for this study

In conclusion, the primary purpose is to explore the concept of CPD in Grenada and to propose a framework that is acceptable to Grenadian nurses. Pragmatically it may be difficult to predict a single purpose for this study, in the real world it may become more fluid. Within one study the interests may shift back and forth over the study's span. Initially from the technical where direction is suggested due to expertise, in the more traditional sense. Then, moving to the practical, with partnerships formed and acceptance of a variety of knowledge and skills from all participants. Lastly there may be an awareness of what is accepted, followed by action, empowerment and having self-

determination. As discussed, going into this study the emphasis was practical, with the PART accepting and encouraging collaboration and plurality of knowledge and experiences.

4.8 Rationale for PAR

In reading and preparing for this study it became apparent that there are many forms of action research.

The decision to focus on PAR rather than other types of action research was considered, namely feminist, ethnography, education and community based action research. As discussed, the study is based on collaboration, fostering a symmetrical reciprocal relationship between myself and others involved to introduce a framework and policy change to improve the profession as a whole (Carr and Kemmis, 2003).

This holistic approach to the profession to include male and female perspectives, departs from the feministic lens, although I recognize the intimate relationship nurses have with this viewpoint (Reid and Frisby, 2008). Similarly although this study is set within a rich Caribbean culture, which influences many aspects, it is not a description of the customs of individual peoples and cultures (Tacchi et al., 2004). Furthermore while CPD is linked with education the notion that this research is confined to the classroom setting does not allow the study to appreciate the full scope of the aims.

Lastly I view the use of community based AR as a geographical entity, where people living in a particular community in a specific locality share a common concern. Whilst acknowledging the concept of a community of nurses, the ability to open up the discussion to other disciplines which may affect CPD was appealing. I acknowledge that all of these perspectives are influential and ebb and flow into this study but do not direct it.

In conclusion the decision to follow a PAR lens was clear. The value of PAR lies within a systematic review of specific concerns through involvement and participation of all stakeholders to discover effective solutions and implement them, with the process owned by all. Because the nurses are most familiar with the practice, they are most likely to have knowledge about the practice and commitment to improvement. There was a practical issue at hand; I wanted to work with those involved to fully understand their perspective, as well as my own assumptions of the CPD issues and needs. This is interlinked with hierarchy and politics, observing who is controlling those policies pertaining to CPD in order to improve opportunities for us. The process appealed over other research methodologies because PAR does not separate theory from practice and the results of testing demonstrate the interactions of knowledge and action (Reason & Bradbury, 2008). For instance a quantitative design was not suitable for this study because measurement development, sampling, and the control of variables would be difficult to achieve in this process of change and the design would not suit the research

objectives of this study. Similarly although the results of a qualitative study would have been very useful for building a understanding issues surrounding CPD in Grenada, actions would have to be separated from the research process. Moreover, participants would not have been able to shape their own professional development and practices actively and might have felt excluded from further decisions after having given insights into their very personal views.

In conclusion, a quantitative, a qualitative, or a mixed method design would not have allowed for exploring issues of professional development in combination with the planning and reflecting on actions. Action research, in contrast, with its simultaneous generation of knowledge and improvement of practice through and within change was a more relevant methodology for the purpose of this study. In addition, this methodological approach was innovative since it was new in the Grenadian context providing opportunities to gain new insights and addressing the last research question of how does the use of PAR contribute to achieving the development and proposal of a CPD framework in Grenada?

The study design of action research was chosen to support the aims of this research

This concludes an overview of PAR including the common characteristics, differing interests and lenses. Following, is an analysis of reliability and validity offering criteria for

measuring this within PAR. Also presented are some of the limitations and specific considerations for this study.

4.9 Reliability, validity and rigour in PAR

In this section the reliability, validity and rigour in PAR is discussed as it has been noted that there have been challenges in defending PAR (Hope and Waterman, 2003; Levin, 2012). In order to establish credibility, the researcher must describe in detail how the research results were arrived at. In order to establish validity the researcher must present a coherent persuasive point of view. Morse et al., (2002, p.2) unequivocally state that "without rigour, research is worthless, becomes fiction, and loses its utility", to support this, research should be valid and reliable, independent of the methodology. The characteristics of PAR require sound research processes, including how the context is assessed and captured, the quality of collaboration, and evidence of reflection (Munten et al., 2010; Coghlan and Shani, 2014). A clear statement of aims and objectives and data collection should be in coherence with the research question (Munten et al., 2010). If research is secondary to the practice change, there is a threat of missing comprehensive data which could add to the body of knowledge (Waterman et al., 2001). It is essential to establish reliability and validity at all stages in the research process rather than retrospectively, so that knowledge can be produced and analysed as the process evolves (Morse et al., 2002).

Morse et al., (2002) argue that there needs to be a shift from the responsibility on the reader to the onus on the author to integrate strategies to ensure rigour. Ensuring rigour and evaluating rigour are different qualities, while strategies of trustworthiness may be useful in attempting to evaluate rigour, they do not in themselves ensure rigour (Morse and Niehaus, 2009).

In summary, if the aspiration of PAR is to contribute to the general body of scientific knowledge, it must comply with scientific procedures and standards (Levin, 2012).

4.9.1 Establishing criteria for rigour in this study

There are several resources to assist the novice researcher with establishing rigour in PAR. This acknowledges that PAR is now an established mainstream methodology under conventional scrutiny (Kelly and Simpson, 2001; Abad-Corpa et al., 2010; Froggatt and Hockley, 2011; Langlois et al., 2014).

Within the field of action research the emphasis is on the practice or behaviour, with research being a tool to bring about and support change (Waterman et al., 2001). It logically follows that these, along with the process of action research, be included in any evaluation. Waterman et al., (2001) offers a set of questions as a tool for critical reflection for the assessment, implementation and interpretation of action research (see Appendix B). Further guidance by Clarke et al., (1993) suggests the report should demonstrate a sense of responsibility towards its own intentions, its data, its various

potential audiences, and the participants in the investigation. Also conventionally it should make clear how data were selected, collected, and analyzed.

Langlois et al., (2014) suggest three criteria of rigour, focusing on the aims of PAR, empowerment, action for personal and social transformation and equity. Alternatively, Lincoln and Guba's (1985) trustworthiness is based on four criteria; credibility, transferability, dependability and confirmability. However, transferability may be problematic within the context based environment PAR works. Instead, Coghlan and Shani (2014) considered the context rather than transferability, their criteria included how the context is assessed and captured along with the study being rigorous, reflective and relevant. Similarly to Langlois et al., (2014) they focused, not on the aims of PAR but the definition to include the quality of collaborative relationships and quality of the process and lastly the outcomes reflect some level of sustainability. Furthermore, Davison et al., (2004) suggests criteria are expressed in the form of questions. These are formed on five principles. Firstly, what was relationship between the researcher and client? Secondly was there adherence to the cyclical process and to the theory? Fourthly, is change evident through action; and lastly did learning through reflection occur.

Lastly the pragmatic approach of action research has been argued, with the primary focus of action research being practice (Hope and Waterman, 2003, p. 124) and the goal of practical wisdom, "revealed only when the multiple determinants of action,

interactions and interpersonal relations are explored in their unique context". Similarly, Reason and Bradbury (2008, p. 454) avoid a set of criteria as "We know that this is neither possible nor desirable because each piece of inquiry/practice is its own work of art, articulating its own standards".

4.9.2 Criteria chosen in this study

For the purposes of this study, the criteria focused on is delineated by Morse et al., (2002) which includes; investigator responsiveness, methodology coherence, sampling, data analysis and saturation. Although associated with qualitative inquiries the framework was complementary to PAR. Within this, the guiding questions specific to PAR as set out by Waterman et al., (2001) were included and considered (Appendix B). The rationale is four fold; methodology coherence was the focus, as this study could not guarantee a positive outcome and the creation of a framework. The concept of transferability as described by Lincoln and Guba (1985) is problematic as for many action researchers (Coghlan and Brydon- Miller 2014). Although desired in this study it could not be assured, the emphasis was to bring about improvement and change in Grenada. This concept is also applied to the term repeatability. As this was a participative and collaborative effort any criteria used would need to represent the iterative nature of PAR, both investigator responsiveness and adherence to methodology would represent this.

Finally a criteria was chosen, departing from Reason and Bradbury's (2008) avoidance of any criteria, as this study needed to meet the obligations of traditional research for defence, publication and possible grant applications. The criteria's sampling, data analysis and saturation would satisfy these and will be transparent.

Each criterion will be critically discussed with relevance to this study.

4.9.3 Investigator responsiveness

Morse (2002) frames investigator responsiveness as awareness and being responsive to the research in situ, this is congruent with the cyclical and iterant nature of PAR. In this study it is essential that all participants are able to use creativity tempered with realism to relinquish ideas or methods that are not producing quality data as the cycles progress (Morse et al., 2002). There is a need, by everyone conducting the study, for constant movement between the theory, research and the practice critically examining tensions, contradiction and complexities. Additionally, in this study the decision to collect and analyse the data concurrently forms a mutual interaction between what is known and what one needs to know.

As a group we needed to allow new interpretations and constructs to form, allowing a joint construction of meaning. Reflexivity and dialogue is essential, not just on a practical or descriptive level but a critical appraisal of one's own understandings and bias (Moon,

2004). In this study researcher and co-researcher credibility will be apparent and demonstrated through the data, transparency of the cycles and reflection.

4.9.4 Methodology coherence

Verification strategies ensure the research question and aims match the method. Waterman et al., (2001) offers several questions which are related to the methodology and to the aims, for instance clear delineation of the cycles and consideration of co-researchers. To support methodology coherence clear documentation of how the cycles evolved and informed the subsequent cycle is necessary. This may involve audits, accurate field notes and minutes of meetings which allow those involved to understand how certain decisions were made (Munten et al., 2010). Furthermore with the selection of the most appropriate method of data collection, credibility is recognized (Levin, 2012). Reason and Bradbury (2008) advocate for the use of PAR in health care to improve and monitor services. This indicates how traditional research rigour can be applied to PAR if the methodology is clear and consistent.

In this case the participants will use reflexivity, exploring and documenting bias, assumptions, conflicts and research decisions throughout to support the validity (Munten et al., 2010). It will be demonstrated through the reflective accounts that the link between the data and participants own commentary and interpretation is clear (Waterman et al., 2001).

In conclusion, coherence is key in this study, by adherence to the phases of each cycle and a focus on the aims of the study, improvement and thus rigour will be shown.

4.9.5 Saturation

Saturation verifies the information gained as being complete and comprehensive (Morse et al., 2002). In this study to aid rigour, multiple research strategies, and full details of data collection for sample techniques, recruitment and size is outlined. Data saturation is reached when the ability to obtain additional new information has been attained (Guest et al., 2006), or when further coding is no longer feasible (Guest et al., 2006). There will be a clear demonstration that no additional data is found and the methods chosen and data analysis techniques are appropriate for the study aims (Waterman et al., 2001). Practical methods such as utilizing an interview protocol allowing the same question to be posed to multiple participants, facilitating documentation and thus an awareness of saturation will be implemented (Guest et al., 2006). In terms of the quantitative data specific notation of the number of surveys returned will be explicitly stated in the results. Utilizing the PAR approach subsequent cycles cannot be planned until there is sufficient and complete information gather this will be transparent in the analysis.

4.9.6 Data analysis

In this study, a variety of approaches will be utilized, acquiring several sources of data to answer the research questions. Waterman et al., (2001) suggest in their guiding questions that rigour is demonstrated by in-depth information regarding data analysis and handling. Quantitative, and qualitative methods are used and the analysis will be transparent. Within the qualitative context, interviews, meeting notes, personal voice recordings and reflective writing were thematically analysed. Diversity aids rigour, in this study, it can also assist with transferability as the data read can promote others to make sense and understanding in differing contexts. These will be described in more detail in the next chapter. The opportunity for co-researchers to review data, enabling clarification and direction, was used to ensure accuracy of their perspectives.

In conclusion using Morse et al's (2002) criteria and Waterman et al's (2001) questions it is possible to create valid, reliable and rigorous PAR data.

4.10 Limitations of participatory action research

Consistent with other research methods, action research has several recognized limitations. These are briefly outlined using the studies by Makaroff et al., (2010) and Condor et al., (2011) as a basis for discussion. Both of these studies reflected on some of the challenges of utilizing PAR 'in the field'. Each is taken separately to illustrate some of

the limitations, firstly tensions and differing expectations within groups, then power

imbalance and finally dissemination.

Makaroff et al's (2010) PAR study was aimed at trying to find ways for nurses to

incorporate into their workplaces and work schedules regularized and spontaneous

discussions about ethical situations and concerns. Another study by Condor et al., (2011)

utilized PAR to investigate whether or not the support provided by a service provider for

people with intellectual disability, actually contributed to people leading lives that they

themselves felt were enjoyable.

4.10.1 Challenges identified by those 'in the field'

Differing perceptions and expectations: PAR studies involve many different people from

varying backgrounds, this may cause tension as the group negotiates the aims, scope and

methods. Perception was reflected on by Makaroff et al., (2010), the study described

how those unfamiliar with the research process became frustrated at the detail and time

required. It was also found in this study that the nurse leaders linked the research to

other initiatives such as recruitment and retention, which was not included in the

research proposal. Similarly, the iterative nature of PAR, can make planning for the

unknown problematic; this may affect budgeting, scheduling and long term commitment

to the project. Furthermore external or larger more powerful influences should be

considered, as not all new knowledge and awareness leads to change. Condor et al.,

(2011) highlighted how the funder of the study required explicit timelines, methods and process which made it difficult to stay true to PAR. Moreover, just who should participate, in what capacity and when, also requires negotiation. Participants may have differing interests or capacities for data collection, time availability or abilities to perform tasks to create data. More specifically Condor et al., (2011) reflected on the fact that the co-researchers, who had learning difficulties, were unable to fully participate in the data analysis. This required a careful balancing act of managing participation though being conscious of who controlled the power.

Power imbalance: Action research requires collaboration, with novice negotiators power imbalances may occur. This has to go beyond 'lip-service' demanding an authentic commitment to power sharing. Condor et al., (2011) describe how the co-researchers felt it was important that they name the project, this emphasises how utilizing ideas from everyone involved enhances shared ownership. Participants may exhort their own power acting as gatekeepers with the ability to aid or hinder the study. Makaroff et al., (2010) describe the fact that work pressure on the nurse leaders impacted their ability to join meetings, requiring renegotiation of the team. To reduce the power differentials, both studies recommended and used communication and honesty. Each study emphasised the need for 'safe' spaces allowing voices to be heard. Additionally they stressed the need for ongoing dialogue in order to renegotiate roles and aims.

Issues surrounding assumptions of knowledge, misperceptions or minimal explanation were challenging as academic nurses tried to understand the clinical area (Makaroff et al., 2010). Similarly due to the participants intellectual disabilities Condor et al., (2011) found some had difficulty in expressing themselves.

Dissemination: Finally, for many collaborative research teams, tensions exist around what is considered to be dissemination, who does it, where it should occur, and who is acknowledged. Ideally the research results need to be shared equitably in ways that both community members and academics can understand. Makaroff et al., (2010) illustrated this by admitting these issues were not addressed until the final stages of the study, when a publication was discovered, which had failed to acknowledge all the members. Participants may want to have their views acknowledged rather than appropriated by the researcher writing up the project (Locke et al., 2013). This highlights the need for a clear sense of who (as a collective) can make decisions regarding publications or who can build upon the work through transparency and excellent communication techniques before research begins.

4.10.2 Specific problems related to this study

In preparing for this study I considered some specific issues. Essentially my cultural, ethnic, historical and economic backgrounds implicitly represented authority and privilege. There is a need to situate this study in the Caribbean as a post-colonial country.

To counter these images, acknowledgment and awareness can prevent tensions; this will be elaborated on next; generally then specifically in this study. Firstly, perspectives and parallels with critical theory are noted. Next an analysis of post-colonial perspective and how this relates to and influences action research and this study is presented. Then a discussion on how I aimed to reduce these effects are outlined.

There is a need to acknowledge the complex interplay between 'culture' and the social make up of Grenada as a post-colonial country. Quayson, (2000, p.2) proposes the following definition to describe a post-colonial perspective, 'post colonialism involves a studied engagement with the experience of colonialism and its past and present effects' this is aimed at the local and global context. As described in Chapter Two, in the local Grenadian context, it was not until 1973 that Grenada gained independence from the UK. In this post-colonial era efforts were made to recognise the rich culture and history and to reclaim local dialect.

4.10.3 Parallels between critical theory and post colonialism

Parallels can be drawn within the disciplines of post-colonial theory, critical theory and action research. Although borne out of distinct theories, they make natural companions. There are comparisons with critical theory and action research, agreeing with Said (2000) that post-colonization theory challenges Western perspectives and the exclusionary effects of dominant ideologies. For example, this echoes Kincheloe and McLaren's (2002,

p. 90) description of critical theory as centring on concerns with 'power issues between groups and individuals within a society'. Also the influence of action research as a vehicle to influence and which is influenced by civil rights, anti-racism and feminism as people collaborate to address a shared concern (Reason and Bradbury, 2008). Fanon, from Martinique, wrote on post-colonial studies and critical theory. He utilized critical reflection to clarify his experiences and relate them to others regarding the effects of racism and colonial domination (Gordon, 2015a). Fanon refers to a collective unconsciousness echoing Freire's work and explaining the feelings of dependency and inadequacy by those colonized. Fanon is referred to by Freire, illustrating the similarities regarding the decolonized and oppressed people (Freire and Macedo, 2005).

4.10.4 Post-colonial theory within this study

Understanding the post-colonial perspective helped to inform this study with a commitment to democratize nursing research in Grenada. Understanding that voices and knowledge have been largely ignored and that they should be sought and valued as legitimate.

Usually PAR is illustrated through research concerning disparities and health issues related to racial, gendered and class discrimination of patients. In contrast, this study focuses on the nurses. This group, utilizing PAR is able to reflect on the accepted,

acknowledging that culture cannot be separated from the other social influences. Also utilizing the need for praxis to engage and change social norms for improvement.

As discussed in Chapter Three, the literature describes the chronological perspectives of CPD and reveals that historically Caribbean nurses were trained by colonial UK nurses in the '50s. These nurses experienced more privileged working conditions establishing a hierarchy and culture which has ramifications for this study (Barros et al., 2009).

In alignment with action research, the commitment to reducing power differences, decentring of knowledge production and reflexive practice is essential. Earlier, in discussing the different lenses that PAR can be viewed through, there must be acceptance of intertwining these theories with post-colonial theory. Furthermore to reduce this study to a singular focus without considering gender, race, colonization and culture would be too simplistic.

In conclusion, understanding the oppression or subjugation of people's language, customs and ideas due to colonization enables my role to be more empathetic and reflective. I was able to appreciate how I could potentially be perceived as a representation of that era, this reflection will be further discussed in Chapter Nine, section 9.5

4.11 Summary

Rather than exploring current practice through qualitative or quantitative methodologies, the use of PAR will provide an opportunity to collaboratively review and transform current practice for CPD in Grenada. This chapter discussed the justification of such a methodology and the foundations of PAR. The PAR spiral of plan, act, observe and reflect was described. Acknowledgement of the importance of reflection was offered. The use of reflexivity to explore personal bias, assumptions and research decisions are tools seen to support validity. My own background, being from a different, cultural and ethnic environment, was discussed. Whilst historically my colour is representational, I attempted to minimise any effects through discussion, honesty and belief in the philosophy of PAR. This was followed by the establishment of rigour and validity in PAR through the characteristics of investigator responsiveness, methodology coherence, sampling, data analysis and saturation. A brief discussion of the limitations of PAR using reflections from both Makaroff et al., (2010) and Condor et al., (2011) followed, highlighting the need for pre-planning, communication skills and realistic aims and objectives.

In conclusion PAR can offer a rigorous and valid methodological approach, through responsiveness and methodological coherence there is an ability to move between action and reflection, to allow for analysis and guidance of subsequent cycles for improvement. Importantly for the novice researcher, I sought advice and guidance from

my supervisors who in supporting and challenging decisions and processes kept this study on track.

The next chapter, Chapter Five outlines the research design and methods that this study employed to answer the research questions posed.

CHAPTER FIVE – STUDY METHODS

This chapter will give a broad overview of the methods used in this study, specifically mixed methods. To recap the study's aims were;

- Utilize PAR to identify the organizational and personal issues surrounding CPD and the changes required in Grenada in order to develop and propose an effective framework for CPD in Grenada.

With the following objectives and research questions:

1. How can Grenadian nurses engage in meaningful CPD?

2. What is the Grenadian nurses understanding of CPD?

3. What are the internal and external issues surrounding CPD in Grenada?

4. How does the use of PAR contribute to achieving the development and proposal of a CPD framework in Grenada?

This would generate knowledge about CPD that could then inform the development of a CPD framework for Grenada. A PAR methodology was chosen as the approach, allowing participants to collaborate and to take action in this framework development.

5.1 An overview of the study design

A reconnaissance phase commenced in January 2016 for three months, followed by three cycles over one year. A mixed methods approach was adopted in collaboration with co-researchers who formed the PAR team (PART) from the nursing sector. A detailed account of the team and recruitment will be explained subsequently in Chapter Six, Section 6.5.2.

This initial phase focused on scoping and reconnaissance. The aim of this was to find a shared concern and begin discussing the issues with those most affected (Kemmis et al., 2014). It serves as a basis for preparing an overall plan.

It was during this phase that ethical approval was sought and granted, this allowed me to fully engage with reconnaissance. This is elaborated on in section 5.1.2 'Planning-Applying for institutional approval to conduct the study' below.

After ethical approval, the first PAR cycle focused on the first aim which was to explore the organisational and personal issues surrounding CPD in a participatory and collaborative manner. This involved engaging support for the study and formation of the PART, including establishment of roles, scope and responsibilities. Along with the PART's experiences and views, a policy and framework scoping investigation was undertaken revealing pertinent data. Also in this cycle a collaborative decision was taken for a mixed methods approach to generate further knowledge on the issues and understanding of

CPD. This method of generating the data required in order to develop a CPD framework for Grenada, was agreed to and planned.

The following PAR cycle focused on the question 'How can Grenadian Nurses engage in meaningful CPD? The PART worked together to pilot, distribute, receive and analyse the questionnaires. This validated questionnaire (see Appendix C) used numerical item scores to describe the motives, importance and conditions surrounding uptake of CPD and the extent of actual CPD undertaken by nurses practicing in Grenada (Brikelmans et al., 2016). Sequentially, the semi-structured interviews which aimed to gain a deeper appreciation of nurses' understanding of CPD, and the internal and external issues surrounding CPD were carried out. The PART collaborated on the data collection and to a certain extent, the analysis of both data sets. Several themes emerged, the groups collective discussion and reflection led to cycle three.

The third cycle was to identify the changes required to propose an effective framework for CPD in Grenada, this was achieved in the final PAR cycle which focused on the development of a CPD framework. The collaborative approach proposed a conceptual framework which would enable nurses to engage in meaningful CPD. The procedures and outcomes of the reconnaissance and the three PAR cycles will be elaborated upon within the relevant chapters.

The fourth aim; to analyse PAR as a methodology in achieving the aims of the study was integral to all three cycles in both joint and personal reflection. This is further analysed and discussed specifically in Chapter Nine.

Visual Model

Diagram 8 Components of the PAR Cycles and Visual model for chapters

- Exploration and overview
- Applying for institutional approval

- IRB approval

Reconnaissance & Scoping Chapter Six

CYCLE ONE
Planning the action and intervention Chapter Six

- Formation of the PART
- Role establishment
- Scope and research design

- Study design
- Study recruitment
- Data collection tools
- Data analysis methods
- Anaysis of results

CYCLE TWO
National survey and interviews Chapter Seven

CYCLE THREE
Evaluation of action research and recommendation for CPD Framework Chapter Eight

- Creation of Framework
- Recommendations for Nursing Council

For clarity, and to assist with transparency for those involved, it is recommended that the research process should be illustrated (Ivankova et al., 2006; Creswell et al., 2011; Creswell 2013). The cycles associated with PAR were noted to help us to visually comprehend where the stages fit, along with points of 'interface' (Morse and Niehaus, 2009). The phase, procedure and outcomes are noted in the text.

5.1.1 Study setting

As discussed in the background to the first chapter, the study was undertaken in Grenada, West Indies. There are three government funded facilities consisting of 476 beds and in addition there are 30 medical stations and six district health centres. As previously stated, presently the nursing population stands at 520 nurses licensed to practice. All of these sites and the current nursing population will be included in the study.

5.1.2 Planning- Applying for institutional approval to conduct the study

I began planning for institutional ethics approval between June and November 2015.

Approval was required from Cardiff University. The university required the study to comply with all the ethical and scientific principles for conducting research with humans, ensuring the protection of rights, safety and confidentiality.

The Ministry of Health in Grenada was also contacted to seek approval and to grant access. In the absence of a formal document the Cardiff University application was used.

In November, 2015 I received permission from the Permanent Secretary in the Ministry of Health, giving permission for the study to commence and agreeing to as much access and assistance as required (See Appendix D). I also received IRB approval from Cardiff University (see Appendix D). I felt confident to move onto the next phase which was to fully engage in reconnaissance and recruitment.

Next is a focused discussion regarding ethical considerations within PAR, as there are a unique set of challenges both in the conduct and participation of the researchers (Brydon-Miller, 2006). The methodology differs from conventional research with a focus on change, cyclical phases utilising group reflection and collaborative relationships. Additionally, due to the dynamic and collaborative nature of PAR, the notion of flexibility and the need to modify ethical approval is constant. There appears to be differing emphasis on where ethical issues may occur and these will be discussed as they relate to this study (Kelly and Simpson, 2001; Lofman et al., 2004; Levin, 2012; Brainbridge, 2013; Locke et al., 2013; Mikesell et al., 2013; Langlois et al., 2014).

5.2 Ethical considerations in PAR

As with all research there are measures in place to ensure that the rights and welfare of human research participants are protected, however as mentioned earlier there are unique challenges associated with PAR. Using the core principles of the Economic and Social Research Council (ESRC) of informed consent, confidentiality and anonymity, minimising benefits and minimising risks as a framework, the following were identified as specific to PAR and this study (ESRC, 2018).

5.2.1 Informed consent

Issues of informed consent regarding an honest appraisal of what is involved, can be problematic. As the process is iterative, growing and changing as the phases progress,

the scope, commitment and obligations can change for all those involved (Löfman et al., 2004, Locke et al., 2013). In this study, it was decided that any major changes during the process, would be avoided by careful planning and design if this was not possible to return to Cardiff's IRB panel for amendment. However, each phase would be renegotiated through open dialogue and planning, gaining consent from the entire team. As described by Locke (2013, p. 113) as the 'principle of negotiation and consensus' there is a recommendation that the "research aims and design, ownership of data and dissemination processes in relation to an investigation should involve consultation with all stakeholders in the research". This was successfully carried out in the cycles during reflection, for instance see 'renegotiation of roles' in Chapter Seven, Section 7.2.3. As with conventional research the right to withdraw was made explicit both verbally in the first meeting and written in the consent form (see Appendix E). Condor et al., (2011) and Makaroff et al., (2010) described how the team changed as time constraints and the escalation of the research affected participants.

As the initiating researcher, I distributed the information sheets (see Appendix E) and gained consent from the members. Consent for the survey is described in Chapter Seven section 7.4.2. In relation to the interviews, I ensured that the consent and information sheet was understood and documented (see Chapter Seven section 7.4.6). This included confidentiality, data storage and the right to not answer any particular question or even withdraw completely.

5.2.2 Confidentiality and anonymity

Confidentiality and anonymity of the participants should be considered as everyone involved needs to feel secure and a sense of trust should be established (Löfman et al., 2004; Loke et al., 2013; Mikesell et al., 2013). It should be considered in PAR as those who collaborate and become a part of the research team may not be able to maintain anonymity thus requiring careful consideration. Also, conversations regarding dissemination strategies should be undertaken upfront as discussed in Chapter Four section 4.10.1 (Makaroff et al., 2010). Additionally in the scoping review on collaborative community based research Wilson et al., (2018) noted the duality of roles as participant and researcher problematic and suggested repeated review and renegotiation of expectations relating to roles and responsibilities of researchers and participant co-researchers. In the Grenadian context it was impractical and undesirable for the team to be anonymous. However, this study explored personal practice, knowledge deficits, and challenges to the institution, so the team must feel able to share experiences and knowledge in a 'safe' environment. This was specifically addressed and jointly agreed to in the first meeting (see Chapter Six section 6.6.4 and 6.7).

The setting is intimate with participants being easily identified. Within the consent form for the team it was explained that members will not be anonymous, however all data collected from the team such as discussions, reflections and debates will not be attributable to an individual on publication. To further protect members their specific

roles within the team would be confidential. The data in the form of interviews, group

discussion and meetings were anonymised (Löfman et al., 2004; Loke et al., 2013).

Additionally, the team participants signed consent forms and developed guidelines

regarding anonymising the interviews. The printed data was stored securely in a locked

filing cabinet, the recordings of interviews were secured through a password protected

hand-recorder and all other data on an encrypted laptop.

5.2.3 Maximising benefits and minimising risks

According to the ERSC principles the research should maximise benefits and minimise

risk or harm. In utilizing a PAR methodology these principles are considered. Three

positive benefits of being involved with this study were identified, firstly we could

potentially experience development by gaining practical and theoretical knowledge in

the field of CPD. Secondly there would be an opportunity to gain insight and develop

competencies through the research process and collaboration (Stringer, 2007). Thirdly,

the potential for empowerment and personal development through involvement in a

change was a possibility and an opportunity (see Chapter Seven section 8.10.2).

However, according to Kotter (1996) changes make emotional and physical demands. As

a characteristic of PAR is to implement a change intervention, the project must progress

at a rate that the team is comfortable with, they must feel valued and that they have

something to contribute (Löfman et al., 2004). To reduce this emotional and physical

burden, protected time for the team meetings was requested and granted, indicating a

level of commitment and understanding by management. Equally, I identified with both

Condor et al., (2011) and Wilson et al., (2018) discussion surrounding the effects of

academic deadlines impacting on the natural flow of a study and potentially pressuring

the team. Similarly, relationships formed during the study can create a sense of loss

when the study is concluded. Brainbridge et al., (2013) countered these issues by

developing genuine relationships, ensuring that fears or vulnerabilities were spoken of.

In this context, these and perhaps other feelings during change were addressed through

communication and reflection exercises as a team.

5.2.4 Inside and outside considerations for the researcher

According to the ERSC principle that research should be conducted with integrity and

transparency; my role as an insider or outsider was considered (ERSC, 2018). This is

further reflected on in Chapter Nine, section 9.5 in relation to my experience. In relation

to PAR and a wish to collaborate and demonstrate authenticity the researcher may

operate as either emic or etic, an "insider" or an "outsider" (Naaeke, et al., 2012; Holian

and Coghlan, 2013; Locke et al., 2013). Insiders typically have a pre-existing connection

with the community or subculture under study and are active members in it. By contrast,

outsiders are new to the community (Naaeke, et al., 2012). Each approach has its

advantages and challenges (McGarry, 2007). Insiders have the advantage of immediate

rapport, as well as a strong familiarity with the socio-cultural context. Traditionally they

are also familiar with the language or appropriate gatekeepers for communication or

recruitment, the researcher can assimilate quicker. Insiders tend to have increased

commitment to the study as the positive effects are also personal (Coghlan and Brydon-

Miller, 2014). However, insiders are often faced with the challenge of myopia: unable to

see the routine and norms as vividly as an outsider might. Additionally, familiarity does

not represent knowledge (Naaeke, et al., 2012). Having familiarity with something does

not necessarily translate to knowledge, for instance everyone is familiar with 'smart'

phones but often limited to the individual needs or regular usage, potentially losing

wider or alternative applications. Similarly there can be a tendency to overestimate ones

knowledge due to familiarization.

By contrast, outsiders are challenged by needing to establish trust, communication

channels and manoeuvring within the new context. Specific to PAR this may hinder the

ability to collaborate or highlight inequalities. However, to their advantage the

researcher brings a fresh perspective, able to see the nuances which others may take for

granted (Waterman et al., 2001).

Bainbridge et al., (2013) worked with aboriginal patients, concluding that the

development of meaningful relationships, being reflective, by recognizing difference and

making research relevant, increases ethical practice. In this context, although working as

an outsider, acceptance is possible due to shared commonalities, as a naturalized

Grenadian familiar with the social context. I wanted to understand CPD thoroughly, as a nurse who completes UK CPD requirements also as a nurse working in Grenada.

In summary, there are additional ethical considerations specific to PAR and these should be considered. These are the areas of informed consent, confidentiality, reducing harm and insider / outsider status.

In this next section an outline of what was utilized to collect data and procedures in the three cycles is described.

5.3 Mixed methods

A mixed method approach has been used successfully in PAR, the flexibility allows the inclusion of multiple approaches regarding methods of data collection, methods of research and related philosophical lenses (Johnson et al., 2007). In the following section considerations as to what is mixed, when the mixing occurs and why mixing is carried out, is discussed. Essentially, mixed methods research is a research design (or methodology) in which the researcher collects, analyzes, and mixes (integrates or connects) both quantitative and qualitative data in a single study or a multiphase programme of inquiry (Creswell, 2013). For instance, Conder et al., (2011), used interviews and a questionnaire to develop a quality of life tool for people with intellectual disabilities. Collet et al., (2014) utilised observation, interviews, focus groups and three surveys to collect data to inform the PAR process for practice improvement.

In relation to CPD, one paper used a mixed method approach, using both interviews and a survey to understand the motivation for undertaking CPD (Brekelmans et al., 2013).

5.3.1 What mixed methods can offer

It is accepted that different methods have distinct strengths and limitations, mixing the data collection methods can provide a stronger understanding of the research question (Creswell et al., 2011; Creswell, 2013).

There are four other main reasons for using mixed methods in health science research which are as follows: firstly this begins with the ability to seek multiple perspectives, secondly the capacity to process and enrich the data through triangulation. Mixed methods can also assist in the evaluation of an intervention and lastly the prospect of data to build on another will be critically examined.

Researchers may seek to view problems from multiple perspectives to enhance and augment the meaning of a singular issue. Being able to observe through these lenses exposes a variety of data.

Correspondingly, the need to include quantitative and qualitative data to develop a more complete understanding of a problem is appreciated (Creswell and Clark, 2011; Creswell, 2013). This is especially noted in healthcare where the patient's experience is just as crucial as a measurable outcome. To illustrate this, the mixed methods study by Sanderson et al., (2010) collaborated with rheumatoid arthritis sufferers to develop a

core set of the patient's priority outcomes in pharmacologic interventions as these were not commonly measured in clinical trials. In conclusion, one can appreciate scales in terms of numbers but it is through the stories and considering the personal experiences that the outcome for patients can be fully comprehended.

Similarly, the ability to have more data to compare, validate, or triangulate results showing congruity within a study, aids reliability and validity (Creswell, 2013). Triangulation can involve differing data sources, investigators, methodological approaches or combinations. The effect is to strengthen the design to improve the ability to interpret the findings (Plano Clark, 2010, Polit and Beck, 2013). However this will not negate a substandard study and may compound shortcomings due to the increased complexity. Although generally considered advantageous, triangulation can be problematic if the data is contradictory requiring further analysis and explanation (Fetters et al., 2013). Similarly the assumption that collecting more data is better, should be questioned, as without reason or process it would create a confused and suspect study.

Lastly, in data creation one set of data can build on another. This is demonstrated in the core literature, Brekelmans et al., (2013) used mixed methods to present an inventory of opinions from the initial results of a survey.

5.3.2 Order and intent within mixed methods

The order is considered, and is crucial in the planning of a study. For instance, when a quantitative phase follows a qualitative phase, the intent of the investigator may be to develop a survey instrument, an intervention, or a programme informed by qualitative findings. Conder et al., (2011) used this sequence to develop a quality of life tool. When the quantitative phase is followed by the qualitative phase, the intent may be to help determine the best participants with which to follow up or to explain the mechanism behind the quantitative results (Clark, 2010). Also Abad-Corpa et al., (2010), utilizing PAR in a quasi-experimental design followed by qualitative data, was able to identify changes required and link these to outcomes to implement evidenced based clinical practice.

5.3.3 Elements to consider

The Institute of Health in answer to the growing use of mixed methods in the field of healthcare research called for guidance and 'best practice' (Creswell et al., 2011). Many have explored principles and practices to assist the novice mixed methods researcher to produce rigorous and reliable studies (Creswell and Clark, 2007; Creswell, 2013).

It is understood that the procedures for both qualitative and quantitative data collection and analysis needs to be conducted rigorously with full explanation and rationale. Additionally the two forms of data are integrated in the design analysis through merging, connecting or embedding the data. To answer the research questions

it will be shown that the procedures are incorporated into a distinct mixed methods design. Additionally the justification for the timing of the data collection, as well as connection and emphasis, has to be described and clarified. There are challenges due to the extensive nature of the data collected, in terms of the time to gather both sets of data and subsequent analysis.

5.4 Types of mixed method designs

A discussion of the three main strategies, including reference to the study being investigated and the main challenges of its design are outlined. Finally the approach in context to the research will be delineated and described. According to Creswell and Clark (2007) there are three main designs for mixed methods: convergent, sequential and embedded.

5.4.1 Convergent

In this approach the researcher collects both quantitative and qualitative data from the same sample. The analyses are carried out separately and then compared for confirmatory or dissenting information. The key assumption is that both sets of data provide different types of information around the same concept. The researcher is able to compare the statistical results and qualitative themes, drawing conclusions in the discussion. Alternatively data can be compared by displaying both types of data merging

in a single visual concept to effectively communicate the results. For example, the key qualitative concepts on one axis and the quantitative responses on the other.
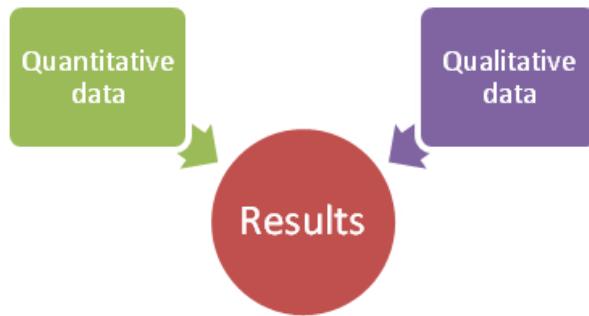
Diagram 9 convergent approach

However there are disadvantages, namely the sample size for the quantitative treatment would have to be large enough to have statistical significance. The rationale and description for the quantitative sampling strategy, sample numbers, and if these differ from the qualitative treatment, these would have to be explicitly described. Additionally as both components are to be collected in unison, there could be difficulties if one phase is lagging behind the other. This typically entails a survey component being much faster to conduct and analyze than a qualitative one (Bryman, 2007). In this context this approach was questionable as the reality of the survey being processed and analyzed before the interviews could take place was not possible.

5.4.2 Embedding

In this form of integration, a data set of secondary priority is embedded within a larger primary design. Through embedding mixed methods, data can be collected before,

during and after to evaluate an intervention (Creswell, 2013). This is illustrated in the

case of Collet et al., (2014) who wanted to measure a quality improvement programme

in the PICU, taking quantitative data to measure engagement, and activities at specific

intervals. Another reason is to have one set of data build on another. An example of this

would include collecting supplemental qualitative data on participants' experiences of

an intervention during a quantitative trial.

Consequently this integration accepts that one data set is less significant, which at the

extreme could be reduced to playing a 'bit role' in the data collection. Furthermore

unconsciously the researcher may favor one methodological approach, structuring the

design accordingly by 'tagging on' the embedding phases as an afterthought.
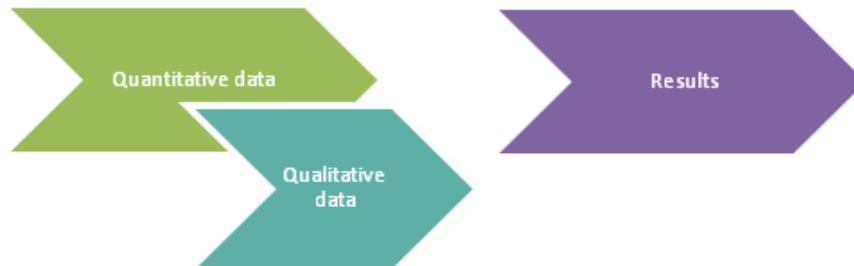
Diagram 8 Embedded approach

5.4.3 Sequential

In comparison, sequential design involves a two phase approach in which the first set of data collected, either qualitative or quantitative, are analyzed and used to inform the second phase (Creswell, 2013). The data analysis is analyzed separately with the first phase results used to plan the second phase. When a quantitative follows a qualitative phase, the intent of the investigator may be to develop a survey instrument, an intervention, or a programme informed by qualitative findings. The instrument is developed using the themes identified, qualitatively informing on scale development, variable inclusion and psychometric properties. When the quantitative phase is followed by the qualitative phase, the intent may be to help determine the best participants with which to follow up or to explain the mechanism behind the quantitative results (Clark, Prosser and Wiles, 2010).

One of the challenges of this method is if the first stage does not inform the next stage, or the second phase contradicts the previous findings. Described as 'discordance' by Fetters, Curry and Creswell (2013) this phenomenon occurs if the qualitative or quantitative findings are inconsistent, incongruous, contradict, conflict or disagree with each other.

Diagram 11 Sequential approach

In conclusion, the reasons for utilizing mixed methods are compelling. In this study the completeness is appealing. Similarly the ability to view the aims through differing lenses will strengthen the study. Likewise the research questions would be best answered though multiple data points. To repeat, the questions were;

1. How can Grenadian nurses engage in meaningful CPD?

2. What is the Grenadian nurses understanding of CPD?

3. What are the internal and external issues surrounding CPD in Grenada?

In this study a sequential method was chosen. Namely a quantitative survey followed by qualitative interviews helped explain in detail the initial results. Qualitative data from our PART meetings, reflections and consensus would also be included. Also appealing is the fact that with this approach, the qualitative interviews helped provide a richness and depth to the data not assessable by the quantitative approach.

5.5 An overview of data collection tools and procedures

In summary, the data collection procedures included researcher field notes and notes from our meetings, email and texts. A national survey to assess understanding and motivation for CPD and semi structured in-depth interviews to understand the issues surrounding CPD in Grenada. The PART met regularly in a collaborative way to develop, implement and discuss the analysis of the data in order to develop a CPD framework. The PART planned and distributed the survey and created the interview protocol.

A national survey was undertaken to answer the first research question; what is Grenadian nurses' understanding of CPD. As seen in the literature, identified in Chapter Three, surveys have been used by other authors to investigate CPD successfully (Gaspard and Yang, 2016; CXuereb et al., 2014; Katsikitis et al., 2013; Onuoha et al., 2013).

The second question, what are the external and internal issues surrounding CPD, would be answered by interviews with Grenadian nurses. As illustrated in Chapter Three, interviews were effectively used to understand personal issues, attitudes, views and barriers surrounding CPD (Pool et al. 2016; Govranos and Newton, 2013; Cleary et al., 2011).

As these two methods, questionnaires and interviews, to collect data were used, an analysis on mixed methods follows.

5.6 Summary

This chapter provided information about the study methods required to understand the reconnaissance and the three cycles of PAR outlined in the subsequent four chapters. The study design was outlined as a series of action cycles with planning, analysis and reflection. A visual model clarified the process. Firstly, the ethical issues were addressed along with obtaining IRB approval from Cardiff and the Ministry of Health in Grenada. Then data collection tools and procedures were outlined. To answer the research questions, a sequential mixed method was chosen to explore the issues from multiple perspectives. The quantitative survey would inform the semi-structured interviews.

This concludes Chapter Five. In Chapter Six the first steps in the study, beginning with reconnaissance and the acceptability of such a methodology in Grenada are defined.

CHAPTER SIX – INTRODUCTION TO RECONNAISSANCE AND CYCLE ONE

The following three chapters outline the cyclical development of the action research study, describing and analysing each cycle in chronological order. As described by Lewin (1948), using the results of one step as a basis for planning the next step is viewed as a cycle rather than a linear progression (see Chapter Four, section 4.6.3). In action research the process is driven by the analysis and interpretation of the data to progress, as each cycle's data informs the next cycle (Tripp, 2005).

In keeping with the cyclical process of PAR, each of the chapters will outline the problem or issue at hand. Then a plan, to address the issues identified, action and implementation, data gathering and results, is presented. Finally an evaluation with reflection from the PART which informs the subsequent cycle. In addition, there is consideration of relationships and level of participation. This is acknowledged to adapt depending on the aim, phase and personal factors throughout a cycle (Waterman et al., 2001).

Aims of each cycle

Each cycle has a specific aim and this will be critically reviewed in each chapter. Chapter Six describes reconnaissance, the first phase in the action research process following

IRB approval. It focuses on fact finding, problem identification and acceptance of the methodology. Additionally, in this chapter, cycle one which is concerned with the formation of the PART and the establishment of roles, scope and responsibilities is delineated. In Chapter Seven, cycle two represents the implementation of the study in the form of a national cross sectional survey and semi structured interviews. The aim of cycle two was to execute the planned research, data collection, and to analyse the data in order to answer the research questions posed. Subsequently in Chapter Eight, the third and last cycle's aim was to conceptualize a CPD framework using the data collected. Also planning and agreement on how best to disseminate the study's findings is presented. For clarity the visual model regarding the components of the cycles and associated chapters is again presented.

Diagram 12 Components of the PAR cycle and visual model for chapters
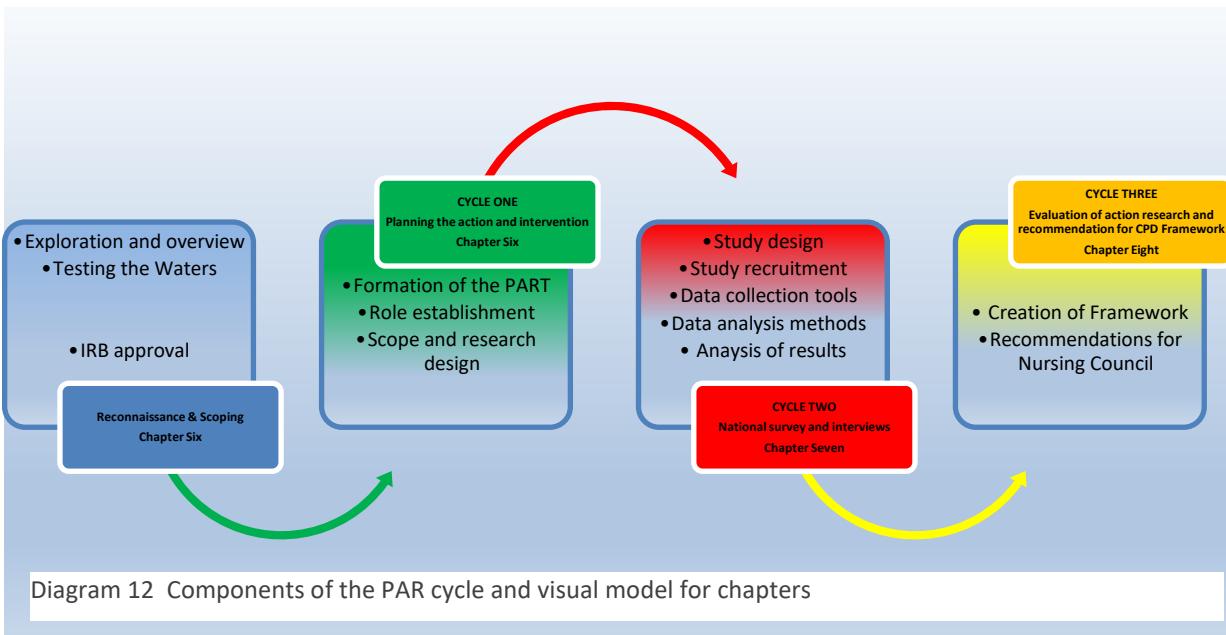
6.1 Reflection

As stated earlier, reflection will not be a separate phase in the cycles, and will be included throughout each phase. Having the ability to be self-aware, of the impact of the 'self' and ensuring transparency to the values and beliefs that influence the process increases rigour for this study and is a key component (Vandenberg and Hall, 2011). A personal reflective journal was kept to record my PAR study and journey. Primarily the focus was on personal assumptions, agendas, values and experiences. I also acknowledged the extent of my influence and impact on the study.

For specific situations the use of Gibbs' reflective cycle (1988) was used; consisting of six items; description, feelings, evaluation, analysis, conclusions and action plan. Its purpose

is to assist in reflection. The idea is to systematically reflect on a particular situation to ensure that all aspects have been considered and evaluated, as this will assist the reflector in understanding what to do next time they are in a similar situation.

Reflection is also essential for effective planning, implementation, and monitoring of subsequent phases (Borge et al., 2012; Coghlan and Brydon-Miller, 2014). Furthermore, reflection on the research design and ethical aspects would be included.

6.2 Introduction

This chapter outlines the first steps of the study. Primarily the aim of the initial discussions was to refine the scope and acceptance of such a study. Also, the chapter explores some of the issues relating to the formation of the PART. This planning phase of the cycle defines the process of ensuring our understanding of the intent of PAR, role definition, access and responsibilities. It also presents the context of the establishment of the PART to explore the first three research questions of this study:

1. How can Grenadian nurses engage in meaningful CPD?

2. What is the Grenadian nurses understanding of CPD?

3. What are the internal and external issues surrounding CPD in Grenada?

6.2.1 Initial contact

My first interaction was in November of 2015, whilst awaiting IRB and ministerial approval. Consultation was confined to informal discussions with the Chief Nursing Officer (CNO) and President of the GNC, also Grenada's nursing governing body. The aim was to confirm or refute my perceptions surrounding the nurses' engagement with CPD. This would inform the decision as to whether any actions were required. Additionally I could understand the historical context of the mandatory hours required for registration as no written policy was found in an initial search. The candid responses and insights to the challenges faced by the governing body and CNO enabled me to understand more about the nature of the problem in context and to formulate how I might approach cycle one to address these challenges.

In my discussions, I was also able to gain a sense of the actors or gatekeepers who would potentially form the PART. I could gauge what the feeling were towards my presence and the acceptability of such a study and methodology by presenting to the GNC and the Permanent Secretary for the Ministry of Health. Once ethics approval was granted, a presentation via power point at the hospital in January 2016, outlined the principles of PAR, what was involved and what level of commitment was required. Most of the members of the GNC, including the CNO and the Permanent Secretary, were present. As discussed in Chapter Three, I saw my function as supporting and facilitating rather than imposing. In this exploration, I felt open to how the research could be guided by those I

spoke to. In conclusion if a negative or apathetic response had been noted at this initial stage, a different methodology or research question would have been chosen for instance a case study or mixed methods approach.

Of importance during exploration was to gain an understanding of the suitability of such a study. Initial discussions with the Chief Nursing Officer (CNO) and hospital staff, centred on whether PAR would be of interest and acceptable as a methodology. Also whether the issue of CPD was significant to the nurses. My initial contact with these various nursing staff was neutral, showing interest and value in their views and listening and absorbing their thoughts and opinions (Stringer, 2007). This was to reduce any influence or manipulation which may be perceived from the nurses due to my eagerness for such a research project. My personal influence was mediated through awareness and critical reflection (McNiff and Whitehead, 2009). Additionally, a conscious decision was made that the involvement and inclusion of the nursing staff had to be from the participants' free will, I could not 'force' transformative practices using action research. In their discussion into the ethical issues surrounding PAR, Lofman et al., (2006) support this notion stating a 'bottom up' approach is more effective, promising change and success.

I also considered that every opportunity to network in this phase in order to gain trust and familiarity was essential. I viewed those I spoke to as potential co-researchers (Stringer, 2007., Reason and Bradbury, 2008). I was genuinely curious to know the

nurses' feelings and did not consider this as a calculated political move but essential to the methodology of PAR and ultimately the success of the research.

As discussed earlier in Chapter One, my interests centred on capacity building in Grenada and more specifically education and development in nursing. It was clear in my initial discussions with the CNO in Grenada that employing a PAR methodology was not only advisable but essential, to ensure that end users collaborated and formed the end product. In relation to the context it was felt this situation, population and conditions had many unique factors which would only be illuminated by working with those who are required to undertake CPD. Additionally as action was needed, embedding it in the research was the best method. As a methodology, as explained in Chapter Four, it is associated with social and cultural change with praxis (Coghlan and Brydon-Miller2014).

6.3 Reconnaissance January – March 2016

The reconnaissance or scoping is a situational analysis which produces a broad overview of the action research context, current practices, participants, and concerns. This began once IRB approval had been granted (Appendix D). The aim of scoping is to find a shared concern and begin discussing the issues with those most affected (Kemmis et al., 2014). It serves as a basis for preparing an overall plan.

In this context, the aim was to critically discuss the issues of CPD with Grenadian nurses in order to assess the importance of the issue, prior to the study taking place.

Additionally, this phase would include examination of the historical and cultural influences; to better understand the context in which this study takes place. As discussed in the background, some of these issues have already been identified such as the influence of history, policies or working conditions, and this knowledge would be built upon. Central to this phase was an exploration of the concept of CPD in Grenada.

This phase took time, as attention needed to focus carefully on the issues, this is borne out by Mackay et al., (2014) who included workshops, a questionnaire and brainstorming in their extensive two-year reconnaissance.

6.3.1 Functions of reconnaissance

This phase aims to provide a broad overview of the action research context, current practices, participants, and concerns. At this point I needed to look at what was going on in detail and consider what needed to change (Stringer, 2007; Mackay et al., 2014). During this activity, the researcher endeavours to find out more about the nature of the problem and the problem context, who are the key stakeholders in the problem-solving context, and to provide early identification of collaborative participants (McKay and Marshall, 2001).

Lewin (1946) suggested that there were four functions of reconnaissance. Firstly, to evaluate any actions required. Secondly, to gather new insights surrounding the phenomenon in context. This is followed by a fact-finding exercise to aid planning and

finally a basis to modify the plan. In this case reconnaissance also gave a broad overview

of the action research context, current practices, participants, and concerns. Along with

these functions the acceptability of the study and PAR was key, as having access,

resources and 'buy in' would contribute to the success (Kotter, 1996). Approaching

nursing personnel in a respectful and a conscious manner would keep to the

characteristics of PAR and establish parity. In the following section each function of the

reconnaissance will be described and the conclusions drawn.

6.3.2 Fact finding and Acceptability – a basis to modify the plan

In fact finding I was able to understand the context better. I also received positive

responses regarding my presence and the acceptability of the study and methodology.

During the presentation and discussions with nursing staff and GNC, there was evidence

of curiosity and openness to the methodology and subject matter. I also received open

assistance and collaboration, through the identification of potential members and

stakeholders who would be amenable, helpful and cooperative with such a study and

methodology. During reconnaissance many commented that it was not just about

changing behaviours but also about changing the ways nurses perceive their CPD so that

they are better informed, leading to a sustainable change. This offered a basis to expand

and modify my initial plan. Similarly, I noted any influence I exerted due to my

enthusiasm. Having self-awareness and willingness to accept my role and potential

influence on the study was reflected upon. I agreed with Hill (2008) that an element of 'self-reconnaissance' was undertaken by self-examination.

I interpreted and attributed the curiosity and animated discussions as acceptance and validation that this was important to both staff and GNC and that the scope and implications were wide ranging.

In conclusion, three circumstances were present to support the acceptability of such a study. Firstly those nurses intimately involved with CPD for licensure expressed concern and recognized this as an issue to improve. Secondly influential gatekeepers such as the CNO and Nursing Director of the Hospital expressed support and desire to improve practices. Finally, due to the reconnaissance I had the conviction and confidence to collaborate with the nurses to achieve the aims of the study.

The next section moves onto cycle one. This is illustrated by the model below highlighting cycle one. Here the formation of the PART, role establishment and scope of the study was agreed. This is fully discussed subsequently.

6.4 Cycle One

Diagram 13 Components of the PAR Cycles Emphasis Cycle One
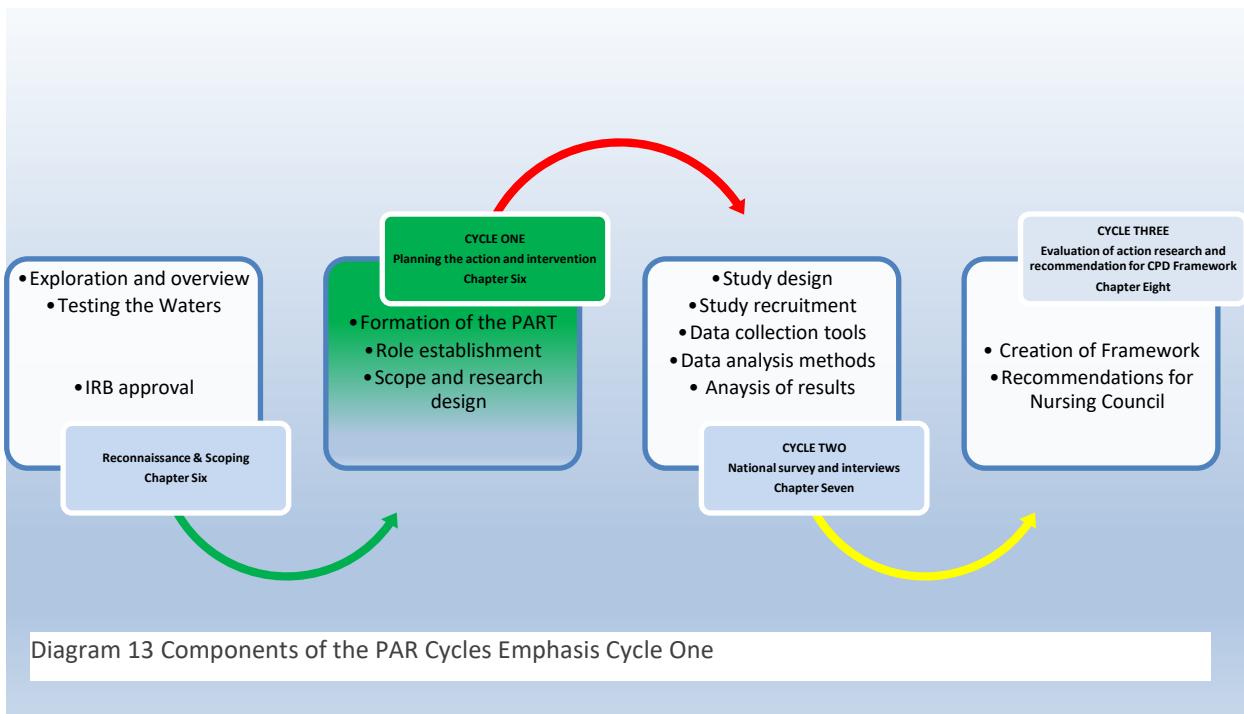
This section outlines Cycle one. This focuses on the formation of the PART and planning specific actions and subsequent interventions required to begin the study. Primarily the aim of cycle one was to refine the scope of the study and agree on the research design. An in-depth analysis of the sampling and recruitment of the team is detailed. This planning phase of the cycle defines the process of ensuring the understanding of the intent of PAR, role definition, access and responsibilities. It also presents the context of the establishment of the PART to explore the first three research questions of this study:

1. How can Grenadian Nurses engage in meaningful CPD?

2. What is the Grenadian Nurses understanding of CPD?

3. What are the internal and external issues surrounding CPD in Grenada?

6.5 Forming the Co-Researcher team - March through May 2016

The planning phase of cycle one focused on the formation of the PART and preparation of the PAR study. The team committed to the process and disclosed their opinions and views on the issues surrounding CPD. During this phase provisions were identified as far as possible to ensure the study would be a success. Throughout this stage of the study it became apparent that the plans formed discrete phases culminating in the research design and protocol, these phases became the basis for the first cycle (McNiff and Whitehead, 2010).

The following sub-sections summarize the planning phases.

6.5.1 Planning - formation of the PART

PAR requires active participation and inclusion of those involved in the research, moreover those not directly involved or recruited were also engaged for support, for instance those in the Ministry of Health (Reason and Bradbury, 2008). The rationale was to develop and communicate a clear vision to all personnel who would be affected by the study. I considered that the involvement and motivation on all levels increases the chances of success of the process (Marquis and Huston, 2012). In this study, this was addressed by including as many as possible in discussion and information sharing. As

Lewin (1951) suggests, the change process is a journey rather than a step, thus requiring support and sensitization at all levels.

Furthermore, identifying change agents or research champions in action research is supported by the literature (Coghlan and Brannick, 2014, Wittmayer and Schäpke, 2014). One such champion was the CNO. The leadership and vision of the CNO was invaluable for three main reasons. Initially it enhanced my understanding of the organization of GNC and nursing in Grenada in general, the insights, information and her perspective was candid and supportive. Secondly, she acted as an enabler; I could gain access and credibility across the organization (Kotter, 1996). Lastly, she agreed to oversee the research, acting as an intermediary between GNC, Ministry, and us. This created a space in which the research could progress without interference from the very institution under investigation. In action research, there is a need to create sufficient openness in which the participants can express freely contradictions, issues and views to fully explore the issues being researched, in this case, how can Grenadian nurses engage in meaningful CPD (Bergold and Thomas 2012).

The CNO identified several people as stakeholders during reconnaissance. The sampling and recruitment of the PART will be elaborated on later in this section. A conscious decision to select persons was taken. In action research, stakeholders are at the centre of the research, "designing interventions, alterations and redirections to activities as

determined by stakeholders" (Reason and Bradbury, 2008, p.125) in this active partnership, action and direction arises with the stakeholders.

As Stringer (2007) describes, in PAR there is a desire to engage and empower stakeholders to be active participants, working towards resolution through research. Those who could influence change, form part of the leadership and management or have policy jurisdiction, were considered as stakeholders. Actively seeking these participants acknowledged that their contribution would have a greater impact on outcomes (Koshy et al., 2011). As critically analysed below, these local authorities in their field were identified during two separate meetings.

6.5.2 Study Population and Participant Recruitment Procedures

A team of twelve people was chosen as a minimal number to ensure effective meetings and ability to move the study forward. I considered the project could be vulnerable if numbers too small, relying on the expertise of a few. I also considered the added dimension of coordination and the logistics of a larger group being able to meet. Similarly too many can lead to procrastination, unable to form a collegial atmosphere and could affect engagement in the study (Sundstrom et al., 1990).

For the initial formation of the co-research team, the strategy of expert sampling was chosen (Rowe and Wright, 2001). This strategy is used when the research requires the assessment and opinions of participants who have a high level of skill and act as major

stakeholders or gatekeepers. Participants were identified early on during reconnaissance, with the assistance of the CNO two separate meetings were held to fully discuss the merits of all potential individuals. Those participants from senior managerial and education positions were selected using the following inclusion criteria; their ability to move the study forward, ability to generate significant data through their views or perspectives, and those who have intimate knowledge of the problems to be researched.

Additionally, they were identified as being able to effect change and influence policy decisions (Onwuegbuzieand Leech, 2007; Koshy et al., 2011). Accordingly, as co-collaborators their insights, knowledge and comprehension of the institution, system and culture was desired.

A total of six nurses were invited, without obligation or coercion. Of the six, four stated that they were willing to commit to the research. Of those who declined, the issue of time to attend meetings and carry out the research was given.

In keeping with the inclusive nature of PAR, I was keen to include other less senior staff or "end users". In PAR, research of, by and for the people with less hierarchy is encouraged (Stringer, 2007). It was agreed by the initial four that the inclusion would allow a unique insight, since the rest of the team would be comprised of a broad spectrum of nurses who were aware of the issues. Therefore, this strategy would reduce the most reported weakness of bias (Rowe and Wright, 2001; Onwugbuzie and Leech,

2007). Consequently, the diverse team would be able to develop practical solutions knowing this research was being conducted in the 'field' using experts, not in academia but in practice. (Stringer, 2007; Reason and Bradbury, 2008).

Accordingly, to supplement the original four a flyer asking for interested persons to participate in the study was posted on each ward and specialized area in the hospitals (Appendix E). These areas were identified as the four medical and surgical wards, maternity unit, theatre and Accident and Emergency at the hospital. Additionally, the four main community health centres and psychiatric hospital were also included to ensure a wide range of respondents. Additionally, the same flyer was placed at each medical station and health centre. The broad inclusion criteria was the same; their ability to move the study forward, ability to generate significant data through their views or perspectives and those who have intimate knowledge of the problems to be researched.

A flyer was chosen because the technique is congruent with critical social theory (Kemmis, 2009). This also proposes that the people who are affected by the issue of concern should have the opportunity to make change for the better by challenging the status quo (Crotty, 1998; Kincheloe and McLaren, 2005). Having flyers throughout the hospitals and clinic areas was an attempt to reach as many people within the hospital community as possible, therefore to give everybody an opportunity to respond if they were interested. A four-week period allowed people to indicate interest and ensured

adequate time for consideration. Sensitization also occurred during those four weeks through individual discussion with nurses who expressed an interest during reconnaissance. In doing so, potential co-researchers would feel they had an opportunity to have a voice in the proceedings and ultimately the framework.

The response rate was very positive and recruitment was completed in three weeks, of the four original members a further eight respondents were recruited. Reasons for partaking varied amongst the group, some spoke of being interested in carrying out research in general, and others a commitment to the subject and need for CPD. Lastly, a number wished for change and saw the methodology as a way to bring this about, by rooting the research in the reality of practice they could relate it to their situation and not the abstract (Meyer 2000).

The team consisted of the following members; the details give some background whilst maintaining a level of anonymity that was agreeable to all.

Work Area	Years of service in descending order	Identification #
Senior Administration	26	#1
Senior Administration	25	#2
Senior Administration	25	#3

General Hospital	20	#4
General Hospital	14	#5
Clinical/Administration	13	#6
Faculty at community college	19	#7
General Hospital	19	#8
Princess Alice (satellite hospital)	17	#9
General Hospital	17	#10
General Hospital	12	#11
General Hospital	11	#12

Table 1 Members of the PAR Team

6.6 Action -Mobilization of the Co-research team

An introduction to action research theory and methodology was conducted through a workshop and question and answer session. The presentation given to GNC was slightly adapted for the audience. This was carried out for several reasons; to discuss the main characteristics of PAR and how it differs from traditional research, to ensure the inclusive and collaborative characteristic is understood as it relates to commitment to the project.

Finally, to appreciate the iterative and dynamic design and cyclic process, this embraces creativity and a pragmatic approach (Koch and Kralik, 2009).

Of those who had volunteered, none had heard of PAR. However, the group through discussion after the workshop unanimously agreed that this methodology had the potential for improving practice and generating knowledge that would, both locally and regionally, stand up to critique, prove valid and give legitimacy to the findings. Consequently, acceptability of the research methodology and support of the initiative was further agreed to. This is described by Koch and Kralik (2006), in discussions on a diabetic initiative with an aboriginal community in Australia, as being key to action research. Discussion and analysis took the form of brain storming other traditional methodologies and investigation and understanding of the definition of action research against the backdrop of critical theory and the island's culture. Having fully disclosed the commitment and possible issues as discussed earlier in Chapter Five section 5.2.1, informed consent from the co-researchers was sought and obtained (Appendix E) at this point (Stringer, 2007; Banks et al., 2013; Wilson et al., 2017).

6.6.1 Action -Establishment of role, scope and responsibilities of PART

The co-researchers and myself formed the PART. The rationale for establishing the roles and responsibilities of the PART was to ensure the group progressed in a mutually agreed framework. In keeping with the PAR methodology, it was central that all members'

values and beliefs were heard and acknowledged (Waterman et al., 2001; Whitehead and McNiff, 2006; Springer, 2007; Reason and Bradbury, 2008).

6.6.2 Setting

We met in the hospital in what is known as the clinical teaching unit, a classroom style room where meetings are held. The room in the hospital was chosen as opposed to the university, as I wished to distance myself from the intimidating world of academia and put this research firmly in the field of practice. I was putting myself forward as a member of the PART, in their environment, symbolically asking for acceptance as a co-researcher and member. As critically analyzed in Chapter Three, one of the key characteristics of PAR is to remove the elitist notion of research and knowledge production (McNiff, 2002; Coghlan and Brydon-Miller, 2014). Moreover, the hospital setting served as a reminder of the aim of the study, being surrounded by those affected kept the group focused as we set to identify the organizational and personal issues surrounding CPD in Grenada. Lastly it was a practical place, most of the team were based in the hospital, it was accessible via public transport and the room was freely available.

The room was booked for two hours, although my intention was that the meetings should take no more than one hour. This was for two reasons; I did not wish to overburden participants with material and expectations of creative thought so that the

research became onerous. Also, I was aware that many of them had work or family commitments. I anticipated that some might arrive late as is culturally acceptable; also, I wanted to be able to 'run' over if required. The PART meetings continued in this manner throughout the research process.

6.6.3 First Meeting

I purchased refreshments knowing this would be interpreted positively as trying to thank the team for their time and participation. However, I acknowledged homemade cake would not suffice in ensuring group dynamics, functionality and cohesion. Burnes and Bargel (2017) in appraising Lewin's work emphasized the need to focus on the group rather than the individual. Consequently, an appreciation of group dynamics and the process involved was central. Much of the evidence cited in the literature about change included reference to the effectiveness of groups in enabling change. In particular, Hackman and Morris (1975) acknowledge that cohesiveness leads to a more efficient and effective group, however it is problematic to state which factors have the most effect. They suggested that the interplay between group composition, cultural, knowledge, task design and coordination may affect the effectiveness, but reliance on a general theory or a single intervention to improve effectiveness is elusive.

Tuckman and Jensen (1977) describe a sequence that each group must go through before work can be accomplished. These stages were forming, storming, norming and

performing. I interpreted this meeting as 'forming' for the action group, this is coming together, agreeing on commonalities and a common purpose in keeping with the first cycle. On reading this theory I was prepared to be more directive, answer multiple questions, allay fears and tolerate a level of disorganization as the team formed and understood the aims and objectives.

Similarly, and specifically in relation to action research I acknowledged the need to establish relationships with a concerned group of people, to move together towards an agreed goal (Kemmis, 2010). This as defined by Wick and Reason (2009), building on the work of Habermas (1984), as a process of opening communicative space to establish relations with an appropriate group of committed people who have a common concern and through dialogue can develop for the success of the research. Similarly, Kemmis and McTaggart (2000) describe the characteristics of these communicative spaces as, building solidarity, underwriting the understanding and decisions that people reach with legitimacy. Because, they are free to choose for themselves what is understandable to them, what is true in the light of their own knowledge, and lastly, what participants themselves judge the right action to be (Kemmis and McTaggart, 2000). These spaces are in the physical and conceptual realm with consideration to the geographical convenience and suitability to have confidential discussions as well as conceptual to encourage dialogue without fear of censorship or judgement (Bevan, 2013).

Addressing group success, Marquis and Huston (2012), identified tasks that each group performs, stating that a member may perform several tasks. In addition, inclusion in the process and collaboration emulates the characteristics of PAR and was chosen. This is elaborated on later as co-researchers identified roles for themselves.

6.6.4 Ice-breakers building the PART

Planning to engage the group that had committed to the study involved group activities that would allow co-researchers to feel welcome and begin the process of cohesion. The first activity, although uncomfortable for some, involved sharing experiences and vulnerability which created an atmosphere of honesty and cohesiveness. My aim in doing these activities was for us as a group to act as a team with an emphasis on open communication and candour. In telling our stories the aim was to allow people to feel safe, and although time consuming, it is only when people feel safe amongst each other that they can express themselves, thus the problem identification, direction of the research and problem solving will occur (Schein, 2003). Whilst these activities were taking place and also when the group brain-stormed, the seating was changed to a circle. During these activities, all co-researchers wrote feelings, issues and shared stories to encourage a sense of equality and participation. These feelings and stories of CPD experiences also helped the group to focus on the study. I could identify with McArdle (2002, p.182) in her research into women in management as she describes having to move all the furniture around into circles stating the 'un-normalness of what I was going

to propose it helped me to communicate this non – verbally'. I felt as though I was communicating equality and questioning established norms through moving from the structured class room style seating to a circle. To me the circle was representative of the non-hierarchical and participative characteristics that are associated with PAR. The second was an ice breaker game demonstrating accuracy in communication (Appendix F). This was two-fold; to create a fun atmosphere where the participants can get to know each other, also to emphasize the fact there is never a trivial question or request, or the "Vegas rule" where confidentiality of our meetings was vital.

6.7 The PART commitments

The following was agreed by us, the PART, during the initial meeting.

Relationships: The team agreed to embark on a study and methodology unfamiliar with uncertainties; I was aware the outcome would be affected by the working relationships established by us (Slavin, 2011). In Grenada, the challenges of hierarchy, traditional roles and reliance on very formal interactions could impact on the working relationships. Seeking how we would prefer to be addressed, contacted and an awareness of cultural norms was sought through open dialogue. The members of PART were diverse and this was compounded by the differences in terms of hierarchy, clinical experience and roles. The promise to value opinions and work towards a common process was agreed to. Members spoke of understanding the principles of participatory research, also their

contribution and commitment to the planning, acting, observing and reflecting as outlined by Kemmis and McTaggart (2000) was agreed. We decided to work as a team without hierarchy, rather an appreciation for each member's diversity and expertise.

Commitment and process: Informed consent was sought and gained from all the team members at this initial phase (Appendix E). The amount of commitment and expectations were set out; in an honest estimation enabling an informed consent. A general time table was drawn up during the first meeting and it was agreed to meet every two weeks for an hour (Appendix G). Drawing on the objectives and actions decided upon, roles and responsibilities within the team were identified and agreed. The evidence in the literature clearly shows that for group meetings to enable change, participants need to be interested in the work and research undertaken, moreover this is in line with the bottom up approach characterized in PAR (Hackman and Morris, 1975; Hart and Bond, 1995; Meyer, 2000; Burnes, 2004; Slavin, 2011). As discussed by Marquis and Heuton (2012), for the work of the group to be accomplished all the necessary tasks must be carried out. I sought consensus and volunteering for these tasks. This focused on individual's strengths, experiences and motivation; each action had assigned persons responsible. Participants agreed to act as fact finders, recorder to summarize decisions or actions and coordinate. I recognized that the others would need to determine their roles, and decide when and how the meetings would fit into their schedule for optimum participation and efficiency (Hackman and Morris, 1975; Slavin, 2011). An action plan

during the phases was drawn up and agreed upon by the team, this was put into a flow chart and distributed (Appendix H).

6.8 Action -Establishment of role and responsibilities of researcher

As an individual committed to the principles of action research, I felt that my communication and inclusion in the team should set the tone for the project. In doing so I felt this was an ethical imperative and that it would maximize participation and ensure a successful project (Locke, 2013). I felt comfortable guiding the research, however acknowledging the expertise of the members in the context and situations that would inform the project.

Furthermore, I made a commitment to partnering through open discussion, each providing distinct contributions (Koch and Kralik, 2006). Israel et al., (1998) offers the example that researchers learn from the knowledge that community members have and in turn they acquire the skills in how to conduct research first hand. I wanted to learn as well as to conduct research. This highlighted my role as a facilitator, I was there to enable the research process, rather than lead (Stringer, 2007).

My role was to develop a medium where the group could come together and construct a picture of the present and in turn critically look at what has been accepted to see possibilities for the future. I saw that to be successful in building an agenda and plan for the next cycle, it was important to expose and clarify the many different perspectives of

the members. As Stringer (2007) suggests, it is by discussing the differing perspectives that a consensus on the action to be taken can occur. This is further described by Schon (1991) as the basis for reflection and planning for the subsequent cycles; by offering context, enabling us all to make sense of the present situation. Guba and Lincoln (1995) called this a hermeneutic dialectic process, where new meanings emerge through discourse being contrasted and compared. The aim is to encourage the questioning of things and through conversation bring people together (Coghlan and Brydon-Miller, 2014).

Integrity in the process would be unified by enabling the team to use their ability to explore and consider other perspectives. To facilitate cooperation, researchers should generally work "to align the interests and agendas" of all stakeholders involved (Bradbury and Reason, 2003, p. 157). Thus ensuring the most effective resolution in context would be possible.

In conclusion as interpretation of the parts and issues that make up CPD are explored with those involved, the wider issues concerning nurses may also be explored.

The following section outlines planning decisions made by the newly formed PART; namely agreement on the research design and data analysis methods.

6.9 Action - Policy and Framework Scoping

We decided to source local documents regarding hours of mandated CPD, existing guidance or frameworks regarding CPD, for instance study leave policy, monitoring procedures, and structures to enable and support CPD. This would provide a local understanding of what was current.

Online searches were carried out using the key words 'Grenada Nursing Council and license renewal' for policy documents and press releases. In addition, a simultaneous discussion with Council and CNO was also conducted to discover internal documents and policy, with notes taken for verification and reflection. This process allowed for confirmation of the data, emphasis and meaning from the participants (Creswell and Miller, 2000). Moreover, the aim was to collaborate and include the persons involved during reconnaissance, encouraging dialogue and transparency.

6.9.1 Results

No CPD policies, guidelines or documents were found in Grenada and the only documentation relating to CPD or licence renewal in the region was in Jamaica. A discussion with the CNO regarding frameworks, policy and regulations showed that most decisions were being taken on a case by case basis.

6.9.2 Mandated hours required

Verbal affirmation of the hours required for registration was 60 hours over three years by GNC (N. Edwards 2016, personal communication, 20 Jan). Related documents from Jamaica for renewal of licensure were obtained, these stated that 30 hours of continuing education was required biennially. This was further clarified by stating 25 hours had to be classed as nursing activities and five (5) as non-nursing or related activities.

6.9.3 Infrastructure and Support for CPD

Evidence of non-specific policy but a call for investment were noted, for instance in a press release the Pan American Health Organization (PAHO) called for members across the region to transform nursing education in several ways including 'creating lifelong educational opportunities for nurses' and 'improve nursing education and practice to fully develop and utilize nurses' skills, knowledge and experiences' (PAHO, 2016).

There was evidence of lack of regulation regarding CPD and licence renewal, the GNC would revalidate nurses' registration without documentation (N. Edwards 2016, personal communication, 17 Jan). The reason given was that Council understood the constraints and challenges that many faced to fulfil the CPD requirements. A lack of infrastructure to assist regulation was illustrated by visiting the secretary of the GNC where the hand-written ledger with registration details was shown. Consequently, the

difficulty of administering, updating and ensuring current license was discussed, however there are plans to computerize this system.

6.9.4 Local Provision of CPD

Provision was evidenced by notices for workshops (Appendix I). As a volunteer my delivery and participation in workshops was welcomed. Other 'outside' agencies from PAHO, the Commonwealth Nurses Federation, and visiting nursing schools also offered sessions on a variety of subjects in an ad hoc way. I was told that certain funds to assist nurses to travel for conferences were occasionally available, however no details or written documentation was offered (N. Edwards 2016, personal communication, 17 Jan). Nevertheless, the majority would be classed as 'in house' education such as case presentations by certain wards. Similarly, Ministry initiatives or relevant training, both in island and regionally, in response to occurrences such as Ebola or the Zika virus were noted on occasions. Lastly, there were minimal alternate activities or events that would constitute CPD such as a journal club, improvement projects or ongoing research.

In conclusion, the PART discovered a lack of documentation, infrastructure to track CPD and a lack of coordination of existing CPD activities. The renewal of nurses' registration without any CPD was revealed.

The next section continues the PAR cycle with reflection of the first cycle.

6.10 Observance of the first Cycle Data collected and analysis

6.10.1 Initial PART meeting

During the initial meetings I paid attention to some of the obstacles such as, those who dominated, made assumptions or held back, yet to find their voice. I became more aware of openings for communication as the members felt comfortable, I gained more data and direction through creating what is termed a 'communicative space' where the members felt able to contribute and confident to challenge and explore differences (Bevan, 2013). Reading and understanding the concepts surrounding communicative space was important in these initial meetings. We needed to reach agreement, "unforced" (Kemmis and McTaggart, 2000, p. 298).

During discussions, the members described how they enjoyed the process of planning and brain storming. The use of a flip chart recorded the salient points and was agreed by us. This served as a visual and current record of points raised, generating more discussion. This data collection technique also encouraged agreement for the flow chart produced (see Appendix H).

6.11 Analysis of qualitative data

The following shows the process undertaken for both qualitative research activities. Firstly, the data after cycle one from the discussion and minutes of the PART meetings, then the data obtained from cycle two, the semi-structured in-depth interviews.

It was decided to use thematic analysis as the overall method chosen for the examination of the qualitative data during the study (Braun and Clarke, 2006). The advantage of utilizing thematic analysis is that it can identify concepts or patterns offering analysis of more tacit meanings, thus adding the advantage of subtlety, not dependent on the frequency of certain phases (Joffe, 2012; Vaismoradi et al., 2013). Reading the literature the range of what types of data can be thematised was considered. In this study data from interviews, discussions, personal field notes, minutes of our meetings and brainstorming activities were gathered. The process is not dissimilar to others in the literature, where the approach is step by step with an aim to move to a deeper understanding of the data, representing it clearly, and making interpretations which may relate to a larger context (Creswell, 2009; Lodico et al., 2010). Lastly as one of the more accessible forms of analysis, not requiring the detailed theoretical knowledge such as grounded theory, it appealed to the members.

6.12 Planning - Data analysis choices

6.12.1 Transcription decisions

To turn the transcripts into written words for analysis I read the literature regarding approach, who to transcribe, and textual information (Wellard and McKenna, 2001; Davidson, 2009; Halcomb and Davidson, 2006). These three decisions as discussed with the members will be taken individually.

6.12.2 Approach

The transcription process is a representational process involving selection and interpretation and it is theoretical. It asks the researcher to make decisions on how to represent the data. An interest in the research questions guided how we would approach the data (Braunand Clarke, 2006). However, Davidson (2009, p. 38) argues that it is impossible to record all the structures of dialogue and interaction and that 'all transcripts are selective in one way or another'. The members felt the steps outlined would reduce selection and potential bias, all felt confident in the process. A broad and flexible approach was appealing to the team as action research focuses on exploring values, thoughts and beliefs and to work collaboratively to improve practice (Waterman et al. 2001).

6.12.3 Who to transcribe

The PART fully discussed the issues surrounding who would transcribe the qualitative data. A decision on who should transcribe considers several factors; expertise, trustworthiness, time or cost issues. Involving a third person to transcribe can be problematic if there is a lack of direction for the transcribers to follow, the risk of interpolation or 'human error' by adding grammar or inserting missing words, either inadvertently or deliberately, can affect the results (Davidson, 2009). Practically, the researcher would have to consider and meet the considerable costs involved (Wellard and McKenna, 2001). As Gillham (2005, p. 126) states, 'transcription is the beginning of

the process of analysis.' To conclude, the researcher may become distant from the data. It was felt by us that there was a level of intimacy with the content through repeated listening, that hearing the emotion and other cues could be lost when not transcribing for oneself (Wellard and McKenna, 2001; Seidman 2013).

Two different approaches were decided, firstly to transcribe the minutes of the meetings and discussions by the PART myself and to distribute these via E mail for corrections and final agreement. Secondly, the interviews would be transcribed as a group, with all members involved as much as possible. This will be discussed in the following chapter, as in reality the members did not transcribe.

The data provided a wealth of information that provided a deeper understanding of the issues surrounding CPD. Additionally, throughout the study the minutes and notes taken informed the development of the cycles, showing the plans made and action taken. Each plan and action is described within the cycles in chronological order with accompanying observations and reflections. At the end of each cycle the analysis of the data shows a clear direction for the next cycle.

6.13 Data analysis process

To help examine the qualitative data in this study, Braun and Clarke (2006) presented a comprehensive process of thematic data analysis by outlining six procedural steps. Following these steps enabled myself and the members to successfully analyse the data

in a systematic and rigorous way (Appendix J). Specific details of the analysis of the PART

meetings is described below in section 6.1.4.

In summary, using Braun and Clarke's (2006) thematic analysis recommendations as a

checklist helped focus the work within guidelines that were methodical, thorough and

easy to follow.

A discussion on the approach and thematic analysis with a working example from the

study follows.

There was familiarity with the entire data set through transcription, re-reading and

listening repeatedly. Once conversant, the process moved to the second phase of

generating initial codes. As described in the literature, codes are labels used to describe

text segments. It is developed by an abductive or exploratory approach, moving back and

forward, examining what codes are formed from the data and how that informs the

analysis (Dubois, and Gadde, 2002; Braun and Clarke, 2006; Bogdan and Biklen, 2007;

Joffe, 2012). As described by Braun and Clarke (2006) this started by simply writing notes

in the texts, going back over with differing colours to indicate potential patterns or

interesting phases. Subsequently a frame was devised using an excel spread sheet format

to transfer these notes into a more manageable format. An example of 16 code names

with associated words used is shown below. In creating codes, 'splitting' was utilized to

create a nuanced analysis which was also entered on a spread sheet (Saldana, 2009). The

following table is used as an illustration.

Code-name	Codes / words used	Example of quotes
Motivations	Part of the profession Aggression have to be proactive Dynamic nature of nursing Maintenance of standards Defines profession	I'm in profession and in order for me to keep in this profession and to be always be on top of things I need to be always be aggressive in keeping up to date with changes. You know there are always changes, it's part of the profession So it's all about achieving goals and trying to maintain a sort of a standard for our profession. We want to be at a certain standard

		so you tend to want to develop yourself.
	Being left behind Self-motivation Centre of locus Comparing to other colleagues Self-motivation Suspicion	You know what you have to do it otherwise you will get left you will sit down and everyone just passing you by so you have to push. I don't want to be left behind I want to be up there if I see my colleagues leaving me I say I need to step up I'm not doing anything now but I would watch the others
Professional tensions	Ambiguity as to role of nursing council	Nursing council is for registration we give them

		$150 for registration a license to practice that is all.
	Agreement to mandated CPD	They should ensure we do cpd. I have family in the states they are nurses and every 6 months every year they have to do something they always have to prove what they are doing as it ensures that nurses are keeping up to date.
	Awareness of other countries requirements	
	Grenada not to same standards	
	Effect of CPD	
	Lack of audit from Nursing Council	They do not check if we or I am doing anything I just pay my money
	Collegial distrust/awareness.	
	Reflecting on professionalism	I know some who do not do what I am doing but

	Role of nursing council and the Ministry of health	they are able to still practice, it's not right.
		Nursing council is looking at ministry to put on a cpd program they alone don't want to take it on.
	Lack of leadership/planning	They should be more proactive.

Table 2 to show codes, code name and example

Creating these tables facilitated organization of the coding, especially where certain phases had other meanings as well, for instance 'being left behind' also occurred in collegial distrust. The next phase took the list of codes and searched for potential themes. Using Excel enabled me to move the codes into differing colour coordinated boxes. I also used a thematic map on paper (Braun and Clarke, 2006). The visual map was valuable to display the relationships between the codes, themes and different levels of themes.

The spreadsheets enabled me to gain a sense of what was significant. Also, the ability to further analyse for overlap and to refine the data, thus ensuring reporting was accurate. As described by Saldana's (2009) coding manual, this process of refinement is essential to go beyond the words and progress towards the concepts and the theoretical. In this phase, 'analytic memos' as described by Saldana (2009) were written. These reflective memos allow movement from description of the data to a discussion of the data as it relates to the research questions.

The following section represents some of the decisions made by us with regard to the pertinent issues of thematic analysis and PAR.

6.1.4 Action - Data analysis of PART meeting minutes

Data collection took place as planned, this consisted of field notes and the meeting minutes of including flip chart and notes. These were discussed as a team and a consensus was agreed as to emerging themes and patterns (Braun and Clarke, 2006). We agreed with Kemmis and Mc Taggart (2000) recommendation for keeping field notes as a means of keeping track of the complexity of an action research study.

The data was recorded using the following headings; *action, observation, reflection* and *plan.* This was consistent with the action research terminology, aiding organization and congruity. A large ring binder was used, with *observation* and *reflection* written from my point of view whilst *action* and *plan* was created by us all as the PART. I was meticulous

in keeping these notes, as the speed of the research demanded that I kept track of the information discussions and insights. To assist with *observation* and *reflection* I recorded my thoughts as I drove home after each meeting, transcribing these into the relevant headings as soon as possible. I also kept a separate, personal reflection diary taking information from these meetings to record my internal challenges, thoughts and successes.

It was considered important to record the minutes of the meetings so that a summary could be distributed for member checking. As described by Lincoln and Guba (1985) and Creswell (2000) this consists of taking data and interpretations back to the participants for confirmation that the direction, meaning and overall account is accurate. Moreover, this process ensures the collaborative and transparent characteristics of action research (Koshy et al., 2011). As agreed, I took the minutes and redistributed them via E mail for corrections, at the beginning of each meeting these would be further confirmed as in a traditional meeting, again allowing for confirmation and to bring others not present up to date.

Other data included was the large poster paper used during the brain storming sessions. The term brainstorming refers to a technique to generate ideas within a group setting, this was done at the beginning of a project to help identify ideas in a creative fashion (Appendix K). In looking at possibilities without the usual constraints, such as budgets or

infrastructure, members can explore freely. We felt this lent context to the way decisions and opinions progressed. These brain-storming meetings enabled members to express their concerns and to voice their desire to improve professional development in a research orientated lens, not just policy change. Brydon-Miller et al., (2003) describe how brainstorming sessions and the social nature of action research can bring joy and a collective passion. Many talked of the values they held and concern as to the lack of development guidelines in Grenada and the wider region. These candid conversations where members expressed their values and the importance of professional development, added to the connection and commitment to common goals. The team put the brain storming sessions and minutes from meetings into different categories and then further distilled these into headings or themes. As analysed in Chapter Three, broad discussions surrounding theoretical foundations, requirements and what constitutes CPD documentation required. Also, mechanisms for monitoring and compliance, assessment and evaluation strategy, process and policy for poor evaluation or compliance were undertaken.

This took considerable time and was conducted during two one-hour meetings. The process of spreading this activity over two meetings was to enable all members an opportunity to understand where the themes originated, as not everyone attended all meetings. Additionally, it enabled reflection and 'stewing' so we could mull over the decisions made.

The next section presents the results from cycle one.

6.14.1. Results

The data gathered in cycle one centred on the broad aims of the first cycle which included the primary question of how can Grenadian nurses engage in meaningful CPD, moreover, problem identification and consensus on method and design was considered. The outcomes of the first cycle will be presented according to the themes identified in the analysis of the meeting notes and brainstorming exercises during these first meetings. The three themes identified were, organizational culture and support, opportunities and motivations, problem identification and logistics.

6.14.2 Organizational culture and support

The theme of organizational culture and support appeared to have several features and characteristics. These were identified as; infrastructure, inconsistencies, access and availability, in addition the roles of GNC and the Ministry of Health were noted.

The theme surrounding the organizational culture and support was evidenced by us all agreeing that institutional support was key to engagement but was not always evident as other challenges such as staffing, and budgets took priority.

One member explained;

If other's or even those in charge don't support us or help us by encouraging and recognising the commitment we have then its really hard you feel not to bother" (PART#2)

This is echoed in the literature and is not unique to Grenada. Rhoades and Eisenberger (2002) found that perceived organizational support significantly affected commitment, engagement and retention. It was felt that it was not enough to simply attend workshops or other initiatives, but that engagement and change had to occur.

"you *know the understanding of our profession is limited we don't understand the true scope of the profession and we just limit it to the work by the bedside"* (PART#9)

6.14.3 Opportunities and motivations

The theme of antecedents and motivations also had several distinctions. These were coded as; Internal or external control, partnerships, opportunities, dynamic nature of nursing, patient care, competency and change in knowledge skills or attitude.

When discussing the issues surrounding motivations and antecedents, all agreed that nursing was a very dynamic profession requiring constant 'upgrading' as patients' needs and the healthcare delivery system changes. Lengthy discussions centred on what constituted professional development and the characteristics of life-long learning as we sought to critically analyse personal perspectives. We viewed CPD as a vital component to enable nurses to respond to the patients' needs and help to define the profession.

One stated

"CPD is not just about learning is not just knowing what you know but exploring on what you don't know" PART#4

6.14.4 Problem identification and logistics.

Lastly problem identification and logistics, including discovering the issues, team work, mechanics and language, documentation.

This last theme centred on the problem identified, design of the research and related logistics. It was generally agreed that to question how nurses can engage in meaningful CPD, an investigation into the issues surrounding and understanding what constitutes CPD in context was needed. This was summed up by one member stating,

"We need to find out what the issues are here, if we want to construct a framework then we have to ask those who are to be impacted" PART#2

The brainstorming and practical aspects of the survey and interviews was successful with a high level of commitment and engagement. Ideas to ensure enough data was collected to facilitate with the rigour, reliability and validity led to an animated and excellent discussion. An example from one member is as follows:

"in order for the survey to work we need to figure out how best to distribute, collect and keep an eye on how many are coming back" PART#5

Other aspects such as cultural sensitivity in relation to language and format were also considered. Furthermore, the need for the questionnaire to be sensible, logical and

practical was important. Minor details were discovered and corrected, accuracy and particulars of the document became a focus to start with, moving to logistical issues. This also illustrated the need for a trial to ensure the burden of time was accurate and feasible.

"we definitely have to look at the survey to make sure its right, make sure we can all fill it in and makes sense to us" (PART#7

6.15 Personal Reflection

The first planning meetings were dynamic with a strong sense of engagement and confidence from the team. Having acknowledged my expertise and potential influence, I was pleased that the oft written power issues among the traditional role of researcher and participants was unfounded (Reason and Bradbury, 2008). These colleagues embraced the concept that they had the ability to understand and address the issues confronting them and their community (Stringer 2007). To them, without knowing it, they embodied PAR. I was concerned as to the differences in experience and obvious hierarchy within the team, but for the most part my fears were unfounded. This was noted by their ease in each other's company. Although welcoming, I was not privy to the 'in' jokes and clear collegial bond shared, I was not 'one of them'. I understood my limitations relationally, but focused on cohesions. Similar to McFarlane and Hansen (2013), who as disabled women explored the experience of disability in women, I, as a

nurse had comparable experiences which we could draw from. However, I was pleased that the members with differing expertise and variety of backgrounds had shown an interest and a strong desire to improve professional development.

I wrote

I felt relieved that anyone had shown up! Everyone looked to me to run the meeting but once we started they practically ignored me. They really were passionate. I was intimidated having the CNO there, I wanted it to go well, I tried too hard I think. Everyone knows each other and considering how formal things are normally they are all chipping in and coming up with great ideas! (Diary entry, 2.2.16)

As I have written earlier, my role as the educated, Caucasian nurse in a country still in post-colonial infancy meant that I was aware and nervous of how I would be perceived. Consequently, I felt that the atmosphere created in the first cycle would be crucial. I was pleased at the level of concern, commitment and enthusiasm for the research, methodology and the acceptance of my presence. I acknowledged our differences but tried to highlight our commonalities, namely as a novice researcher I felt connected and understood their apprehensions in undertaking a study of this size.

I wrote:

I could see some are concerned as to the scope of what we are going to do, they

whispered in the meeting and 'wide eyed' the research timetable. I didn't know how to

reassure them that it will be doable I don't even know! I don't know what pressures

they are under except that I am here working as they are and trying to juggle home

education and work. (Diary entry, 13.2.16)

This whispering and non-verbal communication amongst the members was

disconcerting, but I respected that some did not wish to voice opinions to the whole

group during this forming stage (Tuckman and Jensen, 1977). I managed to keep with

the characteristics of PAR (Koshy et al. 2011). The first meetings had a strong sense of

collaboration and participation; the team identified many issues that became the

themes. Problem solving became apparent with a proposed plan being put in place to

research these in context. Lastly all agreed that the process and research would lead to

an improvement in practice as part of the process for change.

I reflected on the partnership related issues in these first meetings critically analysing

three aspects; trust and respect, distribution of power, differing emphasis on the task

and processes (Israel et al., 1998). Trust and respect is a mutual process and is ongoing

in PAR, Stringer (2007) offers strategies to enable relationships to grow for the benefit

of the research. Accordingly enabling space for all members to speak, valuing their

expertise and opinion, I hoped power would be distributed. This was evidenced by my consistent demonstration of the principles of PAR.

I wrote:

even though none have heard of action research they get it, they understand this is driven by us, not just me. I can feel the sense of ownership and collaboration happening (Diary entry, 11.3.16).

As analysed previously, the success or failure of a PAR study can sometimes rest on the initial discussions and initiation with the members (Wicks and Reason, 2009). In conclusion although an 'outsider' I felt encouraged by the success of cycle one, feeling more confident going into the subsequent cycles.

6.16 Discussion

The discussion of the results of the first cycle and meetings of the PART is presented according to the research question discussed and addressed at these meetings. Further in depth discussion on the research aim, the primary and secondary questions will be further discussed in Chapter Eight. The following is related to the first cycle.

6.16.1 How can Grenadian Nurses engage in meaningful CPD?

The themes identified by us in those initial meetings were; organizational culture and support. These themes define and conceptualize our perceptions of the need for organizational support and a culture for lifelong learning and development. Institutional

and professional support for organized CPD is evident in several frameworks suggested in the literature (Gould et al., 2007; Duffy et al., 2014; Ryley and Barton, 2015).

It was noted that there are financial resources and organizational challenges at an institutional and individual level, however the true extent would necessitate further research. Current research outside Grenada appears to support the concept that finances are a major barrier to accessing CPD, factors cited include budget cuts, cost of registration, travel and materials (Friedman and Phillips, 2001; Ross et al., 2013; Summers, 2015). With many regulatory bodies, including Grenada, underscoring the need for CPD by mandating hours to ensure nurses are competent to practice, the implication for provision, investment, access and support is tacit and an inferred requirement (Joyce and Cowman, 2007).

Additionally, with the Caribbean experiencing a negative migration of nursing workforce, these organizational structures and support for CPD may help to negate some of this crisis (Salmon et al., 2007). This concept is supported in the US with hospitals investing in CPD to increase nurse satisfaction, low nurse turnover and improved clinical outcomes (ANCC, 2014).

Also significant is the paper by Trinchero et al., (2013) which suggests that the perceived organizational support is relevant and has an impact on nurses' engagement in the

workplace setting. This issue of whether the support is visible in the Grenadian context is not clear without research and investigation.

The implication that we as PART recognized the need to research antecedents and motivations towards CPD is significant in understanding the issues surrounding CPD and the Grenadian nurses' understanding of CPD. These formed the secondary questions to be researched. The link between CPD motives and CPD activities and engagement, whether through mandated or self-directed learning, needs to be visualized to inform the PART's development of a framework. Nurses elsewhere value CPD as important and cite several reasons for engaging in CPD, for example: career progression, improving standards and improving patient outcomes (Nalle et al., 2010; Govranos and Newton, 2014). To achieve personal and institutional goals nurses use a spectrum of CPD activities. It is unclear what constitutes these activities and what goals are set in the Grenadian context. In order to create a context-based framework these need to be investigated. Presently we could only discuss and identify formal activities, it is not evident what reflections, informal opportunities and challenges took place. To investigate these, research was required.

6.16.2 Implications and Informing Cycle two

The findings of the initial PART cycle were fed back to the members and discussed. This provided an agreed platform for moving to phase two of the research study. We agreed

the next cycle would need to gather data to gain an understanding of the issues

surrounding CPD. This would identify the structures required to allow the development

of CPD. Consequently, by offering a better means to meet the nurses' CPD needs there

would have to be increased opportunities and participation.

We decided that a sequential mixed methods design would give this additional

information (Ivankova et al., 2006). The research design, as critically discussed in Chapter

Five, consisted of a validated questionnaire to describe the motives, importance and

conditions surrounding uptake of CPD and the extent of actual CPD undertaken by nurses

practicing in Grenada (Brikelmans et al., 2016). It was decided that these results would

be discussed by us to understand their significance and the impact for the next phase in

the research. The subsequent semi-structured interviews would explore the issues

illuminated by the quantitative data in order to comprehend the attitudes and

understanding of CPD (Fontana and Frey, 1994; Gillham, 2005; Brinkmann, 2014).

Additionally, the ability to elaborate and clarify results, aiding the description on the

state of CPD in Grenada, would enable a practical application of a framework for CPD. It

was planned that if discordance in the data was observed we would further discuss

these, seeking explanations and ensuring the ideas form part of the research cycle. It was

agreed to report on possible reasons such as bias or methodological procedures which

may lead to recommendations for re-analysis or gathering additional data.

This concludes Chapter Six where the aims of reconnaissance for each cycle were described. The process of reconnaissance was able to gather information and begin discussing a shared concern with those most affected. Cycle one is discussed, including the sampling, inclusion criteria and formation of the collaborative team. This is followed by agreement of the PART's commitments, scope and responsibilities. Once formed, we planned and conducted a policy and information scope. This exposed a lack of documentation, infrastructure and coordination regarding CPD in Grenada. The methods of the study were agreed to, specifically a sequential mixed methods with a quantitative survey followed by qualitative semi-structured interviews. Observance and critical reflection was undertaken during the process. On completion of cycle one there was a clear direction for cycle two (Tripp, 2005).

CHAPTER SEVEN – CYCLE TWO

7.1 Introduction

Diagram 14 Components of the PAR Cycles Emphasis Cycle two
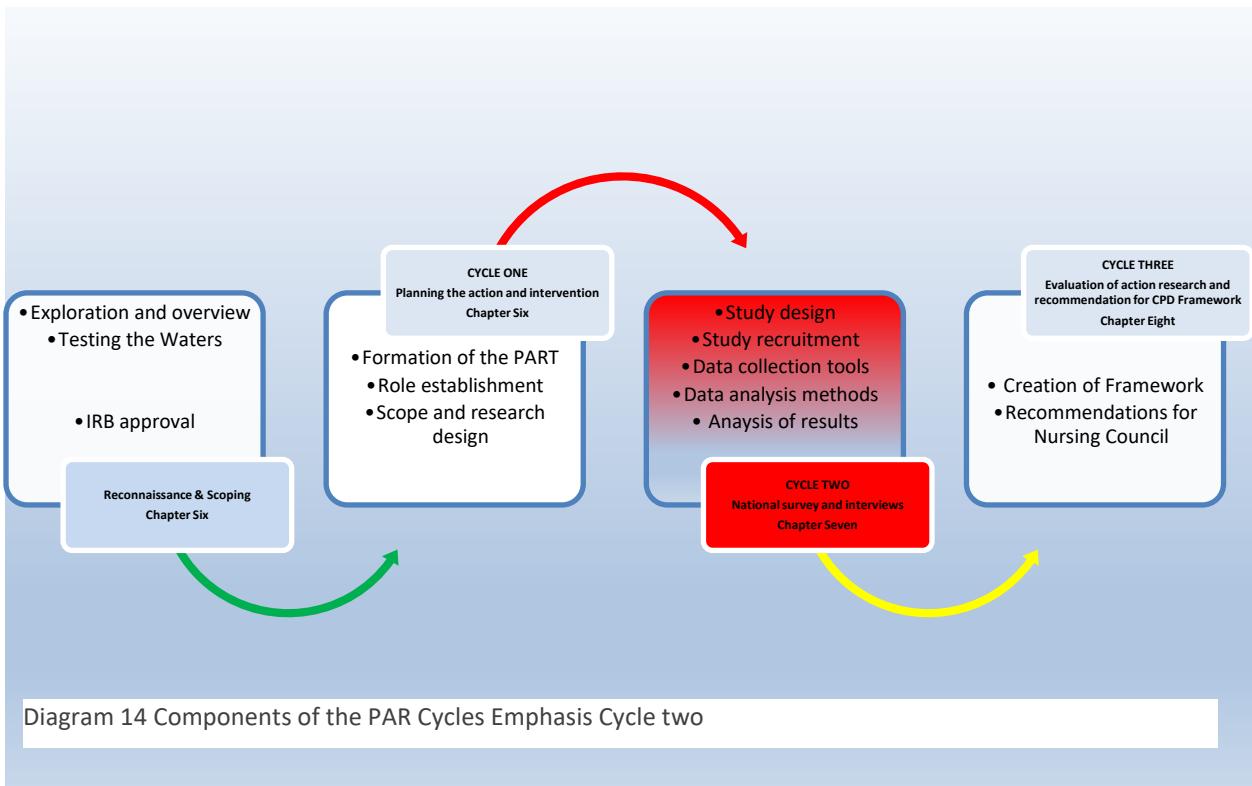
The next section moves onto cycle two. This is illustrated by the model above highlighting the second phase. Here the study was conducted as planned in cycle one. The sequential method of collecting data from both the national survey and interviews were gathered and analysed. This is fully discussed in this chapter.

This chapter presents the second cycle of the PAR. The cycle began in mid-April, 2016 and finished end of October, 2016. The purpose of this chapter is to provide a description of the four phases of the cycle, planning, acting, observing and reflecting. The key goal

of this phase was to establish how the PART could work together to pilot, distribute, receive and analyse the quantitative questionnaires. Similarly planning for the qualitative aspect, the interviews including recruitment and analysis were carried out. The PART conducted the survey in congruence with the research questions:

1. How can Grenadian nurses engage in meaningful CPD

2. What is the Grenadian nurses understanding of CPD

The last question, what are the internal and external issues surrounding CPD in Grenada, would be best answered by the semi-structured interviews.

In keeping with the principles of PAR, the observance and analysis of both methods will be summarized leading to a short discussion and reflection on this cycle. In conclusion, the data, analysis, discussion and reflection will be discussed with regard to the way it informs and relates to the third cycle.

7.2 Aim Cycle two

The aim of cycle two was to identify areas for intervention and action to ensure that pertinent data is collected. The data gathered to answer the issues surrounding an understanding of CPD would ultimately inform the primary question: how can Grenadian nurses engage in meaningful CPD?

7.2.1 Planning

The members were involved in every stage of the planning making decisions and in the reflections on the results of those plans. The first phase of cycle two involved planning for the actions, namely how the design would be implemented. Four sub-sections report the planning process, the first is a critical analysis of the overall research design in context, building on discussion in Chapter Four. Following this, there is an investigation and discussion of the study population and participant sampling, including the recruitment process, for both the survey and interviews. Thirdly, an in-depth examination of the data collection tools and procedures is discussed.

7.2.2 Planning - Design Challenges

We discussed several options for the research design. As analysed in Chapter Four, mixed methods research approaches are commonly utilized in PAR and in the health sciences (Johnson and Onwuegbuzie, 2004; O'Cathain et al., 2007; Ivankova and Kawamura, 2010; Wisdom et al., 2012,). Initially there were differing opinions amongst PART members. Some of the PART felt that the questionnaire would provide enough data for the research questions, contrastingly others thought the qualitative interviews would be enough. To reach a decision on the proposed design an appraisal of the design issues was undertaken. Additionally, we met to discuss people's thoughts on knowledge production. Drawing from Povee and Roberts, (2015) the challenges of limited exposure and time and resources to carry out the research were debated at length.

Limited Exposure; None of the PART (including myself) had carried out action research or a mixed methods design. Of the twelve, four had conducted quantitative research and one qualitative, none had any published research. During the discussion, some expressed reservations at their lack of experience and summed this up by stating.

"I would not feel comfortable doing this on my own, it seems so complex with so much going on" PART#10

This is not unusual, the literature suggests that relatively few researchers are familiar with the critical philosophy behind action research or the specifics of mixed methods (McNiff and Whitehead, 2010, Povee and Roberts, 2015). Members spoke keenly of their desire to learn an unfamiliar research methodology in the form of PAR and willing to broaden their experience in both quantitative, qualitative with a mixed method approach. It became apparent within the PART that there were positivist and post-positivist stances.

The members positively viewed the experience of being immersed in research, "learning by doing" as one member named it. However, the lack of experience and the time required to fully participate in the research process was challenging. The members held full time jobs with added responsibilities such as families, committee memberships and outside interests and this was a concern. There was apprehension that the research would become onerous. Many felt this mixed methods design would be more time

consuming, especially the four members that had experience of conducting quantitative research.

7.2.3 Renegotiation of roles.

As discussed earlier, it was envisioned that all processes of the study would be undertaken collaboratively, however the realisation of the time commitment to fully engage in all aspects required renegotiation.

In conclusion, it was decided that as facilitator I should make decisions on certain research areas. These included the timing between the questionnaire and interviews, choice of statistical package used for analysis and administrative duties such as interview appointments (Creswell and Clark, 2007). This was reported back to the members via E mail. This contrasts with Creswell et al's (2015) recommendation of a core team whereby members can familiarize themselves with the design allowing for a systematic approach and addressing the decisions involved, however it was a practical solution.

Once this had been renegotiated all agreed to the design, feeling it would give the breadth and depth needed.

7.3 Planning - Study Population and Participant Sampling

7.3.1 Survey

The selection method utilized for the survey was whole population sampling. This is where each person, in this case Grenadian nurses, has an equal chance of being included

in the sample (Creswell, 2014). The inclusion criteria included all nurses and midwives registered and practicing in Grenada. The size of the population was determined by using the GNC's registry of all registered nurses in Grenada. Consequently, this formed the basis for the sampling frame (Teddlie and Yu, 2007). It is understood that with randomization a representative sample from the population provides the ability to generalize to that population, in this context all the population was sampled, relying on response rate to infer statistical reliability and validity (Creswell, 2014).

7.3.2 Reliability and Validity in questionnaires.

Statistical reliability reflects the accuracy and consistency in measuring a specific attribute. It refers to the ability to reproduce the results consistently; this is related to the design, process and method used. Quantitative methods in the form of a national survey or census would be used; questionnaires are the most widely used data collection tool employed by nurse researchers (Polit and Beck, 2012). In the literature the four papers which used quantitative methodology all utilized validated questionnaires to investigate differing aspects of CPD (Katsikitis et al., 2013; Onuoha et al., 2013; CXuereb et al., 2014; Gaspard and Yang, 2016).

Furthermore, validity is the extent to which a test measures what it is designed to measure. The question of validity is raised by the construction of the test, the purpose of the test and the population for whom it is intended. In this study, validity is supported

using a previously validated questionnaire (Brekelmans et al., 2015). Additionally, the PART scrutinized the questionnaire, ensuring the questions were relevant to the Grenadian context and that the language was clear.

Moreover, validity is reflected by the response rate. This is a key consideration as it ensures that the survey results are representative of the population (Baruch and Brooks, 2008). The two concerns in terms of internal validity or what generalizations can be derived are sample bias and inaccuracy. The most common source of bias is non-response. Essentially it was hoped the experiences of Onuha et al., (2013) in nearby Trinidad of achieving a 70% return rate would be replicated.

Furthermore, it is important that numbers and reporting are transparent (Krumpal, 2013). Inaccuracy in self-reporting surveys is noted in the literature (Krumpal, 2013; Cornell et al., 2014; Savin-Williams and Joyner, 2014). In this study incomplete or spoilt papers would be counted and included in the results. The debates regarding administering questionnaires were discussed by Rea and Parker (2012), the limitation of ensuring truthful answers or correct interpretation of the questions can be a consideration. We discussed the notion of underreporting or inaccurate reporting as noted in undesirable behaviours such as illicit drug use or unpopular character traits such as racism. In contrast the opposite is evident in desirable behaviours, such as diet and exercise (Patten, 2016). Alternatively, as Paulhus et al., (2003) discusses, unintentional

self-deception may exist as the responders aim to maximize positive feeling of approval and conformation. In this context, the desire for the participants to be perceived as individuals who undertake scholarly activities or professional development may be seated in a desire to impress. To reduce these effects, in the planning and piloting, question wording was carefully examined by us, not only for cultural sensitivity but to reduce focus on the 'right' answer. Consequently, the advantages of using an alternative data set through the interviews would give more breadth to the study.

7.4 Planning Data Collection Tools and Procedures

7.4.1 Planning - Questionnaire

To gain information on the research questions; how can Grenadian nurses engage in meaningful CPD and what is the Grenadian nurses understanding of CPD quantitative method in the form of a national survey was agreed to. For the analysis of the quantitative questionnaire a software programme, Statistical Package for the Social Sciences (SPSS vers. 24.0 2016), commonly used in health care research, was used. Descriptive statistics provided frequency distributions and ranges.

Although considered, we felt that a web based, or phone questionnaire would be impractical due to the participants' lack of technology and reduced island-wide internet infrastructure. We decided that a six-week period was adequate to distribute and collect the questionnaires. The use of questionnaires is the most widely used data collection

tool employed by nurse researchers (Polit and Beck, 2013). It is accepted that the creation of a questionnaire requires considerable expertise and time (Polit and Beck, 2013; Patten, 2016). A validated study was sought and desired due to the advantage of being able to compare data to previous studies, also the questions would have already been tested at the time of their first use. In this context I saw published work in this area could indicate methodological insights, thought and discussion which I could build on adding to the body of knowledge. Moreover, in this study using the questionnaire as a vehicle to collaborate, inform and add to the data from the qualitative interview was desired, adding to the depth and scope of the research.

The questionnaire most suitable to this study, (see Appendix C) had been previously developed to measure the following: motives towards CPD, importance attached to CPD, conditions deemed needed for CPD and actual CPD activities undertaken (Brekelmans et al., 2015). The questionnaire had been previously validated and reliability analyses showed satisfactory to good Cronbach's alpha scores on all factors (Brekelmans et al., 2015). This cross-sectional survey would provide information on the motives behind engagement in CPD activities, the efficacy of CPD to Grenadian nurses and what support is needed to undertake in meaningful CPD.

Permission to administer the questionnaire was sought and granted (see Appendix L).

7.4.2 Planning - Supporting response rates

There was discussion amongst us on ways to best support the response rate for the questionnaires in Grenada. A decision was taken to create advocates within the system, through sensitizing the nursing populous, asking for a willingness to participate and return the questionnaires. A flyer was designed to sensitize and give notice of the up and coming survey (Appendix M). The members felt that this approach using the familiarity of the Grenadian nursing population, the support of the GNC and the uniqueness of being surveyed would enhance return rates. In this case the survey was a low-cost process.

Piloting for the survey was arranged in the initial phase of cycle two within the PART. This was to identify issues such as linguistic and cultural inferences, additionally these were timed to ensure accurate information would be given to the participants. As analysed earlier, another function for piloting was to reduce inaccurate self-reporting by implying desired answers. There were minimal changes, so it would not to impose on the published reliability and validity namely; one category relating to part time work was removed (Brekelmans et al., 2015). Discussion and a 'dry run' aiding feedback was carried out. This data was noted to make any general improvements, for instance increasing the font size.

Lastly, we also decided that the questionnaires would be numbered and coded

(hospital, community and psychiatric) and distributed to the nurses via their work

place. This coding was a means of overseeing which surveys were being returned from

which areas. Information regarding the survey was distributed with the survey form,

also a consent form was included. Consent was implied through completion and return

of the survey (See Appendix M)

7.4.3 Planning - Interviews

I felt that the opportunity to interview the nurses, being able to listen to their individual

stories, would lead to an understanding offering a richness that is not translated by

numbers (Rubin and Rubin, 2011). In the literature, several studies employed

interviewing methods, two utilized semi structured interviews (Cleary et al., 2011; Pool

et al., 2016). Whilst Brekelmans et al., (2013) interviewed 38 nurses as part of a mixed

methods study. Another undertook two rounds of interviews six months apart (Clarke et

al., 2015). Lastly the study by Govranos and Newton (2014) applied a combination of

focus groups and follow up semi structured interviews to understand various dimensions

of CPD.

7.4.4 Semi structured interviews – rationale for choice

The semi-structured nature does not necessitate a rigid question and answer format. The

questions acted only as a guide, with an emphasis on the participant to shape the content

of the interview (Seidman, 2013). Moreover, the use of reflexivity allows the researcher's interview to be more participant centred rather than following a fixed agenda, dominated by assumptions, this is further explored subsequently in 7.10.1. This may illicit a greater depth of information as the participant explores the issues related to them (Vanderberg and Hall, 2011).

7.4.5 Planning - Rationale for interview protocol

It was felt that since more than one member of the team would potentially take part in interviewing, having an interview protocol would ensure the same general areas of the information were collected. Additionally, it aids a focus that allows participants to talk freely within this structure (McNamara, 2009). Moreover, as novices, the semi-structured interview design allows for the use of the questionnaire as a framework for the interview with the flexibility to explore other questions that may emerge (DiCicco-Bloom and Grabtree, 2006; Fontana and Frey, 1994). The guiding interview questions broadly centred on the following, the full interview protocol is included (see Appendix O)

1. What does CPD mean to you?

2. What motivates you to take part in CPD activities?

3. Tell me about your CPD activities this year.

4. Who should decide what activities are important to your CPD?

5. Tell me about some of the barriers or challenges you have when engaging in CPD.

6. How do you engage and choose activities that are meaningful for you?

7. What would a CPD framework look like to you to fulfil your professional registration?

Discussions took place regarding the interview process, sample size regarding the research approach, interview setting, the length of time for each interview and lastly the coding and recording was extensively explored. A chronological discussion on the planning is set out below.

7.4.6 Planning - Recruitment

To recruit for the interviews, respondents from the survey were used as the sampling frame. The inclusion criteria was broad; all registered Grenadian nurses would be considered. Subsequent qualitative methods centred on interviewing relating to the primary research question of the study; to gain further insight on how Grenadian nurses can engage in meaningful CPD. Additionally the intention was to expand on the data received from the survey. It would explore and lead to an understanding of the secondary research question of 'what are the internal and external issues surrounding CPD'.

Prior to this an information sheet was given and a consent form was signed, (See Appendix N) the purpose of the interview, the process, and the rights of the participants were explained. This included the right to withdraw, take a break, or ask for clarification at any point. As discussed earlier in the ethical considerations, the subject matter is of a sensitive nature; therefore explicit confidentiality, method of recording and transcription, data security and coding was outlined comprehensively in the research protocol.

7.4.7 Planning - Who should conduct Interviews

It was in exploring these issues that we debated who should conduct the interviews. Unlike the quantitative research decisions, myself and three junior staff expressed an interest in conducting the interviews. We discussed how interviewing is not seen as an easy option with issues apparent (Creswell 2013). The challenges of bias, and technique are raised by many (Chenail, 2011; Baker and Edwards, 2012; Creswell, 2012; Polit and Beck, 2012). Having the junior staff present gave two advantages; to have an 'insider' present to facilitate the interview and for the member to learn the skill of interviewing and engage in the research process. However, there are certain challenges faced by nurses who undertake action research in their own hospital. For instance, having presumptions on certain issues, transference of experiences or knowledge to participants as well as experiencing departmental, functional or hierarchical boundaries due to their position (McNiff and Whitehead, 2010; Coghlan and Brannick, 2014).

Negating these challenges was the decision that their knowledge as an insider and ability to empathize with the participants' experiences in professional development would lead to a richer interview (Coghlan and Casey, 2001).

My presence was also debated, in the Grenadian context, the perceived power differences due to my ethnic and educational back ground may lead to coercion, or participants may be eager to please, inadvertently biasing answers (Coghlan and Brydon-Miller, 2014). Moreover, as discussed, the complexity of race and culture is acknowledged, employing reflexivity will help limit these factors. My professional and personal experiences have afforded opportunities to develop communication skills, bringing these practices into this study is an advantage.

Moreover, in keeping with the characteristics of PAR, collaboration and equity during the research process was desired. This illustrated how the intent moved from the technical to the practical interest as described in Chapter Four section 4.7 (Kemmis et al., 2014., Coghlan and Brydon-Miller, 2014). However, we, including those senior staff identified, believed that those in management should not participate, due to feelings of intimidation that may be experienced by the participants.

7.4.8 Planning of number of interviews

As illustrated by Baker and Edwards (2012), the number of interviews planned is influenced by both theoretical and practical considerations and is not without

controversy as they "have lost count of the number of times students have asked how many interviews they should do" (Baker and Edwards, 2012 p.3).

The concept of saturation is often debated, how to decide when themes are exhausted and there is justification to cease interviewing (Francis et al., 2010; Baker et al., 2012). Whilst numbers seem at odds with qualitative methodology and a priori sample specification may imply inflexibility, we felt this enabled planning, scheduling and the practical realities of conducting PAR. Drawing on the advice by Koshy et al., (2011), especially when planning for events that could knock the interviewing process off course, for instance, for time required to conduct such interviews, was vital. In this study we decided on a target of 24 interviews. It was also agreed to conduct analysis after each interview, to assess when data saturation was achieved by demonstration of the absence of new codes.

7.4.9 Planning - Setting, timing and length of interview.

A decision was made to interview in the sites selected; hospital, community, psychiatry, midwifery, education and private to reduce inconvenience and burden on the interviewees. It was unanimously agreed that the interviews would not occur during working hours but either before or after. This was to be as unobtrusive to the hospital routine as possible. Inclusion of the differing sites would allow a full understanding of the issues across the nursing specialties.

Deciding the length of time for the interview required planning and critical discussion as a group. Utilizing the work of Seidman (2013) Rubin and Rubin, (2012) and Gillham (2005), it was decided that an hour would suffice to gain answers regarding the Grenadian nurses understanding of CPD. Two main factors influenced this decision; subject matter and who was being interviewed. Firstly, the scope of the subject matter, in this case nurses understanding of CPD, their personal experiences and recommendations of CPD, was extensive needing time to explore and discuss fully. Secondly as nurses and 'end users' of CPD, their expertise and hopeful engagement in this subject warranted a substantial length of time to understand their issues.

7.4.10 Planning - Method of data collection

In the planning stage, it was decided that the interviews would be recorded and the transcripts typed verbatim. However within cycle two this became a contentious issue, with all four PART members who attended the meeting expressing reservations that people would agree to be recorded due to cultural norms. There was a concern that this would negatively impact on recruitment for the interviews.

One summed up the issue

"you don't understand, our history, um the lead up to the revolution just the idea of you sitting there with a recorder, I really don't think people would be comfortable" PART 9.

Alternatives were explored such as making extensive notes following the interviews and making the recording device unobtrusive, but ensuring it was declared and consented to. A decision was made to wait for the responses from those agreeing for their interview to be recorded as stated in the consent form and revisit the issue if necessary. The rationale for this was on reading, I felt the most robust data analysis was through recording and transcribing (Fontan and Fey, 1994; DiCicco-Bloom and Crabtree, 2006; McNair, Taft and Hegarty, 2008; Brinkmann, 2013). This is discussed later in the reflection below.

Having a notion of the time required to transcribe the interviews, we decided that this should be done in small groups with myself being the constant member in order to ensure uniformity of the process. Agreement was given for me to make the decision regarding the specific type of analysis with rationale and feedback to the members (Braun and Clarke, 2006; Joffe, 2012; Vaismoradi et al., 2013). This has been critically discussed in Chapter Seven section 7.2.3 with the decision to follow thematic analysis.

In preparation and planning, I read extensively on the history of Grenada and discussed cultural protocol with the team and colleagues to ensure respectful engagement was adhered to (McNiff and Whitehead, 2010; Coghlan, Brydon-Miller, 2014).

7.5 Disappointment and success

Participants were asked to respond to the initial survey, to indicate and give contact details if they were willing to be interviewed, they would then be contacted for scheduling. Those who responded to the survey were contacted and given information and a consent form. As this method yielded an unsatisfactory response of 14 participants, it was decided to seek other participants using a different method.

The subsequent sampling method utilized snowballing sampling, this involved the principle of gradual selections or sequential sampling. This type of sampling is associated with grounded theory, where the researcher samples people wherever the theory leads the investigation (Glaser and Strauss, 1967). Furthermore, snowballing as described by Bienacki and Waldorf (1981) and Robinson (2014) is a method particularly appropriate when the focus of the study is on sensitive issues. In the Grenadian context and culture, being interviewed and recorded is viewed as an intimidating process so for this reason the above strategy was employed. Although the subject matter was not sensitive the method was perceived as daunting, thus hampering recruitment. The original 14 started the process of referral. Fortunately, these individuals were from differing nursing backgrounds, experience and specialization, therefore confidence in their eligibility and ability to find and engage other respondents was credible and realistic.

The use of snowballing for recruitment in this circumstance has not been discussed in the literature; however, it proved very successful with 24 participants agreeing to be interviewed. These ongoing modifications and reflexive characteristics of PAR is further discussed during reflection on action later in this chapter.

7.6 Action

7.6.1 Action – Conducting the survey

The survey was distributed as planned. We all displayed the flyers which proved to contribute to the sensitization, this was demonstrated by staff asking when the survey was coming out and general questions as to what would be involved. The plan of creating advocates within the areas was of mixed success, the hospital held three meetings to explain and discuss the survey, whilst in the psychiatric hospital only one meeting was held, lastly the community areas proved too fragmented to be able to conduct any meetings. Consequently, the reliance on the flyers and 'word of mouth' was used, proving to be successful with anecdotal evidence of knowledge of the survey.

The members took responsibility for the various areas where the survey was being distributed, the aim was to monitor the response rates, collection and return for safe storage. These areas were the hospital, psychiatric hospital, community and outlying areas such as the hospital and clinic. The anonymous questionnaires were filled in and returned in a sealed envelope to the distribution point or mailed directly.

As prearranged, a reminder notice was sent out in week three. Collection was carried out every three days to have a 'real time' assessment of response rates. The questionnaires were stored securely for entering, organizing and cleaning prior to analysis and reporting.

7.6.2 Action – Conducting the Interviews

As discussed, person to person interviews were used to collect data and in building rapport, by creating an atmosphere of intimacy the aim was to elicit detailed narratives to understand the issues surrounding undertaking CPD in Grenada (DiCicco-Bloom and Crabtree, 2006).

The interviews had the characteristics of a conversation (Fontana and Fey, 1994; DiCicco-Bloom and Crabtree, 2006). Taking this stance rather than an interrogative one it was hoped to reduce hierarchy and build rapport (Rubin and Rubin, 1995). The semi structured interview design allowed the use of the interview protocol form as a guide without being concerned about the exact wording or order of the questions (Merriam, 2009). As I became more efficient, the protocol served more as a reminder and allowed for adjustment or to follow a line of inquiry to obtain more detail or information (Jacob and Furgerson, 2012).

The interviews took place between July 2016 and November 2016 in a variety of settings, for the participants' convenience, as shown in the table below. Prior to commencement

of the interviews the consent form was reviewed with the participant, this ensured that they understood the conditions under which the interview would take place. In this context it ensured the participants were aware that the interview would be recorded, equally it explained that all information would be confidential, and that any identifying information would be excluded (Flory and Emanuel, 2004). The recorder was acknowledged but placed unobtrusively so as not to distract the interviewee.

Interestingly, none of the participants expressed verbal or non-verbal indication of being uncomfortable with their interviews being recorded, they accepted the recorder as a tool for accuracy. The interviews were digitally recorded and then downloaded onto a computer for transcription. On leaving the interview, written notes and verbal comments on each recorded interview were taken. Having these two methods was for practical and methodological reasons. Practically initial thoughts and observations were written on the individual's interview whilst fresh in my mind. However, a deeper internal dialogue was recorded as connections were made and meaning making construed whilst I drove (Kemmis and McTaggart 2000; Wellard and McKenna, 2001). This textural information enabled the process of transcription to be more about interpretation and generation of meanings rather than being a clerical task (Halcomb and Davidson, 2006). It is accepted that attention to non-verbal cues such as gestures, sounds and tone of speech is valuable as data.

We discussed at length some of the non-verbal language used culturally and the meanings. We agreed that these factors should be noted.

The study followed the same thematic analysis as described earlier Chapter Six section 6.11

Below is a table showing the composition of the interview participants, their location and years of service and gender. This demonstrates the diversity obtained through snowballing whilst protecting their anonymity.

Specialization	Identifier	Interview area	Service	Male/Female
Accident and Emergency	#11	General Hospital	11	Female
Male Surgical	#2	General Hospital	19	Female
Male Surgical	#22	General Hospital	3	Female
Male Medical	#5	General Hospital	14	Female
Male Medical	# 21	General Hospital	12	Female
ICU	#14	General Hospital	11	Female
ICU	#8	General Hospital	8	Female
Female Medical	#23	General Hospital	7	Female

Female Medical	#18	General Hospital	8	Female
Female Surgical	#20	General Hospital	10	Female
Theatre	#9	General Hospital	9	Female
Female Gynae	#19	General Hospital	2	Female
Health Centre	#3	St David's	4	Female
Health Centre	#10	St Georges	10	Female
Health Centre	#13	St John	1	Female
Health Centre	#7	St Andrew	12	Female
Health Centre	#17	St Georges	18	Female
Health Centre	#4	St John	18	Female
Rural Clinic	#1	St Patrick's	17	Female
Mount Gay	#6	Mt Gay facility	3	Female
Mount Gay	#15	Mt Gay facility	2	Male
Mount Gay	#16	Mt Gay facility	27	Female
Mount Gay	#12	Mt Gay facility	31	Male
Private Clinic	#24	St Georges	5	Female

Table 3 the interviewee specialization, location of interview and the years of service

Unfortunately, due to time and work constraints, the three members who had expressed a wish to conduct the interviews could not do so, I was the only interviewer, this is reflected on subsequently.

7.7 Results

The following outlines the results from both data sets. The survey is reported on first, followed by the semi-structured interviews. Descriptive statistics were used to determine the importance that nurses attached to specific CPD activities, the conditions they considered necessary to do so, preferred modality, the extent to which they participated in the activities and their motives to do so. Next, the results of the semi-structured interviews are presented. Each theme, choice and control, professional tensions and constituents of CPD is discussed separately. Following this, reflection on cycle two is critically discussed. Lastly, there is consideration and debate on the findings as they will inform the third and final cycle.

7.7.1 Results – Survey

This is a summary of the data. A total of 520 surveys were distributed, this resulted in 348 responses. This number of responses represents a 70% response rate.

7.7.2 General characteristics

There was a majority of female respondents (94%). Age ranges were fairly evenly distributed with the largest proportion being 21.8%, their stated age was between 30-34 years.

Age Range	Numbers of Respondents	Proportion
20 – 24	4	1.1%
25 – 29	42	12.1%
30 – 34	76	21.8%
35 – 39	43	12.4%
40 – 44	51	14.7%
45 – 49	33	9.5%
50 – 54	33	9.5%
55 – 60	17	4.9%
60 and older	1	0.3%
Undisclosed	48	13.8%

Table 4 to show the age range of survey respondents

7.7.3 Employment Status and shifts worked.

Employment Status	Numbers of respondents	Proportion
Full time	261	75%
Part time	11	3%
Agency	7	2%

Table 5 to show employment status of survey respondents

Shift Rotation	Numbers of respondents	Proportion
Morning Evening and Nights	199	57%
Morning and Evening	51	15%
Morning only	45	13%
Nights only	2	1%

Table 6 to show shift rotation of survey respondents

Work Experience in years	Numbers of respondents	Proportion
working <1 - 4 years	44	12.6%
working 5 - 9 years	47	13.5%
working 10 -14 years	77	22.1%
working 15 - 19 years	49	14.1%
working 20 - 24 years	34	9.8%
working 25 - 29 years	39	11.2%
working 30 - 34 years	21	6.0%
working 35 - 39 years	15	4.3%

Table 7 to show work experience in years of survey respondents.

Position	Number of respondents	Proportion
Staff Nurse	142	41%
Registered Nurse	84	25%
Nurse Manager	29	8%
Nursing Administration	6	2%
Educator	5	1%
Clinical Nurse specialist	3	1%
Nurse Practitioner	2	1%

Table 8 to show position held by survey respondents

7.7.4 Level of education

In this study respondents were asked to record details of academic post registration education. There are no doctoral prepared nurses in Grenada.

Table 9 to show level of education of survey respondents

Level of Education	Frequency	Proportion
BSN	38	11%
Masters	9	3%

7.7.5 Area of employment

It is noteworthy that the psychiatric hospital, with 100 beds, had 8% of the population; this relatively low number may be due to a heavy reliance on nursing aids who would not have met the selection criteria. A relatively high number of respondents, 21%, in the survey stated working in 'other' these areas included Richmond home for the elderly with 80 beds and private institutions.

Area of employment	Frequency	Proportion
General hospital	100	29%
Community	74	21%
Elderly care and Private institutions	73	21%
Midwifery	30	8%
Psychiatric	29	8%
Subsidiary hospitals	25	7%

Table 10 to show areas of employment of survey respondents

7.7.6 Motivation for individuals to undertake CPD activities

Respondents were asked what motivated nurses to undertake further professional development. There were three overall focuses for the nurses; internal factors, career progression and mandatory factors. Most of the nurses responding thought motivating

factors for undertaking CPD were professional or an intrinsic focus with the majority, 91%, stating that professional development is important to the individual. Second to this, 91% of responders stated the motivation for undertaking CPD was to increase the quality of health care.

In the second category, focusing on career progression, 85% felt that CPD that increased their professional status was a motivation. In contrast the least motivating factors were in the category of 'mandatory' or imposed reasons to undertake CPD with 60% of nurses agreeing that the reason for undertaking CPD was to prove professional competency.

The table below utilizes a colour key to illustrate the differing focuses.

Internal / Intrinsic focus	Mandated / Imposed focus	Career Progression	
Motivation to undertake CPD		Frequency	Proportion
Further professional development is important to me		316	91%
Increase the quality of health care		315	91%
Make a positive contribution to nursing practice		305	88%
It is important to increase the status of my profession		301	87%
Increase my professional status		296	85%
Support my career		295	84%
Carry out my work better		291	84%
Achieve a higher level of training		288	83%
Support my career potential/choice		283	81%
Improve my current qualifications		283	81%
Improve my leadership abilities		270	78%

It is considered highly important in my professional environment	264	76%
Meet the requirements of the organization I work for	147	71%
Requirements for registration in the future	230	66%
Increase my chances of promotion	212	61%
Prove to my employer that I am professionally competent	210	60%

Table 11 to show differing focus for undertaking CPD

7.7.7 Activities deemed important to professional development

Nurses gave a rating of which CPD activities they deemed important to professional development. This included two categories, formal activities such as "writing articles" and "attending short courses" and the other informal, such as "reflect critically on practical situations" and "learning through practice".

In relation to the 23 recognized CPD activities, the scale rated from "very important" descending to "not important at all". Of the 23 activities, the nurses' activities were evenly split between the formal and informal.

Formal activities	Informal activities		
Activities deemed important to professional development		Frequency	Proportion
Training courses		324	93%
Learning through practice		320	92%
Making sure that I keep up to date with professional developments		315	91%
Determining whether I performed well and whether I could perform better next time		264	89%
Attending clinical practice meetings		312	87%
Discussing with colleagues any developments that might have an adverse effect on professional practice		293	84%
Informing my supervisor if I notice any developments at work that could have an adverse effect on professional practice		293	84%

Actively participating in team discussions about team performance	284	81%
Making sure that I keep up to date with policy developments	282	81%
Reviewing medical literature with regard to best practices	281	81%
Putting scientific research outcomes into the practice of my profession	279	80%
Participating in feedback discussions	278	80%
Reflect critically on practical situations	276	79%
Carrying out research	269	77%
Participation in policy development	264	76%
Participating in reflection meetings	160	75%
Following short courses (duration 2-8 hours)	155	74%
Receiving feedback from colleagues regarding my performance	245	73%
Participating in internal projects	241	68%

Exchanging best practices or setting up projects with other institutions	180	42%
Participating in recruitment and selection interviews with new members of staff	172	49%
Writing articles for professional journals	150	33%
Serving on editorial board of a professional journal	111	31%

Table 12 to show CPD activities deemed important

7.7.8 Activities actually undertaken

Nurses rated the frequency of their CPD activities in relation to the 23 recognized CPD activities. This list reflected the previous set of questions for two purposes. Firstly, to consider what formal and informal activities are taking place and secondly to compare what is deemed important to what is actually done. The scale was presented as, "very often" descending to "never". As with the previous portion, these activities were of a formal nature and the other more reflective and informal. Of the 23 activities, most nurses actually undertook more informal or reflective activities.

Table 13 to show CPD activities actually undertaken

Formal activities	Informal or Reflective activities		
Activities actually undertaken		Frequency	Proportion

Determine whether I performed well and whether I could perform better next time	250	72%
Make sure that I keep up to date with professional developments	172	50%
Reflect critical on practice situations	167	48%
Make use of scientific nursing outcomes in my professional practice	155	46%
Inform my supervisor if I notice any developments at work that could have an adverse effect on professional practice	159	46%
Discuss with colleagues any developments that might have an adverse effect on professional practice	159	40%
Review medical literature with regard to best practices	124	36%
Make sure that I keep up to date with policy developments	123	35%
Participate in feedback discussions	103	30%
Actively participate in team discussions about team performance	111	28%
Follow training courses	96	28%
Follow the CPD activities in my own time	92	27%

Take part in CPD activities at my own expense	87	25%
Follow short courses	84	24%
Participate in reflective meetings	64	18%
Attend clinical practice meetings	52	15%
Participate in internal projects	51	15%
Perform research	49	14%
Participate in policy development	33	10%
Participate in recruitment and selection interviews with new members of staff	27	8%
Exchange best practices or set up projects with other institutions	23	6%
Write articles for professional journals	17	5%
Participate in the editing process of a professional journal	15	4%

7.7.9 Activities deemed important to what was undertaken

The following shows the largest discordance was clinical meetings, training courses and carrying out research. As shown 87% deemed attending clinical practice meetings important but only 15% of respondents actually undertook this activity. This is significant as these activities, thought to be important to CPD by the nurses, were not undertaken.

There was only one question where there was concordance. Respondents agreed that determining whether I performed well and whether I could perform better, was an activity deemed important and undertaken by 76% and 72% respectively.

Questions	Deemed important	Actually done
Attending clinical practice meetings	87%	15%
Participation in policy development	76%	9%
Training courses	93%	28%
Carry out research	77%	14%
Determining whether I performed well and whether I could perform better	76%	72%

Table 14 to show the correlation between activities deemed important and undertaken

7.7.10 Conditions required allowing CPD to be realized

Nurses rated 22 statements with regard to which factors facilitated CPD. These included three main areas, institutional support, financial support and time allowance. Of the 20 statements, the majority of the nurses responded to a mix of institutional, time and financial support as the main factor which facilitated CPD.

Institutional support	Financial support	Time support		
Conditions required allowing CPD to be realized			Frequency	Proportion
CPD activities result in a certificate			278	80%
Supervisor provides me with the necessary time			276	80%
There are career possibilities within my organization			261	75%
CPD activities are not expensive			242	70%
CPD activities have a clear perspective			141	69%
Receive an annual appraisal			220	63%
Receive support from my supervisor			220	63%
Expenses are fully reimbursed by the employer			212	61%
Appreciated from within my organization for the work I do			211	61%
Have more independence			107	60%

Suitable supplementary training courses are offered by my immediate supervisor	205	60%
Other positions are offered within my organization	201	58%
Follow other CPD courses	199	57%
Receive career guidance	192	55%
Taking part in CPD activities allows me to have a say in ward/team policy	185	53%
Clear reduction in workload	181	52%
Immediate supervisor discusses my career possibilities with me	180	51%
Follow the CPD activities in my own time	180	51%
CPD activities are offered in a multidisciplinary context	157	45%
Immediate supervisor coaches me	139	40%
Colleagues coach me	111	32%

Table 15 to show conditions required to undertake CPD

7.7.11 Preferred modality of CPD activities

To gain insight into the way nurses would prefer professional development to be offered, a section giving four options for modality of CPD activities was presented. These were online, peer or group learning, case presentations and experiential, and formal lecture or classroom setting.

Modality of CPD delivery	Frequency	Proportion
Lecture of classroom setting	262	76%
Peer learning	250	72%
Case studies	233	70%
Online	206	59%

Table 16 to show preferred CPD modality

This concludes the results from the survey. The results of the quantitative data influenced the qualitative data gathering significantly. Data illustrated that nurses undertook predominately informal and reflective activities but rated formal activities as important, required further investigation. Similarly the discordance between activities deemed important and what was actually undertaken was significant; the need to appreciate what was preventing nurses undertaking activities which were valued was included in the interview protocol. Additionally nurses rated 22 statements with regard to which factors facilitated CPD. The quantitative results indicated that institutional

support was the primary factor, however these statements needed a deeper

understanding to include the context and how the institution is viewed by the nurses.

Being able to further examine and have a deeper appreciation of the issues

surrounding CPD through a qualitative lens was appealing. As discussed in 5.3.1 the

ability to seek multiple perspectives, being able to triangulate the data was agreed and

is discussed subsequently.

7.8 Results - Interviews

The following presents the results from the semi-structured interviews. Utilizing

thematic analysis as delineated by Braun and Clarke (2006). The outcomes of the

interviews will be presented according to the themes identified.

7.8.1 Results of the data analysis

The purpose of this PAR was to identify the organizational and personal issues

surrounding CPD in Grenada and to identify structures required in order to propose an

effective framework for CPD in Grenada.

Three themes were identified

1. Choice and control

2. Constituents of CPD

3. Professional tensions

The following sections provide a comprehensive examination of the Grenadian nurses' understanding of CPD. As illustrated earlier (table 3 section 7.6.2) the variety of interviewees in terms of work areas and years of service is evident.

It should be noted that two interviewees were male, working in the mental health facility, Mount Gay Hospital. This ratio is roughly correct for the population of male nurses in Grenada. I was not aware of any particular gender issues related to CPD, with the male nurses expressing similar issues and experiences. This is discussed further below in section 7.10.2.

7.8.2 Theme 1: Choice and Control

Nurses verbalized numerous ways in which choice and control affected how they engaged in CPD. Within this, there were sub-themes which included the concepts of lack of availability and accessibility including finances, time, and lastly work pressure. These sub-themes will be discussed below.

7.8.3 Choice and Control – Availability and Accessibility

The most readily available activities were hospital-based workshops or seminars. All the nurses interviewed had attended at least one workshop in the last year and could readily remember the names and course contents. The topics appeared to be varied, including care of specific diseases such as Zika, procedural techniques such as dressings and more

generic skills such as communication or leadership theories. These were of varying levels of organization, planning and execution. The lack of consistency led to the feeling of disorganization and irrelevance with the nurses believing their learning was reactive to what was 'on offer' rather than a systematic deliberate process.

The lack of planning compounded the availability; this respondent had a sense of desperation that anything is better than nothing.

"I don't get a choice I just do it, you never know what will be coming up. There isn't a roster to say oh later so and so will be happening you just do any workshop that turns up! You never know you have to grab it even if it isn't relevant'. #7

Other activities available were courses or conferences abroad; of the 24 nurses interviewed none had attended a conference, issues of travel are discussed subsequently. None could recall a nursing conference being held in Grenada. Two had travelled abroad for courses, one to Jamaica for intensive care training and another to China for a management and leadership certificate. Unfortunately for both, these were not seen as positive experiences, citing lack of preparedness, support and finances.

There were opportunities for development formally. Two of the 24 nurses were currently enrolled in a formal academic programme. One was enrolled in an online bachelor's programme and the other was attending a phlebotomy course at the local college. Both nurses had self-funded their education and felt they were investing in their future. These

participants had taken the concept of choice and control, utilizing strong internal motivations to be proactive.

"I plan myself I want to develop myself as much as I can I took upon myself not to wait on a scholarship and took a loan to do my BSN and when I have finished I want to do my masters and I would like to specialize in ICU. So, that is a long-term goal". #24

The lack of regularity of the sessions created the feeling of lack of control as workshops would be announced without warning, making access difficult.

Interviewer – "did you know it was going on?"

Interviewee #7 – "no until I got the phone call saying there is a workshop telling me about it".

Certified basic life support (BLS) training is offered four times per year at minimal cost at the local private university. Of the 24 interviewed six had up to date BLS cards. One wished to attend but was unable to attend on the day it was offered. Another stated she had not attended training in over eight years, whilst one had never attended, both citing a lack of advanced notice to sign up for the course.

"I've never done my BLS, I can't organize with a day's notice, I have three kids, yes, I think there are certain things we should know how to run a crash how to do certain things certain procedures and how to assist. I would love to get the hands on". #12

The workshops, in house teaching and seminars offered were free of charge. It was also noted that if given permission to attend certain courses or activities, the time and thus pay would be compensated.

Related to finances affecting accessibility, the island is geographically isolated relying on air transportation. Without a low-cost airline, travel to regional or international courses is beyond most nurses' finances. Similarly, the nurses were aware of monies available through grants or assistance, but the process was not fully understood by the majority of participants. The lack of scholarship or financial aid was stated as an issue.

"Finances. For sure. I know a lot of staff nurses and ones like me, we would like to do things but we don't have the finances.". #10

Lastly, the lack of transparency in study policy was also felt to affect access, many gave up applying for courses or leave. None could give clarity on policies regarding CPD. This issue regarding transparency and parity cut across all three of the themes.

Not surprisingly, the majority cited lack of control over their time, and work pressures as major issues effecting accessibility these two themes are discussed next.

7.8.4 Choice and Control - Time

Engagement with CPD was affected by nurses being able to find personal time or being granted time. Finding time to learn was a huge challenge for all the participants.

"I'd like to do my BSN but I couldn't afford the time, I hear it's tough. I find it hard enough just to keep up with all the changes that happen. If I was given the time off, then maybe but right now no way. #6

Being granted time depended on several factors, namely if staff could be spared. Staff absenteeism was a significant factor where the interviewees worked.

"Tomorrow they don't have staff so I can't go to class tomorrow I must work the evening so sometimes we have a break down. I find it frustrating". #13

Related to this, none of the participants owned a car, consequently reliance on public transport resulting in longer commutes exacerbated the time required and thus access. Additionally, time spent on child care and family chores follow a traditional pattern, predominately falling to the female nurses.

"When I go home I want to be there for my kids, they need their homework looking, braiding and cooking it all takes up time. I don't mind learning or doing things when I'm at work but when I'm home I'm home". #22

7.8.5 Choice and control - Work pressure:

This was related to a heavy workload as expressed by the participants, rendering them too tired to undertake CPD, again this was felt to be beyond their control. As explored earlier, it was only on probing that learning whilst working was considered at all. Most

of those interviewed felt their work load and pressure did not allow them to feel able to learn during worktime.

"So sometimes you feel like giving up, put it like that, sometimes you can't be bothered you just want to get through the day. They pressure you so much it is a lot, its just go go go from the minute you get on shift. # 19

Lastly, the nurses expressed a lack of control in the passive language they used, phrases such as 'if I was chosen', 'if given the opportunity', 'if selected' were always mentioned at some point during the interviews. As there was a lack of organisation, notice and planning, this compounded the belief of lack of choice or control. I noted a strong reliance on external forces by the Grenadian nurses, thus they do not feel in control.

This concludes the main theme of choice and control, within these five sub-themes; availability, accessibility, time, finances and work pressures were identified. Next, an exploration of the second theme, professional tensions, where the sub-themes of institutional support and collegial awareness are discussed.

7.8.6 Theme two Professional tensions

Nurses verbalized numerous examples of the ways in which professional tensions affected how they engaged in CPD. Within this, the concepts of institutional support or being enabled or blocked, and collegial awareness were mentioned. Within these themes the concept of motivation and general morale was brought up at length by all

the participants. Although not the focus of this study, most nurses discussed emotional exhaustion, referring to physical and emotional overload regarding staffing levels and problems with their working environment. Lastly there was dissatisfaction in terms of their personal accomplishments, they viewed themselves negatively because of unrewarding conditions.

7.8.7 Professional tension - institutional support

This sub-theme related to being enabled or blocked by those in authority or 'gatekeepers'. The concept of equitable opportunities was closely linked with those gatekeepers and perceived transparency in the policies related to study leave, scholarships or selection. It was evident that the power of these individuals and more anonymously the institution influenced CPD. The participants acknowledged they were not in a position of authority and wanted support from the institution.

"The point is it should be easy but it isn't you make appointments but they stall, I see the problem is them in charge they have all the power, they can make or break its as simple as that" #13

Similarly, in the interviews it became apparent that there is a gap between those who make decisions about offering CPD and the end users. The initiation and CPD development are seen to be top down, without obvious consultation or feedback from the participants.

The process of applying and being granted leave is on an individual basis, this process is not fully understood by the end users and there is no clear policy or guidance, this led to a perceived lack of support or encouragement:

"Policy for leave, that is a no, it is all up to them, you have to apply I'm not sure if there is a form but you definitely need to apply then it's up to them. I know of some who went to China but I don't know how that happened I think they were selected." #5

7.8.8 Professional tensions - Collegial awareness

This last sub-theme was evident in three main characteristics of apathy, hostility and distrust. These related to three areas, those unseen in charge, those seen in charge and peers. In relation to the issues surrounding CPD and those unseen in charge, the following comments were made. Firstly, showing an assumption of how those in the institution have a bearing on personal CPD, one said;

"So as a result they don't give us the needs we want, such as education, development and providing opportunities for us to develop in the field to help make the institution a better place. To be honest I have no idea what they do or how they fit in with my plan" #15

In this exchange the lack of clarity, leading to apathy as to whom and how CPD could be enabled, is discussed

Interviewee #17: "I think they should make provision for CPD".

Interviewer: "you say they, who is they, could you expand a bit?"

Interviewee #17: "I don't know! They who is responsible for it. I don't know really, whatever, they should that is all, I don't care really".

There was evidence of hostility or a sense of frustration at the institutional level. The general lack of understanding at the function and scope of the GNC, was felt by the majority of those interviewed. The perception of inactivity, disorganization and remoteness was discussed by many; similarly, several of the junior staff did not understand the role of the GNC. This is summed up by the following.

"Nursing council is for registration we give them $150 for registration a license to practice that is all. They should ensure we do CPD. They do not check if we or I am doing anything! Nursing council is looking at Ministry to put on a CPD program they alone don't want to take it on. They should be more proactive. #9

Nurses also discussed the support of their immediate supervisors or those seen and in charge. The relationship was more immediate and not as abstract. Therefore, there was less apathy, hostility and distrust. However, these managers were viewed as being constrained by those 'unseen'. All those interviewed had received a staff appraisal by their managers, at which professional development was discussed and noted.

"She (the supervisor) *tries her best, you know through motivating us, getting us to do little things on the ward but I really think she doesn't have the power, she's one of the good ones" #2*

There were many examples of peer hostility or jealousy surrounding the issue of CPD. There was jealousy of others who had gained access to CPD and conversely felt by colleagues when undertaking development. The hostility expressed was also against those who were perceived as unwilling to undertake CPD thus, in the interviewee's opinion compromising standards, professionalism and patient care. In this context, the participants viewed mandatory CPD as a positive means of combating this.

"Yeah, because there are those who really don't want to do anything. I find it disgraceful they are just there I see them, not caring, not bothering. So maybe if it's mandatory then we might see more positive things coming out." #1

Admitting to jealousy was not difficult, one articulated it thus

"Do I feel jealous, hell yes! When you know someone is picked over you, maybe they are friends with that person." #4

Another explained how this hostility made her feel

"I don't tell many about what I have planned, I don't trust them and they can make things difficult by not swapping shifts and well let's put it this way they can just make life difficult" #16

Related to this, the idea of being watched or watching others in terms of being left behind were strong. The phases 'being overtaken, being passed by, got to keep up' was referred to time and again, especially by the younger nurses. This was succinctly stated by one:

"I'm not doing anything now but I would watch. Yesterday my colleague said she said she is going to study so I ask her to find out for me so I doesn't want to be left behind." #24

In summary the disconnect between those unseen and in charge, has led to a perceived lack of support and tension amongst the nurses. There is a mistrust possibly due to the lack of clarity and discourse regarding decisions made for CPD planning and initiatives. This appears to put those seen and in charge in difficult positions as they attempt to support their staff. As a final consequence there are tensions between colleagues for those wishing to undertake CPD and those undertaking CPD.

This concludes the exploration of the theme professional tensions which included the sub-themes of institutional support and collegial awareness. The last section discusses the theme of constituents of CPD including the four sub-themes of learning and CPD, effect of CPD, where CPD takes place, and finally activities are presented.

7.8.9 Theme three Constituents of CPD

What the nurses felt constituted CPD was discussed; this topic was of interest as the survey showed many activities deemed important were not carried out.

7.8.10 Learning and CPD

All interviewees felt that CPD was essential for effective practice and for an individual's development. The responses went beyond just being able to 'do the job' with performing to a high standard, patient welfare and quality care, illustrating commitment to learning and CPD.

"It means continuing education either theory or practical just knowing just keeping up with recent information to administer nursing care to my patients also as an individual growing in the profession you need to be knowledgeable to teach others coming up behind you" #4

The younger nurses interviewed spoke of accomplishing skills or gaining experience, this contrasted with those who had several years' experience and who focused more on communication and a sense of legacy by instructing others. Similarly, there was a strong association with the concept of lifelong learning and CPD with CPD being described as less rigid and more personalized. Interviewees discussed the differences in their learning and professional development on a continuum, adapting and evolving depending on their career, tenure and personal goals.

"I am not too old to learn every day you learn something new. I now try and pass on my experiences my knowledge. Every day is learning process I think nursing is evolving and I have to evolve with it" #17

The concept of being a lifelong learner was accepted and the dynamic nature of nursing requiring ongoing education was mentioned by all the nurses. How the nurses as a body can adapt for the future was discussed.

"Lifelong learning is part of what makes us nurses, you can't just stand still, things are changing so much, technology its all coming even here, we must keep up I think #24

7.8.11 Effect of CPD

The nurses interviewed characterized the effects of CPD in terms of being able to work more efficiently and effectively, with patient care being a key component. Similarly, the concept of maintaining and upholding standards was discussed by many as an effect of CPD. There was also a strong association of CPD being a component of professionalism. Additionally, many reported increased confidence as a practitioner as a result of engaging in CPD

"to be able to perform the skills that makes you feel wonderful, wow, if you do good you feel good you can respond and perform well it feels good it encourages you" #3

Along with confidence, a sense of pride was noted, all kept and cherished their certificates either in folders or framed for display and proof. It was evident that these certificates held a source of inspiration along with evidence of accomplishment.

7.8.12 Where CPD takes place

The concept of where learning took place and the modality of delivery was asked, the majority associated learning with the classroom. As discussed earlier, those questioned viewed the work environment as not conducive to learning due to the workload. In terms of modality the majority preferred the formal classroom, referring to the structure and collegial support. It was also noted that irrelevant of age there was an unfamiliarity and wariness associated with computer-based learning.

"Classroom setting, definite, I learn best with classroom setting. You know the instructor the tutor is there. You are able to ask questions, you know, to work along as a group, with other colleagues" #15

7.8.13 Activities

Those interviewed spoke initially in terms of formal activities such as short courses, seminars and workshops. The association between activities and workshops was strong, when asked 'tell me about what activities you have done for CPD' all referred to the last workshop they attended. There was also a tendency to limit activities to learnt tasks or those which resulted in a certificate of attendance or completion. Informal opportunities such as departmental or ward meetings, were discussed by most of the nurses as activities they felt worthwhile, but these did not immediately come to mind as CPD. One summed this up

"Well I never thought about documenting in that way. I never looked at it as CPD, I just thought I just looked at it as my own personal reading, so maybe that's why I never really documented it". #3

Notably absent was the concept of reflection and work place learning as activities that could lead to growth. This was incongruent to the survey; participants did not consider the importance of reflection and were unable to articulate the act of reflection and how it related to CPD. It was only through probing that work based learning, reflection or informal activities were recognized as CPD.

Reflection was described informally for instance:

"Yeah, I always think back on my day, on the bus, how a patient responded or if one touched me in some way I also talk to my husband on what happened and how things went. #1

Lastly the use of appraisals was spoken of very highly as an activity to enable CPD. All of those interviewed had received an appraisal where personal goals and areas for improvement were discussed. Similarly, participants kept documentation of their formal activities in the form of diaries and notes on calendars and journals, only one contributor referred to their documentation as a portfolio.

To summarise the final theme, termed the constituents of CPD consisted of four sub-themes; learning and CPD, effect of CPD, where CPD takes place, and finally activities. In summary the nurses valued CPD enabling them to work more effectively and efficiently. Consequently, on completing CPD activities there were positive outcomes such as increased confidence. It was felt that the workplace was not conducive to learning with formal classroom learning being preferred, however the use of appraisals was valued as CPD.

This concludes the results of the qualitative data. In summary three themes were identified from the interviews conducted; choice and control, professional tensions and constituents of CPD. The nurses felt they had a lack of choice or control mainly due to organizational factors, however personal time and finances were also issues. The tensions stemmed from a disconnection between the institutions involved with providing CPD opportunities and the nurses. The lack of clarity and implementation of policies surrounding CPD has reduced confidence in the processes, resulting in mistrust towards the institution and amongst colleagues. The constituents of CPD showed the nurses valued CPD enabling them to work more effectively and efficiently. Increased motivation and confidence were noted because of formal CPD. However, it was felt the workplace was not conducive to learning, preferring formal learning.

7.9 PART reflection on Cycle Two

7.9.1 Reflection on Action

Meetings took place to digest and make sense of the data, these took the form of reflection and critical discussion as a team. Along with the formal meetings scheduled I was able to use E mail to gain consensus on some issues and to ensure those who did not attend the meetings had a chance to contribute. For the formal meetings, the format was organic, usually starting with one or two themes or observations made during the initial coding. Then through analysis as a group we were able to move to deeper discussion and meaning making. During these meetings the quantitative data was revisited and comparisons made to the qualitative, observing for contrasts and congruence. Use of methodological triangulation as described by Heale and Forbes (2013) to explore different levels and perspectives of the same phenomenon it was possible to gain a more complete picture. Being able to combine both quantitative and qualitative data it was noted that the data complemented, converged and at times was contradictory (Heale and Forbes, 2013). As illustrated earlier the analysis of these was a group through discussion. Agreeing with O'Reilly and Parker (2012) there were contradictory and inconsistent results; however, as a team we were able to make sense of them which demonstrated the richness of the information gleaned from the data. We noted through triangulation many similarities and agreement with the two data sets such as nurses intrinsic motivations for engaging with CPD and the preference to classroom

or formal settings. However discordance was noted in the area regarding activities undertaken in the survey specifically, informal CPD was a significant activity but during the interviews this was not immediately recognised. This back and forth across the data sets contributed to our confidence and belief that the data was representative. A total of four meetings took place in this manner which was supplemented with E mail discussion to agree on the final themes. The use of PAR felt authentic and ensured rigour was maintained. As the cycle progressed, we worked together using action research and critical social theory to develop a CPD framework. The collaboration, communication and cohesiveness of the team developed at each of these meetings, as opinions, improvements and plans were expressed and implemented. The advice and experiences of action researchers in healthcare, namely Koch and Kralik (2006) and Koshy et al., (2011), were being played out as through collaboration, change was being planned. By meeting, working together on my initial ideas, observing and reflecting, further refinements were implemented. Described as 'the glue that binds the other components of action and research together' the use of reflection enabled us to review and resolve the group's problems (Koshy et al., 2011 p. 82).

During the second cycle there were two projects occurring almost simultaneously, with the planning, action, and observation overlapping. At times this felt chaotic with many elements being considered whilst trying to keep the 'bigger picture' of the research aim in focus. We used reflection as an opportunity to re-group and consolidate. This

cohesion, with the ability to optimize our efforts as a team in order to pursue the objectives, was not only advantageous but was in keeping with PAR (Boud et al., 2013). However, despite the pace, the members felt this overlaying was the best way of ensuring the two research methods complemented each other.

The reflections represent the members of the team over a series of reflective meetings. Minutes from the meetings along with E mail were thematically analysed and feedback to the group by E mail or discussion, thus confirming or honing these reflections (Braun and Clarke, 2006). The process was lengthy, however we agreed this was crucial to inform the final cycle. The shared reflection led to decisions being made, confirmation of what had been achieved and steps to be taken.

Two main themes were identified, gaining confidence in the methodology and use of PAR to effect change. Each theme will be taken separately.

7.9.2 Gaining Confidence in the methodology

At this stage we all felt more confident in the concept of PAR. The realization of getting a complicated project from planning to implementation and analysis amazed most.

The members acknowledged that the study aims were realized because of the cohesive nature and commitment to the change process. There was an understanding of the team's strengths to effect change, not only with the traditional gatekeepers but also those who could encourage and were visual 'champions' of the processes. As

recommended by Brydon-Miller et al., (2003) tolerance of the ambiguities and uncertainty within the process was accepted as part of the methodology. Moreover, the members approved of the ability to move back and forth over the process in a dynamic and iterant manner, allowing for refinement and development. The goals set out at the end of cycle one were implemented generally as envisioned. The ability to problem solve based in practice was reflected on; for instance, adaptation in recruitment methods for the interviews was a positive outcome. In addition, members felt the cycles involved in PAR assisted in problem identification and planning. Lastly, the practical solution for me to initially identify the themes, leaving the refinement, collapsing and final decisions of these themes as a group was efficient.

7.9.3 Use of PAR and Empowerment

The members showed evidence of self-assurance and empowerment that grew from the research approach and process (Langlois, 2014). Initial doubts were unfounded, this fed into the confidence to act as change agents and commit to the research. The success of the first two cycles enabled us to recognise our ability to work together as co-researchers and thus to feel able to take on the last cycle to effect the change. Everyone agreed that as a group we had developed and become empowered due to a growth in confidence and engagement in the research process.

7.10 Personal reflection on Cycle Two

7.10.1 Participants; engagement, cohesion, consensus building and support

In the second PAR cycle a considerable amount of planning and action occurred. As discussed, in the previous cycle the group was forming, achieving consensus and gaining an appreciation of the research issues at hand (Kemmis and McTaggart, 2000; McNiff and Whitehead, 2010). In anticipating the next stage, known as 'storming, norming and performing' there was some trepidation. This was because there can be a time of conflict as the members feels comfortable enough to challenge and disagree (Tuckman and Jensen, 1977). In witnessing these heated discussions around what motivated nurses to undertake CPD and criticisms voiced by the interviewees, there was evidence that the members were critically reflecting on their positions and feelings. The debate, opinion and the passion shown was viewed positively as it clearly illustrated the importance and interest of the research to the members (Reason and Bradbury, 2001). I found it less disturbing during these debates, as my confidence grew and I felt able to 'let go' allowing dialogue to flow. The focus moved away from simply problem solving to a deeper understanding of change and what was required. However, I identified with Heron (2013) initially as there was a tendency to close reflection once a singular solution was identified, yet over time this changed to a more in-depth reflective discussion.

During the second action cycle, a growing sense of trust grew between the team members and myself and I felt comments were candid and honest. I was experiencing 'relational knowledge' as described by Reason and Bradbury (2008). The formation of respect, caring and authenticity was beginning, I hoped this relational knowledge would sustain the group through "the good times and bad" (Reason and Bradbury, 2008 p. 86). I acknowledged this stage as 'norming' with us evolving as a group to get the work done. This led to 'performing' where we concentrated on the tasks and their completion (Marquis and Huston, 2012). The members clearly enjoyed the problem solving with the 'task list' becoming a source of inspiration and celebration as we collectively 'ticked off' the errands.

I wrote

"watching them thrash out the logistical issues is wonderful, they are full of ideas, possibilities and they are good at this. I'm grateful, I would have never have thought of some of those things, it really goes to show many heads are better than one". Diary entry 24.6.16.

I was grateful to the team for explaining how intrusive and intimidating the use of a recorder might be for the interviewee. This kind of feedback is one of the valuable characteristics of PAR, where the researcher does not remove themselves from the participants but collaborates with and takes guidance from them (Stringer, 2007). In this

meeting, there was a shift from my usual role as facilitator to listener, gaining knowledge, consequently valuing and respecting what was shared. This characteristic of PAR allowed us to explore and change the recruitment strategy effectively (Coghlan and Brannick, 2014). As discussed in Chapter Seven section 7.5 the team reconvened, utilizing the action research cycle and finally decided to employ snowballing, this was successful. Similarly, the members paid attention to the ethical considerations, discussing at length the consent form and confidentiality, to ensure that participants were fully aware of the process.

There were a few incidents resulting from our unity that came across as amusing. I was teased about my concern regarding the return rates for the questionnaires, having reviewed the literature I was anxious that if too few returned it would compromise the results (Baruch and Holtom, 2008). In contrast the members were confident that we would have an excellent response. They began singing a Bob Marley song "three little birds" with the chorus "don't worry about a thing, 'cause every little thing gonna be all right" to me whenever the subject came up (Bob Marley and the Wailers, 1977). They used humour and empathy to allay my fears in a collegial and supportive manner, this also showed that the group felt relaxed and comfortable in breaking down traditional barriers.

However, meeting attendance was a challenge with attendance inconsistent. I noted a drop-in attendance after the planning stage with difficulties achieving attendance of more than six members during the action phase. To combat this I increased the e-mail and text correspondence from once to twice a week, keeping the team up to date with survey return numbers and interviews carried out. This was for two reasons, to keep members informed that the plan was being carried out as agreed and to retain the enthusiasm and interest of the group.

Similarly, although planned, none attended the interviews, mainly due to logistical issues of work and home commitments. I took the transcribed interviews to a meeting to gain consensus on some of the data I had obtained. This proved difficult for the members, they became agitated by the amount of work, asking that I complete the analysis. This is supported in the literature, Coghlan and Brydon-Miller (2014) suggest community members tend to prefer and take roles with research design tasks rather than data collection and analysis. Renegotiation had been agreed upon earlier (Chapter Seven section 7.2.3), as the iterant nature of PAR has some uncertainty (Coghlan and Brydon-Miller, 2014). The members were still committed, but the analysis and data collection were proving untenable due to their schedules. In the meeting it was suggested that I transcribe the interviews and create the initial codes and themes. I agreed to do so and to communicate with the others on a two-weekly basis. The level of commitment and logistics involved in conducting the interviews and transcribing them, proved unrealistic.

I interpreted this positively, we had found a solution that met their needs and did not compromise the research. I still felt we were working collaboratively and an ebb and flow of engagement is understandable. In conclusion, as principal investigator in conjunction with a personal dedication to completing a doctorate, my commitment was greater.

7.10.2 My role as a researcher

Reflection during the interviews allowed me to analyse my role as a researcher. I felt privileged to hear participants' stories, frustrations and dreams of development. In talking to the male and female nurses I noted how similar their experiences and aspirations were. I reflected how different my experiences regarding CPD have been and gained insight into my colleague's world. I identified with Ann Oakley's (2013) research on women, I too was asked for information, contacts or advice on CPD. I thought it would be exploitative and inconsistent with PAR if I did not engage, I had shared an hour of a person's time building a relationship, to then become disengaged and not answer a direct question would have been unfair. This is supported by Vanderberg and Hall who suggest (2001) that relationality and reciprocity can reduce researcher dominance. Additionally, transcribing and listening to the interviews enabled me to critically reflect on my technique and improve as I went along forming part of the learning process. Utilizing reflexivity allowed an examination and conscious acknowledgment of the assumptions and preconceptions I had and the possible effects of my influence. I noted and listened to my reactions and how my subsequent interpretation of those discussions

could impact on the data. Good communication techniques such as refraining from paraphrasing, becoming too focused, and fostering a curiosity and genuine interest in the participants were also employed to improve the interview and ultimately the quality of data received.

7.10.3 Conclusion and Informing the third cycle

This concludes this chapter where the planning and execution of the questionnaire and semi-structured interviews sought to explore ways in which nurses engage in CPD and their motivations and understanding of CPD. Additionally the internal and external issues surrounding CPD in context, were investigated. The data produced was extensive and illuminated the many facets surrounding CPD in Grenada. The data gained and illustrated in this chapter highlights many internal and external issues surrounding CPD in Grenada and the individual's understanding of what is meant by CPD. Also as expressed earlier in section 7.8.8 as an understanding of the issues surrounding CPD were explored, illumination to the wider issues including the GNC were revealed.

In summary, we were focused and worked on the common goal, however some tensions in the analysis stages involvement had to be renegotiated. The input from the members was valuable, resulting in a comprehensive understanding of the issues at hand and in context.

This data and the conclusions formed the basis for the third and last cycle, the creation

of a framework that would enable Grenadian nurses to engage meaningfully in their CPD.

We agreed to move forward with this goal in mind to the third cycle.

CHAPTER EIGHT – ACTION RESEARCH CYCLE THREE

Diagram 15 Components of the PAR Cycles Emphasis Cycle Three
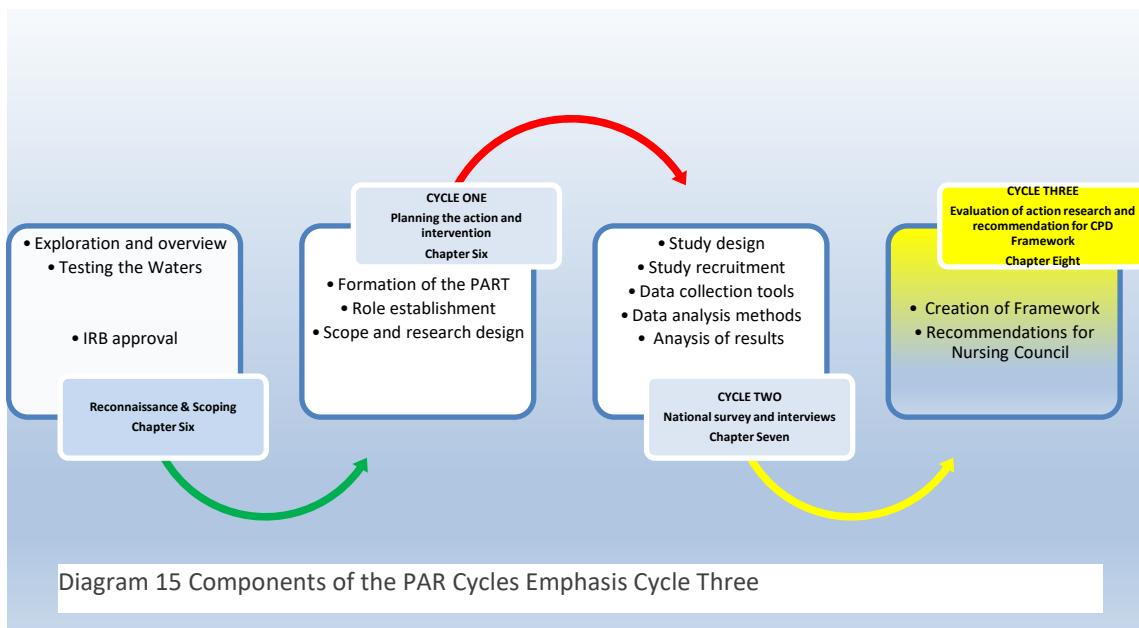
8.1 Introduction

This chapter discusses the way in which the PAR process set out to achieve the overall research aim of developing a CPD framework for Grenadian nurses. The framework seeks to incorporate the findings from cycles one and two into a usable and flexible process which can be used individually or implemented by GNC to facilitate registration. The framework consists of categorising the CPD hours required, an individual CPD plan consisting of reflection, planning, action and evaluation and the use of a portfolio for documentation and organization. Two tools were developed to facilitate the nurses; a

conditions table and constituents of CPD tool. For clarification a reiteration of the research aim:

Utilize PAR to identify the organizational and personal issues surrounding CPD and the changes required in Grenada in order to develop and propose an effective framework for CPD in Grenada.

8.2 Aim

The aim of this chapter is to report on the third cycle. Also, a discussion on the dissemination strategies, and lastly the next steps for us in the PART is outlined.

8.2.1 Process for Cycle three

In this final cycle, we undertook the phases of PAR; planning, acting, observing and reflecting in order to propose a CPD framework. This last cycle began in late September 2016 and finished in December 2016. The meetings drew on the knowledge gained from the research and insights from ourselves. As with the previous cycles, detailed minutes and observations were collected. The PART met a total of seven times with E mail and text correspondence to confirm certain aspects and agreement of the framework. The meetings were methodical and systematic, dependent on finalization of one issue before moving onto the next. As with the previous meetings the hospital was used and the meeting lasted between one and two hours with follow up discussions via phone, text and E mail.

The following is a summary of these meetings. The first three reviewed the literature and the new knowledge gained from this study. Only on conclusion did we move onto ways in which the mandated hours could be broken down to help define the differing aspects of CPD. The fourth meeting focused on documentation of activities, and tools to aid organization, choice and sustainability. This led to the fifth meeting which centred on the institutional support required and recommendations for the GNC. The sixth meeting reviewed the framework holistically and practically from the 'end users' perspective. Critical questions such as was it easy to follow, fit for purpose and operational informed this meeting. Lastly, the final meeting involved dissemination strategies, options were reviewed and a plan was agreed upon.

These are presented in order.

8.3 Planning to Conceptualize a Framework for CPD in Grenada

8.3.1 Planning - Conceptualization strategies

The overarching aim by the PART was to develop a CPD framework which reflected the research carried out. We identified three main characteristics of CPD that needed to be incorporated. Firstly, the framework would provide content that is evidence-based and relevant to the area of practice. It would also be context based and relevant to the profession and health needs of the Grenadian and Caribbean community. Secondly we felt that for the framework to be successful, two-way communication and collaboration

between learners and stakeholders and also between learners should be incorporated into CPD (Khan and Coomarasamy 2006). The support for this came from the research from cycle one where organizational support and culture along with opportunities and motivations for CPD were identified. Lastly the CPD framework must be flexible, multifaceted and provide different types of formal and informal learning opportunities and provision. These would constitute broadly as structured courses supported by learning through practice, reflection and peer support (Giri et al., 2012).

The literature illustrated that nurses globally face many of the same CPD issues. Whilst there is a significant amount written on CPD however, there appears to be nominal evidence regarding rationale and the theory behind policies and frameworks as evidenced by a lack of standardization (RCN, 2014; Lliffe, 2011). In this study, seeking guidance to introduce a CPD framework in Grenada there was clearly an information gap.

As previously explained, it was not the scope to change GNC policy, namely 60 hours of mandated CPD every three years, rather to clarify this policy into a useable framework for the nursing profession in Grenada. Additionally, as the hours stated are for registered nurses without any additional requirements for specialties such as midwives, this was not addressed.

8.4 Meetings one and two

8.4.1 Planning - summary what was discovered

The first and second meetings focused on what was discovered, this approach was systematic discussing the results of the survey then moving on to interviews and our reflections from the first and second cycle. The following draws out the key items from the survey and interviews that the PART considered should be taken into account when devising the CPD framework.

8.4.2 Quantitative data

The response rate was unusually high at 70%, illustrating the interest in the topic and the desire to express their feelings around the issues of CPD, as the PART had predicted.

8.4.3 Level of education

Acknowledging the low levels of degree and masters prepared nurses is a concern. Provision in the framework to incorporate formal university courses should be considered. Citing the evidence on patient outcomes and education, the IOM report recommends that by 2020, 80% of nurses should hold a bachelor in the US (IOM, 2009). Additionally the Ministry of Health can use this data to explore avenues to provide university degrees in coordination with the Ministry of Education.

8.4.4 Area of work

The framework and provision of CPD needs to address the fact that 65% of nurses do not work in the hospital. Availability and accessibility should be considered through innovative solutions such as using technology and workplace learning.

8.4.5 Motivations

The survey indicated that Grenadian nurses felt that professional development was personally important and that it would improve the quality of health care. It also showed that there was a significant gap between activities deemed important and what was done. Lastly the factors facilitating CPD were congruent with other studies; affordability, time allowance, relevance to career and gaining formal recognition all scoring significantly.

It was evident that the motivation for undertaking specific activities, the importance of CPD to the individual and the belief that CPD improves the quality of health care needs to be incorporated. To address this the framework should consider individual requirements for professional development.

8.4.6 Qualitative

The use of interviewing enabled reconstruction and an understanding of events that I have never encountered, my CPD experiences were very different from those being

interviewed, however the members of the PART identified with these themes (Seidman, 2013).

8.4.7 Choice and Control

In terms of choice and control it was felt that a transformation would have to occur through a raising of awareness and empowerment, where individuals and therefore the profession would be able to visualize their full potential. Friere (2000) discussed 'conscientization' encouraging those to develop the confidence and capability to find their own answers, pose questions and analyse their own meaning making. We wanted the framework to address this by encouraging choice and autonomy in their CPD selections.

8.4.8 Professional tensions

Frustrations surrounding parity, lack of policies, the role of the gatekeepers and nepotism were revealed. Furthermore, organizational issues were identified, these included lack of notification, planning and understanding who is responsible for providing CPD. Within this data there was evidence of burn-out with collegial distrust, anxiety about being left behind and de-motivation at the lack of support for professional development and general working conditions.

We hoped that through a more open dialogue and transparency in policy, tensions within the profession might be addressed. It was also a recommendation that the framework would offer, within formal and institutionally required activities, conflict management.

8.4.9 Constituents of CPD

It was clear that the constituents of CPD were varied but often not recognized by nurses. Attending courses, or undertaking personal CPD had tangible benefits, with nurses reporting increased confidence, improved skills and motivation to improve and progress within their profession. The value of workplace learning, reflection and interdisciplinary discussion was undervalued with an emphasis on formal workshops or classroom learning. By incorporating opportunities for informal activities, the members wanted nurses to engage and acknowledge these activities as they had been shown to be effective and sustainable (Schostak, 2010; Benner, 1984; Giri et al., 2012).

Of relevance, the constituents of CPD need to be relevant to the individual's context of practice in order to address the needs of those who work in the clinical, managerial or educational areas for example.

Utilizing the outcomes from the research, the PART formed the following guidelines for structures required for an effective CPD framework.

8.5 Meeting three

8.5.1 Concept of organizational culture and support

In the third meeting we returned to some of the issues highlighted from the three frameworks identified in the literature. We wanted a specific framework that could be adopted by GNC for revalidation. To help inform our decision we examined the other frameworks, specifically the purpose, process, challenges, evidence for CPD and theoretical links.

8.5.2 Purpose

In relation to the Caribbean domains of nursing (see Appendix P) there is an assumption of life-long learning and professional development (Caricom, 2011). As stated the nurse is expected to;

1. Identify one's own professional development needs by engaging in reflective practice in the context of lifelong learning.

2. Develop a personal development plan which takes into account personal, professional and organizational needs.

3. Takes action to meet identified knowledge and skills deficit likely to affect the delivery of care within the current sphere of practice.

It ensures the nurse develops professional practice with the understanding that the impact on patients and contribution to a culture of professionalism is supported. This framework can create standards to which a nurse can illustrate their CPD activities.

8.5.3 Process

It was decided to break down the CPD hours into manageable and separate entities. The following illustrates this simplification and the rationale is discussed presently.
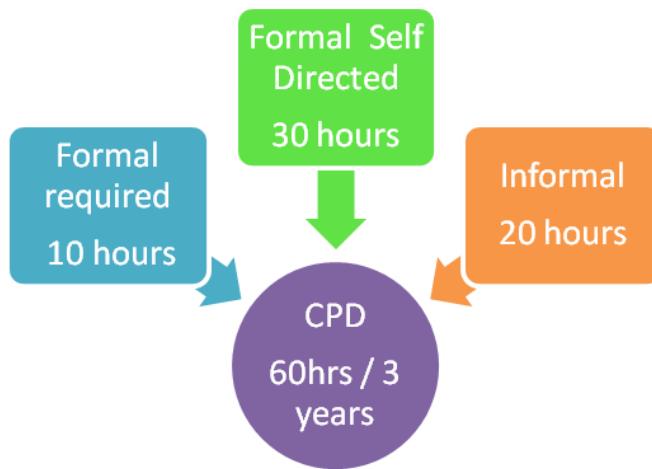
Diagram 16 proposed breakdown of CPD hours

The balance between the institutional and personal requirements and required support was important to us. Lengthy discussions as to the ratio and what could be practically mandated were considered. The rationale and activities in each block will be discussed below as differing sections. As stated by Hayes (2016) it was the intention to attend to professional behaviour within the affected domain, not just the acquisition of

knowledge and skills. This approach would ensure a holistic engagement as the research had shown an over reliance on workshops or short didactic courses to fulfil CPD. Moreover, there was a need to align institutional and personal professional development. There was agreement with Munro (2008) that tensions could adversely affect the individual's development and affect the organisation. It is envisioned that the activities would be undertaken in collaboration and negotiation with the institution, ensuring support.

Having acknowledged the hours set by GNC were mandated, the analysis of established models helped illuminate the tensions to inform us of a suitable framework (Kennedy, 2005, Lliffe and McCarthy, 2013; Ryley and Barton, 2015). As discussed in Chapter Two, we critically analysed the two concepts of CPD: mandated hours and those activities centring on voluntary engagement proposing these were interrelated. The interviewees supported the premise that mandated hours would ensure standards and competency was upheld. Agreeing, we felt that the concept of mandatory hours was required to provide an oversight of the profession, through the standardization of training opportunities, but it should not negate the need for professionals to be proactive in identifying and meeting their own development needs (Brekelmans et al., 2013).

Similarly, I acknowledged criticisms by Kennedy (2015) that the mandated hours and activities could focus on institutional requirements and be too prescriptive. Clearly a

balance was required. The members felt that certain mechanisms such as collaboration and the use of appraisals would reduce this (Kolb, 1984; Friedman and Phillips, 2004). Moreover, it was felt that to include more hours on formal chosen activities, as described subsequently, would facilitate self-determination and engagement. This was identified by the lack of choice and control the nurses described during the research. Furthermore, we agreed with the literature, that the barriers to carrying out CPD are numerous, (Gould et al., 2007; Cleary et al., 2011; Brekelmans et al., 2013; Onuoha et al., 2013; Ousey and Roberts, 2013; Duffy et al., 2014). With these challenges, it is doubtful that nurses would remain current and broaden their professional competence without some form of mandatory CPD.

8.5.4 Formal Self Directed Activities 30 hours every 3 years

We agreed that having formal but self-directed activities would encourage sustainability and enable nurses to conform as opportunities for development would be systematically explored. This formed the largest block of how the 60 hours would be translated into activities.

The PART felt this offered most variability and would be easy to follow, aiding sustainability, acknowledging there were multiple ways to develop professionally. Additionally the need to be pertinent to nurses' context of practice, allowing those in non-clinical areas to fulfil CPD requirements. The survey revealed popularity for learning

through practice, keeping up to date by taking part in activities and discussions thus illustrating variety. Correspondingly we felt the variability and choice could offer support for lifelong learning and learning on a continuum independent of speciality, status and expertise.

The interviews indicated a need to encourage autonomy and engagement, as discussed through the lack of control or choice. It was understood that if nurses had choice and independence their CPD would be more operative, embedded in the real world and significant to the individual (Knowles, 1970; Campbell, 2010; Brecklemans et al., 2015; Pool, 2016). Similarly, due to the findings, we wished to encourage decision-making, empowerment and self-determination amongst colleagues.

During a brain storming session and analysis of the survey, numerous activities fitted into this category. It was felt there were several excellent resources that were not costly in time or money from webinars, audits, peer and inter-professional activities and special interest clubs. Chiefly, the use of the work appraisal and other tools to identify, justify and gain support for activities would be used to create a personal CPD plan. These tools will be discussed later.

Other activities which would be counted as formal self-directed activities.

- Relevant workshops

- Short courses

- Presentations

- Research

- Mentoring

- Quality improvement projects

8.5.5 Formal institutionally required 10 hours every 3 years

This formed the least amount of hours in the block and resulted in the most discussion so that a consensus could be reached. A review of the literature confirmed that currently there were no guidelines of what the CPD needed to consist of, except that all health professionals tend to predominantly focus learning towards knowledge relevant to their current practice (Ross et al., 2013). Although controversial due to the prescriptive nature that mandating certain activities may have (Friedman, 2013). Also the concern was that such activities might not translate into a change in practice was compelling for us. Besides the threat of promoting procedural practices, reducing development and critical thinking is acknowledged (Boud and Hager, 2012). Likewise, in promoting these practices we did not want nurses to be unable to identify and challenge assumptions or develop the ability to problem solve so that they passively accepted an established method. This was in contradiction to what was desired. However, as discussed, the interviewees and PART felt it necessary and acceptable to mandate certain activities for quality and safety (Lawton and Wimpenny, 2003; Thomas, 2012).

In this context, as the GNC had mandated hours they had created an emphasis and priority for CPD to include competence and safety. With the knowledge gained we agreed with this premise, sensing that some activities should be obligatory based on the imbalance noted in the study.

The issue of whether mandating activities would reduce motivation and engagement was countered by reviewing educational theories that encouraged good practice and motivation for learners (Knowles, 1970; Kolb, 1984; Benner, 1984). Similarly, we centred on activities which were generic and practice based and non-reliant on position or experience. We agreed with Benner et al., (2010) who propound the view that to improve general nursing education, the following is recommended

- Integrate knowledge into the practice setting.

- Decrease divide between classroom and clinical knowledge.

- Emphasize clinical reasoning and multiple ways of thinking along with critical thinking.

- Focus on the formation of professional identity along with socialization.

We noted that by following these simple guidelines there would be increased understanding of the 'why' by focusing on intrinsic motivation, consequently contributing to learner retention and success (Rose, 2011).

In mandating not only hours but also the activity, it was agreed that the onus on the provision should be at the council or ministerial level. Schostak (2010) put forward the concept that delivering a service and ensuring access to and attendance were intertwined, especially if mandated. The PART agreed with the interviewees, that the employer had a key role in providing the necessary support, infrastructure and policy. The participants identified the provision of appropriate training in the use of new and existing equipment, orientation programmes, in-service education, performance review and feedback opportunities. The PART added to these the following recommendations for the Grenadian context based on participants' responses in both the survey and interviews.

- Basic life support

- Infection control

- Conflict management

- Health and safety at work

8.5.6 Informal 20 hours every 3 years

The inclusion of 'informal' activities was to support the value of development through the workplace and not easily defined, but key strategies for development such as reflection. We wanted to capture and value these activities within the framework, namely reflecting, questioning, providing or obtaining feedback.

The research clearly recognized that learning processes took place at or surrounding the workplace (Eraut, 2004; 2007). Data from the survey noted reflection on practice in various forms, however in the interviews there was reluctance to acknowledge these activities as not being academic or recognized compared to formal activities.

We debated the suitability of the workplace as the interviews indicated that due to workplace pressure, development was challenging. However, it was felt by most in PART, that the recognition of these activities may encourage critical reflection and allow for a shift, allowing a suitable environment for learning and development.

The findings in this study showed wariness of learning from each other, thus missing out on the advantages of such activities, Eraut (2007). Lastly it was felt by us that a self-critical attitude, in conjunction with self-reflection, will provide the self-realization, the motivation and the ability to act, thus the development moving from the internal to external and being more quantifiable.

Examples of these were:

- Reading

- Journals or Reflecting

- Discussion or informal meetings

- Workplace or experiential learning

8.6 Meeting four

8.6.1 Documentation

As the data revealed a lack of compliance with the mandated hours, documentation and evidence of activities were a key area that we wanted to address. We decided that a portfolio would not only represent a way in which nurses can record and provide evidence of skills, achievements, experience, development and learning, but for the rigour and scrutiny of the GNC. It was seen to be ideal to have the individual's CPD plan to align directly with their portfolio, to provide evidence of maintaining continued competence to practice (Andre and Heartfield, 2011). We recommend that the formal self-directed and institutionally required activities should have confirming documentation from the facilitator or colleague involved, whilst the informal activities would be self-documented, this is to make the portfolio a workable document and not onerous. It is accepted that a portfolio can link experiences and practice to the individual's level of competence and the development that has been achieved (Andre and Heartfield, 2011; Hayes, 2016). We also agreed that through documentation the individual would be able to appraise and critique their own practice via a more rigorous and robust tool. Accordingly, it could also be used by GNC as a means for audit and assessment.

8.6.2 Use of portfolios in Nursing

The use of a portfolio is accepted practice in nursing (EDCAN, 2008, Sinclair et al., 2013).

Global acceptance is evident, for example, the Australian College of Nursing online

portfolio is designed to meet the CPD registration standards set by the Australian board

(ACN, 2017). Similarly in Africa, namely Malawi, Lesotho, Botswana and Zimbabwe,

nursing boards have recommended portfolios to support the new CPD frameworks

(McCarthy et al., 2014). In the US portfolios were recommended over 20 years ago, in

1996 the National Council of State Boards of Nursing (NCSBN) developed a position paper

that recommended the use of a professional portfolio to organize and evaluate

professional development (NCSBN, 1996). Moreover, focusing on the individual,

portfolios have been shown to encourage active engagement with the elements of their

role in nursing practice (Joyce, 2005; Green et al., 2014; Hayes 2016). Another beneficial

outcome is that a portfolio across time represents a collection of evidence to

demonstrate skills, knowledge, aptitudes and achievements (EDCAN, 2008). It affords an

invaluable snapshot of current skills (Oermann,2002) and provides nurses with the

opportunity to reflect on their professional growth and develop new goals. Utilizing the

definition by Brown (1995, p. 3) "A private collection of evidence, which demonstrates

the continuing acquisition of skills, knowledge, attitudes, understanding and

achievements. It is both retrospective and prospective, as well as reflecting the current

stage of development and activity of the individual". We viewed the portfolio as a

reflective document to promote self-directed learning, thus assisting career development and planning (Meister et al., 2002; Hallam et al., 2008). This study identified this as an issue, so it anticipated this would go some way to address this.

We all acknowledged that the portfolio should showcase developments, ensuring the individual is controlling the content and presentation that is relevant to their practice, independent of area or speciality. At this stage we did not want to prescribe the format or method (electronic or paper based), however there are some key inclusions that will assist the nurse in demonstrating how they maintain their competence to practice and these are outlined below. We agreed with Joyce (2005) and McMullan et al., (2003) that if portfolios were introduced, direction and guidelines including purpose, content and structure should be provided.

Portfolio Table of contents	
qualifications and experience	• CV • Research activities/ publications/ organizations involved in
Self Assessment	• Identification and priorities of learning needs using domains of nursing practice • Discuss with line manager
learning plan or appraisal	• Goals related to learning needs • Outline a strategy to achieve goals using requirements list
CPD log	• Keeping record of formal institutional required , formal individual choiceand informal CPD
Reflections on learning and practice	• May be directed to a specific activity that led to development. • May support self - assessment /appraisals to support cyclincal nature of CPD

Diagram 17 proposed outline for individual portfolio

8.6.3 Using Professional Domains to Identify Learning Needs

An overview of the Caribbean domains of nursing practice and competencies was undertaken to identify areas for self-assessment. The Regional Nursing Body outlined seven domains which serve as anchors for the nursing profession. These domains are;

- Nursing practice.

- Professional conduct.

- Health promotion and maintenance of wellness.

- Nursing leadership and management

- Communication

- Clinical decision making

- Professional reflection and visioning.

These domains give rise to the competencies expected of the practitioner in the delivery of nursing care and expected levels of functionality.

During the exploration phase and both cycles, we identified confusion as to what constituted CPD and how participants identified, planned and prioritized learning needs. We agreed and understood TenCate's (2013) argument that the use of elaborate competencies and milestones may cause further confusion and misunderstanding. If individuals cannot identify areas for development using competencies, compliance would be a challenge. A simple tool was needed, therefore an investigation of the Caribbean domains by PART as a means to direct individuals to identify learning priorities proved valuable, as the language was digestible and based in daily practice.

As highlighted in the data earlier in section 8.4.9 in order to satisfy those not in clinical practice, adaptation and interpretation of these domains would be needed. The PART felt this was possible as the domains offered broad guidance that could incorporate those in education, research or management positions. The focus is on activities which are pertinent to the individual's practice. Relevance is explicitly stated within the domain of reflection and vision, stating that nurses are to identify their own professional

development needs and to develop a personal development plan. This is in alignment with both the Australian and UK frameworks highlighted in the literature (Chapter Three, section 3.4.10) who emphasize the CPD undertaken by the individual can be broad and accepted as long as it is appropriate to their nursing practice.
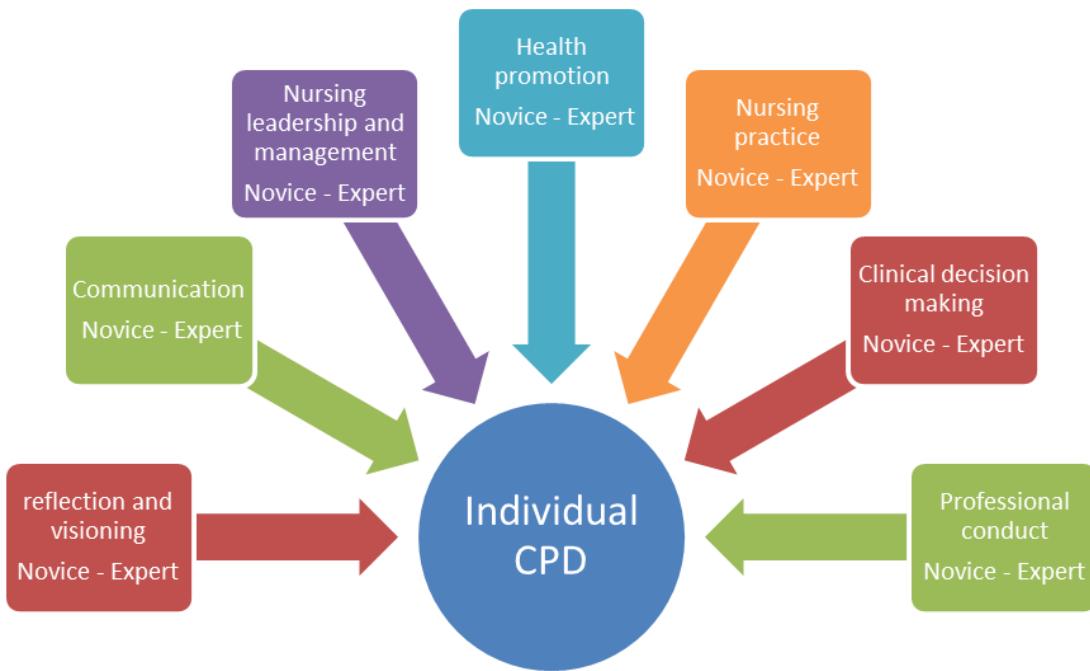
Diagram 18 Professional domains contributing to CPD in Grenada

As critically analysed in the literature in Chapter Two, the concept of competence, competency and the relationship with CPD is complex. However, there is an agreement that clinical competency is an essential requirement to carry out safe and effective

nursing care (Bradshaw and Merriman, 2007; Rouse 2010; Clarke et al., 2012; Oranye et al., 2012).

8.6.4 Competency and Learning Plans

Competency frameworks are an efficient mechanism through which training, development and education needs can be identified and developed (Vernon et al., 2013; Pijl-Zieber, 2014). Competency-based CPD emphasizes self-directed learning processes and promotes the role of assessment as a professional expectation and obligation (Campbell et al., 2010). We wanted to move the focus away from the cognitive or knowledge based domains as illustrated by reliance on workshops or formal classroom learning, to those of other 'ways of knowing'. As described by Carper (1978), considering knowledge in the domains of personal, ethical and aesthetic along with empirical would generate a clearer and more complete way of thinking and learning about experiences.

In the Grenada context, the team and interviewees were familiar with these core competencies, additionally elements appear in the guidelines for the staff appraisals. Notable these domains were created by Caribbean nurses and are context based. Likewise, the evidence supports the underlying argument that competency and CPD is related (Pool et al., 2013; Govranos and Newton, 2014; Casey et al., 2016).

8.6.5 Learning Plans and use of Appraisals.

Throughout this process of creating a framework, the PART wanted to develop a focus on autonomy for the individual throughout the framework to counteract the issues of choice and control. Along similar lines, we felt a learning plan and use of appraisals would promote the alignment of competencies with appropriate activities identified by the individual and line-manager during the appraisal (Schostak et al., 2010; Jasper et al., 2013).

We agreed with Frank et al., (2010) that this framework would centre on developmental outcomes, an emphasis on abilities, de-emphasise time based training and promote self-development. As discussed, this emphasis on planning reflected the findings in the study where scheduling and organization was lacking.

Through the interviews, the PART learnt that these appraisals were felt to be constructive and highly valued as a means for nurses to identify gaps in their knowledge skills and attitudes. However, as they lacked structure, it was felt these could be further developed and utilized to more effectively aid CPD. It was also felt that these competencies could span the novice to expert continuum, thus addressing nurses' needs at various points in career, experience and specialty (Benner, 1984).

In requiring collaboration and inclusion in the staff appraisals, it is envisioned by us that three consequences could occur.

Firstly by including line managers and providers, there would be a more collaborative, responsive and collective attitude invested in the individual's CPD needs. It was felt to cultivate an environment where CPD and its impact on practice are valued and prioritized, with the inclusion of line managers vital.

Secondly, by ensuring collaboration there would be alignment within the institutional priorities and individual plans avoiding tensions and unnecessary direction where resources are scarce (Munro, 2008).

Moreover, as staff appraisals are carried out regularly, an inclusion of these competencies and the requirement to address them would counter the findings that the end users were not proactive or systematic in their engagement with CPD.

8.6.6 Conditions Table

In supporting these decisions, a simple table asking for details of conditions or circumstances surrounding the CPD activity (Table 18) was thought to be useful for the individual and line manager to aid and plan for activities. The key features of the table can be used to assess the practicality, motivations and how to structure the process and planning, especially in the Grenadian context where resources, access and relevance is often an issue. Moreover, to counter the distrust in the selection process for CPD and encourage parity, a more transparent process was required. Institutional support and a

positive organisational culture has been well defined as a key component in the provision

and engagement in CPD (Clark et al., 2015).

The table is premised on the assumption that this would be completed individually and

lead to discussion and support from the line manager. Each item is briefly discussed.

Is this CPD activity	✔
Relevant to your needs	
Defined	
Achievable (SMART)	

Table 17 Conditions table

The research showed that the CPD had to be relevant to the individual's needs for

engagement to occur. As adult learners, relevance is a key component for meaningful

participation (Knowles, 1970; Merriam and Bierema, 2013). Moreover, as an institution

with limited resources, having the right people proficient in the relevant skills is essential.

To aid the creation of development objectives, articulation of that activity is encouraged.

Identification of what skills or other competencies are required to meet these objectives

assists in the planning and decision making. The study participants showed there was a

lack of personal planning or organization and also passivity in enrolling for CPD. Utilizing

SMART (specific, measurable, achievable, realistic and time based) goals has been shown

to increase active learning (Tofade et al., 2012). Moreover, setting SMART objectives is an effective way of breaking down development goals and selecting the right activities which are relevant to achieving these goals. Considering the learning objectives as a part of the development process would encourage individualization and require planning. However, we agreed that 'measurable' should incorporate higher order or abstract reflection to encourage critical reflection on attitude which is typically difficult to measure (Wong, 2014). The aim for completing this exercise would be to help the individual articulate reasons for undertaking activities, again encouraging autonomy and scheduling.

Setting goals and activities that are achievable, is key to accomplishment. Issues around time, expense and resources required should be considered (Tofade et al., 2012). This would empower the individual and enable them to realistically assess and plan their development. Given the dominant concern expressed by the Grenadian nurses in relation to accessing CPD was financial, collaborative judgements and discussions are needed. We felt this discussion with the line manager could encourage transparency as to funding, policy for selection and overall benefits to the individual and institution. Along with this requirements table it is also intended to seat these activities within the three domains of learning; cognitive, practical and emancipatory domains (Mezirow, 1981).

8.6.7 Constituents of CPD

Taken from the theme raised during the interviews, there was overwhelming support that CPD should centre on the individual's values, choice, goals and plans. In the survey, a motivation for undertaking CPD was to support the individual's career. We were of the opinion that personal and career development should be supported through investment in lifelong learning and this should form part of the culture. The data from the interviews indicated that participants felt CPD was integral to professionalism and quality of practice, which in turn was linked to personal as well as career development.

CPD can offer an opportunity to develop transferable skills in order to aid career progression (Schostak et al., 2010). Also, the ability to construct professional identity was apparent in the desired outcomes for CPD, echoing Benner's thoughts on utilizing nursing education to focus on professional identity, this was a recurring theme in the research (Benner et al., 2010). Therefore mechanisms which allow for reflection on the present in order to determine where Grenadian nurses would like to be in the future, should feature. Additionally, not only the future but determining how to set and achieve these goals should be included in CPD. It was felt that although initially developed and owned by the individual, utilizing the appraisal system could allow collaboration with managers to help facilitate planning, supporting activities and goal articulation (Jasper, et al., 2013). Similarly utilizing the appraisal system would constitute one strategy

capable of addressing the huge diversity of practice within nursing and Grenada, as those within the specialty, as in line managers, would be in place (Schostak et al., 2010).

We acknowledged the role of the line manager as shown in the data collected. Like others globally, participants in this study felt they were crucial to creating a supportive learning environment (Hegney et al., 2010; Pennbrant et al., 2013). Also for creating 'an organisation that endorses learning' (Govranos and Newton, 2014, p. 659). In agreement with Gould et al., (2007) the evidence that managers act as gatekeepers with respect to access to CPD, was also discussed.

8.6.8 Constituents of CPD tool

I presented the following tool to the members for approval during the fourth meeting, all supported it and thought it useful. The tool was created as a result of this study as there was general misunderstanding on what constituted CPD. When asked to discuss activities, participants overwhelmingly recognised workshops as CPD. The following would guide and assist nurses with identifying different activities, giving a broader range and a more holistic approach to development. This would be a practical tool and would be included in the appraisal and portfolio.

The horizontal lines depict the transmission and mode of learning in the broad sense, on a continuum, from delivered to experiential. The vertical line runs from remembering and understanding, to creating and evaluating, based on Bloom's revised taxonomy (see

Appendix Q). This helps nurses consider the higher orders of learning and development,

moving away from the reliance on didactic workshops (Anderson and Krathwohl, 2001).

Whilst encouraging other activities it is correct to acknowledge the place and value of

didactic workshops. Examples of certain activities within these areas are outlined as a

guide, not as an exhaustive list but to inspire and motivate. I recognised that many nurses

had not had the choice or exposure to the various options available so this would act to

stimulate thought.

Diagram 19 Constituents of CPD
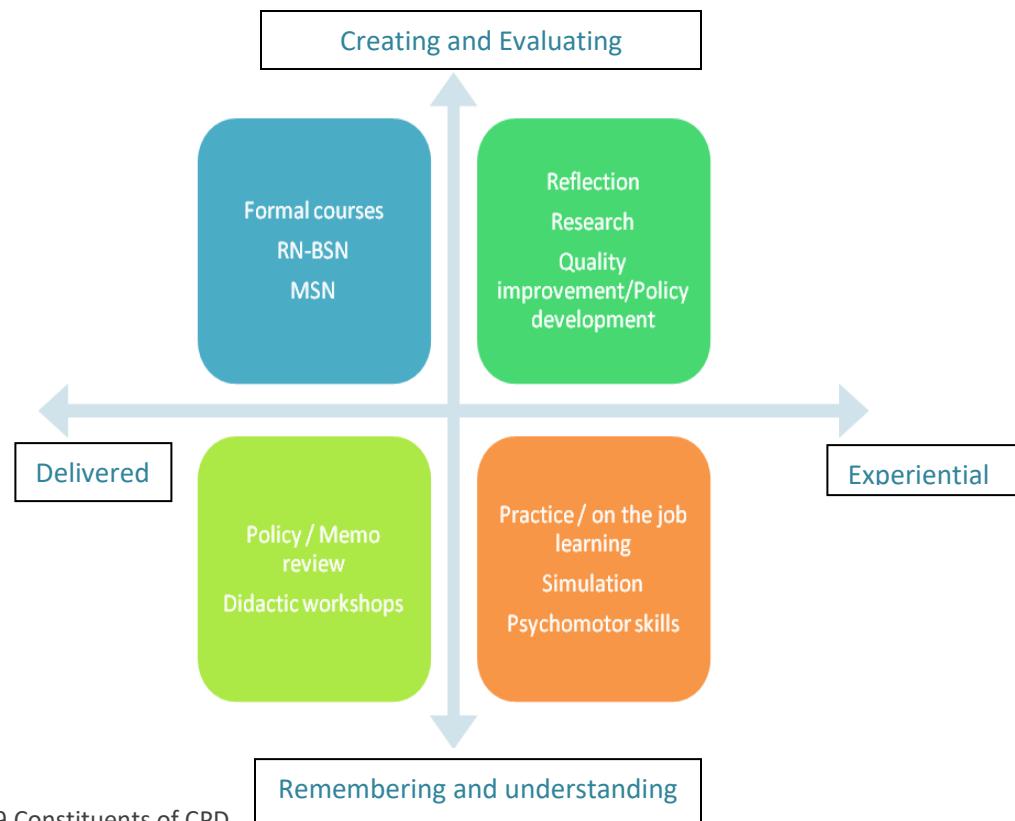
8.7 Meeting Five - Challenges

8.7.1 Role and Inclusion of GNC

PART discussed the GNC as an entity, as the link between this agency and creating a framework for CPD was logical. The need for institutional support was highlighted in the literature (Brekelmans et al., 2013; Katiskits et al., 2013). The research highlighted the GNC as an area for discussion. There was a perception of ambiguity as to the role, involvement and support that GNC provided. The tensions, once analysed, centred on their role within CPD provision, the lack of direction in terms of what the requirements meant and unwritten policies for reference and transparency. The argument by the IOM (2009) regarding continuing education in the health professions had many similarities in the Grenada CPD context as revealed by this study. The members recognized issues with fragmentation between the institution, GNC and the nurses. Also, the support, role and value of CPD for the individual and institution were divided and needed alignment.

8.7.2 Role definition – being visible

To address the first issue of role, we considered it important to utilize the intimacy and 'smallness' of the nursing population to be coordinated, creative, communicative and responsive so their part in the process is fully understood by the nurses. Furthermore, a more harmonized approach would strengthen linkages among providers, end users, the institution and GNC for a more cohesive approach. It was recommended that traditional

avenues for dissemination of the role of GNC should be utilized, written, oral and media orientated communication. Additionally, we recommend that GNC conduct its own consultation amongst stakeholders to fully understand the perceptions of the role and involvement.

8.7.3 CPD Provision – being supportive

We suggest that having a collaborative stance with other stakeholders could result in more reliable provision and give direction for CPD. These stakeholders were identified as the Ministry, providers, organizations and representation from the nurses and other disciplines. Due to the broadening involvement of stakeholders such as PAHO this would enable pursuit and connections to assist with financing and provision. This would support the recommendation that formal required activities should be provided for a minimal cost or free of charge to the individual. Our suggestion is that the GNC identify those for the coalition but maintain authority. Particularly as they are responsible for regulation of the nursing profession and the registration or enrolment of people in the nursing profession (Nurses act, 2008). This approach would also create greater coordination and standardization in certification, accreditation and evaluation for registration with a wider alignment amongst the stakeholders.

In view of the lack of BSN, MSN and PhD prepared nurses, our recommendation is that a collaborative educational needs analysis is undertaken. This would ensure equitable

distribution and would offer further education and development of staff so that they can meet the needs of the country. It was also suggested that this coalition would set priorities, research objectives and assess outcomes to inform local, regional and global knowledge on CPD. This is aligned with the PAHO (2016) directive to offer standard advanced degree programmes and lifelong learning opportunities in the region.

8.7.4 Documentation and Policy – being transparent

The last issue of lack of documentation and written policy should be addressed by the GNC and the Ministry. We did not feel it was within our remit to suggest the content of such policies or documentation, however the research showed a need for transparency, parity and clear guidelines around access to CPD. The aim should be the fair and equitable provision and uptake of CPD by individuals. Whilst acknowledging that the responsibility for CPD and maintenance of competencies lies with individuals, the GNC and collaborating agencies should provide support and guidance visibly. Our suggestion is that the GNC should have written and available policies on applying for funding or scholarship and study leave. It is also recommended that guidelines should be put in place so that line managers could ensure transparency and equal opportunities.

Documentation and policies regarding current midwifery and other specialized areas certification and license was not identified, our recommendation is this be addressed.

We suggest a critical analysis of what is in place and requirements in terms of written policy.

Lastly, as an unintentional finding during the research, the presence and indicators for chronic and diffuse staff burn-out should be addressed. It is recommended further investigation centring on this specifically, be undertaken.

8.8 Meeting Six

8.8.1 Planning - Dissemination strategies

There is a view that a research study is not complete until the study findings have been disseminated, in this case primarily to all the PART members, then the GNC and nurses (Curtis et al., 2017). The aim of dissemination and translation is for the uptake of evidence based practice and change for improvement (Chen et al., 2010; Curtis et al., 2017). Additionally, there is an ethical element, with an obligation to share the findings (Fernandez et al., 2003). Within the realms of PAR, there is added emphasis on responding to issues raised by a community to empower and improve their environment thus the urgency for dissemination and translation into action is considerable (Reason and Bradbury 2008). In more traditional research settings, there is a significant time lag between research discoveries and their eventual impact on health populations (Morris et al., 2011). During the meetings, there was consensus that this methodology could address this. Yet there was a certain amount of myopia with the focus on the

development of the framework relegating the focus of dissemination. I agreed with Chen et al., (2010) reporting that dissemination is valuable, both as a core principle of PAR and for its role in developing and maintaining relationships between the academic and community partners, but similar to Makaroff et al., (2010), until the last meeting it was never fully discussed.

In planning dissemination, we based our discussion around the following questions:

- What is the aim for dissemination?

- Who is our audience?

- What is the most effective way to delivery?

- Who is responsible?

Consensus was achieved via several methods; E mail and minuted agreement was taken. Those who were not present were given the opportunity to discuss their views after the minutes were distributed via E mail. If there was strong disagreement another meeting would be held, however, this was not necessary.

8.8.2 Aim

The aim was twofold, firstly to inform and influence GNC for policy change 'top down'. Secondly to raise awareness of CPD in Grenada within the nursing profession, to begin to engage nurses in CPD 'bottom up'. Discussion on regional dissemination was

considered, however this was a long-term goal after a CPD framework had been established locally. Our aim is to present this study at the Caribbean Nurses Association, biannual conference in late 2019. In planning dissemination, the practical aim was to identify structures required to propose an effective framework for CPD. The traditional routes of academic publication were not a priority, instead, the PART centred on local dissemination to encourage social chance and promote sustainability (McDavitt et al., 2016). We felt that dissemination would contribute to the implementation and change required by giving understanding and rationale for the change (Chen et al., 2010). Our aim was to have a collaborative dialogue, giving feedback and meaningful information which would expand consultation on the framework and keep developing relationships and critical analysis.

8.8.3 Audience and Delivery

The GNC and the nurses were identified as target audiences as per the overarching aim of the study. We felt these two groups required differing approaches. It was decided that a summary document or policy brief would be produced, summarizing the key conclusions from the research and key recommendations for the Council to consider. As the research pointed to several policy recommendations these would be included as solutions based on the evidence and implications for a policy. This document would also include a portfolio 'mock up', a revised appraisal form and outline of the framework

proposed. Those at the meeting agreed to present as a group, indicating the collaborative nature of the research and give a voice to those nurses they represent.

In contrast, for the nurses who would use the portfolio and supporting tools, several interactive presentations were proposed. We agreed that introducing such a change would require a pilot with feedback and re-evaluation, all of which would be important to the process. Likewise, to reach the diverse nursing body, variation of locations and times was agreed. I felt these presentations could form part of an individual's CPD. The use of multimedia outlets such as; press releases, news items, fact sheets and posters were agreed to. One member raised the possibility of collaborating with technicians to facilitate publishing via a CPD website, this could contribute to ongoing learning and the sharing of ideas. Koshy et al., (2011) suggest this becomes part of a collaborative network, although outside the PART's knowledge, it was very appealing due to sustainability and as a resource.

8.8.4 Responsibility

As discussed, we felt we should present as a group to ensure the core principle of collaboration is evident and also that it empathises with end users rather than academic spheres (McDavitt et al., 2016). As with the characteristics and culture of the team, this was open for negotiation with those able and willing to be present. All present were

committed to seeing the study disseminated, this was echoed by those unable to be present via E mail.

8.9 Action - meeting seven conceptualization of framework into a model

The PART met to put into action the brain storming and discussions to formulate the framework. It was decided that I formulate the decisions made at the previous seven meetings into the framework and report back to the members once completed (see section 8.11.1 diagram 19). This moved the study into the 'technical' interest, I acting as the facilitator, using my knowledge and time to present their ideas. I suggested, and the members agreed, that there was a need for structured systems to promote professional competence and that a diagrammatic model was required (Vernonet et al., 2013). This visual model would help disseminate and aid end-users understanding of the main elements and how they interrelate.

8.9.1 Conceptualization of Framework and Dissemination strategies

At the beginning of the third action cycle we had two specific goals; to create the framework to a point that could be disseminated for discussion and evaluation by GNC and registered nurses. Secondly, to make recommendations for GNC that would facilitate nurses' uptake of CPD from the results of this research. We discussed the elements of the framework in detail referring to the data, however, as discussed, the actual synthesis

and creation was delegated to myself. This was due to the ever-present time commitments, however utilizing E mail ensured members had input and participation.

At this point we, as the PART, had been moving through the dynamics of group process effectively to create a framework for CPD in Grenada (Tuckman and Jensen, 1977). The actions taken by the PART were aligned with the planning phase, with the ultimate presentation awaiting finalization. Members felt committed to the plans agreed, despite the extent of the task to formulate a framework for CPD, incorporating the evidence and an appreciation of the context.
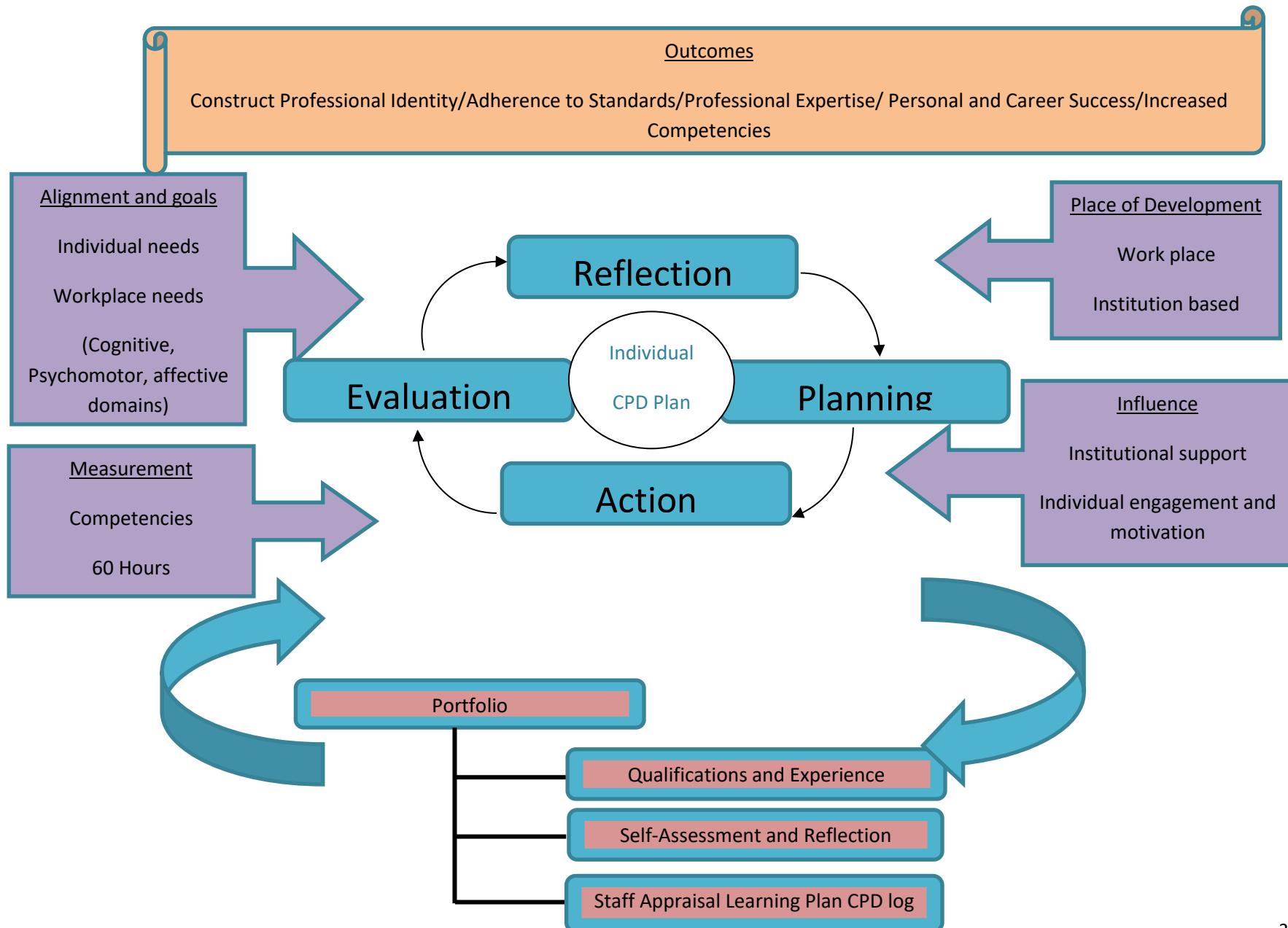
Diagram 20 conceptual model for CPD framework

294

8.9.2 Description of the CPD framework.

At the centre is the individual both physically and metaphorically, to place the onus and choice with the nurse. The personal CPD plan would be formed using the cyclical reflection, planning, implementation and evaluation that would form part of the appraisal process. As stated the use of critical reflection and collective critical dialogue would raise consciousness, enabling change and development. The framework reflects the constructs that control and influence CPD and determines which mechanisms need to be in place for CPD to be effective;

- Measurement – Hours of CPD based on the competencies

- Influence – Individual engagement and institutional support

- Places for development – Work place and institutional based

- Alignment and goals – Individual needs and institutional needs

These constructs are included to remind the individual and line manager of the influences on CPD to simultaneously reduce or increase impact and thus encourage engagement. Once a personal CPD plan has been formulated there would be an evaluation process either by audit from the GNC or more practically the line manager. Several processes would make up this evaluation of CPD including certificates, staff appraisal, documentation and self- documentation within the proposed portfolio.

The audit and evaluation would then feedback into the personal CPD plan in a cyclical fashion reflecting the dynamic nature of CPD and encouraging lifelong learning.

Based on the research, the outcomes desired were the ability to construct a professional identity, adherence to standards, increased competencies based on the domains of practice, professional expertise for that individual's personal and career success and finally a positive impact on practice.

8.9.3 Ongoing work

The members did not feel their task had finished, observing instead the framework open for refinement and improvement. However, it was felt it was complete to present and defend; it was ready to be viewed.

The planning phase was very in depth, as described earlier when planning the distribution of the survey the team excelled, using brainstorming and coming to a consensus quickly. The issues and recommendations for GNC were revealing, with a need to improve practice through change evident. However, the action phase did not transpire as planned due to time constraints from both ourselves and GNC. We had decided to present as a team, the logistics of getting an agreed time were made more difficult by the fact that the GNC only met monthly. Dissemination to the nursing body also suffered the same issues, as it was felt the two strategies should be concurrent. The

lack of scheduling and focus on the development of the framework clearly hindered this important process.

In conclusion, the team remains committed and it is envisioned this thesis will contribute to the final report and dissemination, but as a separate task not part of this study. Similarly the members also recognized and committed to evaluating the framework once implemented. Presently the PART has taken a hiatus as this thesis is written, resolved to continue the work.

8.10 PART reflection on Cycle Three

During the third cycle members observed how the data collected and then analysed could transform into a practical solution, a framework to enable individuals to effectively engage in CPD. Similar to the previous cycle we worked together using PAR to improve practice. As with cycle two, reflection allowed for difficult conversations to be aired leading to some resolution. Members acknowledged the complexity as many of the issues borne out in the data lay with multiple parties namely; the individual, the institution, and the GNC. Within these reflections there was an emancipatory interest, empowering members through knowledge creation and a sense of 'can do' associated with personal efficacy as the framework took shape (Conger and Kanungo, 1998; Kemmis et al., 2014). Similarly to cycle two, the reflections presented are the result of a

series of reflective discussions by members. These reflections were often embedded within the planning and action cycles later identified through minutes and notes.

As previously discussed, thematic analysis was undertaken (Braun and Clarke 2006). The meeting minutes, Emails and personal notes were analysed. Two main themes were identified, decisions through data and confidence and consensus, these shall be discussed subsequently.

8.10.1 Decisions through Data

The members devolved responsibility for the data collection and analysis then re-engaged with the results to create a framework that was practical, in context and applicable to the Grenadian nurse. The data was accepted by all members as reliable and valid, this was aided by the transparency and adherence to the process, methodology coherence including documentation and saturation (Morse et al., 2002; Stringer, 2007). The seven meetings previously described showed there was constant movement between the two sets of results. The members engaged with the quantitative data and qualitative themes, identifying personally with the results. The members recognised the 'voices' of their colleagues in the data, this congruency allowed both their colleagues and themselves to be heard (Reason and Bradbury, 2008). As discussed earlier, some felt uncomfortable as the results indicated multiple agencies had deficiencies with lack of transparency, policy and organization. However although

disquieting, this was accepted as reliable and valid. The members agreed that the decisions made should follow a process which is visible and credible to ensure stakeholders understood where the framework originated. We agreed with Creighton (2005) that the framework had to not only be feasible but also reflect opinion and the data, therefore acceptance and sustainability was achieved.

8.10.2 Confidence and Consensus

The members reflected in an open dialogue on their successes and achievements by completing the three cycles. Many noted increased confidence and an awareness of their own professional and personal situations as a result of working through the cycles. Consensus and unity was reflected at length as a strength of PAR, many discussed the inclusivity, creating spaces in which members had a voice where dialogue was heard and respected, thus feeding back in, gaining more confidence in the project and achievability of this last cycle (Kemmis and McTaggart, 2000). This supports the study by Glasson (2008) that through active involvement and ownership of their PAR, participants expressed increased confidence in their practice. Everyone agreed the cycles allowed for acclimatization, breaking the study into manageable phases. They appreciated that the participation was open to re-negotiation in response to interest and commitments, although this was a challenge for me I accepted and understood their needs. It was also noted that through increased confidence and consensus praxis was achieved, these elements ensured participants took conscious control, changing themselves and their

surroundings in the form of openness, transparency, and honesty. It was through the active interventions, leading to discussion and breaking down the issues surrounding CPD which allowed for comprehensive understanding and the establishment of the framework (McNiff and Whitehead, 2009). As analysed earlier the members felt ready to share their work with their peers and Council.

8.11 Personal Reflection on Cycle Three

8.11.1 Participants engagement, cohesion, consensus building and support

In the third and last PAR cycle the aim was to create a CPD framework allowing Grenadian nurses the ability to fulfil their obligations to GNC and engage in meaningful CPD. The members had not been as involved in the data collection and analysis, I was curious as to how re-engagement would occur. Members took over where they had left, the focus was on the data to inform the basics of the framework. Constructive efforts through collaboration were made to complete the framework; as described by Tuckerman and Jensen (1977) 'performing' was achieved quickly. However, two individuals never returned, tensions rose as it became clear that there were certain shortcomings on the part of the GNC. My role as a lecturer was seen as a conflict of interest by these individuals, using the promotion of CPD as a vehicle to raise the profile of the university I worked for. Unfortunately, this was never satisfactorily resolved and although not communicated I believe this to be the reason why they left. I wrote:

"we were talking when PART # 3 said 'sounds like you want to run all the cpd on the island to me'. I was shocked I explained that I didn't teach cpd and that the university ran undergraduate studies. I was talking too much, uncomfortable. Then PART #6 said 'that is not what we are here for, we are to come up with a framework, recommendations, why are you being so, stop getting on'. I didn't know how best to handle the aggression. It clearly is not the majorities opinion. I changed tack bringing the focus back to our discussion, she never talked of it again"

Drawing again from Reason and Bradbury (2008) I found relational knowledge allowed for conflict as it led to understanding and illumination of some of the conflicts present. Additionally, I understood that PAR questions assumptions and this can be uncomfortable. Most of the members noted that sharing their experiences had helped make sense of them, the opportunity to verbalise matters previously kept between themselves provided a sense of release. Furthermore, I noted the effect of participation and collaboration lessened the sense of blame or isolation as the focus was on finding a solution. I also became aware of the hierarchical lines blurring, the team was more supportive of each other and myself focusing on the aims not the personalities.

The ever-present challenge of attendance and communication was particularly felt in this last cycle. As previously noted, there was a drop-in attendance after the planning phase with meetings being held with three members at times. However, I focused on

the level of critical discussion and reflection deciding that 'quality rather than quantity'
was required. I again ensured that communication and updates were available via E mail
and also a phone app used by us. I used this regularly, viewing this as flexibility on my
part and taking their lead by using tools they were familiar with rather than forcing 'my
way'.

Moreover, the informality of this medium aided responsiveness with decisions being
made quicker, in agreement with Marquis and Huston (2012) adopting a less rigid style
would encourage communication and efficiency. The group chats became part of the
data as refinements to the framework were worked on. As you can see from the
exchange below the use of humour was evident again, many other exchanges such as
family pictures, jokes and inspirational quotes added to the collegial feeling and
communication.

Group chat 15.10.16

Area – Work place and institutional based

Me- what do you think to the wording?

PART #7- nah it looks like the area is fixed I'm not getting it.

PART # 4 – I get the work place or institutional base as it includes those in teaching or

admin perhaps if you change the word area?

PART #9 – What about environment? 😍

PART #7 – What about places? 🤔

Me – How is this?

Places for development – Work place and institutional

PART #7 – Yeah! 👍🤩

PART #2 - Good!

PART #5 - 😜

PART #4 – Happy now! you go girl!

Me – Thanks guys! Have a good weekend.

Diagram 21 Decisions made via Group Chat

It is pleasing that although we have taken a hiatus, the messages and communication on a social level has continued, evidence that the team has gone beyond the task, forming working and social relationships.

8.12 Conclusion

Although this final phase has come to an end, we shall present the findings and framework to the GNC and the nurses in general presently. Additionally this study will be discussed at the Caribbean Nurses Association, biannual conference in late 2018. This commitment indicates the integrity of the process, showing the ownership of the study is firmly with us, myself being a member not the leader in a reciprocal research relationship. This is described by Herr and Anderson (2005) as a relationship which is internally co-constructed rather than externally regulated. The members showed interest in the issues surrounding CPD with passion, I noted their ownership by their willingness to continue, engage and ensure their input was felt.

As stated in the introduction, the idea to continue with a CPD committee has been agreed to. Additionally, an evaluation process of the framework through piloting was also decided and is discussed subsequently (Chapter 10, section 10.2).

CHAPTER NINE – CRITICAL REFLECTION

In Chapter Four, section 4.9.2 I outlined an initial evaluation of the quality of the data collection and analysis undertaken in this study based upon Morse et al's (2002); criteria of investigator responsiveness, methodology coherence, sampling, data analysis and saturation. Also included are the guiding questions (Appendix B) specific to PAR as set out by Waterman et al., (2001).

In this chapter, I return to critically reflect on the study design; PAR. This leads to a discussion and critique of the conceptual CPD framework developed by us, as it relates to the literature. Within these observations knowledge gained about CPD and how the findings relate to the literature including how this supports and adds to the body of knowledge is presented.

The following utilizes the two distinctive features of PAR to frame the discussion; the cyclical process and the research partnership. This leads to a critical look at the challenges faced within this study focusing on contextual observations including insider and outsider status. Lastly the different interests of PAR in this study are presented. The aim of this is to address the last research question.

- How does the use of PAR contribute to the development and proposal of a CPD framework?

9.1. The cyclical process

I observed that the use of the cyclical process synonymous with PAR was utilized, this enhanced the organisation and progress of the study (Coughlan and Coghlan, 2002; Reason and Bradbury, 2008). As a developing researcher I was able to follow the process in a systematic manner and evidenced this throughout the thesis. The use of the cycles which required careful analysis and reflection, both personally and amongst the members was advantageous. The research findings could be fed directly back by me to the members to effect the subsequent phases (Herr and Anderson, 2005). I saw determining the actions associated with the three cycles occurring during the study, as a characteristic of professionalizing action research (Hart and Bond, 1995). In relation to the cycles, and noted in Chapters Six and Seven, the movement between the cycles was challenging with many 'moving parts'. As Kemmis et al., (2014) point out the cycles do overlap, however having the phases made the study as ordered as possible.

Success could be measured by the cycles translating into practice with the formulation of the framework in cycle three. But, I found this made the process involved and lengthy, like many novice researchers, I underestimated the amount of time this and other tasks would take (Boyatzis, 1998).

On reflection, the most difficult aspect of maintaining congruency with PAR was the iterant characteristics and evolving cycles against the backdrop of completing a thesis

(Herr and Anderson, 2005). However flexibility enhanced the study, as described by Morse et al., (2002) following a pre-determined strategy in rote fashion would not have been successful.

9.1.1 Research partnership

Throughout the study my stance was to make a commitment to the characteristics of PAR focusing on parity, reciprocity and support through facilitation rather than a prescriptive approach (Waterman et al., 2001; Kemmis et al., 2014). This is echoed by Conder et al., (2011) as they questioned utilizing a strength based approach as this would favour the lead investigator. This thesis emphasized this commitment by agreeing that those who had not interviewed before should be afforded the opportunity. Evidence of partnership in the research process was apparent, for instance the members sought guidance on certain choices of data analysis as discussed in Chapter Six, section 6.12 (Coghlan and Brydon-Miller, 2014). At other times their knowledge led the way, for example by ensuring the questionnaire was contextual and coding to assist with return rates (See Chapter Seven, section 7.3.2 and 7.4.2). Like Conder et al., (2011) individuals were able to contribute within their 'comfort zone' not prescribed or forced.

The development of skills and subsequent achievements amongst the members through the partnership not only kept the study 'true' but was congruent with the concept of CPD (Reason and Bradbury, 2008). In this context, the literature suggests CPD is

contextual, utilizing PAR ensured this occurred (Lliffe, 2011; Giri et al., 2012). Members, including myself, were able to document this study into CPD as a CPD activity. As healthcare workers conducting PAR within the work setting, this methodology could promote this type of CPD activity to other nurses traditionally intimidated by research (Kelly et al., 2013).

Members stated how they had developed their knowledge and confidence in participating and contributing to the process (Koch and Kralik, 2006; Koshy et al., 2011). Glasson et al., (2008, p. 35) note a benefit of conducting PAR is to 'invigorate their practice' through knowledge acquisition. However, this contribution can be dependent on the motivation and to some extent the expertise of the group, and absence could disrupt the study. This echoes Jones and Gelling (2013) who describe the need for engagement if a PAR study is to be successful.

This study uncovered an ebb and flow which I defined as collaboration in motion. This supports Herr and Anderson's (2005) description of participation on a continuum, and an awareness that participation can take on many guises. However, at times the degree of engagement was challenging and illustrates the complexity of partnership (Conder et al., 2011).

It is evidenced throughout the thesis that the change interventions in the study were neither determined by hospital management or institutions, the 'top down' approach

(Beringer and Fletcher, 2011). Nor were they undetermined, which can occur from the 'bottom up' approach (Hart and Bond, 1995). We worked progressively towards achieving the aims of the study seeking differing perspectives then consensus. As illustrated Arieli et al., (2009) the need to understand goes beyond simply meeting.

In this study the notion of power differentials were not overtly apparent, I believe due to an open discussion at the beginning of the study (see Chapter Six, section 6.7 and 6.8). This important finding adds to the premise that PAR is concerned with power differentials, in presenting a solution, not *the* solution. It adds to the discussion on this complex process and brings forward awareness (Slavin et al., 2011; Waterman et al., 2001; Koch and Kralik, 2006).

9.1.2 Challenges

Time required was underestimated. As described earlier in Chapter Four, section 4.10 Makaroff et al., (2010) were faced with challenges from the nurse leaders who were unable to attend many meetings. This is a common issue with PAR. However, in this study it did not compromise consensus and thus praxis. It illustrated that by increasing correspondence via a variety of platforms consensus and participation is still possible. Correspondingly, the 'performing' described by Tuckman and Jensen (1977) was evident in this study, using a pragmatic approach and technology the members felt comfortable with. This finding could inform other PAR studies which suffer from absenteeism.

The focus was to use reflection and discussion as a means to examine and resolve the group's problem, not the individual. This was problematic at times, meetings where only two members were present were not as productive and I noted a lack of discourse and reflection. The strength in the PAR methodology, through collaboration, inclusion and reflection can also be its weakness as data cannot be analysed and planning is deferred due to lack of participants.

Challenges of participation and reflection is noted, Moon (2004) suggests that reflection is hard for some, consisting of superficial or descriptive accounts. This study illustrated that on differing levels the utilization of reflection at the end of each PAR cycle enabled us to critically explore the relationships observed, to acknowledge, challenge and thus bring awareness to the methodological processes and personal involvement.

I identified with Lee's (2009) discussion on how members felt apprehensive and guarded when reflecting on the process. This study unearthed additional co-researcher characteristics, the members needed time to learn their role as co-researchers and to feel confident to fully engage and challenge design aspects. Arieli et al., (2009) noted in their study that due to lack of critical reflection, the relations never achieved true participation despite many meetings and discussions. In this study, I observed members exploring their personal and professional values and opinions in order to agree on the central principles that would drive the study (Koshy et al., 2011). This is congruent with

Bevan (2013) who utilized communicative space both physically and conceptually when working with young mothers to encourage sharing of perspectives to reach understanding.

Moreover, this study supports that of Lee's (2009) when at times the reflection consisted of 'how are things going with the study' rather than a deeper philosophical exploration. However, we discovered the main factor for taking discussions deeper and more critical was the level of commitment to the process adding to the concept of collaboration in motion. Additionally and realistically, this study identified that the team found reflection demanding and if tired were reluctant. Although respected it was challenging to gain insights at times. In retrospect more time could have been spent on understanding the individual's worldview, also the beliefs and understanding of the very institutions they were changing. The important point this study bought forward is that group work in PAR requires more time.

9.2 Evaluation and Observation in context

It could be argued that PAR is contextual, as each study is situated within the community in response to an issue affecting those persons (McNiff and Whitehead, 2010; Kemmis et al., 2014). In this study and context the sampling for the interviews was problematic and illustrated some of the challenges of cultural nuance (Merriam et al., 2001). Based on the experiences in this study it can be reasoned that utilizing the knowledge of the

members led to some achievements. The suggestion and use of snowballing to recruit participants for the interviews created a solution which proved successful; this was fully discussed in 'disappointment and success' (Chapter Seven, section 7.5). Also, as predicted by the members, the survey yielded a 70% return rate, attributed to the rarity of surveys carried out in Grenada. This is in contrast to the literature which recognizes there are challenges surrounding response rates (Edwards et al., 2002).

In this study all areas where Grenadian nurses work, including the sister isle of Carriacou, were investigated. Although this proved time consuming, using multiple sites was advantageous to aid saturation and comprehensiveness. As discussed in Chapter Four, although PAR is unique for each study, generalizability is not always achievable (Stringer 2007). It is hoped that in this context transferability will be possible, at least regionally, adding to knowledge.

9.3 Different Interests observed

As discussed in Chapter Four, section 4.7, in PAR, there can be differing interests; technical which aims to improve practice, or practical where the emphasis is on collaboration, fostering a reciprocal relationship between the practitioner and the others involved and lastly, emancipatory is guided by liberating people and communities and questioning accepted norms or practice (Carr and Kemmis, 2003; Kemmis et al., 2014).

In this study, technically, it sought to solve a problem, such as the study by Harrington et al., (2013) on intentional rounding to reduce call-bell use. However the 'problem' identified in this study sought a more multidimensional solution making it at times unwieldy and complex. Members used the knowledge gained from the study to introduce changes and improvements for CPD via the developed framework.

Secondly, on a practical level there was collaboration and participation to varying degrees, with members expressing their view that knowing the outcomes of this study and decisions taken would have long term consequences (Kemmis et al., 2014). The more reciprocal and equal relationship amongst the PART led to a better understanding and efficiency, thus as a consequence improved research. As discussed earlier in section 9.1.1, collaboration was dynamic supporting the literature that calls for a flexible approach and to remain open to the views and responses of the other members (Waterman et al., 2001; Conder et al., 2011; Kemmis et al., 2014). However, it could be argued that there remains a tension in PAR and academic pursuits with the temptation to 'smash and grab' or to lessen the relevance of the research in search of data (Rapoport, 1970, p. 506). In this study there is evidence of attention to members' voices, going beyond a 'consultancy' as together we explored the environment and culture in which CPD took place (McKay and Marshall, 2001). Then using action research processes of observation and reflection to consider options to move forward (Habermas, 1984; Kemmis, 2001).

PAR proved effective in empowering us to identify the need for practice change and to work collaboratively to implement actions that best suit the context and the situation (Hughes, 2008; Reason and Bradbury, 2008; Kemmis, 2009). This formulated an authentic and bottom up approach resulting in a conceptual CPD framework that is anticipated to work in the Grenadian context. Hart (1996) suggests that PAR may merely be another strategy for getting nurses to collaborate and to achieve managerial goals rather than to challenge accepted practice. This study was not characterized in this manner, although supported throughout by the CNO the PART members determined the phases through discussion and consensus. Again this adds to the literature by highlighting the contextual nature of PAR and the culture within which we conducted this study.

9.4 Critical theory in context

Critical social theory provided a framework for challenging the accepted values and assumptions about CPD provision, uptake and parity. It also provided a framework in which the project aimed to empower Grenadian nurses to take control and change their situation by challenging the assumptions surrounding the provision, policy and constituents of CPD in Grenada (Kemmis et al., 2014). Moreover, action research within critical theory acknowledges the power of various perspectives because they uncover previously unknown truths about unacceptable practices and enable them to be

challenged (Carr and Kemmis, 2003). In questioning these 'normative' practices the members questioned imbalances which had been in 'plain sight' for instance, regarding who attended certain conferences and courses. Our study supports the argument by Whitehead and McNiff (2006, p. 58) "it is especially important to question when everything seems satisfactory".

Critical social theory processes are enlightenment, empowerment and emancipation (Harden, 1996). In this study enlightenment resulted from the pooling of knowledge and expertise by a group of people so that all members of the group benefited from increased knowledge about CPD in general and in the Grenadian context. In the literature this supports Collet et al's (2014) study with nurses on a paediatric intensive care unit, who, through developing policies noted through knowledge acquisition changes in their capabilities and competencies. Similarly, in the PAR study to develop educational materials with people living with diabetes and visual impairment this led to four "transformational moments" that enabled unique insights and learning (Williams, 2009). This notion is supported and added to in this study, although not classified as such, participants had 'ah-ha' moments. For instance the member's awareness of the stages required for thematic analysis.

Empowerment came from the increased knowledge combined with the collective force to enable practice change (Conger and Kanungo, 1988; Manojiovich, 2007). This is

consistent with Glasson et al's (2008) assertion that through their study, nurses were able to construct their own knowledge leading to empowerment. Reform of accepted CPD practices involved challenging the status quo in respect of the fundamental organisational structures that enabled these practices to continue without review for some years. Essentially, when members realized CPD had been mandated since 2009 without guidance, there was a commitment to change, challenge and action, in other words the members took control. This study identified a lack of control and choice, this was followed by a cooperative effort by PART to address these injustices. The resultant self-development and self-reliance was evident as we moved through the cycles together as discussed in section 8.10.2 (Reason and Bradbury, 2008). This study illustrated use of reflection within each cycle, which increased knowledge. This stimulated thinking beyond practical problems, however, this at times was uncomfortable (Koch and Kralik, 2006). Similarly, Kelly and Simpson's (2001) study to introduce clinical facilitators to the wards used the reflective phase to explore challenges beyond practical issues examining the organisational deficits and offering support to aid this change. Based on the experiences of this study, the action research cycles gave us a process for investigating the issues surrounding CPD thus uncovering unfairness and demoralisation. The study helped to uncover and address practices that resulted in inequity for some in accessing CPD. One of the successes of this study was to

incorporate critical reflection as data and evidence thus enabling understanding and change within.

Acknowledging the complexity and ability to express or measure emancipation claims are speculative (Hall, 2003). This study aimed to advance professional development by removing structures which prevented engagement. The processes of enlightenment and empowerment, and the appetite for collaborative engagement experienced within the group, may have formed a foundation for the ongoing emancipation of individual members. That is, harnessing and sharing knowledge about practice change techniques, not only empowered us, these knowledge sets provided the catalyst for taking collective action and freedom to control and improve our own professional development. In this study there was some evidence of emancipation in the broad sense, as there was a liberty to question accepted practices and consciousness was raised within. There were members who became freer by an awareness of the dominations of particular interests and powers, these were most notably during the analysis of the interviews (see Chapter Seven section 7.8). This is evident by the recommendations regarding GNC (see Chapter Eight section 8.7). The evidence indicated that collectively we were part of the system that enabled de-motivation, disempowerment and distrust, we tried to make sense and to some extent come to terms with this using critical reflection. This study's finding supports Cahill's (2004, 2007) suggestion that during PAR into stereotypes it was

through the emotions felt participants consciousness was raised and fueled their research process.

In summary, applying critical social theory as a model helped us understand the varying structures and institutional policies that were in place and how to negotiate and make recommendations for change (Lewin, 1948; Freire, 2000). Subsequently, the collective knowledge, planning and action of the collaboration were all aspects of critical social theory.

9.5 Issues surrounding insider or outsider status.

In Grenada the word *'sketel'* means someone who is born outside Grenada but lives on the island, originally referring to substandard imported cars, it is a derogative term as the tight-knit community is wary of outsiders; this can also be applied to the often challenging role of the researcher. Continuing on from Chapter 5, section 5.2.4, considerations in terms of conducting research within their own work setting is acknowledged in the literature (Brinkman, 2014; Onwuebuzie and Leech, 2007; Carr and Kemmis, 2003; Stringer, 2007; Creswell, 2003). The common consensus to be one of caution, discouraging those who would conduct or become too close with participants for fear of 'going native' (Kanuha, 2000; Fuller, 1999; Sandelowski, 1986).

This study will be used as an example to counter this discussion. Firstly situating the role of the action researcher and co-researchers and then offering a unique insight into the

need for proximity to achieve cultural competence, especially surrounding the effects of post-colonialism.

To recap, insider research refers to those who are members of the organisation they are researching, this may be in collaboration with others within the organisation but not necessarily. Within the field of action research Kangovi et al., (2014) utilized PAR to explore patients' perceptions of post-hospital recovery and generate ideas for improvement. The reasons for doing research in one's own organization are varied, for example having a good understanding or interest in the subject to be studied, or a unique context that is not answered in the literature. For instance Poncet et al., (2007) utilized their unique position in ICU to work with colleagues to study burn out in the ICU setting. Whereas McFarlane and Hansen (2013), used their perspective as disabled women to explore the experience of disability in women. In this study nurses were working collaboratively to investigate a nursing professional development issue. The PART had an understanding of some of the issues their colleagues faced and they could offer and bring insight and experience surrounding this phenomena.

My and the member's positionality was clear, I was an outsider but the members as insiders were often too busy to fully participate, although collaboration was always sought. As described by Bainbridge et al., (2013) the outsider researchers were accepted

by virtue of their ethnicity, similarly as a nurse who had worked voluntarily at the hospital I was proffered a certain credibility and accepted authenticity.

In academia the concern of insider research is the perceived lack of rigour, with the loss of objectivity to achieve valid or reliable research (Anderson and Herr, 1999, Kemmis, 2009; Coghlan and Casey, 2001; Coghlan and Brydon-Miller, 2014). This apprehension is discouraging to many would-be researchers who are practitioners and ideally placed as insiders to bring the research into practice. This has been shown in the field of education where action research in the classroom leads to immediate implementation (Kemmis et al., 2014). Additionally Brannick and Coghlan (2007, p. 60) argue that 'we are all insiders of many systems' bringing a rich experience and insight which cannot be separated. Again the work by McFarlane and Hansen (2013) identifying themselves with the disabled, this gave authenticity and 'right' to work in this field.

Utilizing reflection as part of the cycle helped us to maintain a professional distance, especially as some interviews were unsettling. As described by Kindon et al., (2007) in their work with youths, reflection can reduce the difficult environments and realities some action researchers are exposed to. As with others, the notion of duality was discussed due to the intimacy of the environment. We saw this as an advantage as we had a vested interest in the research and due to the intimate nature of the Grenadian profession did not have a sense of being separate or separated (Cohglan and Casey,

2001). However one disadvantage was that of logistics, as nurses the members had limited time available for data analysis and meetings (Holian, and Coghlan, 2013). Additionally, as a team there was an element of trying to fix everything as we attempted to address multiple factors raised in the interviews (See Chapter Seven, section7.8). This is a recognized issue within the literature, Coghlan and Casey (2001) discuss how nurses face many challenges of doing research in their own hospitals due to the multiple issues PAR can uncover.

Within the field of action research, the explicit understanding is one of collaboration and participation to conduct research and create knowledge. This participatory paradigm as described by Heron and Reason (1997) along with critical theory, encourages reflection and critical analysis during the research process. As discussed, this type of research encourages involvement in order to understand the shared concern.

To understand the issues surrounding CPD, there was a need to be close to the issue, to understand from an insider the challenges of availability and access. I was an engaged participant working with colleagues to define the issues. Reflecting Conder at al's (2011) study with participants who had learning difficulties, there was a commitment by all of us to value both the academic and practitioner knowledge.

As discussed in Chapter Four, section 4.10.3 an additional layer was to acknowledge the team's perception of my role and function within a back drop of post-colonialism, the

definitive outsider. Without being reductionist, my role and appearance could have connotations of the colonizer. As previously discussed in Chapter Four the power differential is an important concept within action research generally (Koshyet al., 2011; Stringer, 2007; Coghlan and Brydon –Miller, 2014). Within this context another layer of complexity had to be addressed and agreed. To achieve this, attention to cues of imbalance were addressed by all members of the PART as described in Chapter Four, section 4.10.4. In order to make the research genuine, the members had to accept that although different I was able to understand the shared values. This was done incrementally over the whole research period, although always present, its impact was reduced as understanding, trust and relationships were built. Agreeing with writers of post colonialism I saw that the dialogue and participatory nature of PAR allowed an interconnectedness between the 'them' and 'us', exploring the issues related to CPD but to a wider understanding and debate about colonialism and its legacy (Kindon,2007; McEwan, 2008;). To revisit the cautionary notes against being too close, in this context it could have potentially underscored the stereotype as a white middle class academic.

In summary, in agreement with Coghlan and Brannick (2014), action research provides the basis and evidence that insider research can be achieved and should be embraced. What is highlighted by this study and adds to this body of knowledge is that action research may also be a methodology well suited to issues and studies within post-

colonial countries as through collaboration, participation and reflexive action, voice and ownership is given back to those people most affected.

9.6 Findings and recommendations in relation to the literature

There has been and continues to be an interest in research regarding CPD for nursing globally, studies identifying the benefits to the individual or profession and the influence of mandatory CPD to safeguard the patient are examples (Katsilitis et al., 2013; Ross et al., 2013; Govranos and Newton, 2014; Mack et al., 2017). Previous studies valued evidence linking competence and competency with CPD (Sykes and Temple, 2012; Lauer et al., 2014). Likewise descriptions of frameworks and considerations for CPD frameworks (Giri et al., 2012; Moetsan-Poka et al., 2014). Also factors influencing CPD have been analysed extensively (Schostak et al., 2010; Brekelmans et al., 2013).

This study suggests a theoretical explanation of the nature and context of CPD offering a conceptual framework and adds to existing knowledge regarding CPD. The framework has utility for practice as a means to aid nurses in Grenada to engage and document their CPD.

The following outlines the findings in relation to the literature, focusing on the descriptive statistics to include demographics and educational levels. Next, the motivations and factors which influence engagement are presented. Within this account suggestions for further research are outlined.

This study departed from data produced by the UK and USA regarding age of workforce as illustrated in the table below (NCSBN, 2015; RCN, 2017). Much of the literature debates the impact of an ageing nursing population, addressing diverse topics such as the generational characteristics as described by Sherman (2006) which can define and shape values and professional aspirations or work hazards and safety concerns to the older nurse (Phillips and Miltner, 2014). Elsewhere strategies to retain older nurses in order to meet shortages are discussed (Cohen, 2006; Fitzgerald, 2007). Of significance is that this younger workforce in Grenada could have different characteristics and career motivations, these nurses may be more accepting of change and technology for instance. However, they may need support to fulfil family commitments and the introduction of flexible working hours may be a consideration (Sherman, 2006). In relation to this study the educational needs could be more skills based and may require investment in simulation and mentoring (Berragan, 2011). Specific examination of the needs for a younger nursing population would be beneficial to inform policy and planning.

Age Range	Proportion GND	Proportion US (2015)	Proportion UK (2017)
20 – 34	35%	19.4%	19.5%
35 – 54	36.1%	41.9%	57.8%
55 – 60+	5.2%	38.7%	16.4%

Undisclosed	*13.8%*		

Table 18 Comparison of age ranges Grenada, USA and UK

In a similar vein, the findings in this study showed that only 11% of Grenadian nurses held a bachelor's degree in nursing, this is in sharp contrast to the US statistics of 65% (NCSBN, 2015). To my knowledge, this data has not been published in the region and can inform policy as PAHO (2016) plans collaborative centres to aid with professional development. This quantitative data supports the recommendations by PART to the Government to address these issues (See Chapter Eight section 8.4.3). Moreover, in a developing country such as Grenada, investment into education may prove astute and is aligned with the PAHO (2016) directive to offer advanced degree programmes in the region.

9.6.1 Motivations

The survey indicated that Grenadian nurses felt that professional development was personally and professionally important and that it would improve the quality of health care. This is congruent and supports previous studies, showing a clear link to professional identity, commitment to the profession and key to engagement (Cleary et al., 2011; Lee et al., 2005; Katsikits et al., 2013; Mulvey, 2013). Further research into how these factors interrelate and whether one is more significant than another may be of interest.

It has been previously suggested in the studies by Pool et al., (2016) and Brekelmans et al., (2016) that the primary motives for engaging in certain activities were considered if significant to the individual. This study suggests this was not the case, showing discordance between certain activities deemed important and the actuality of undertaking the activity, for instance attending clinical meetings or participating in policy development (See Chapter Seven, section 7.7.9). This incongruity illustrated motivation and thus engagement was stymied by access and availability and could be considered a more influential factor than previously understood. To understand what are the key influencing factors and the role of environment would substantiate this finding.

In this study the factors facilitating CPD reinforced other studies, demonstrating the need for institutional support. In agreement with Ross et al., (2013) the need to facilitate nurses working in rural Australia resonates with the transportation difficulties expressed by participants in this study. Additionally, nurses in Grenada expressed issues with life-work balance, which was also described in the literature. Investigation and the effects of flexible approaches and opportunities to access CPD should be explored deeper as it is a common issue possibly independent of context (Brekelmans et al., 2013; Merriam and Bierema, 2013).

The study by Brekelmans et al., (2013) and Ross et al., (2013) identified the impact of finances related to accessibility. This issue was supported in Grenada with participants expressing concern at the cost of certain CPD activities. This is particularly acute in light of the earning potential (see Chapter Two, section 2.1.2). It could also be viewed that nurses in Grenada appear to face similar challenges as their colleagues in more developed locations.

In summary, the implication of the concordance of institutional support and financial challenges suggests unifying characteristics that can help or hinder CPD. Further exploration into these features and comparing the findings to other settings could be valuable.

This study found that attending courses, or undertaking personal CPD, had tangible benefits, with nurses reporting increased confidence, improved skills and motivation to improve and progress within their profession. This concept of increased confidence through professional development is expanded on by Skyes and Temple (2012), however the presence of self-esteem, feeling valued and respected noted in their systematic review was not as apparent in Grenada. It could be surmised that the effects of 'lack of choice and control' (see Chapter Seven, section 7.8.2) is significant and could be investigated further.

This study found that there was a variety of activities which could constitute CPD but that it was not always recognised as such, for instance workplace learning, these can offer solutions to some of the challenges uncovered. It is the recommendation of this study to encourage such activities, this is also endorsed by Eraut (2007) who advocates the use of the workplace as a legitimate alternative to formal learning because it encompasses a wide range of settings and a variety of activities. Examining the impact and influence of workplace learning would be of interest.

9.7 Discussion of the findings – the conceptual CPD framework developed

The aim of this next section is to show the significance of the findings and how these were incorporated into the conceptual framework. Discussion and critique of each part of the framework; congruence with learning theories, documentation required, the use of competencies and staff appraisals followed by levels of reflectivity follows. Each part is compared and contrasted with the three frameworks discussed in the literature (see Chapter Three, section 3.4.8) namely UK, Australia and Malawi. This is to show the strengths and limitations of the proposed framework relevant to the literature.

This illustrates why 'one size cannot fit all' as this study indicates that CPD needs to be linked with the individual, the profession and institutional needs. Although transference is possible, it is correct that each entity instigates its own framework

The conceptual CPD framework was created collaboratively and included the following six elements; a breakdown of CPD hours into differing categories, the use of appraisals to set goals, the utilization of a portfolio with specific guidelines, a conditions table (see Chapter Eight, table 18) to increase transparency and help set goals and a tool to help identify differing activities (see Chapter Eight, diagram 17). The aim of this framework was to construct a professional identity, assist with adherence to standards, develop professional expertise, and offer strategies to aid personal and career progression and increase competencies.

Of the three frameworks discussed in the literature, their overall concepts are echoed in the Grenada proposal. This is unsurprising as the broad aim of CPD is to increase professional expertise, competence and individual well-being, enabling the practitioner to work more effectively and efficiently (Mulvey, 2013). This study showed the majority of Grenadian nurses felt that a framework was essential to further their own professional development, increase the quality of healthcare and fulfill mandated requirements for registration. The benefits of CPD for the individual, profession and institution were articulated by those interviewed. This study in agreement with Pool et al., (2016) noted that nurses used a spectrum of CPD activities motivated by a desire to improve competence. Furthermore the Grenadian nurses agreed with Xuereb et al., (2014) study that there would be an improvement in patient care.

The need for lifelong learning is accepted across all frameworks and thus is viewed as a process as well as an outcome. However there are differing emphases, complexities and approaches, for instance it is only the Grenadian framework which breaks down the overall hours into three elements; formal self-directed, formal required and informal.

Congruity with learning theories: the conceptual framework demonstrates a close alignment to learning theories (see Chapter Three, section 3.4.1). This study unexpectedly showed mandated activities would be acceptable to nurses. This disagrees with Knowles, (1975) Brekelmans et al., (2013) and Mulvey, (2013) assert that voluntary activities offer a more meaningful outcome. This study presented that mandated CPD was synonymous with institutional support and recognition, adding another dimension to mandating CPD. Others believed there was reluctance by colleagues, to take on the additional commitments voluntarily, hence mandating would enforce compliance. In this context, formal or mandated activities were viewed as a motivator, necessary to embed CPD into the Grenadian nursing culture. Whilst the need for institutional support is agreed in the literature the link between mandated activities and embedding lifelong learning in the nursing culture was not made (Cleary et al., 2011; Govranos and Newton, 2013; Ross et al., 2013). CPD has not been a priority in Grenada for the profession or individual, making it mandatory could be a vehicle to establish this culture. It highlights the complexity that CPD is not a uniformed concept important to some, a burden to

others. This finding adds to the literature and supports, Friedman, (2013) in that the nurses in Grenada trusted themselves but not their colleagues to keep up to date.

Referencing Benner (1984), Grenada's framework allows for learning from the more simplistic (but vital) transmission of certain skills or facts for instance, to the more intangible transformative learning. This is evidenced by the use of work appraisals, to be focused on the level of the learner, this is discussed subsequently. However in the Grenadian context the reliance on the individual to develop their learning plans could be problematic, as it was evident that some did not have the insight or commitment to undertake this activity.

Only Malawi attempted to articulate the 'weighting' of certain activities with a points system. Whilst understandable this was rejected as being reductionist, focusing on the task rather than the process and outcomes. Rather, in line with the UK and Australia frameworks a self-declaration of the number of hours spent was agreed.

Documentation: As discussed the use of a portfolio was agreed to. Of those countries examined, all discussed documentation utilizing templates or log books. Conversely, we felt within the Grenadian framework the term 'a portfolio' captured the concept of showcasing the differing knowledge and skills of all the CPD activities in one place. The five items included encompassed a more holistic approach to CPD to encourage active engagement and promote self-direction (Hallem et al., 2008; Hayes, 2016). However,

unlike the UK the use of a confirmer was deemed unnecessary as the use of staff appraisals would replace this. Mechanisms for self-declaration are present, underlining professionalism and trust. The timing, duration and intervals between CPD activities is not explicit in any of the frameworks. In the Grenadian context this was addressed by including the annual CPD plan and staff appraisal to assist and guide scheduling. This living document would enable facilitation for auditing. An obvious limitation is the unfamiliarity of using portfolios as discussed in Chapter Eight, section 8.6.2, training would have to be implemented (Mc Mullan et al., 2003; Joyce, 2005).

The use of staff appraisals: In the Grenadian context the use of appraisals across all specialties enables the nurse and manager to set priorities and evaluate achievements (Jasper et al., 2013). This was viewed as a clear method to encourage dialogue between the individual, profession and institution. Also to capitalize on a successful system that was already established, was attractive. Only Malawi specifically stated these in their framework. In the UK appraisals were mentioned to comply with the feedback requirements in relation to future practice. As described in Chapter Eight, section 8.6.5, the benefits of using appraisals were three fold; increasing collaboration, alignment with and support from management and the institution. Linking with the known competencies it is envisioned that there would be an emphasis on self-directed learning processes and promotion of personal assessment as a professional expectation and obligation (Campbell et al 2010). However this could be problematic as this self-direction

332

and motivation was not evident in the interviews (see Chapter Seven, section 7.8.5 Still, the PART supported the argument that competency and CPD is related and wanted to support this through the appraisals (Pool et al., 2013; Govranos and Newton, 2014; Casey et al., 2016).

Use of reflection: The proposed Grenadian and existing UK and Australian frameworks utilized reflection, drawing on reflective observation in the experiential cycle (Knowles, 1970; Kolb, 1984; Benner, 1984). We agreed on the value of utilizing reflection and how this can be beneficial to the nurse. However, departing from the UK's framework of mandated reflective discussion and essays, this activity is implied in the Grenadian framework. The rationale for this was data driven; the nurses did not recognise reflection as part of their activities, however it was apparent that it occurred. A limitation of this could be that reflection is problematic for most and that it is a skill that develops over time (Moon, 2013).

A limitation of this framework is reliance on the very organization it aims to support. Principally, the nurses reported a lack of institutional support surrounding CPD leading to apathy in some. Furthermore there was a lack of transparency in policy and guidelines creating mistrust. As discussed in Chapter Eight, section 8.7.1, the PART noted a fragmentation between the individual and institution. Although recommendations;

being visible (8.7.2), being supportive (8.7.3), being transparent (8.7.4) were made, acceptance and commitment to change is unknown.

This concludes a discussion on the proposed framework, it shows how the literature and results from the study informed the facets of the framework. Also highlighted were some limitations and unknown quantities.

9.8 Conclusion

The purpose of this chapter was to critique and reflect on the research process in context in the development of a conceptual CPD framework that can be either used by GNC to evaluate registration or the individual nurse to guide their own CPD. This answered the last question; How does the use of PAR contribute to the development and proposal of a CPD framework? The framework was critiqued utilizing current literature. Doing so highlights the strengths and limitations of this study.

CHAPTER TEN

CONCLUSION AND RECOMMENDATIONS

In this chapter a review of the work undertaken is summarized. It highlights the two outcomes from this study; illustrating how this study contributes to the field of CPD and the use of PAR as a methodology. Although the application is local the transferability and functionality elsewhere is emphasized. Following on, implications and recommendations for further research for CPD, namely practice and policy are discussed.

10.1 Introduction

The aim of this research has been to explore the issues surrounding CPD in Grenada as a means of developing a framework to enable nurses to engage in meaningful CPD. The findings from this research will be used to report to the Grenada GNC and make recommendations for the implementation of the proposed framework as described in Chapter Eight.

The outcomes of this study are twofold, namely the knowledge about CPD in Grenada and the development of a CPD framework in context to meet the specific needs of the Grenadian nurse. With this framework the study contributes to the field of CPD.

10.2 Review of work undertaken

At the beginning of this study, CPD in Grenada was found to be lacking both individually and institutionally. There was an imperative for change, this process was made possible through myself as the initiating researcher with members using a collaborative, bottom-up approach. As a result of the research the framework (see Chapter Eight, section 8.9.2) was developed and this will act as a tool to assist nurses in Grenada to engage in CPD in a meaningful way.

The framework reflects the constructs that control and influence CPD as revealed by this study, also the changes required to put in place for CPD to be effective;

- Measurement: hours of CPD based on competencies.

- Influence: individual engagement and institutional support.

- Places for development: work place and institutional based.

- Alignment and goals: individual needs and institutional needs.

The framework also utilizes the processes in existence, namely the staff reviews, for nurses to identify their own professional development needs, including non-traditional areas such as education or research. To help facilitate nurses two tools were developed, namely the conditions table (table 18) and constituents of CPD (diagram 17). Finally documentation for audit in the form of a portfolio was devised. The complex processes

between the individual and institutional needs were revealed and it is hoped addressed. Meaningful engagement with CPD is better understood and opportunities to facilitate that engagement are now in place as a result of this study. Additionally organizational shortcomings were exposed leading to a series of recommendations to change the culture and support professional development (see Chapter Eight, section 8.7).

The knowledge gained about how Grenadian nurses engage in CPD adds to the body of research and significantly the region where there is limited understanding. Furthermore this study can offer guidance and recommendations to other countries within our region who are seeking to implement a CPD framework.

The use of critical theory as a theoretical perspective guided this study. The use of critical theory identified power relations and inequities within the Grenadian nursing system. This study revealed the complex interaction of the individual and institutions revealing power and dynamics which had important implications for the development of this framework. It also enabled the investigation and questioning of accepted practices thus having an emancipatory component.

The methodological approach enhanced the study as both gatekeepers and end-users generated the knowledge which informed the framework. This buy-in will assist in a sustainable framework, this is consistent with Glasson et al's (2008) assertion that the clinical nurses involved in the action research became committed by participation as the

co-researchers. Also evident was the crucial knowledge that the members as co-researchers, brought to the study, their ability to confer to the research ensured it was effective and efficient. Through the use of PAR and the formation of the PART there was a unique opportunity to introduce a research methodology to Grenadian nurses. Additionally, this study supports other studies in this area showcasing PAR as successful and effective methodology (Kelly and Simpson, 2001; Koshy et al., 2010; Collet et al., 2014). As discussed, we feel the work is not yet done and have agreed that an evaluation of the framework is required. The members are willing to utilize the methodology again, for a further PAR study, once the framework is in use.

The key findings from this study include both what we set out to do and what happened through the critical social theory processes of enlightenment, empowerment and emancipation (Harden, 1996). It can be argued that this study shows and supports the usefulness of collaborative research as a means of engaging nurses in improving practice. In this study the PART formed to address the introduction of mandatory CPD hours without organizational support, policy recommendations or an understanding of what constituted CPD. What emerged from this study and adds to the body of knowledge is an awareness of the interplay between the needs of the profession, the individual and institution (Brekelmans at al., 2013).

From an ontological stance the 'what' was constructed through the data and the interpretations of the PART's shared experiences. It was our ability to communicate and disseminate. In essence this study articulated what CPD should look like. The nature or epistemological stance of how that knowledge was constructed, was through multiple types of data with an emphasis on the qualitative to produce new knowledge.

10.3 Summary of contribution to literature

Through the use of PAR two main contributions to CPD in Grenada can be identified. The first is the conceptualization of a CPD framework to enable Grenadian nurses to significantly engage in professional development. In creating such a framework the nurses have an opportunity to engage in CPD in a more meaningful way. Following implementation and assessment in Grenada then following dissemination and discussions regionally, this framework may be adopted at a regional level. This framework could then be used to inform other similar Caribbean Countries such as St Lucia, Barbados and Antigua, which, like Grenada do not have a CPD framework.

Secondly this study supports the use of PAR as a methodology and contributes to a meta-analysis across countries and cultures. The findings which emerged in our study and the use of PAR as a methodological approach are unique in the Grenadian context of CPD. The use of an accepted methodology and methods utilizing established guidelines can add to the use and evaluation of such tools (Langlois et al., 2014; Davison,

2004; Morse et al., 2002; Waterman et al., 2011). The success of the methodology adds to the growing use of PAR in the healthcare setting (Koshy et al., 2010). Transferability of the findings to other CPD contexts in the region and wider is feasible.

Whilst developing a framework for CPD the focus of this study was locating an effective way of applying the research findings in practice. The imperative for CPD was evident and understandable. Critical theory was the theoretical framework that enabled the PART to question assumptions and gain insights into the organizational hierarchy that exists (Habermas, 1984; Kemmis, 2001). In addition this study sought not to criticise without making recommendations, evidenced by the suggestion that the GNC should be visible, supportive and transparent (See Chapter Eight, section 8.7.1). Utilizing a participatory and collaborative approach allowed for the contribution of multiple perspectives on a shared issue (Reason and Bradbury, 2008). The use of PAR ultimately led to the aims of the study being achieved, also significantly the change, development and expertise of us all as we conducted the study was evident. The practical knowledge gained through the interactions and interpersonal relationships was apparent with the PART describing the benefits, listing professional development and insight into the complexities of the issues surrounding CPD. This supports the idea that PAR goes beyond the project at hand (Cahill, 2007; Kindon et al., 2007; Reason and Bradbury, 2008).

There were challenges throughout each phase, in scoping there was limited written polices surrounding study leave, reimbursement for development initiatives or what documentation was required for proof of CPD. This lack of data as a starting point became data in itself. The outcomes of PAR are the final key elements and in this study the result was an understanding and knowledge surrounding the issues of CPD in Grenada.

10.4 Implications for future research

These implications are written from our perspective and in the Grenadian nursing context. However these implications have a wider interest for other professions in healthcare contexts involved in CPD. The following will focus on implications for practice and then policy.

The findings suggest that increasingly the requirement for formal CPD is on the rise and is linked with patient safety and competency (Lauer et al., 2014, Aiken et al., 2003). However, this emphasis should not negate individual professional development and career progression. The link between CPD and revalidation is established and required in Grenada, facilitating a culture for life-long learning and professional development is recommended. Furthermore, this study showed that CPD should be a collaborative and democratic process, avoiding a centralised agenda from the institution or governing bodies, continuing the top down approach.

This study identified what constitutes CPD activities, indicating the means of delivery needs to be rationalised. Although preferred, in this context, classroom activities are resource intensive. Investment into the infrastructure and awareness of alternative development opportunities such as online resources, workplace learning or inter-professional discussions should be explored (Schostak, 2010; Giri et al., 2012). The shift from measurable 'classroom' activities needs to be addressed with a focus on the question of "what is it I am doing that will improve and develop me as a professional". In this study it has been demonstrated that nurses learn through everyday activities and make meaning in context, contributing to CPD and thus shaping the framework to support workplace learning, this endorses the extensive work by Eraut (2000, 2004, 2007, 2009). As said, this study resonated with other findings regarding the value of workplace learning, however this work also highlighted the literature concerning conflicts of work-pressure negating learning (Johnson et al., 2014). Further investigation as to how work-pressure influences learning could be of interest for further investigation.

This research also illustrated how reflection was used by nurses to improve and develop, however it also indicated that this was not appreciated as such. The further exploration of these opportunities and how they translate into change of practice and development is recommended. In these explorations, within this study, the hope is that the individual would shape the professional identity recognising the evolving nature of CPD.

In the context of Grenada it is recommended that a framework be implemented in practice. Initially this implementation would be in the form of a pilot which would be evaluated for effectiveness, ensuring it was fit for purpose. The CPD framework (diagram 18) represents the findings in this study for nursing practitioners in Grenada and would be recommended for use in similar contexts. Accordingly, it should be noted that this study indicated the need for a framework that was contextual, therefore the ability to evaluate in context is recommended. In relation to evaluation, it has been shown, in this study, the utility of PAR and critical theory as a means for discovering the complexities surrounding CPD and successful framework development. Furthermore PAR may also prove an effective methodology to continue the research, however it is recommended that the evaluation aims to steer the appropriate methodology and theoretical framework (Stringer, 2007). The sustainability of such a change should be evaluated, and has been a key consideration throughout this study, this could be viewed as a criterion as to the success of PAR as described by Kemmis (2010) when evaluating what can and cannot be undone.

As for further research in to CPD there is still much to learn, which activities have the most impact on the individual, profession and institution, the value of workplace learning and refinement of definitions of CPD for instance. Exploration to add to the body of knowledge is recommended.

As stated earlier PAR was utilized to successfully implement change which was research driven. The ability to cross the theoretical practice divide is significant, taking the findings of the research into a physical model which can be discussed, implemented and evaluated is an opportunity. However, to reiterate the previous section, PAR is one of many methodologies and whilst CPD is situated in the real world of practice of those charged with implementation, evaluation, delivery and engagement with are recommended to choose a methodology which is suitable.

This emphasises the need for authority to establish a macrosystem to set vision and goals to guide the micro- and mesosystems by providing an enabling context and leadership for change. In this study nurses identified shortcomings in management's ability to be attentive to its own development and preparation to successfully lead the cultural change. The argument by the IOM (2009) regarding continuing education in the health professions had many similarities in the Grenada CPD context as revealed by the research.

Policy regarding the three recommendations focused on transparency, parity and fairness. Policy strategies that support the relationship of the nurses and those in management or GNC are therefore recommended.

10.5 Limitations to the study

At the outset of this study potential limitations were identified and strategies employed to reduce their impact, this was illustrated by the limited respondents for the semi-structured interviews for instance. It was beneficial to use the validated Q-PDN questionnaire (Appendix C) even so, it may have been advisable consider other instruments which exist. From the field of education one considered was the 'education participation scale' developed by Boshier (1971) to determine motivational orientations of adults enrolled in education programmes. This has been reoriented for the professional context and used in nursing but still retained an undesirable predisposition towards continuing education (DeSilets, 1995).

Working in collaboration takes time, Hughes (2008) acknowledged that one of the most important barriers to achieving outcomes in action research projects is the time taken in the context of busy health care settings. We were challenged by the tension between the members' desire to collaborate in achieving group aims and objectives as set out in the initial action cycle, and the reality of doing so amid the busy health care setting and demanding work roles. This tension challenged the group's ability to investigate, evaluate requiring flexibility and alternative forms of communication (See Chapter Eight diagram 19).

Other tensions in the form of group dynamics were expected (Tuckerman and Jensen, 1977) however two in the group left, although this did not affect the study it was unsettling and affected me. I was able to discuss this and debrief with my supervisor, resulting in an understanding and closure, however this could have negatively affected the study. The study exposed shortcomings and a lack of transparency in some of the policies surrounding CPD. It can be speculated, once discoveries had been made, for some it was solved by distancing themselves, whilst others set about addressing the issues (see Chapter Eight section 8.11.1). This is eloquently phrased as 'opening a can of worms' (Whitehead et al., 2008 p. 11). Using PAR to investigate and resolve one problem it may unearth more problems along the way.

10.6 Looking back at what has been achieved

The key elements of PAR as outlined were successfully mobilized in this study. Additionally these elements related back to the aims and research questions investigated. During the cycles three accomplishments can be identified; change was initiated, participation was achieved, finally improvement and increased understanding of the issues surrounding CPD was evident (Waterman et al., 2001). These will be discussed.

The first key element was the purpose of the study, which was change within the profession through involvement and to identify issues surrounding CPD in Grenada. Also

for us to have a collective understanding and engagement. It can be argued that this study resulted in learning and change of perspectives for most of the members, they have an understanding of the respective issues surrounding CPD and have acquired an understanding for a change in culture to support lifelong learning respectively.

The next element was the nature of the hospital staff's participation in the study. In this study members collaborated to identify and address through the use of PAR. Utilizing the cyclical process of planning, action, evaluation (observation) and reflection occurred throughout the study. As discussed, the PART worked on a shared concern, committed to change and improvement. This study showed how the participatory characteristic of PAR translated and influenced the success in context. The finding of this study that working in a group enhances the research on many levels is significant.

The outcomes of PAR are the final key element and in this study, namely the increased understanding and knowledge surrounding the issues of CPD in Grenada. We did have conflicts and challenges and some members did not engage as hoped, however the optimism and sense of collegial support was overwhelming. It was clear that the choices and degree of participation were made in negotiation. This whole process enabled a reduction in the theory/practice gap with the creation of a framework to enable Grenadian nurses a practical tool in which to engage in CPD.

10.7 Summary

While the development of a CPD framework was the focus of this study, the most important study outcome was locating an effective and facilitative way of applying research findings into practice. Critical social theory was the theoretical framework that enabled this achievement through its liberating insights in a culture influenced by domination as a post-colonial country (Fay, 1987; Kemmis, 2009). PAR provided the vehicle for planning, acting, observing and reflecting on what was necessary to develop a CPD framework. Undertaking the study through collaborative group work allowed the contribution of multiple perspectives on the issue of concern and ultimately was instrumental in achieving group goals and increased the professional development of the PART.

On the international stage CPD is evolving as it adapts to the changing landscape, this study adds to the knowledge and understanding of the subject whilst simultaneously addressing a pressing need in Grenada.

In closing two concepts carried me through this journey, the first attributed to Kurt Lewin (1890-1947) is that if you want to truly understand something you have to try to change it. It was through the framework creation to change the accepted, that my understanding and appreciation of Grenadian CPD and the wider context occurred. Secondly, my supervisor Dr Waterman suggesting that action research cannot be

understood through intellectual argument but by at least attempting to do it (Waterman

et al., 1995). It was this 'doing' as a practical exercise that I gained so much experience

and appreciation.

Appendices

Appendix A: Table illustrating differences in CPD regulations.

Country	Uk	France	South Africa	Australia	USA
Who establishes the competences required to become a nurse?	Regulating Authority	Regulating Authority	Regulating Authority	Regulating Authority	Regulating Authority
Cost of license UK sterling	$120 / year	$21 / year	$28 /year	$74/ year	Varies per state
CPD compulsory or voluntary	Compulsory	Compulsory	Voluntary (under review)	Compulsory	Mixed (2/3 of states compulsory)
Professional development needs identified and communicated	Yes	No	No	Varies on employer	Varies per state
Study days or credits per year required	5 days per year	None	Nil	20 hours in 1 year	Varies per state
Proven evidence required	Yes Portfolio	No	No	Yes Portfolio	Yes
CPD activity funding	Co-financed	Co-financed	Self-financed	Co-financed	Co-financed
Country	**Grenada**	**St Lucia**	**Jamaica**	**Canada**	**Malawi**
Who establishes the competences required to become a nurse?	Regulating Authority	Regulating Authority	Regulating Authority	Regulating Authority	Regulating Authority
Cost of license UK sterling	$40/ 3yrs	$ 25 / year	$64 / 2 yr	87/ year	$13 / year
CPD compulsory or voluntary	Compulsory	Compulsory	Compulsory	Voluntary	Compulsory
Professional development needs identified and communicated	No	No	No		Yes
Study days or credits per year required	60 hours in 3 years	15 hours in 1 year	30 hours in 2 years	Self-declaration of practice	25 points in 1 year
Proven evidence required	No	Yes	Yes	No	Yes portfolio
CPD activity funding	Co-financed	Co-financed	Co-financed	Co-financed	Co-financed

Appendix B Guidance for assessing action research proposals and projects

1. Is there a clear statement of the aims and objectives of each stage of the research?

2.Was the action research relevant to practitioners and/or users?

3. Were the phases of the project clearly outlined?

4. Were the participants and stakeholders clearly described and justified?

5. Was consideration given to the local context while implementing change?

6. Was the relationship between researchers and participants adequately considered?

7. Was the project managed appropriately?

8. Were ethical issues encountered and how were they dealt with?

9. Was the study adequately funded/supported?

10. Was the length and timetable of the project realistic?

11. Were data collected in a way that addressed the research issue?

13. Were data analyses sufficiently rigorous?12. Were steps taken to promote the rigour of the findings?

14. Was the study design flexible and responsive?

15. Are there clear statements of the findings and outcomes for each phase of the study?

16. Do the researchers link the data that are presented to their own commentary and interpretation?

17. Is the connection to an existing body of knowledge made clear?

18. Is the extent to which aims and objectives were achieved at each stage discussed?

19. Are the findings transferable?

20. Have the authors articulated the criteria on which their own work is to be read/judged?

Waterman, HA, Tillen, D, Dickson, R & Koning, KD 2001, 'Action research: a systematic review and assessment for guidance.' *Health Technology Assessment*, vol 5 (23).

CONTINUING PROFESSIONAL DEVELOPMENT OF NURSES (CPD)

Questionnaire Professional Development Nurses (Q-PDN)

PART 1 – General Characteristics

Gender:

- ☐ Male
- ☐ Female

Age:…………………. Years

Employment status:

- ☐ Full time
- ☐ Part time
- ☐ Per diem/TAR
- ☐ Shift rotation
    - o Days, evening, nights
    - o Day, evening
    - o Straight days
    - o Straight nights
- ☐ Other (specify): ……………………………………..

Work experience: How many years have you worked as a nurse?

………….. years

On which unit do you currently work? (Pick only one)

- Surgery
- Medicine
- Intensive Care
- Paediatrics
- Oncology
- Emergency
- Obstetric/gynecological
- Palliative care
- Psychiatric
- Out patient

Level of education?

Registered nurse

- Doctoral
- Master degree in nursing
- Bachelor of Science in Nursing (BSN)
- Associate degree
- Other

Please list your certification

- Intensive Care Nursing
- Coronary Care Nursing
- Accident and Emergency Nursing
- Paediatric Nursing
- Paediatric Intensive Care Nursing
- Neonatal Intensive Care Nursing
- Oncology Nursing
- Obstetric Nursing

What is currently your main position?

- Staff Nurse
- Nurse leader
- Nurse manager
- Clinical nurse specialist
- Nurse Practitioner
- Nursing administration
- Educator

PART 3 - Continuous Professional Development (CPD) Questions

_____

1. **The term Continuous Professional Development (CPO) refers to all activities which may contribute to your professional development. Below are a number of reasons and motivations for participating in CPD activities. Please indicate the extent to which you agree with each statement listed below with regard to motivations.**

    1. Mainly disagree

    2. Partly disagree

    3. Neither agree nor disagree

    4. Partly agree

    5. Mainly agree

	I take part in CPD activities:	1	2	3	4	5
1.	... in order to meet the requirements for registration in the future					
2.	... in order to increase my chances of promotion					
3.	... because further professional development is important to me					
4.	... to increase my professional status					
5.	... to improve my current qualifications					
6.	... because I consider it important to increase the status of my profession					
7.	... to support my career					
8.	... in order to carry out my work better					
9.	... in order to meet the requirements of the organisation I work for					
10.	... in order to increase the quality of healthcare					
11.	... to prove to my employer that I am professionally competent					
12.	... because this is considered highly important in my professional environment					
13.	... in order to achieve a higher level of training					
14.	... in order to make a positive contribution to nursing practice					
15.	... to support my career potential /choice					
16.	... to improve my leadership abilities					

2. **Several CPD activities are listed below. Please indicate the degree to which you consider the items listed below to be important to your own professional development.**

1. = not important at all

2. = not important

3. = somewhat important

4. = important

5. = very important

	The following issues are important to my professional development:	1	2	3	4	5
1.	Participation in policy development					
2.	Attending clinical practice meetings					
3.	Training courses					
4.	Receiving feedback from colleagues regarding my performance					
5.	Putting scientific research outcomes into the practice of my profession					
6.	Participating in feedback discussions					
7.	Reviewing medical literature with regard to best practices					
8.	Learning through practice					
9.	Carrying out research					
10.	Actively participating in team discussions about team performance					
11.	Discussing with colleagues any developments that might have an adverse effect on professional practice					
12.	Following short courses (duration 2-8 hours)					
13.	Writing articles for professional journals					
14.	Making sure that I keep up to date with policy developments					
15.	Participating in recruitment and selection interviews with new members of staff					
16.	Participating in reflection and/or intervision meetings (getting together to talk about activities and growth in your ward and organization)					
17.	Participating in internal projects					
18.	Exchanging best practices or setting up projects with other institutions					
19.	Informing my supervisor if I notice any developments at work that could have an adverse effect on professional practice					
20.	Making sure that I keep up to date with professional developments					
21.	Reflect critical on practical situations					
22.	Serving on the editorial board of a professional journal					
23.	Determining whether I performed well and whether I could perform better next time					

3. **Below are several statements about the limiting conditions under which your own Continuing Professional Development (CPD) can best be realised. Please indicate the degree to which you agree or disagree with the statements in the list.**

1. Mainly agree

2. Partly agree

3. Neither agree nor disagree

4. Partly disagree

5. Mainly disagree

I take part in CPD activities:		1	2	3	4	5
1.	... if the expenses are fully reimbursed by the employer					
2.	... if there are career possibilities within my organisation					
3.	... if my immediate supervisor discusses my career possibilities with me					
4.	... if I follow the CPD activities in my own time					
5.	... if the CPD activities are offered in a multidisciplinary context (e.g. together with doctors)					
6.	... if I receive career guidance					
7.	... if suitable supplementary training courses are offered by my immediate supervisor					
8.	... if my supervisor provides me with the necessary time					
9.	... if the CPD activities result in a certificate					
10.	... if I receive an annual appraisal					
11.	... if my colleagues coach me					
12.	... if taking part in CPD activities allows me to have a say in ward/team policy					
13.	... if I have more independence					
14.	... if the CPD activities have a clear career perspective					
15.	... if my immediate supervisor coaches me					
16.	... if there is a clear reduction in workload					

18.	... if I am appreciated from within my organisation for the work I do					
19.	... if other positions are offered within my organisation					
20.	... if I receive support from my supervisor					
21.	... if I follow other CPD courses					
22.	... if the CPD activities are not expensive					

4. **Several CPD activities are listed below. Please indicate how often you <u>actively</u> perform each of these activities.**

> 1. Never
>
> 2. Occasionally
>
> 3. Sometimes
>
> 4. Quite often
>
> 5. Very often

		1	2	3	4	5
1.	I participate in policy development					
2.	I attend clinical practice meetings					
3.	I follow training courses					
4.	I make use of scientific nursing outcomes in my professional practice					
5.	I participate in feedback discussions					
6.	I review medical literature with regard to best practices					
7.	I perform research					
8.	I actively participate in team discussions about team performance					
9.	I discuss with colleagues any developments that might have an adverse effect on professional practice					
10.	I follow short courses					
11.	I write articles for professional journals					
12.	I make sure that I keep up to date with policy developments					
13.	I participate in recruitment and selection interviews with new members of staff					
14.	I participate in reflection and/or intervision meetings					
15.	I participate in internal projects					
16.	I exchange best practices or set up projects with other institutions					
17.	I inform my supervisor if I notice any developments at work that could have an adverse effect on professional practice					
18.	I make sure that I keep up to date with professional developments					
19.	I reflect critical on practical situations					
20.	I participate in the editing process of a professional journal					
21.	I determine whether I performed well and whether I could perform better next time					

22.	I follow the CPD activities in my own time					
23.	I take part in CPD activities at my own expense					

Appendix D IRB Approval Cardiff

School of Healthcare Sciences
Head of School and Dean Professor Heather
Waterman

Ysgol Gwyddorau Gofal Iechyd
Pennaeth yr Ysgol a Deon Yr Athrawes Heather Waterman

CARDIFF UNIVERSITY
PRIFYSGOL CAERDYDD

19 November 2015

Cardiff University
Eastgate House
13th Floor
35 – 43 Newport Road
Cardiff   CF24 0AB

Tel Ffon: +44 (0)29 20 688559
Email E-bost HCAREEthics@cardiff.ac.uk

Prifysgol Caerdydd
13ed Llawr
Ty Eastgate
35 – 43 Heol Casnewydd
Caerdydd   CF24 0AB

Ms Jennifer Solomon
7 High Fields Grove
Highgate, London
N6 6HN

Dear Ms Solomon

The development of a model for continuous professional development for nurses in Grenada through participatory action research.

At its meeting of *17 November 2015* the School's PGT Research Review and Ethics Committee considered your research proposal. The decision of the Committee is that your work should:

Pass –and that you proceed with your Research

Please note that if there are any subsequent major amendments to the project made following this approval you will be required to submit a revised proposal form. You are advised to contact me if this situation arises. In addition, in line with the University requirements, the project will be monitored on an annual basis by the Committee and an annual monitoring form will be despatched to you in approximately 11 months' time. If the project is completed before this time you should contact me to obtain a form for completion.

Please do not hesitate to contact me if you have any questions.

Yours sincerely

Mrs Liz Harmer – Griebel
Research Administration Manager

Cardiff University is a registered charity, no. 1136855
Mae Prifysgol Caerdydd yn elusen gofrestredig, rhif 1136855

GOVERNMENT OF GRENADA
MEMORANDUM

FROM: PERMANENT SECRETARY - MINISTRY OF
         HEALTH AND SOCIAL SECURITY

TO: CHIEF NURSING OFFICER – MINISTRY OF HEALTH
         AND SOCIAL SECURITY

DATE: MARCH 27, 2015   REF: MHE 61/1

SUBJECT: CONTINUING PROFESSIONAL DEVELOPMENT (CPD)
          PROGRAMMES FOR NURSES IN GRENADA

Reference is made to your memorandum dated March 20, 2015 on the above-captioned matter.

The Ministry of Health duly noted the information and wishes to indicate that if there is any request to facilitate this research, the same should be made on a timely basis.

....
Javan F. Williams (Mr.)
PERMANENT SECRETARY

GT/rr   Received 27/3/15
          Edwards
          CNeo

361

Consent form: Participatory Action Research Team Member

Researcher: Jennifer Solomon

Research title: The utilization of participatory action research to propose a model for continuous professional development in Grenada West Indies.

The investigator conducting this research project abides by the principles governing the ethical conduct of research and at all times affirms to protect the interests, comfort and safety of all participants.

This form and the accompanying action research group participant information leaflet have been given to your for own information. They describe the study and possible risks and burden.

Please initial the box below

1	I have received the subject information and have read its contents dated ……………………….	

         Agree   **Disagree**

2   I clearly understand the nature of the study
         and the possible risks and burdens,
         additionally I have been given the opportunity
         to discuss the contents of the information leaflet
         with the investigator prior to commencement of the study
         and that I have had all my questions answered fully.

         Agree   **Disagree**

3   I understand that all data I provide will only be revealed
         to the investigator. When the results of the study
         are published I will remain anonymous.

         Agree   **Disagree**

4   I understand that participation is voluntary
         and therefore may be ended at any time by
         myself without comment or penalty

in addition it will not jeopardize my registration
to practice or opportunity for CPD
involvement in the future.

Agree   **Disagree**

5   I agree to receive feedback on the results at the
         time of the study and dissemination
         of the results to interested parties.

Agree   **Disagree**

6   I agree to participate in the study as set out by the information leaflet.

Name and address

_____

_____

_____

I may direct further questions at any time to Jennifer Solomon or Supervisor: Professor Heather
Waterman E mail - watermanH1@cardiff.ac.uk

Please sign and return.

Name   **and**   **phone**

_____   _____

Signature   **and**   **Date**

_____   _____

Witness Signature   **and**   **Date**

_____   _____

Researcher – Jennifer Solomon:

Signature   **Date**

_____   _____

Be a part of a research team!

——The development of a framework for CPD in Grenada

——Your expertise is needed!

——Look out for the information sheets in your clinical areas

——Contact us if you are interested to learn more!

Jennifer Solomon

If you wish to collaborate with the aim to develop a CPD framework pick up an information sheet in your area.

jsolomon@sgu.edu

459 3036

J Humphrey 440 2607

N Edwards 444 4167

The development of a model for continuous professional development for nurses in Grenada through participatory action research.

Participatory Action Research Team

Dear Colleague,

I would like to invite you to consider joining a participatory action research team that will be formed for this research study to explore continuous professional development for Grenadian nurses. Before you decide if you are willing I would like to explain why the research is being done and what it will involve of you. If you are interested, would like more information or if something is not clear please contact me, my contact details are at the end of this sheet.

What is the purpose of the study?

This research study seeks to have a greater understanding of continuous professional development in Grenada and to develop a model that meets the needs of Grenadian nurses.

I would like

- To collaborate with a team of nurses, in Grenada to explore nurses understanding of continuous professional development.
- To identify the internal and external issues surrounding undertaking continuous professional development in Grenada.
- To discover how best can nurses in Grenada fulfill continuous professional development requirements for registration.
- To develop a model for continuous professional development.

Why have you been invited to take part?

As you have expressed an interest in the study you have been invited to take part. Your experiences and opinions on continuous professional development are important. Additionally previous research experience is not necessary.

Do you have to take part?

You do not; if you wish to be part of the participatory action research team it is completely voluntary. I will ask you to sign a consent form. You are free to withdraw from the team at any time, without comment or penalty. Your decision not to participate will not affect your registration or the ability to engage in continuous professional development activities. As your contributions may have informed other parts of the study, it will not be possible to remove them, but I can destroy the raw data if you want to.

What is involved?

If you are involved as a member of the participatory action research team, your role in the project would be in an ongoing nature, over a period of 18 months. The purpose of this group is to explore the concept and issues surrounding continuous professional development. With knowledge gained the team will then develop a model.

 I would anticipate that the group will meet on a monthly basis with meeting lasting no more than two hours, for accuracy the meetings will be tape recorded.

Additional reading during the process may be needed, but will be agreed upon before hand. The tape recorded data would inform the study and feedback for additional stages as the study progresses.

Benefits that may result from the research

Being involved in the participatory action research team is being part of an improvement process concerning CPD in Grenada. Personal benefits such leading a positive change in nursing are anticipated. Those new to research may enjoy the collaborative process, learning research design and seeing theory directly being translated into practice.

Possible risks that may occur

I do not see any direct risks taking part; however your time will be utilized, with every effort to ensure meetings and data gathering are efficient and effective as possible. If you feel any discomfort or distress during the process you may withdraw at anytime.

What about confidentiality and data storage

Members of the participatory action research team will not anonymous, however all data collected from the team such as discussions, reflections and debates will not be identifiable to an individual on publication. Member's specific roles within the team would be confidential. Quotations maybe used but these will be always in an anonymous format. All summaries of the participatory action research team's meetings will be kept secure, in a locked filing cabinet in a secure office. Data stored electronically

will be password protected and locked in the same office. All data will be kept secure for 10 years from publication.

What will happen to the results of the study?

When the study has been completed the results will be shared through published articles, conferences and presentations. As part of the participatory action team you may wish to be involved in the dissemination, this is completely voluntary and will not affect you being able to take part or contribute.

What if there is a problem or concern?

If there is a problem or issue regarding your involvement in the study, speak to me or my supervisor, Professor Waterman she can be contacted via E mail WatermanH1@cardiff.ac.uk In the UK where approval has been granted you can contact a University Research Practice and Governance Co-ordinator at Cardiff University on +442920688559.

Is there any funding for this research?

The research is being conducted as part of my PhD thesis in Nursing at the University of Cardiff. The study sponsor is the Cardiff University and Professor Heather Waterman is supervising the study. The research is self-funded by myself and I will not receive any payment for carrying out this study. Participants will not receive remuneration during the study.

Who has reviewed the study?

The Cardiff University has reviewed the aspects of the study in a rigorous process. The committee called the Research Ethics Committee ensures that correct procedures are followed to protect your rights. The committee has granted the study to commence. Your safety, wellbeing and full understanding of what the study involves is very important. Even though the study is being carried outside of the UK every measure to ensure international standards are met has been followed.

How can you find out more?

For further information regarding any aspect of the study or are interested in taking part please contact:

Jennifer Solomon

Tel: 417 5702

Email: jsolomon@sgu.edu

Appendix F Lego Icebreaker

Lego ice breaker game

You will need a group size of at least 2 teams; a small lego model and an extra set of lego materials per team.

 Split the group into teams of 4-6 people and give each team a set of lego materials. Place the lego model away from the team's view but make sure it is of equal distance from each team. Ask one member from each team to come forward to view the model for 20 seconds.

Send this person back to their team, when they should then instruct the rest of the team on how to build the model. They are not allowed to touch the model themselves. After one minute ring a bell or ask the teams to send another person to view for 5 seconds. This continues until the first team to declare that they have the perfectly replicated model. The model is checked and if they are correct, they win, if not the exercise continues. The exercise can continue until all teams have finished.

For discussion:

- How accurate were the instructions?
- How hard is it to re-create something without being able to see?
- How difficult is it to view but not build?
- How pressured were individuals?

Appendix G Meeting Outline

| Date 1hr Tuesdays	Meeting title	Stage in PAR	
26.1.16	Introduction and Ground rules work shop on AR CPD	Reconnaissance	3 hr workshop
2.2.16	Personal views on research and learning	Reconnaissance	
9.2.16	Discussion and feedback on themes from transcripts.	Reconnaissance	
12.2.16	PART understanding of CPD	Reconnaissance	
16.2.16	Discussion and feedback on themes from transcripts. Agreed Action/Intervention	Reconnaissance	
1.3.16	Perceived Issues and Barriers identified by PART for GND	Reconnaissance	
8.3.16	Discussion and feedback on themes from transcripts. Agreed Action/Intervention	Reconnaissance	
15.3.16	Literature review on CPD frameworks and issues and barriers	Reconnaissance	
22.3.16	Discussion and feedback on themes from transcripts. Agreed Action/Intervention	Reconnaissance	
29.3.16	Discussion and consensus of preferred CPD elements and frameworks from PART perspective	Cycle 1	
5.4.16	Discussion and feedback on themes from transcripts. Agreed Action/Intervention	Cycle 1	
12.4.16	Research protocol review and agreement mixed methods sequential quan-qual	Cycle 1	
19.4.16	Quantitative survey – review and dry run	Cycle 2	
26.4.16	Discussion and feedback on themes from transcripts. Agreed Action/Intervention	Cycle 2	
3.5.16	Quantitative survey – logistics, distribution and collection, response rates. Aim of survey what data is sought.	Cycle 2	
10.5.16	Discussion and feedback on themes from transcripts. Agreed Action/Intervention. (survey distributed)	Cycle 2	
17.5.16	Review on how survey will inform PART and qualitative interview	Cycle 2	

31.5.16	Update on survey response and contingency plans if needed (3 weeks after distribution)	Cycle 2	2 week gap
28.6.16	Report on data from survey. Discussion on the results and implications. (7 weeks after distribution)	Cycle 2	4 week gap
12.7.16.	Qualitative interviews – logistics, recruitment and sampling. Data analysis methodology. How the interview data will add to PART investigation.	Cycle 2	2 week gap
19.7.16	Discussion and feedback on themes from transcripts. Agreed Action/Intervention (start interviews)	Cycle 2	
23.8.16	Report on raw data from interviews. Discussion on the results and implications. (5 weeks after start of interviews)	Cycle 2	5 week gap
13.9.16	Consolidation of the results on both the quantitative and qualitative data. Discussion and implications for framework (3 weeks after end of interviews)	Cycle 2	3 week gap
20.9.16	Discussion and feedback on themes from transcripts. Agreed Action/Intervention	Cycle 2	
27.9.16	Create a framework for CPD for Grenadian nurses. Discuss literature and local new knowledge. (Two meetings)	Cycle 3	
11.10.16	Mandated hours – breakdown and organization.	Cycle 3	
18.10.16	Documentation – individual and institutional requirements. Tools to aid compliance and understanding.	Cycle 3	
25.10.16	Role of Nursing Council – recommendations to aid sustainability	Cycle 3	
1.11.16	Over-view of framework – does it make sense.	Cycle 3	
8.11.16	Dissemination – Nursing Council and beyond	Cycle 3	
15.11.16	Debrief on process - successes and challenges	Reflection	
29.11.16	Discussion and feedback on the Action Research as a process.	Reflection	
	Where do we go from here? Follow up further research and projects.	Reflection	
		Reflection	
		Reflection	2 week gap
6.12.16	Thank you party Christmas wishes.		

	January – July write up		

Action research cycle	Time alloted
Recconnaisance- situational research/analysis	8weeks
Cycle one- framework elements quanitiative survey	15 weeks
Cycle two- qualitative intervews consolodation of mixed method data	10 weeks
Cycle three- create GND CPD framework	4 weeks
Reflection- on PAR process and follow up research	5 weeks
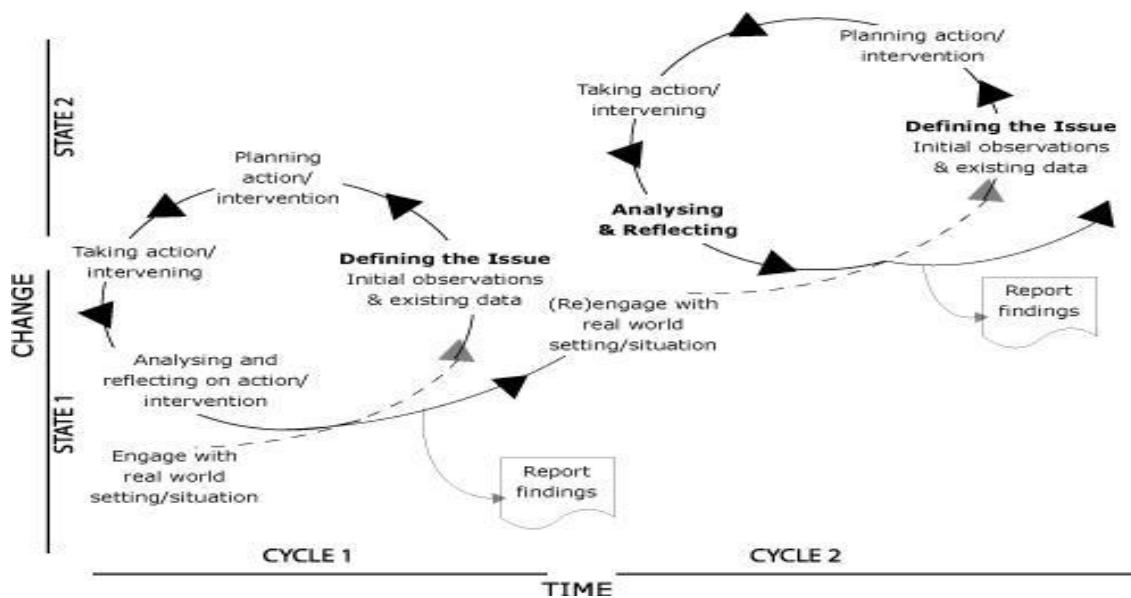
Appendix H PAR Cycle Flow

Phase Proceedure Outcomes	Reconnaissance Ethical Approval Formation of PART Situational Analysis and literature search Defining the Issue	PAR Cycle 1 Planning the action and interventions Taking Action	PAR Cycle 1 Quantitiative and Qualitative methods agreed upon Scope of study

PAR Cycle 1 Analysisng and reflection and the actions, interventions and results Informing Cycle 2	PAR Cycle 2 Planning the action and interventions Taking Action	PAR Cycle 2 Conducting study-questionnaire and interviews Raw data produced	PAR Cycle 2 Data cleaning , thematic analysis Quantitiative and Qualitative results Codes and Themes

PAR Cycle 2 Analysising and reflection on actions and interventions Informing Cycle 3	PAR Cycle 3 Planning the actions and interventions Taking Action	PAR Cycle 3 Development of CPD framework Dissemination stratagies Conceptual Framework produced

WORKSHOP

Kidney Disease
2 – 4pm
Clinical Teaching Unit
24/5/16
Please Register with Secretary

Appendix J Steps in Thematic Analysis

Phases of Thematic Analysis adapted from Braun, V. and Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3 (2). pp. 77-101.

Phase	Description of the process
Familiarising yourself with your data	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme.
Reviewing themes	Checking in the themes work in relation to the coded extracts and the entire data set, generating a thematic "map" of the analysis.
Defining and naming themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells; generating clear definitions and names for each theme.
Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

Appendix K Concept Map
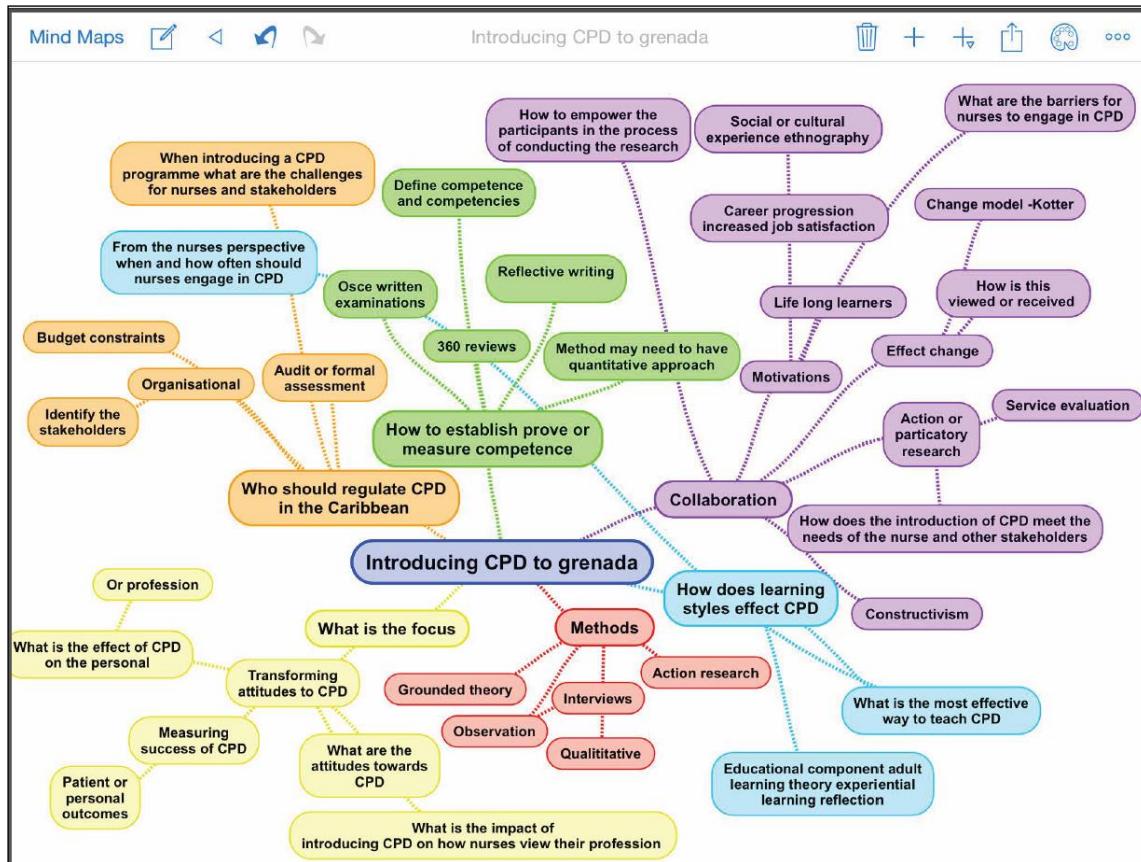
Appendix L Permission to use QPDN

Dear Jennifer,

I'm pleased that our article caught your attention. The questionnaire is available and I'm more than willing to cooperate. Just let me know what you need. Are you going to publish the results? And of course we really are very curious about the results. Is it possible to share these with us? We used this also in a magnet hospital in Chicago so we translate it for the US context. It only was used in a General, University and home care context. We distribute the questionnaire digital and collect the data in SPSS 20.0. Analysis: Descriptive statistics were used to determine the importance that nurses attached to specific CPD activities, the conditions they considered necessary to do so, the extent to which they participated in the activities and their motives to participate in the activities. To establish construct validity a confirmatory factor analysis (CFA) (Arbuckle 2006) was carried out. Confirmatory factor analysis and further analyses aimed at testing the Goodness of Fit using AMOS 21.0, a Structural Equation Modeling (SEM) program (Arbuckle 2006). The factors that affected CPD activities that nurses undertook were examined.   It takes about 20 minutes to complete.

 Looking forward hearing from you.

Kind regards

Gerard Brekelmans

From: JSolomon@sgu.edu [mailto:JSolomon@sgu.edu]
Sent: maandag 15 juni 2015 22:57
To: G.A. Brekelmans
Subject: Q:PDN Continusing professional development
Dear Dr. Brekelmans,

I am a PhD student at Manchester University in the UK. My thesis is regarding continuous professional development situated in the Caribbean island of Grenada, it is entitled " Utilizing participatory action research to establish a nursing model of continuous professional development in Grenada"
I read with interest your article in Nurse Education Today "The development and empirical validation of the Q-PDN: A questionnaire measuring continuing professional development of nurses".
In order to answer the research questions "What are Grenadian nurses understanding of CPD" and "Where are the issues surrounding undertaking CPD in Grenada". I would carry out a survey of nurses in Grenada.
This along with focus groups and interviews would create data which will inform on a model that would be used in Grenada. Presently there are no guidelines or tools to assist nurses in undertaking CPD.
May I get some more information regarding the questionnaire to see, with permission, if it could be used in this setting?

Thank you so much for your consideration.

Jennifer Solomon

Consent form: Interview

Researcher: Jennifer Solomon

Research title: The utilization of participatory action research to propose a model for continuous professional development in Grenada West Indies.

The investigator conducting this research project abides by the principles governing the ethical conduct of research and at all times affirms to protect the interests, comfort and safety of all participants.

This form and the accompanying interview information leaflet have been given to your for own information. They describe the study and possible risks and burden.

Please initial the box below

1   I have received the subject information and have read its contents dated ……………………….

                Agree   **Disagree**

2   I clearly understand the nature of the study and the possible risks and burdens, additionally I have been given the opportunity to discuss the contents of the information leaflet with the investigator prior to commencement of the study and that I have had all my questions answered fully.

                Agree   **Disagree**

3   I understand that all data I provide will only be revealed to the investigator. When the results of the study are published I will remain anonymous.

                Agree   **Disagree**

4   I understand that participation is voluntary and therefore may be ended at any time by

myself without comment or penalty
in addition it will not jeopardize my registration
to practice or opportunity for CPD
involvement in the future.

Agree	**Disagree**

5   I agree to receive feedback on the results at the
time of the study and dissemination
of the results to interested parties.

Agree	**Disagree**

6   I agree to participate in the study as set out by the information leaflet.

Name and address

_____

_____

_____

_____

I may direct further questions at any time to Jennifer Solomon or Supervisor: Professor Heather Waterman E mail - watermanH1@cardiff.ac.uk

---

Please sign and return.

Name   **and**   **phone**

_____   _____

Signature   **and**   **Date**

_____   _____

Witness Signature   **and**   **Date**

_____   _____

Researcher – Jennifer Solomon:

Signature   **Date**

_____   _____

The development of a model for continuous professional development for nurses in Grenada through participatory action research.

Interview

Dear Colleague,

I would like to invite you to consider taking part in a research interview about your experiences of continuous professional development. Before you decide if you are willing I would like to explain why the research is being done and what it will involve of you. If you are interested, would like more information or if something is not clear please contact me, my contact details are at the end of this sheet.

What is the purpose of the study?

This research study seeks to have a greater understanding of continuous professional development in Grenada and to develop a model that meets the needs of you, Grenadian nurses.

I would like to

To identify internal and external issues surrounding undertaking continuous professional development in Grenada.

To discover how best can nurses in Grenada fulfill continuous professional development requirements for registration.

Why have you been invited to take part?

As you have shown an interest to take part and as a nurse licensed to practice in Grenada your experiences and opinions on continuous professional development are important.

Do you have to take part?

You do not have to take part, it is up to you. If you wish to be interviewed it is completely voluntary. I will ask you to sign a consent form. You are free to withdraw from the interview at any time, without comment or penalty. Your decision not to participate will not affect your registration or the ability to engage in continuous professional development activities.

What is involved?

If you indicate that you want to be involved you will be contacted by me to schedule a convenient time for you to have a discussion on your thoughts on continuous professional development. The length of the conversation will depend on how much you have to tell me but you should allow an hour for it. I will want an accurate record of your interview so it will be tape recorded.

Benefits that may result from the research

I am not expecting any direct benefits to those who choose to take part but analyzing and recording your views will help us learn more about your experiences about continuous professional development in Grenada. This will enable development of a model that meets the needs of Grenadian nurses.

Possible risks that may occur

There are no real risks to taking part in these. If you feel any discomfort or distress during the process you may withdraw at anytime. As your contributions may have informed other parts of the study, it will not be possible to remove them, but Ican destroy the raw data if you want to.

What about confidentiality and data storage

Confidentiality is important; all data collected from the interviews will not be identifiable. The interviews will be carried out in a private office. Quotations maybe published from the recordings but these will be always in an anonymous format. All transcripts and tapes of the interviews will be kept secure, in a locked filing cabinet in a secure office. Data stored electronically will be password protected and locked in the same office. All data will be kept secure for 10 years from publication.

What will happen to the results of the study?

When the study has been completed the results will be shared through published articles, conferences and presentations.

What if there is a problem or concern?

If there is a concern about any aspect of the study, speak to me or my supervisor, Professor Waterman she can be contacted via E mail WatermanH1@cardiff.ac.uk. Alternatively you can approach the Grenada Nursing Council who is also acting as a resource for this study. In the UK where approval has been granted you can contact a University Research Practice and Governance Coordinator at Cardiff University on +442920688559.

Is there any funding for this research?

The research is being conducted as part of my PhD thesis in Nursing at the University of Cardiff. The study sponsor is the Cardiff University and Professor Heather Waterman is supervising the study. The research is self funded by myself and I will not receive any payment for carrying out this study. Participants will not receive remuneration during the study.

Who has reviewed the study?

The Cardiff University has reviewed the aspects of the study in a rigorous process. The committee called the Research Ethics Committee ensures that correct procedures are followed to protect your rights. The committee has granted the study to commence. Your safety, wellbeing and full understanding of what the study involves is very important. Even though the study is being carried outside of the UK every measure to ensure international standards are met has been followed.

How can you find out more?

Thank you for taking time to read this information sheet. For further information regarding any aspect of the study or are interested in taking part please contact:

Jennifer Solomon

Tel: 417 5702

Email: jsolomon@sgu.edu

The First National Survey of Grenadian Nurses!
7ᵗʰ – 21ˢᵗ of April 2016 Don't miss it!

The Development of a Framework for Continual Professional Development for Nurses in Grenada

❑Continual Professional Development (CPD) involves every nurse in Grenada.

❑We are carrying out a survey to explore issues surrounding CPD for nurses in Grenada.

❑The survey will ensure a greater understanding of CPD in Grenada to develop a framework that meets your needs as nurses.

What you can do...
✓Look out for the survey forms in your clinical area
✓Fill in the form and return as soon as possible
✓Talk to your colleagues and encourage involvement and support.

Any further questions or if you would like to become more involved please contact J. Solomon jsolomon@sgu.edu 459 3036, J Humphrey 440 2607, D. Charles 459 2251, N. St Bernard 404 8302

THANK YOU!

The development of a model for continuous professional development for nurses in Grenada through participatory action research.

Survey

Dear Colleague,

I would like to invite you to consider taking part in a research survey about continuous professional development (CPD). Before you decide if you are willing I would like to explain why the research is being done and what it will involve of you. If you are interested, would like more information or if something is not clear please contact me, my contact details are at the end of this sheet.

What is the purpose of the study?

This research study seeks to have a greater understanding of continuous professional development in Grenada and to develop a model that meets the needs of you, Grenadian nurses.

I would like to

To identify internal and external issues surrounding undertaking continuous professional development in Grenada.

To discover how best can nurses in Grenada fulfill continuous professional development requirements for registration.

Why have you been invited to take part?

As a nurse licensed to practice in Grenada you have been chosen to take part. Your experiences and opinions on continuous professional development are important.

Do you have to take part?

You do not have to take part; it is up to you. If you wish to complete the survey it is completely voluntary. You are free to not answer any question in the survey, without comment or penalty. Your decision not to participate will not affect your registration or the ability to engage in continuous professional development activities.

What is involved?

If you are willing please fill out the survey. It should not take you any longer than 30 minutes. Once completed, please return via the stamped addressed envelope provided.

Benefits that may result from the research

I am not expecting any direct benefits to those who choose to take part but analyzing your views will help learn more about your experiences about CPD in Grenada. This will enable the development a model that meets the needs of Grenadian nurses.

Possible risks that may occur

There are no real risks to completing the survey. You may skip any questions you would rather not answer.

What about confidentiality and data storage

Confidentiality is important; all data collected from the survey will not be identifiable. All surveys will be kept secure, in a locked filing cabinet in a secure office. Data stored electronically will be password protected and locked in the same office. All data will be kept secure for 10 years from publication.

What will happen to the results of the study?

When the study has been completed the results will be shared through published articles, conferences and presentations.

What if there is a problem or concern?

If there is a concern about any aspect of the study, speak to me or my supervisor, Professor Waterman she can be contacted via E mail WatermanH1@cardiff.ac.uk. In the UK where approval has been granted you can contact a University Research Practice and Governance Coordinator at Cardiff University on +442920688559.

Is there any funding for this research?

The research is being conducted as part of my PhD thesis in Nursing at the University of Cardiff. The study sponsor is the Cardiff University and Professor Heather Waterman is supervising the study. The research is self funded by myself and I will not receive any payment for carrying out this study. Participants will not receive remuneration during the study.

Who has reviewed the study?

The Cardiff University has reviewed the aspects of the study in a rigorous process. The committee called the Research Ethics Committee ensures that correct procedures are followed to protect your rights. The committee has granted the study to commence. Your safety, wellbeing and full understanding of what the study involves is very important. Even though the study is being carried outside of the UK every measure to ensure international standards are met has been followed.

How can you find out more?

Thank you for taking time to read this information sheet. For further information regarding any aspect of the study please contact:

Jennifer Solomon

Tel: 417 5702

Email: jsolomon@sgu.edu

27.10.15

You are invited to participate in a study regarding continuous professional development (CPD). You were selected as a possible participant in this study because you are a registered nurse in Grenada.

The investigator conducting this research project abides by the principles governing the ethical conduct of research and at all times affirms to protect he interests, comfort and safety of all participants.

If you decide to participate, please complete the enclosed survey. Your return of this survey is implied consent. It will take about 20 minutes to complete. No benefits accrue to you for answering the survey, but your responses will be used to understand some of the issues surrounding CPD in Grenada. Any discomfort or inconvenience to you derives only from the amount of time taken to complete the survey.

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will not be disclosed.

If you decide to participate, you are free to discontinue participation at any time without prejudice.

If you have any questions, there is an information leaflet with this survey. If you have additional questions later, contact me or my supervisor:

Professor Heather Waterman

E mail - watermanH1@cardiff.ac.uk

Jennifer Solomon

E mail - jsolomon@sgu.edu

Thank you for your time.

Sincerely,

Jennifer

Appendix O Interview Protocol

<u>Investigating the issues surrounding continuous professional development *(*CPD) in Grenada</u>

Overall aims

To identify the individual beliefs about CPD

Identify the changes required to propose an effective framework for CPD in Grenada

Research questions

What is Grenadian nurses understanding of CPD?

What are the issues surrounding CPD in Grenada?

The national survey looked at four areas surrounding CPD.

- Motivations for CPD
- Important activities for competence/CPD
- Limiting conditions/barriers – including modality of CPD delivery
- Activities actually undertaken

The rationale for interviewing Grenadian nurses is to build on the survey responses and enhance the knowledge gained from the survey.

To be read out to interviewee, give PIS and Consent forms to read.

To facilitate our note-taking, we would like to audio tape our conversations today. Please sign the consent form before we start. We can answer any questions now or later that you may have.

Essentially, this document states that:

1. *all information will be held confidential*
2. *your participation is voluntary and you may stop at any time if you feel uncomfortable*

You have been selected to speak with us today because you, as a nurse registered in Grenada engage in CPD. Our research project seeks to have a greater understanding of CPD in Grenada and to develop a framework that meets the needs of you. We are trying to learn more about the issues surrounding undertaking CPD, and hopefully learn how best nurses in Grenada can fulfill continuous professional development requirements for registration. We shall be mindful of the time and not go over the agreed hour. Thank you for your participation.

Background and demographics

How long have you working as a nurse? _____

What is your current position and where you work?_____

1. What does CPD mean to you?
2. What do you think about mandated hours of CPD?

Probes

- Effects of CPD
- Who should be responsible for CPD?

Motivation

1. How motivated are you to undertake CPD?
2. What motivates you to take part in CPD activities?
3. How much CPD have you undertaken in the last year and why?

Probes

- Patient safety/staff retention/promotion/empowerment?
- External pressures to undertake CPD activities?
- Concept of self development, specialization and career progression
- Are mandated CPD hours or activities a motivator?

Importance

1. What activities do you think are important for your own professional development?
2. Who should decide what activities are important?

Probes

- Concept of relevance of the CPD
- Planning or forethought of CPD activities

Limiting conditions/Barriers and modality

1. Tell me about some of the barriers or challenges you have when engaging in CPD.
2. What do you see the best way of engaging in CPD ie classroom, online, app?

Probes

- Do you feel able to do anything about these challenges?
- Where is the support from (internal external)?
- Do you see personal or external issues more challenging – (personal includes things like time, access, money. External includes study leave, policy on attendance, and provision of in house opportunities).

Actual activities

1. Tell me about some of the actual activities you have managed to do over the past year.
2. How do you engage and chose activities that are meaningful for you.
3. Can you tell me about some of your CPD activities that stand out for both positive and negative reasons?

Probe

- Is there ever jealously from colleagues regarding your own CPD activities?
- Tell me about how you document these actual activities.

CPD Framework

1. What would a CPD framework look like to you in order to fulfill your professional registration?
2. What if any, mandated courses or activities should be included to make up CPD

Probe

- What could be included in your CPD documentation – portfolio of activities/evidence of change/ reflective notes/ peer and management reviews
- Do you see your CPD forming part of a performance review and personal development planning (career guidance).

Appendix P Domains of Practice Defined by GNC

The General Nursing Council of the respective jurisdictions of the CARICOM Member States was created through legislation and operates under the Nurses and Midwives Act. Its mandate is to regulate the education and practice of nurses and midwives in jurisdiction with the view to ensure protection of the wellbeing and safety of the public.

The Nursing Act is the law that establishes the authority for the Council and sets the regulatory framework for the education and practice of nurses and midwives. The Council, as a self-regulating professional body determines the processes by which it carries out its functions under the legislation/Nurses Act. It serves as the final authority in the interpretation and enforcement of the Nurses and Midwives Act, and is responsible to the respective governments of the region for its proper functioning.

Among its functions are (1) to determines standards for the education and practice of registered nurses,, registered midwives, and ensures that these standards are met; and (2) Sets minimum criteria for registration to practice as a registered nurse. These standards include the registration examination, which allows for the use of the legal title of Registered Nurse (RN) on successful completion of a programme of study in nursing education and passing of the Regional Examination for Nurse Registration

Theoretical Framework

Nursing science is organized in keeping within the following seven domains, which serve as anchors of the nursing profession.

These domains are:

• Nursing Practice

• Professional Conduct

 • Health Promotion and Maintenance of Wellness

• Nursing Leadership and Management

• Communication

• Clinical Decision Making and Intervention

• Professional Development

These domains give rise to the competencies expected of the practitioner in the delivery of nursing care. The competencies are used as standards to assess the extent to which nurses can

function effectively. The nursing role is reflected as pivotal to the health and wellbeing of individuals, families and communities and is therefore the object of testing.

Domain 1: Nursing Practice

Descriptor Refers to the holistic approach and treatment of people as human beings of value and worth and the demonstration of caring behaviours and attitudes by the nurse. It also includes the nurse's ability to undertake nursing care within the framework of informed consent. Nursing care should be evidence based on an appropriate repertoire of skills indicative of safe and effective practice. In addition, the nurse is required to demonstrate knowledge of current health care trends, and a sense of accountability for practice in accordance with health and nursing legislation

Competencies

1. Integrates nursing and health care knowledge, skills and attitudes to provide safe, ethical and effective nursing care.

2. Utilizes the nursing process as the framework for providing safe ethical, and effective nursing care.

3. Practises within national, regional and international legal and regulatory framework for nursing.

4. Demonstrates knowledge of the influence of organizational and societal culture on the provision of health and nursing care.

5. Demonstrates sensitivity and respect for patients' rights, diversity in personal choices, socio-cultural practices and beliefs including religion, sexuality, gender issues in patient and family interactions.

6. Demonstrates caring attitudes and behaviour in delivery of nursing care.

7. Selects valid and reliable assessment tools and techniques to collect required data to inform the delivery of nursing care.

8. Collects data systematically regarding the health and functional status of individuals, families and communities through appropriate interaction, observation, measurement and evaluation.

9. Interprets data accurately to inform the selection of nursing interventions in the delivery of patient care.

10. Establishes priorities of care based on the needs of individuals, families and communities.

11. Demonstrates the safe application of cognitive, affective and psychomotor skills required to meet the needs of patients within current scope of practice.

12. Collaborates with the interdisciplinary health care team, patients, families and significant others, when appropriate, to review and monitor the plan of care.

13. Utilizes health information systems and technology to manage nursing care.

14. Demonstrates scientific rigour in using research to solve problems and address issues in nursing and health care delivery settings.

15. Takes immediate action on actual and potential safety risks to patients, self and/or others.

16. Integrates organizational policies, best-practice guidelines and professional standards in the performance of all nursing roles and functions.

Domain 2: Professional Conduct

Descriptor Relates to the manner in which the nurse demonstrates professionalism, which is in keeping with the Code of Ethics of the International Council of Nurses (ICN) and with national nursing legislation and regulations. These guidelines direct the professional and inter-professional relationships that are established during the scope and functions of nursing practice. It also emphasizes the 14 attitude of the nurse to patient care and the need for each nurse to display a professional manner particularly in challenging situations when interacting with patients and co-workers.

Competencies

1. Delivers safe and competent care through ethical decision making that is consistent with national, regional and international nursing codes of ethics and legislation.

2. Provides nursing care within stipulated scope of practice.

3. Demonstrates respect for the roles and responsibilities of the other members of the health care team.

4. Demonstrates accountability for nursing decisions and actions.

Domain 3: Health Promotion and Maintenance of Wellness

Descriptor Health promotion and health education, disease, and injury prevention across the lifespan are essential elements of entry-level nursing practice at the individual and population levels. Health promotion includes assisting individuals, families, communities, and populations to prepare for and minimize adverse health outcomes and maintain wellness. Health promotion and health education interventions prevent the escalation of diseases and assists with the understanding of the link between health promotion strategies and health outcomes. Collaboration with other health care professionals and populations is necessary to promote healthy behaviours that improve population health.

Competencies

1. Assists the patient to understand the link between health promotion strategies and health outcomes across the life cycle.

2. Utilizes evidence-based practices to guide planning, implementation, monitoring and evaluation of health education and health promotion activities.

3. Assesses health/illness beliefs, values, attitudes, and practices to develop health promotion strategies for delivery of primary health care to individuals, families, and communities.

4. Collaborates with the interdisciplinary health care team and patient to implement intervention plans that incorporate the determinants of health through the use of available resources in the delivery of comprehensive nursing care.

5. Uses an ethical framework to evaluate the impact of social policies on health care, especially for vulnerable individuals, families, communities and populations.

Domain 4: Nursing Leadership and Management

Descriptor Relates to use of leadership skills to adequately carry out management functions in the health care environment. The health care environment includes patient care units in a variety of settings at the institutional or community level. Nursing leadership and management also involves the application of the principles of decision making, problem solving and conflict resolution to facilitate a work environment that is supportive to healthy patient outcomes. Integral to evaluation in nursing management are continuous quality improvement systems along with revision and development of practice policies to enhance patient care.

Competencies

1. Utilizes management theories and leadership styles to carry out the activities of planning, organizing, controlling and evaluating patient care within the clinical work environment.

2. Demonstrates leadership and management skills by adequately delegating responsibilities in planning the activities related to patient care within the clinical work environment.

3. Promotes collaborative practice through the application of the principles of decision making, problem solving and conflict management among the health care team to facilitate the effective operation of the work environment.

4. Manages resources to provide safe, efficient and ethical nursing care.

5. Utilizes the principles of change to respond to the health care environment and nursing practice.

6. Integrates quality improvement principles and activities into nursing practice to promote quality care.

7. Participates in the development, implementation, analysis and evaluation of clinical nursing standards and policies that guide the delivery of care.

8. Participates in providing learning opportunities for nursing students to attain required competencies.

9. Develops long and short-term goals which reflect patients' needs and national priorities for health care.

10. Demonstrates knowledge and awareness of contemporary health issues of national, regional and international significance and the roles of various stakeholder groups/agencies.

11. Assesses the health care and emergency preparedness needs of a defined population.

12. Uses clinical judgement and decision-making skills in providing appropriate and timely nursing care during disasters.

13. Assists with coordination of efforts to build, sustain and improve capacity to respond to disasters

Domain 5: Communication

Descriptor Refers to the processes whereby meanings are assigned and conveyed to others to create shared awareness and understanding of phenomena. It includes the ability to recognize and eliminate barriers, and to utilize appropriate methods of effective communication. Nursing practice utilizes constant communication between the nurse and the patient, the family, communities and the interdisciplinary team. Communication is inherent in the establishment and continuation of the therapeutic nurse–patient relationship to facilitate provision of care.

Competencies

1. Articulates the roles and responsibilities of a professional nurse in fostering therapeutic relationships with individuals and groups in the provision of quality nursing care.

2. Utilizes appropriate communication and interpersonal skills to engage in, develop and disengage from therapeutic relationships with individuals and groups.

3. Utilizes effective communication to influence interpersonal relationships that occur in the context of delivering nursing care.

4. Acknowledges the boundaries of a professional caring relationship by demonstrating appropriate communication and interpersonal relationship skills.

5. Demonstrates sensitivity when interacting with patients, families and communities.

6. Utilizes established protocols to disseminate information related to health care activities

Domain 6: Clinical Decision Making and Intervention

Descriptor Refers to the mental processes of reaching agreement on the selection of courses of actions, their rationales and outcomes. Clinical decision-making is context specific and changes according to patient needs and practice-setting circumstances. Critical thinking is integral to decision-making and includes the activities of organizing assessment information, recognizing patterns and compiling evidence to support the conclusions drawn.

Competencies

1. Utilizes critical thinking skills and professional judgement to inform decision making in the delivery of health care.

2. Incorporates evidence from research, clinical practice and patient preferences to inform clinical decision making.

 3. Applies bio-psychosocial knowledge in the provision of nursing care.

4. Provides information to enable patients to make informed choices and to practice self-care skills.

5. Demonstrates sound clinical decision making based on available information.

6. Evaluates the effectiveness of nursing interventions based on appropriate research findings.

Domain 7: Professional Development

Descriptor Relates to self-appraisal and professional development, as well as reflection on practice, feelings and beliefs and their consequences for nurse/patient relationships and interactions. This also reflects the need for planning for lifelong learning and understanding the value of evidence based findings for competent nursing practice. It ensures that the nurse develops his or her professional practice in accordance with the health needs of the population and the changing patterns of disease and illness.

Competencies

1. Identifies one's own professional development needs by engaging in reflective practice in the context of lifelong learning.

2. Develops a personal development plan which takes into account personal, professional and organizational needs.

3. Takes action to meet identified knowledge and skills deficit likely to affect the delivery of care within the current sphere of practice

4. Maintains membership in professional nursing organizations. Participates in continuing education programmes to keep pace with the changing nursing and health care environment.

Appendix Q Blooms Taxonomy Revised

Creating	**Designing, constructing, planning, producing, inventing, devising, making,** programming, filming, animating, blogging, mixing, re-mixing, wiki-ing, publishing, videocasting, podcasting, directing, broadcasting
Evaluating	**Checking, hypothesizing, critiquing, experimenting, judging texting, detecting, monitoring,** blog commenting, reviewing, posting, moderating, collaborating, networking, refactoring, testing
Analyzing	**Comparing, organizing, deconstructing, attributing, outlining, finding, structuring, integrating,** mashing, linking, validating, reverse engineering, cracking, media clipping
Applying	**Implementing, carrying out, using, executing,** running, loading, playing, operating, hacking, uploading, sharing, editing
Understanding	**Interpreting, Summarizing, Inferring, paraphrasing, classifying, comparing, explaining, exemplifying,** advanced searches, Boolean searches, blog journaling, twittering, categorizing, tagging, commenting, annotating, subscribing
Remembering	**Recognizing, listing, describing, identifying retrieving, naming, locating, finding,** bullet pointing, highlighting, bookmarking, social networking, social bookmarking, favoriting, local bookmarking, searching, googling

https://www.effectiveteaching.com/userfiles/cms/unitFiles/29/GoBe235BloomsTaxonomy.pdf

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