# The Rhetoric and Reality of Continuing Professional Development for Critical Care Nurses:

# A Critical Ethnographic Perspective

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**Abstract**

Current research and evidence into Continuing Professional Development (CPD) has mostly centred on effective delivery formats to engage consumers. The perceptions and approaches that influence an individual engaging in CPD have yet to be explored, particularly in nursing. This qualitative research grounded in critical social constructionism and critical ethnography explores the perceptions and influences for regional intensive care nurses from Victoria, Australia as they engage in CPD. Participants from three field sites participated in semi-structured interviews. Through interviews the major themes of fear and vulnerability, isolation, professional inconsistencies and a myriad of concern for the nursing profession were identified. Threaded throughout each theme was the social influence of workplace upon nurses' perceptions and their approaches toward CPD and the sharing of acquired knowledge amongst colleagues.
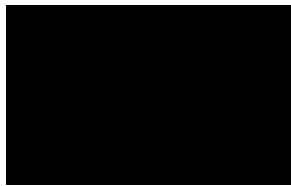
The theoretical perspective of Pierre Bourdieu have been used to explore and discuss the findings of the research through the positions of orthodoxy and heterodoxy. These two positions allow the reality and the rhetoric of mandatory CPD for Australian nurses to be revealed, as shared by the participants. Orthodoxy and heterodoxy bring to light a disconnect between the regulatory body of the Australian Nursing and Midwifery Board (NMBA), and the nurses it registers. Nurses engage in CPD influenced by peers and often as a means of protection or a strategic tool to acquire and hold capital and power. The NMBA mandates CPD for knowledge growth and practice change. The findings reveal that nurses' and the NMBA appear to be playing a game creating a state of illusio, with many nurses looking to mandatory CPD to maintain their employability rather than, public protection. This research highlights the symbolic power of CPD exposing the influences of social culture, habitus and the field in which nurses' practice.

Recommendations of this research suggest that the current model of CPD is fundamentally flawed. Significant changes need to be undertaken to achieve the goal of public protection through a contemporary and knowledgeable workforce.

**Student Declaration**

"I, Joanne Finn, declare that the PhD thesis entitled The Rhetoric and Reality of Continuing Professional Development for Critical Care Nurses: A Critical Ethnographic Perspective is no more than 100,000 words in length including quotes and exclusive of tables, figures, appendices, bibliography, references and footnotes. This thesis contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my own work".

Signature:                          Date:  19th July 2018

# Table of Contents

## Acknowledgements

## List of Abbreviations

| | |
|---|---|
| ACCCN | Australian College of Critical Care Nurses |
| AHPRA | Australian Health Practitioner Regulatory Authority |
| ANCI | Australian Nursing Council Incorporated |
| ANMAC | Australian Nursing and Midwifery Accreditation Council |
| ANMC | Australian Nursing and Midwifery Council |
| ANRAAC | Australian Nurse Registering Authorities Advisory Council |
| CCN | Critical Care Nurse |
| CCRN | Critical Care Registered Nurse |
| CCRNs | Critical Care Registered Nurses |
| CPD | Continuing Professional Development |
| HREC | Human Research Ethics Committee |
| ICN | International Council of Nurses |
| ICU | Intensive Care Unit |
| NMBA | Nursing and Midwifery Board of Australia |
| RN | Registered Nurse |

# Chapter 1

# Introduction

## 1.1  Introduction

The provision of health care carries inherent risks associated with the unpredictability of illness and disease. This is accompanied by a myriad of human elements and adverse events in health care commonly referred to as human error. To help mitigate these risks, health care professionals aim to achieve the highest standard of care possible, based on the evidence of best practice. This evidence is obtained through various forms of research, ongoing learning and contemporary professional development.

The Australian Institute of Health and Welfare (2016) statistics identified that five to nine percent of Australian patients in acute health care settings will be exposed to some form of error. These errors have also been identified in other first world countries. A report of iatrogenic rates of death in the United States of America revealed that 200,000 to 400,000 people die each year from hospital related errors – the equivalent of two jumbo jets crashing each day (Swartz, 2015).

Health care risk can be mitigated to a large extent. Action can be taken to enhance knowledgeable and safe health care professionals that provide care to minimise risk. As nurses, we aspire to provide safe and effective care that leads to positive outcomes for patients. One action that can limit risk to patients, whilst supporting nurses to be contemporary in their practice, is Continuing Professional Development (CPD). It is this aspect of patient safety that is the focus of this research. That is, the contribution of CPD to the provision of safer clinical practice, by Australian Critical Care Registered Nurses (CCRNs).

Australian CCRNs practice in an environment that is complex, challenging and constantly evolving with change. CCRNs, also known as critical care nurses (CCNs) practice in high acuity areas of healthcare that include emergency departments, coronary care and intensive care units. In this doctoral study the

term CCRN and CCN is used to refer to the Registered Nurse (RN) that works within an Intensive Care Unit (ICU). The acuity level of an ICU necessitates nurses having an astute understanding of the current evidence underpinning and influencing advanced practice. The application of a high level of current and advanced knowledge affords CCRNs the opportunity to provide safe and effective care for those patients whose condition can deteriorate or change within a short period of time. Changes in practice and the maintenance of a safe health care environment are dependent on the quality and currency of knowledge, skills, capabilities and capacities of all team members, including CCNs. The scope and role of the CCRN is addressed later in this chapter in section 1.4.

Most adults have the capacity to question the care provided by the RN. A critically ill patient often cannot. The critically ill patient is usually physiologically and emotionally overwhelmed as a consequence of their illness and the associated uncertainty of what lies ahead (Van Scoy, Chiarolanzio, Kim, & Heyland, 2017). The critically ill patient and their families find themselves located in an environment that is foreign and surrounded by life preserving equipment. Machines, cables and wires are connected to the patient at various anatomical sites. Lines and tubes are inserted into the body and connected to more tubing. This creates a situation that often leaves both patients and their families feeling overwhelmed, anxious and frightened.

In this environment, the CCRN becomes a constant (Le May et al., 2016). The nurse and the family often develop a unique rapport over a short and intense period of time. This relationship becomes integral to the emotional experience of the patient and family during this period. The family often view the CCRN as the expert, placing their trust in the CCRN that the best decisions and actions are being made (Van Scoy et al., 2017).

In ICUs throughout Australia and around the world, patients are vulnerable because of their fragile health status (McKinley, Nagy, Stein-Parbury, Bramwell, & Hudson, 2002). The CCRN provides care influenced by decisions made in the belief that their actions will have a direct and positive impact on the patient's progress. This level of patient vulnerability requires that the CCRN remains conversant of contemporary evidence and practice (Hov, Hedelin, & Athlin,

2007). To remain well informed of changing practice, the CCRN must engage in CPD that builds knowledge and skills. These skills and knowledge can be embedded in the care they deliver to patients in the ICU.

CPD is not only a requirement for Australian CCRNs. All RNs in Australia are required to undertake CPD as a mandatory element of their registration with the Nursing and Midwifery Board of Australia (NMBA) (Nursing and Midwifery Board of Australia, 2016g). The NMBA acts to provide public protection. Public protection is authorised and addressed through the monitoring and control of Australian nurses' registration. To achieve this, the NMBA insists that all RNs engage in a minimum of twenty hours of CPD on an annual basis. In doing so the NMBA advises nurses that their focus should be to maintain, improve and broaden their professional knowledge, expertise and competence, facilitating the delivery of safe, effective and competent care (Nursing and Midwifery Board of Australia, 2016d).

CPD is a mandatory requirement for all nurses accommodating a broad range of learning contexts and content. It is common for nurses to engage in CPD during their day-to-day interactions with other health care professionals. The sharing of knowledge through conversations, peer teaching, medical and nursing rounds, journal articles and best practice literature is common practice in the ICU environment (Chaboyer & Blake, 2008; Magat, Ewashen, Wu, & Sun, 2017). However, it may be that many nurses fail to appreciate the professional development aspects of these interactions as many occur spontaneously at the bedside. Monitoring and listing these interactions and recording them as CPD can be troublesome as nurses tend to focus more on formal offerings of CPD.

The current NMBA guidelines for CPD allow nurses to engage in a range of education opportunities from meetings, professional literature, and in-services through to formal courses offered at universities (Nursing and Midwifery Board of Australia, 2014). A nurse determines his/her own CPD activities guided by the necessity of achieving a minimum of twenty hours annually and these relate to the current role of the nurse. This may include the institutional employment related competencies which are undertaken on an annual basis to maintain the standards for that institution (Nursing and Midwifery Board of Australia, 2014, 2016d). Some

researchers (Alberta, Mildred, Etifit, Mgbekem, & Oyira, 2013; Morgan, Cillinane, & Pye, 2008) would argue, this researcher included, that the health care institutional competency requirements are not necessary contributors to a nurse's knowledge. A health care mandatory accreditation is formulated to meet the accreditation standards of the facility, not the educational needs of staff. The use of activities that do not produce new knowledge hinders the NMBA's ability to facilitate a contemporary workforce that continually expands, extends and improves discipline specific knowledge and practice.

Mandatory CPD is not unique to nursing and is used broadly across professional groupings. Notably though are wide variations in the expectations and requirements of each profession such as medicine, physiotherapy, law, social work and accounting to name a few (Fleet et al., 2008; Medical Board of Australia, 2016; Physiotherapy Board of Australia, 2010). Common to all health care professions is the CPD proclamation about public safety through contemporary and current knowledge, evidence and practice (Australian Association of Social Workers, 2015; Physiotherapy Board of Australia, 2010; The Royal Australasian College of Surgeons, 2010).

All health professionals registered under the Australian Health Practitioner Registration Authority (AHPRA) are required to engage in CPD by virtue of the Australian Health Practitioner Legislation (State Government of Victoria, 2009). The expectations surrounding CPD are determined by the registering body for each individual discipline. The approach and standard for Australian nurses is determined by the NMBA. The NMBA, like other health professions, trusts in the premise that CPD builds new knowledge (Australian Nursing and Midwifery Council, 2007). It is this assumption that is used to advise the public, that it has been endowed to protect, that Australian nurses are knowledgeable, competent and able to keep the public safe. The notion that all nurses engage in CPD that yields knowledge that can be applied to their practice area lacks substantive evidence. This proposition tends to be idealistic and is divorced from many of the realities of practice. Thus, my thesis statement is: *That CPD should build new or extended knowledge to apply to practice as a way to enhance patient safety. The current model of CPD for RNs in Australia falls well short of this intent.*

## 1.2 Phenomena of interest

On the 1st of July 2010, the NMBA implemented a mandatory competency-based framework. This framework defined the standards that all nurses would need to adhere to, to renew their practice registration. The objective of the adopted framework is to provide a nursing workforce equipped to protect the public from harm during the provision of care (Australian Nursing and Midwifery Council, 2009). A core element of this framework is mandatory annual CPD.

The continuing competency framework incorporated CPD that was influenced and built around reflective practice. The expectation is that after engaging in reflection on practice and performance the RN will formulate personalised learning objectives, specific to their area of practice and identified need (Australian Health Practitioner Regulatory Authority, 2011; Australian Nursing and Midwifery Council, 2007, 2009). The RN then uses the identified needs and personal objectives to direct their future CPD activities. All nurses must undertake this process annually and complete a minimum of twenty hours of CPD to remain compliant with the regulatory board's mandate.

Nurses are encouraged to undertake personal reflection and engage with peers and managers for feedback and guidance to promote a greater focus on learning. This position is justified by the NMBA (Nursing and Midwifery Board of Australia, 2016d) stating that evidence suggests practice can be enhanced, and learning outcomes improved, when RNs engage others in the planning of their learning. It is unclear however what 'evidence' is being referred to in the NMBA statement: perhaps it is anecdotal. Nevertheless, it seems reasonable that peer feedback has the potential to identify learning needs that directly targets aspects of care provision that can be expanded, extended, or updated. These approaches to mandatory CPD assist the NMBA, as a publicly endorsed self-regulatory body, to meet its responsibility and raison d'être of public protection (Australian Nursing and Midwifery Council, 2006, 2007, 2009; Nursing and Midwifery Board of Australia, 2010b).

Literature on CPD identifies and supports some of the best strategies to engage individuals in CPD activities. This literature tended to promote effective delivery

formats and ways to minimise key barriers, especially for regional and rural health care practitioners, which are often noted to otherwise restrict engagement in CPD activities. The literature appears to be quite shallow in regard to the use of CPD knowledge with articles suggesting this is an area to be explored further. One key limitation is the absence of any relationship between the CPD mandate and its ability to achieve protection of the general public. Another limitation is whether CPD impacts the quality of practice of health care professionals and patient safety.

## 1.3   From eight regulatory bodies to one

Prior to June 2010 Australian nurse registration operated under eight independent bodies in respective states and territories. The movement from eight separate registration bodies to one national body began in 2008. This arose in response to a need to provide the Australian public with nurses that had uniform quality and standards.  The transition was supervised by what is now known as the Australian Nursing and Midwifery Accreditation Council (ANMAC) (Australian Nursing and Midwifery Council, 2007, 2009; Carrigan, 2008).

Prior to its current role and direction, ANMAC was known as the Australian Nursing Midwifery Council (ANMC). The ANMC was the peak professional body representing the nursing profession in Australia. The ANMC role and scope centred on setting professional standards and responding to concerns of the profession (Australian Nursing and Midwifery Council, 2007). At that time, it was not a registering or accrediting body of curriculum as it is today. It was a professional body functioning independently from registering authorities and unions. The ANMC developed the 'continuing competency' framework with the intent to provide 'protection to the public' (Australian Nursing and Midwifery Council, 2007, 2009). This framework became embedded across the registration standards of the newly formed NMBA (Australian Nursing and Midwifery Council, 2006, 2007, 2009; Carrigan, 2008).

The continuing competence framework proposed three elements under a professional portfolio umbrella (Australian Nursing and Midwifery Council, 2009).

1. The nurse is required to undertake an annual self-assessment of their performance to declare themselves competent for practice.
2. This is supported by a declaration that a nurse has undertaken a minimum of twenty hours of CPD annually.
3. The final requirement is that the nurse can demonstrate recency of practice.

These three elements embraced the principles of professionalism and determine a nurse's ability to maintain their registration and continue employment as a RN (Australian Nursing and Midwifery Council, 2009).

Whilst mandatory CPD requirements are found across many other health care disciplines there are significant differences. In the discipline of nursing, for example, CPD is any activity in which a nurse claims that learning occurred (Nursing and Midwifery Board of Australia, 2016d). In other words, it is a self-reporting format. Medicine, however, has taken a more defined approach to activities that it deems acceptable as CPD based on evidence or the ability to establish the benefits. For example, journal reading is not accepted as CPD in medicine on the basis that there is an inability to prove the benefits or learning outcomes (Medical Board of Australia, 2010).

The discipline of social work (Australian Association of Social Workers, 2015) has applied strict standards to its members. Each year a social worker is mandated to undertake a minimum of thirty hours of CPD. At least ten hours each year must be undertaken as supervised sessions. Supervisors are required to meet strict standards and provide direction and feedback on practice, learning and CPD planning. An additional fifteen hours must be focused on knowledge and skills acquisition related to the role of the social worker. The remaining five hours must address professional identity with a focus on self-concepts of attributes, beliefs, values, motives and experiences. This robust structure must be adhered to with written evidence provided to the association upon renewal of membership (Australian Association of Social Workers, 2015). Comparatively the discipline of nursing's approach is significantly more relaxed and consequently risks criticism.

The original document proposed by the ANMC stated that "participation in mandatory continuing education, such as Basic Life Support training or manual handling, should not be counted as CPD **unless** active learning of new knowledge or skills has taken place" [*sic]* (Australian Nursing and Midwifery Council, 2009, p. 8). Despite this strong stand in the *frequently asked questions* released in May of 2010 and as recently as June 2016 the NMBA advised that mandatory in-services such as fire training and basic life support were acceptable forms of CPD, if the RN may be required to perform the tasks in their role (Nursing and Midwifery Board of Australia, 2010a, 2014, 2016d). This movement from 'knowledge acquisition' to potential 'responsibilities of employment' allows nurses to claim employer mandated competencies as forms of CPD. In these circumstances, whether this improves the practice of the RN or enhances patient outcomes and safety is not taken into consideration. Effectively this shifts the focus of CPD to serve the accreditation standards and requirements of health care institutions which moves the focus away from patient outcomes and safety. It is this slippage that causes some disquiet on closer inspection and was the genesis for this research.

Under the NMBA criteria of CPD activities, nurses working in critical care areas may complete their mandated CPD requirement using their employer hospital expectations. Each year CCNs are required to demonstrate a variety of hospital competencies such as advanced life support, basic life support, manual handling, pacing, hand hygiene, occupational health and safety training, fire training, patient service and a variety of other competencies related to their practice and employment role. These competencies are mandated by the hospital to ensure they remain compliant with external accreditation standards that permit the health care institution to operate. To count these activities as CPD the RN is required to demonstrate learning at some level. Whilst undeniably important, these activities rarely produce *new* learning to the experienced nurse, which was the original expectation of the nursing disciplines governing body. Annual competencies are not what the ANMC intended as the source of CPD. The ANMC (Australian Nursing and Midwifery Council, 2007, 2009) intended that the professional nurse would engage in CPD that builds *new* knowledge and *improves* practice and patient care, *validating* nurses as socially accountable.

The implemented framework for CPD requires nurses to reflectively identify their learning needs and then direct their CPD toward addressing the learning objectives. This requirement is contingent upon two factors. First, an awareness of this expectation; and second the knowledge of what reflective practice is, accompanied by the skills to carry it out effectively. While nurses promote themselves as reflective practitioners, caution must be used, as not all nurses understand or engage in this practice. Aastrup Rømer (2003) shared a global hope for nursing to embrace CPD that intertwines practice and knowledge, thus allowing more socially accountable care to be provided. This was accompanied with a warning that success can only occur if nurses understand reflective practice and are open to the process (Aastrup Rømer, 2003).

For reflective practice to be effective the individual must be open to self-exploration and capable of personal critique. This transparency is rarely an easy task and often underestimated.  In applying a process of self-inquiry, deficits and areas for refinement need to be identified (Ekebergh, 2007). The most difficult element of reflective practice is identifying the unknown. After all, how can we identify something that we ourselves do not know? This is why it is suggested by the NMBA that nurses engage others in their evaluations and reflections (Nursing and Midwifery Board of Australia, 2016d). But do nurses engage others in their decisions related to what CPD focus will enhance their practice most? If so how? If not, why not? How do nurses select their CPD activities? What influences impact their decisions? It is these facets that are explored in this research.

The unpredictability of patient conditions and adverse events results in nurses facing situations that may not be the average day-to-day activities. This is especially so in ICUs.  Nurses in regional ICUs often practice with a different support mechanism than their metropolitan counterparts. Metropolitan ICUs are often larger and thus have a larger staffing cohort, both nursing and medical. Metropolitan nurses see patients with higher acuity on a more regular basis coupled with greater variety in speciality resources. These disparities in support structures and frequency of exposure to events may contribute to the challenging work environment for the regional CCRN (Gilligan, Reiley, Pearce, & Taylor, 2017; Iwashyna & Kahn, 2014).

Imagine that you have had a heart attack and are admitted to a hospital over 300km from a capital city. A regional ICU is equipped to manage patients with short-term medical support. They do not have the appropriate equipment to provide you with surgical interventions. Your recovery may be as expected, or you may unexpectedly become critically ill and require a transfer to a higher acuity hospital for more advanced support. The transfer process takes thirty to sixty minutes to organise and at least three hours to occur. During this time, you are cared for by nurses that are knowledgeable and competent in providing care. However, they do not care for patients this critical on a regular basis. Your health outcome is dependent to a large extent on the nurses' and medical professionals' currency in knowledge and best practice. In my view the level of engagement in CPD is a major contributor to the care you receive and your outcome.

Regional CCRNs are at greater risk of challenges related to their geographical location. This often results in the necessity of an increased investment of time and money to attend formal education opportunities. A regional CCRN's workplace usually has smaller staff numbers with fewer employee resources, such as education departments. These smaller staff bases make it much harder to gain time off to attend training as the flexibility of shifts and staff skill mix afforded their metropolitan counterparts is simply not available (Riley & Schmidt, 2016). In addition, regional CCRNs faced the added burdens of distance, time away from home, travel, accommodation and other related costs. So how do CCRNs in regional areas approach their CPD and what processes direct their choices? In what ways do their CPD choices generate new knowledge or reflect the needs of the employers? To what extent, are CPD choices embedded in the practicalities of maintaining their registration which has a flow-on effect on job security and related income? These issues are explored in this research.

## 1.4   Standards of CPD and practice in the nursing profession

The NMBA (Nursing and Midwifery Board of Australia, 2016d) promotes CPD as a means for nurses to demonstrate their competence to practice. The term 'competency' is seen and used in nursing bodies and nurses on a frequent basis. The NMBA, the regulatory body, uses measurable, competency-based standards when discussing CPD. The Australia College of Critical Care Nurses (ACCCN),

as the peak representation body of the CCRN, uses competency to define standards of practice (Australian College of Critical Care Nurses, 2015) but holds no regulatory or speciality registry function with membership purely voluntary. The AHPRA, monitor the fifteen health disciplines within Australia. The AHPRA requires CPD as a competency standard for each discipline, although the criteria of this standard vary across disciplines as previously highlighted. Thus, the concept of competency is worth attention here because of its inclusiveness across disciplines as a standard.

As stated previously, the raison d'être of the NMBA is to protect the public (Australian Nursing and Midwifery Council, 2009). The NMBA does not stand alone in its intent to provide the public with protection. The International Council of Nurses (ICN) represents the global nursing profession. It shares the aim of public protection through the advancement of nursing knowledge and a competent workforce (International Council of Nurses, 2011).

The introduction of formal competency standards for nurses and midwives in Australia occurred in 1990, by the then named Australian Nurse Registering Authorities Advisory Council (ANRAAC). In 1992 ANRAAC morphed into the Australian Nursing Council Incorporated (ANCI), resulting in a title change of standards to the ANCI standards for professional practice. ANCI then transformed into the ANMC with a renaming of standards to the ANMC competency standards (Chiarella, Thoms, Lau, & McInnes, 2008). The standards are now reviewed and monitored by the NMBA and in 2016 underwent the latest review and name change to the Registered Nurse Standards for Practice (Nursing and Midwifery Board of Australia, 2016e).

Irrespective of the professional body and name/title changes all have shared a common theme: setting the expectation of practice and providing uniformity across Australian nurses caring for the public  (Australian Nursing and Midwifery Council, 2006, 2007). A quarter of a century after their introduction, the standards today are broad principle-based statements set to accommodate the range of clinical settings in which nurses' practice. Nurses are directed to use these standards for their self-assessment and reflection to identify learning

opportunities and guide the choice of CPD activities (Nursing and Midwifery Board of Australia, 2016e).

The development of standards has not been limited to the NMBA. Specialist nursing organisations have developed competency standards specific to their area of practice. The development of specialist competency standards began in Australia in the mid 1990s with a view to credentialing specialist nurses (Chiarella et al., 2008). The NMBA, in 2016, stated that following an international investigation into specialist standards of nurses, it's position remained that the current system provided with appropriate level of public protection while maintaining a dynamic, responsive and flexible workforce (Nursing and Midwifery Board of Australia, 2016b).

The NMBA acknowledges that speciality nursing groups have developed processes for recognising their specialisation, stating that these *may be* recognised by the wider health care industry and employers. The NMBA believes that the processes put into place by specialist groups, such as the ACCCN, are sufficient to acknowledge specialisation of practice in Australia (Nursing and Midwifery Board of Australia, 2016b). The NMBA defends its position to reject credentialing. Explaining that while there may be international recognition and credentialing of specialities there is no evidence that this had reduced the risk to the public. The NMBA also reports a lack of sufficient evidence that proves that patient outcomes are improved through regulation of speciality practice (Nursing and Midwifery Board of Australia, 2016b).

Competency standards for specialist CCRNs were introduced in 1992 in acknowledgement of the speciality status of nurses practicing in this area. These standards were built upon the Registered Nurse Standards for Practice, designed to address the nurse working in a critical care environment and offering an extension of the level of competency required (Australian College of Critical Care Nurses, 2002, 2015; Dunn et al., 2000; Fisher, Marshall, & Kendrick, 2005).

An earlier definition of a specialist is an individual highly skilled in a specific field or subject (Stevenson & Waite, 2011). The ACCCN more recently defines the scope of standards for the CCRN, a nurse working in a specialist field with

specialist knowledge. The definition of a CCRN provided by the ACCCN (Australian College of Critical Care Nurses, 2015) is important as it outlines the requirements a nurse must meet to be called a specialist. The ACCCN defines a CCN as a RN who provides competent and holistic care to the critically ill patient through application of an advanced level of knowledge skills and humanistic values. Under this definition a CCRN holds advanced skills in problem solving and communication and incorporates these skills in effective management of the complex patient in a critical care environment. The CCRN uses ethical and legal frameworks to advocate where appropriate for patients and demonstrates accountability for their actions. Working in a critical care environment the CCRN promotes teamwork and collaboration, demonstrating leadership and role modelling. The CCRN specialist contributes to the advancement of practice through professional activities including the development of self and colleagues through promotion of evidence-based practice (Australian College of Critical Care Nurses, 2015).

It is an expectation of AHPRA and state legislation that all advanced and specialised practitioners perform at a higher level. A CCRN who fails to meet the specialist competency standards would be deemed unsafe and face disciplinary action with AHPRA (Australian Health Practitioner Regulatory Authority, 2011). Therefore, the fact that the NMBA has refused to endorse specialised standards may be perceived as creating confusion. It sets a 'one-size-fits-all' approach to standards, regardless of whether a RN is in their first or tenth year of practice. There is also the issue that voluntary membership of ACCCN for CCRN means there may well be substantial discrepancy between members and non-members.

The Registered Nurse Standards for Practice are endorsed as the standard for all RNs by the NMBA (Nursing and Midwifery Board of Australia, 2016e). These have been written with a focus on the performance requirements of a newly graduated nurse entering the practice arena for the first time. At this point the new RN has completed a minimum of 800 hours in a range of clinical settings during their entry education, Bachelors degree. The standards are further used to assess nurses educated internationally and those returning to practice after a period of absence (Nursing and Midwifery Board of Australia, 2016e).

The NMBA stipulates that all nurses, regardless of their speciality and context of practice, must meet the Registered Nurse Standards for Practice. The NMBA further explains that speciality standards, while reflective of the NMBA standards, do not replace the standards developed to address the beginning practitioner; and the nurse, regardless of experience, must address and utilise the NMBA standards when practicing (Nursing and Midwifery Board of Australia, 2016c, 2016e). Again, this decision to set a minimum standard for all nurses, regardless of expertise and period of practice, holds the possibility of creating confusion among nurses as to what standard the NMBA requires. Does the experienced nurse of ten years really have to meet the same level of performance as a newly RN?

With mixed messages and inconsistency across nursing bodies there is a risk that nurses may become confused and unsure about which standards they are to apply to their professional practice. With variable standards, inconsistent reflective self-assessment and CPD planning the risk increases that the current CPD model will fail to achieve the intended purpose of public protection. As a CCRN which standard do I assess myself against? Which standard and level of competency do my colleagues assess me against? This question, although not a specific of focus of this research, requires further clarification.

Understandably, the public has a right to expect that nurses are both professional and competent practitioners. The profession of nursing habitually assigns the word 'competence' in their documents for CPD and continuing practice. As recently as June 2016, the use of the term 'competence' has been removed from the standards for practice. The NMBA has claimed that confusion existed around the use of competency-based assessment in the vocational sector and competency in other settings (Nursing and Midwifery Board of Australia, 2016c). This confusion may be attributed to the elusive nature and inability to apply a universal definition to the term 'competence'.

Despite the absence of an agreed understanding of competence and multiple views the term 'competence' remains heavily embedded across nursing and the nursing profession (Watson, Stimpson, Topping, & Porock, 2002). With such varying views about what defines competence among nurses there is an

associated risk to the self-assessment that underpins the CPD mandate. An individual's perspective of competence compared to their peers may differ significantly. Some individuals will undertake a self-assessment or peer assessment in a critical fashion that magnifies flaws. Others may use rose-coloured glasses and fail to see inabilities or areas of improvement required. A few nurses may see themselves and others as they are. But this lack of uniformity complicates the ability of nurses to approach CPD in a consistent fashion.

Historically, nursing competency was determined by the ability to safely carry out tasks and failed to assess any associated knowledge. Today, definitions of competency include both knowledge and skills (Allen et al., 2008). With many definitions available core components of competency centre on the combination of knowledge and skills with ability and behaviours that allows an individual to perform a task skilfully and accurately (Allen et al., 2008; Axley, 2008; Cowan, Norman, & Coopamah, 2005; Dunn et al., 2000; Robb, Fleming, & Dietert, 2002).

Definitions of competence are subject to multiple influences and interpretations. A health care institution is likely to view competence from the level of service with minimised associated expenditure. The regulatory bodies of health care professions are more focused on the provision of care and perceptions of the general public (Eraut, 1998). It is the variances of invested interests that contribute to ambiguity in defining competence. This then has the potential to influence variances in competency levels of nurses. Saying that a practitioner is a competent nurse is a general statement. It does not imply his or her ability to function effectively in a specialist environment with the requisite specialist skills, such as an ICU requires. The social perception of 'qualified' is often used synonymously with 'competent'. Professions view qualifications as a *rite de passage* resulting in community assumption that those that are qualified are competent (Eraut, 1998): an assumption that professional bodies such as the NMBA and nurses risk making at their own peril.

'Competency' as a concept leads to a more refined interpretation when discussed as a scale (Benner, 1984). An individual may be competent, but this does not indicate they have reached the pinnacle of practice. Benner proposes that with further experience and exposure, the individual ideally moves to being more of a

holistic practitioner. Thus, they are able to manage the complex situations common in nursing. Therefore, *competence* should be used to discuss an individual who is safe but lacks expertise. Whereas, *competent* practitioner should be reserved for those traditionally working in the same area for multiple years before achieving expertise (Benner, 1984).

Whilst some nurses embrace Patricia Benner's scholarly work; others believe that we have moved on to fuller understandings and interpretations. Benner's theory, however, does present an opportunity for nurses to embrace movement along a spectrum of novice to expert (Benner, 1984).

This concept of novice to expert is important when considering the maintenance of competence for a CCRN, working in an area with rapid advances in evidence, practice and technology. The CCRN is regularly perceived as an expert in providing health care. Yet this is true only in their area of practice. If you were to take the highly competent CCRN, regularly providing care to optimise haemodynamic management with invasive organ support, and place them in an emergency department, the nurse would move from the expert position to competent. Of course, the nurse still brings advanced skills to their actions, most of which can be applied to patient care. But, the environments are considerably different. There would be areas of support and guidance that the CCRN would need to seek. Working a triage desk, for example, is vastly different from attending a code (emergency) situation or reviewing a patient on a ward.

Movement along the continuum is not limited to moving the nurse to a new environment. The nurse also moves along the continuum as new practices are introduced and the presentation of patients with different and/or coexisting health care problems. Health care changes at a rapid rate. What was gold standard in cardiac care one to two years ago is now replaced with new practice, because of recent evidence, advancing knowledge and more sophisticated technology. As the CCRN is exposed to changes they move along the continuum in a forward and backward fashion. This movement, forward and backwards, becomes the catalyst for CPD activities and should be embraced and used to drive CPD among nurses.

## 1.5 Experiential knowing

Experiential learning contributes greatly to the knowledge base of a nurse. Many nurses engage in further study to enhance their knowledge and coupled with experience their knowledge becomes embedded within their practice. These foundational elements of learning, formal courses and degrees, are simply the beginning of a nurse's learning with a need for continued CPD (Allen et al., 2008).

The CCRN engages in learning in many ways, often without realising it. The constant exposure to colleagues and peer teaching and sharing of information is invaluable to advancing practice and fostering knowledge growth. This privilege of experiential learning should be embraced by the CCRN. As expertise develops over time, individuals become more adept at dealing with situations and events. This is what is commonly referred to as 'situated knowledge needs'. It is situated knowledge that is obtained through experience and not found within formal qualifications (Eraut, 1994, 1998; Kolb, 1984). It is an essential component of competency within the role of the nurse.

When situational knowledge is accessible, such as when the nurse seeks support from a peer, sharing of knowledge and learning occurs. Whilst this may not be perceived as formal or evidence-based, this experience and knowledge can yield areas that researchers are yet to investigate. To share information at this level requires a high degree of mutual trust amongst peers (Eraut, 1998), which may be a challenge in its own right. Often this level of trust is given cautiously and in small groups.

Competence may be thought of as related to formal knowledge. There is movement to accept informal and tacit knowledge when assessing job performance. Care however needs to be taken so as to not confuse expertise that results from years of experience with simple seniority (Eraut, 1998). Research into competency has occurred since the early 1970s, in particular in the field of psychology. Eraut (1998) referenced this work and highlighted the need to determine between those that are successful at their job and those that simply do their job well enough to avoid concerns.

Nursing as a profession also needs to be cautious toward the CPD activities that nurses select. Jones (2002) presented a concern that nursing places an enormous emphasis on new knowledge and greater professional aspects that lead to career development and role expansion, rather than improving the quality of current performance and moving to expert practitioner status. This concern is important when considering the approaches and adoptions of CPD that nurses are undertaking, and the rationales attributed to their choices. There is a risk that nurses will engage in CPD to advance their career and that there will be little benefit for patients.

## 1.6   Criticism of CPD

Undertaking CPD does not guarantee a change in practice (Allen et al., 2008; Jordan, Orison, & Stack, 2008). It is acknowledged in the literature that CPD activities often result in limited implementation and have little effect on everyday clinical practice (Allen et al., 2008; Jordan et al., 2008). There is also a significant deficit in evidence that supports the effectiveness of CPD on practice change and patient outcomes. Moreover, the overall impact of CPD is said to be vague with research around CPD yielding negative instead of positive results related to practice change (Allen et al., 2008).

The NMBA direct their actions toward protection of the public and managing the standards by which nurses are eligible for registration (Australian Health Practitioner Regulatory Authority, 2017). For this to occur, mandatory CPD is one aspect of bar-setting the standards. Nurses must engage in CPD knowledge acquisition that builds new practice and decreases adverse events for patients. To date there is no evidence that this occurs under the current structure. The profession of nursing has such a wide scope for CPD activities that there is a need to understand how nurses select their CPD activities. This will then enhance decisions made by RNs and regulatory bodies with regard to the suitability, relevance, and effectiveness of the current model. In this context, does mandatory CPD, in its current form, meet its purpose and offer value as a protector of public safety?

## 1.7 The problem

Despite the introduction of mandatory CPD for all Australian nurses, there is limited understanding of how nursing professionals approach their CPD and their motivations (Banning & Stafford, 2008). The Australian public are reassured by the NMBA that they are safe, as its registrants engage in CPD on an annual basis. Yet we do not know what it is that nurses actually do with regards to CPD activities, for it is a box that is checked or left unchecked on the annual registration form. Nor do we know what effect this will have on their practice.

The NMBA have presented a model of CPD that seemingly presents few limitations for what nurses might choose as their CPD activities each year. Thus the guidelines (Nursing and Midwifery Board of Australia, 2016d) are at best vague. This is coupled with a monitoring system based on self-reporting and random audits (Australian Nursing and Midwifery Council, 2009). This increases the potential for exploitation of the intent of mandatory CPD, including public safety. The system put into place by the nursing regulatory body on the surface appears to be compliant and aligned with other care professionals. However, a simple comparison reveals striking inconsistencies and differences.

With such differences between health care disciplines, how does the profession of nursing present itself? Over many decades, the nursing discipline has struggled to be considered a profession (Ballou, 2000; Chaperon, 2010; McKinnon, 1999). The perspective of being a profession must be both earned and protected with evidence of its value, contribution, capabilities, and a willingness to be held to a high standard of accountability. No nurse likes to be thought of as 'just a nurse' or the 'doctor's handmaiden'. The professional regulatory body of the NMBA has a duty to protect the profession's standing by setting appropriate standards and accountability processes. It is well worth considering who represents nurses.

Nurses working in a critical care environment, such as ICUs, regardless of geographical location, care for the sickest patients in the hospital. In their role, the CCRN is regularly required to implement complex care strategies underpinned by contemporary knowledge and evidence. This can only occur

when nurses are current in evidence and equipped with knowledge to provide safe care in the critical care environment. Ongoing education in the form of CPD coupled with sharing of knowledge amongst colleagues and peers provides an avenue for this to occur. CPD and collegial sharing of knowledge also stimulates thinking and questioning, which in turn drives changes to practice and promotes better patient outcomes.

Nurses in hospitals and ICUs are exposed to countless employee competencies along with small in-service sessions designed to benefit institutional accreditation and productivity levels. Sporadically they offer opportunities to gain new knowledge. Under the current NMBA framework for CPD, the CCRN can count these annual repetitive occurrences and in-services as CPD, despite the limited impact or change they bring to practice. The profession of nursing has a responsibility to demonstrate and advance both knowledge and performance. Therefore, there is a need to identify the perceptions and approaches of the CCRN toward CPD. In doing so it becomes possible to identify if their approaches promote the intention of the NMBA, the reality of protecting the public, or presents the NMBA mandate as rhetoric.

## 1.8   Significance of the research

This focus of this research is significant in that it allows the profession of nursing to step forward and examine some of the core structures of the regulatory bodies. This focus seeks to question and reflect upon some of the regulatory criteria set down by these governing bodies to see whether they are of significant calibre, useful to the profession, driven by best practice and efficacious to good patient care. CPD is often looked at from a business perspective or a regulatory board means of protection. In highlighting the perceptions and approaches toward CPD among regional CCRNs it is possible to identify trends and patterns. Thus, we can then elucidate the perceptions regarding CPD, and the key influential elements in nurses' choices and behaviours. In addition, the research integrates the social implications of the nurse and the social structures of influence in which they practice.

To date there appears to be a lack of exploration of the perceptions and approaches of the Australian RN toward the mandated CPD of the NMBA. Internationally research into this perspective is also limited. Comparing nurses' experiences and accounts with the purpose of the NMBA will assist in understanding the approaches of the CCRN in response to the NMBA mandate. Do the two match or is there discrepancy? If so, why does this occur? This research shares the perceptions of nurses toward CPD. In addition, it illuminates what influences a nurse's choices to engage with CPD and the influences that impact their decisions to share or withhold their learning from peers and colleagues. The focus on this by the research question aims to bring the nurse to the foreground and identify the underlying influences that guide a nurses' engagement or disengagement with CPD.

The research aims to explore the reality that nurses create in their approaches to CPD. The implementation of mandatory CPD is still relatively new in the Australian nursing profession. Thus, it is imperative to explain how nurses have perceived and responded to the mandate. It is critical to identify if the NMBA and nurses have a shared understanding and meaning of what CPD is and how it should be managed.

Nurses who work in regional ICUs hold similar postgraduate qualifications to their counterparts in metropolitan hospitals. In Victoria, eight regional critical care units are categorised as Level II. A Level II ICU is capable of providing care for critically ill patients requiring complex multi-system life support, including mechanical ventilation, invasive monitoring and extracorporeal support systems (College of Intensive Care Medicine of Australia and New Zealand, 2011). These patients require high-level care and the CCRN has a professional responsibility to ensure they have maintained an appropriate level of current knowledge and skills. This can be achieved using diverse approaches to CPD that can then directly benefit a wide variety of patient needs. In focusing on the practices of these nurses we bring the nurse to the foreground of the discussion of CPD and the intended public protection.

## 1.9   The research

The research is underpinned by the philosophy of social constructionism. Social constructionism acknowledges that all reality is socially constructed from the experiences and intricacies that ground and influence the way the world is seen (Holstein & Gubrium, 2008). Social constructionism allows for an emphasis on the contingent nature of social activity. People constantly make choices based upon their understanding of the alternatives with a need to account for their decisions. This creates opportunities and constraints as to what preferences they may have and to the choices they make. These preferences are rapidly lost from sight and become taken-for-granted assumptions as the world emerges and evolves. A social constructionist stance allows the penetration of assumptions to recognise and study processes (Holstein & Gubrium, 2008).

The meaning given is said to arise in and out of interactivity with the community and guided by the ritual position of things to each other (Holstein & Gubrium, 2008). The social structures that influence this research are considerable and range from the broad structures of the NMBA and the nursing profession, to smaller and often more powerful structures at the local setting. I have sought to explore the perceptions and approaches of CCNs toward CPD through a critical ethnographic methodology. Cultural influences are acknowledged for their direct impact upon function and behaviour, thus allowing the experience to be understood. Critical ethnography explores the interrelatedness between structures and agency to consider the path to empowerment of the researched (Atkinson, Delamont, Lofland, Lofland, & Coffey, 2007), in this case the nursing profession.

The aim of the research was to reveal what nurses think about CPD and what influences their selection of CPD activities. This knowledge may then be used to enhance the profession of nursing. The key questions addressed in the research were: what do CCNs understand about CPD?; how do CCNs approach CPD?; and what influenced the CCN's decision to engage with and the degree of investment in CPD?

## 1.10 The researcher

As a RN for the past nineteen years, I have spent eighteen years working in intensive care, caring for neonates and adult patients. The chosen research area felt like a natural space in which to conduct my research and contribute to the profession. As a CCRN my experiences have taught me that regardless of the years of experience, there is always a need for more knowledge and upskilling. I consider myself lucky to have spent time in units where the culture embraced and encouraged positive change as early innovators. The goal has been to improve patient outcomes. Most of my colleagues were receptive to change and prepared to invest their personal resources, including time, money and travel, in ongoing education.

In an environment where most nurses were receptive to change, a small number remained resistant. Those that resisted change did so with both overt and passive obstructive methods. Some nurses shared openly their insistence on being paid to engage in further education outside of the workplace, with the belief that the hospital ultimately benefits and therefore should pay. The professional responsibility of continued learning and development (Fleet et al., 2008) is either overlooked or not identified by these nurses.

When the NMBA mandate was implemented I was working casually in intensive care and shared my time between two worlds, academia and clinical, that I continue to reside in today. As the changes to CPD standards came into place, conversations with peers were vibrant. We openly wondered how are we going to achieve our twenty hours of CPD, what did we have to do? Or worse, what would happen if we didn't achieve the twenty-hour mandate? What came to light shortly after implementation was that we could use our hospital competencies for CPD. Something did not seem right to both myself and my peers.

While hospital competencies can be utilised as twenty hours of CPD they are not something that myself or many of my colleagues attribute much value. Employer annual online competencies requirements, for example, Fire Training, are completed to maintain employment, not to acquire new knowledge or knowledge specific to the profession. It is common practice for colleagues to crowd around

a computer working together as a team to make sure the required pass standard on related quizzes is achieved. So 'how can this be CPD?' was the question for me that remained unanswered.

In a conversation with my mentor about my academic career and potential topics for doctoral studies, it became a constant topic. I asked what if nurses were not undertaking CPD as it had been intended? Had we all braced ourselves for a dramatic change with an expected steep ascent to CPD standards? I felt driven to understand what other nurses thought about CPD. How did nurses go about meeting the requirements? Why, and how, did they choose their CPD strategies?

The events that occur in an ICU on any given day are unknown. Planning cannot occur around patients that could deteriorate unexpectedly, or the new admissions from emergency absent of a diagnosis. The unpredictability of a day in ICU adds to the challenges of determining the level of knowledge required for the provision of safe patient care. A sudden deterioration of a patient triggers thoughts and questions of 'did I miss something?', 'did we do something wrong?' Thankfully the answer is usually 'no'. This unpredictability drives my passion to continue to learn and expand my knowledge and evidence-base, directing CPD activities.

Keeping abreast of all the changes in a medical and surgical ICU is a considerable task. But I do believe patients deserve the best: that it is my professional responsibility, to make sure at the end of my shift my patients have either improved or remained stable. It is my obligation as their nurse to pre-empt what is occurring and to communicate with the others in the team to optimise treatment. The only way I can do this is through continual education. I do this at the bedside with my peers or with other accessible educational opportunities.

Quantitative research, for all it offers, did not appear to address the need I had about this topic. The lack of human interaction it encompasses would not have allowed the experiences I felt ought to be unveiled. I wanted to hear from the nurses themselves in their own words, of their personal experiences, feelings and beliefs toward CPD. I wanted to hear their voices and see their body language as we talked about this topic. Ethnography is naturalistic in its orientation, seeking everyday descriptions of life to understand social reality on its own terms 'as it

really is' (Holstein & Gubrium, 2008). It is this that I sought with a need to know their reality.

Critical ethnography opens the exploration of the culture that resides within the CCRN workplace and the impact that this has on CPD. Ethnography also provided with a lens to identify influences external to the professional environment and reveal the impact of the CCN's day-to-day life upon their choices of CPD. While ethnography assisted in seeking the 'what', more was needed. Critical social constructionism provides a means to illuminate the 'how' (Atkinson et al., 2007; Burr, 2003, 2015). When used together critical social constructionism guides the researcher through critical ethnography to look at and hear activities through which everyday individuals produce the orderly, recognisable, meaningful features of their social worlds (Holstein & Gubrium, 2008).

## 1.11 Organisation of chapters

In the introductory chapter, the background of the phenomena has been introduced. This research is undertaken from the perspective of the nurse, not an educational approach that seeks to engage individuals in CPD for financial reward. Through the experiences and accounts of nurses the research aims to illuminate the perceptions and approaches toward CPD and reveal the underlying influences for nurses. In doing so the research shines the light on the mandated model of CPD that is intended to provide protection to the public. This research contributes by revealing the approaches to CPD of critical care nurses from three regional hospitals in Victoria, Australia.

In the second chapter, the literature review will appraise current evidence and understanding of CPD central to this research. Prior to the exploration of the literature available concerning CPD there is a need to explore the influential elements of power and social accountability in relation to nurses. The choice of CPD in nursing is influenced by two distinct levels of authority and power: institutional and social power. The former can be the registering body, NMBA and the employing institutions; the latter arises from within the cultural setting. Both institutional and social power influences the profession and each individual nurse. It is for this reason that power is first addressed in the literature review. Social

accountability underpins the principles of professionalism and ongoing education. It is examined in the context of professional expectations for knowledge. The literature review concludes with an exploration of CPD as it is understood today, with deliberation as to how it sits in the context of this research.

The third chapter presents the methodology explaining the philosophical positions and values that have guided this research. The theoretical underpinnings of social constructionism, the evolution into critical social constructionism, and the methodology of critical ethnography which has grounded this research are shared. Critical social constructionism and critical ethnography have a strong congruency, and this is discussed throughout the chapter. This research has applied a critical methodological approach. This has been taken with the intent of exploring a political issue and identifying opportunities for change in policy. Across the chapter are detailed discussions of how this critical perspective has been used. The positions of realism and relativism are explored to explain where this researcher and research has been positioned. This positionality is important as it situates the lens from which the research was conducted.

The fourth chapter presents the research design and methods detailing the approaches taken to collect and interpret the data of this research. The methods used align to the theoretical positioning and methodology of the research. The chapter begins with an explanation of the research design that is a collective case study and how this has been used in this research. A collective case study has clear boundaries which have been outlined setting the field and boundaries of the research. This chapter addresses the recruitment of participants and setting of the research using the boundaries required for a collective case study. Embracing principles of ethical rigour, the core ethical elements of autonomy, beneficence, non-maleficence and justice are discussed as they have been embraced and adhered to throughout the research to minimise harm to the participants. Ethical considerations of the research are outlined throughout the chapter as they are essential throughout the research process. The steps taken to collect and analyse the data will be described with transparency.

The fifth chapter presents the findings of the research. The findings are presented employing participants' voices through narrative. The findings of the research revealed many common experiences and concerns across participants from all sites. The main themes in the findings are:

- the impact of workplace culture on nurses' approaches to CPD;
- nurses are feeling alone and CPD is used as a tool to overcome this isolation;
- nurses are concerned about nursing as a profession and its standing;
- there is a mismatch between the NMBA and nurses; and
- nurses are working hard to change the culture of the profession and create advancement for all.

Chapters six and seven are the discussion chapters. In chapter six the philosophical lens of Pierre Bourdieu is introduced. This chapter discusses CPD under Bourdieu's concepts of field, habitus, capital and doxa. It highlights the interconnectedness of CPD and Bourdieu's philosophy. Continuing with Bourdieu in chapter seven the positions of orthodoxy and heterodoxy are discussed. These positions are used with the concepts of field, habitus and capital to explore the reality and rhetoric of CPD as illuminated by the research participants. Through Bourdieu's philosophy the chapter explains the games that are played by nurses, the level of engagement with CPD, the power of nurses, the secrets that exist in nursing CPD and what occurs within the secret fold of the profession.

The final chapter of this research presents the conclusions. The strengths and limitations of this research are explained and addressed with openness. The key findings of the research are summarised under the areas of CPD for nurses and implications for the profession. The chapter continues with a summary of conclusions and recommendations for consideration by nurses and institutions such as the NMBA and health care providers. Concluding with recommendations for further research that may assist in expanding knowledge and understanding of CPD in nursing and other professions, and finally closing comments.

# Chapter 2

# Literature Review

## 2.1   Introduction

The literature that informs this research is broadly grounded in the area of professional social responsibility, specifically the concepts of power and social accountability and their connection to Continuing Professional Development (CPD). In Australia, a nurse encounters power, both institutionally and socially, with this power being mandated and regulated by the institutional power of the NMBA and health care facilities. The workplace and culture across the profession are a prevailing influence on social power. The impact of both institutional and social power can affect a nurse's ability to demonstrate social responsibility. Aligned with social responsibility is social accountability where nurses are required to be answerable for their actions. This accountability is inclusive of currency of knowledge. Despite its importance, the literature provides a range of concerns highlighting some continued ambiguity surrounding definitions and the parameters of social accountability.

The current body of knowledge for CPD has predominately focused on effective methods of delivering CPD programs and creating accessibility for potential participants using technology. Unfortunately, little is still known or understood about the application of knowledge, acquired from CPD activities, and its incorporation into a health care professional's role (Allen et al., 2008; Banning & Stafford, 2008). Furthermore, there is insufficient contemporary research to support the view that engaging in CPD has a positive impact upon nursing practice and patient safety (Allen et al., 2008), or whether this engagement is a reasonable means for the professional to demonstrate depth of social responsibility. More specifically there is an absence or paucity of such research on CPD across nursing in Australia with the main research arising from the United Kingdom and Nigeria (Alberta et al., 2013; Drey, Gould, & Allen, 2009).

Power, social accountability and CPD are all layered elements connected to knowledge. These layers explain many of the identified links in the literature and investigate the interlace of knowledge to institutional power, social power, social accountability and CPD.

## 2.2   Power

Power is a broad phenomenon that intersects with all aspects of an individual's life and is often swayed and determined by the social environment in which we interact and exist. Throughout the literature, power has been discussed extensively, applying diverse lenses from a range of philosophical positions and perspectives. These approaches have led to the generation of knowledge and understanding of the impact of power in and of the social world. This literature review acknowledges the broad knowledge base and multiple facets that exist across power and does not intend, nor attempt to address all perspectives. To relate such an exhaustive account would far exceed the parameters of this research. Rather the examination and application of power will be carried out in the context of social accountability and CPD, revealed through the lens of institutional and social power.

Institutional power and social power can be both independent and entwined elements of the social world. Both hold the potential to direct and influence the behaviours of individuals and groups (Armstrong & Bernstein, 2008). Institutions, such as the Nursing and Midwifery Board of Australia (NMBA) and health care providers, determine standards and expectations by which the nurse must conform. Failing to conform means that ongoing registration and therefore employment as a Registered Nurse (RN) is jeopardised. These standards may overlap or have opposing agendas, such as what constitutes socially accountable knowledge. This is observed when health care providers promote employer competencies as forms of CPD. This occurs without consideration of what nurses need in terms of underpinning practice and knowledge requirements related to practice competencies. Nurses practice in a social environment in which they respond to the power of the social majority, often conforming to societal norms as a self-protective mechanism.

Power is defined by Stevenson and Waite (2011) as:

1. The ability to do something or act in a specific way.
2. The capacity to influence the behaviour of others, the emotions, or the course of events.
3. The right of authority given or delegated to a person or body (p. 1225).

In fact, power is derived from multiple sources. The inherent element being actioning and mobilising individuals and groups toward change (Hahn, 2009). This is seen in and across both institutional and social power.

CPD is not immune from the concept of power. This becomes evident in nursing when a failure to comply with mandatory CPD requirements risks a nurse being ineligible to renew their registration to practice (Nursing and Midwifery Board of Australia, 2016g). Without current registration, there can be no employment as a nurse. Power can also be seen across health care institutions with the internal promotion of institutional and equipment training as potential forms of CPD. The social relationship between power and CPD is observable in individuals and groups of nurses, when nurses bring their knowledge and skills acquired in CPD to the workplace to effect change.

Power, viewed by many, lies at the heart of social stratification, influencing the social interactions of groups and society. This widely accepted position observes power as a dispositional concept, referring to the potential for an action to occur rather than its actual occurrence, dependent on the belief that power exists (Scott & Marshall, 2009, p. 593). Pierre Bourdieu has defined power with a strong alignment to the position taken in sociology. Bourdieu (1991) explained power as both symbolic and reflective of the demonstrated "relations between the speaker and the respective groups" (p. 37) as portrayed, for example, how exchanges occur in the relationship. This research embraces Bourdieu's definition of power for its inclusion of social relationships and has applied his definition as the literature on power has been reviewed. This has facilitated the literature to be evaluated inclusive of multiple facets, which include the complexity and uniqueness of social relationships.

In nursing, power is often reported in a negative light. The uses and abuses of power have been itemised and highlighted in the literature. Perceptions of nurses, presented by Peltomaa et al. (2012), described power as a tool to be used to control, or be controlled, and dominate or be dominated. In undertaking this research and examining the available literature I believe this view of power to be simplistic. It underestimates and undervalues the capacity and complexity of power and, importantly, how it can be used.

The presentation of power as a tool that is used to control and dominate may steer the nursing profession away from embracing its power. The focus upon negatives creates a risk of overshadowing the positive opportunities which power creates. Consequently, the struggle for the nursing profession to define itself as independent and equivalent to other health care professions continues. I propose that power ought to be embraced within the profession of nursing. This power is not intended to suppress or control, but to create opportunities for the profession to demonstrate its capacity and value in the provision of safe care using knowledge as a source of power.

Throughout the literature review of institutional and social power, the complexity and influences that each has upon the profession will be discussed. These complex elements are discussed with a critique and explanation of their relationship to knowledge and CPD.

### 2.2.1 Institutional power

To understand where we are today and to propose another way forward Hallett and Fealy (2009) were wise in advising that we must be conscious of the past. Power has become a key theme to explain the past and the future of the profession. Pelc (2009) argued that history often promulgates an impression that the nursing profession is weak. This view has been highlighted across the literature and is noted by government, other peak professional bodies and professions, and by nurses themselves. This is exemplified by examples of power used to control nurses and claims from other disciplines, such as medicine, that nurses cannot manage their own profession (Hallett & Fealy, 2009; Stuart, 1986). Pelc (2009) rightly cautioned nurses in believing the myth that nurses lack the

skills or capacity to manage their own profession. Positively the literature calls upon nurses to question the system and history, and to take a stand to promote the professional capacity of nursing and in turn effect change (Falk-Rafael, 2005; Hallett & Fealy, 2009; Pelc, 2009).

Tierney (2012) appealed to nurses to be political, utilising the example of the Victorian branch secretary of the Australian Nursing Federation, Irene Bolger. Irene oversaw a fifty-day strike by RNs in 1986. This inspired the profession to achieve change through unity and demonstrated, to government, the power of the nursing profession and the need to afford the profession respect. Tierney (2012) exemplified Bolger and the strike of 1986 to highlight to nurses the power that resides through unity and using their voice. Disappointingly, the literature presented little evidence of nurses embracing political advocacy for patients in more recent history. A heavy reliance has been drawn from the experiences of nurses over a century of industrial action to highlight the power that exists within the profession (Pelc, 2009; Stuart, 1986; Tierney, 2012). The question should be asked, by nurses and those interested in the profession, why are nurses not viewed as a political or powerful group? Does the profession of nursing fail to understand and therefore fail to embrace the positives of power? The literature provides some explanation as to why this may be.

For example, the literature does not suggest that nursing is ignorant of the impact of institutional power on the nursing profession and their patients. Instead, Stuart (1986), Falk-Rafael (2005) and Pelc (2009) insightfully proposed that many nurses today have the capacity to exert change, a form of power, drawing from currency of knowledge, but are simply reluctant to do so. Pelc (2009) reasoned that the failure of nurses to exert change may result from the failure of the profession to realise their collective power as a cohesive unit. This was also raised by Stuart (1986) who emphasised a history and continued pattern of preoccupation with internal disagreements and inconsistencies. These have ultimately contributed to nursing neglecting professional unity, a core element required in the acquisition of power. It is regrettable that Stuart's warning of 1986 remains a challenge for the profession today.

CPD and the dissemination of knowledge is one avenue for nurses to unite. Embracing and sharing new knowledge among colleagues creates a wider impact than a single nurse may have. The profession of nursing should be strategic in its attempts to gain ground and acquire increased power: the ultimate goal of such power acquisition being the betterment of the profession, patient care and public health, wellbeing and safety. Within institutions Stuart (1986) suggested that nurses approach power acquisition by navigating the power structures in place. Although the strike of 1986, brought change to the hierarchy of nursing, as a profession nursing must still advance and highlight their financial benefit to employing institutions and government through patient care. The literature is expansive and demonstrates that nursing has contributed to institutions through the improvement of patient outcomes and decreasing their length of stay, thus reducing the financial burden on the institution (Kripalani, Theorbald, Anctil, & Vasilevskis, 2014; Melnyk, Gallagher-Ford, Long, & Fineout-Overholt, 2014; Stuart, 1986).

This reminder from the literature supports the position that CPD leads to knowledge and the generation of power that can be implemented into practice, and create positive patient outcomes and a more cohesive nursing environment. However, in my view, there is little evidence to suggest that nursing has acquired more independence or freedom from institutional power since 1986. Knowledge still offers an avenue for change and the recognition of the nursing profession's value. Knowledge that effects practice change and improves patient outcomes is integral to the progress of the profession and navigation for nurses into positions of power across institutions.

Falk-Rafael (2005) suggested why nursing has failed to navigate itself into a position of power within institutions. Falk-Rafael (2005) proposed that the absence and/or lack of success surrounding social mandates in nursing can be attributed to institutional hierarchies that typically constrain and silence the profession. This can be seen, for example, by education provided within a health care institution. This focus addresses the requirements of the institution and is often promoted as a form of CPD, despite limited evidence to support such sessions addressing knowledge deficits and needs of nurses.

Social advocacy is a core expectation of nurses outlined in the NMBA Registered Nurse Standards for Practice (Nursing and Midwifery Board of Australia, 2016e). Regrettably, the literature (Ballou, 2000; Falk-Rafael, 2005; Grinspun, 2000) advised that the profession of nursing is moving away from politics and policy towards the safety of the status quo. This trend has been attributed to the approaches used in educating nurses. Grinspun (2000) and Sword, Reutter, Meagher-Stewart, and Rideout (2004) suggested this move away from social advocacy in nursing is perpetuated by a failure in undergraduate and graduate nursing curricula to adequately prepare nurses for this part of their professional responsibilities. A lack of understanding by nurses toward political knowledge and skills exacerbates feelings of powerlessness across the nursing profession (Falk-Rafael, 1999).

This critique of education is not without merit but fails to consider the depth or breadth of action required to bring about change. It is unrealistic to suggest that a student nurse or a newly graduated nurse can revolutionise the profession. Research conducted by Shafer and Aziz (2013) confirmed this view, identifying that change is most effective when driven by experienced nurses and management. To effect change there needs to be long-term investment with strong skills in leadership (Shafer & Aziz, 2013). Recent research by Ortiz (2016) identified that nursing graduates struggle for the first six to twelve months with communication, independence and confidence. This research is valuable, countering the argument that education providers should be producing graduates equipped to implement practice change.

Nursing graduates need to consolidate their knowledge and skills to establish themselves as nurses before being expected to drive widespread professional change. The changes needed in the nursing profession should be driven by all members of the profession including regulatory bodies, leaders of nurses and senior practitioners. Demonstration of knowledge creates capacity for changed practice and improved patient outcomes (Lacey et al., 2017). The activity of CPD can contribute to change, offering an avenue for social advocacy underpinned by evidence.

It is clearly evident that to exert change within an institution such as a healthcare provider or regulatory body action is required. Grinspun (2000) called upon experienced nurses to lead change. This call was supported by Falk-Rafael (1999) who revealed successful change is more likely when the advocates of change are viewed as experienced and credible. Falk-Rafael (1999) explained that despite being the largest discipline in health care; nurses often go unnoticed with their expertise overlooked or ignored. In an effort to explain such lack of recognition of expertise Falk-Rafael (2005) continued to conduct research in the area, suggesting that nursing commonly addresses issues as if they were micro politics and confined to the unit in which they practice, or the local health care institution. This approach leads to issues and related knowledge not being shared across the profession and confined to the location. When knowledge is not shared, due to micro political issues, changes to practice do not occur and nurses are unable to have a significant impact across local and broader health care. Consequently, nurses are ineffective at demonstrating their true power in relation to institutions.

Regulatory bodies such as the NMBA are seen to hold all the power determining the standards for performance that practitioners rarely feel able to challenge or question. But, Hahn (2009) reminded nurses that a regulatory body is simply a governmental instrument that transforms policy into action. This policy is equipped with the power to set expectations and standards. However, policy is influenced by agenda setting and directed by the impact of special interest groups, referred to as the 'window of opportunity' (Hahn, 2009).

The NMBA, enacting the policy of government, should be accessible to nurses through the 'window of opportunity'. This window has been minimised and hidden behind multiple layers of policy and internal structures. Yet, the CPD policy also creates opportunities for nurses to demonstrate their power. In mandating CPD, the NMBA enforces knowledge acquisition. Together acquisition and application of knowledge can be a means for nurses to demonstrate their value and improved service to the public as well as acquire greater power.

Poignantly, year after year nursing ranks as the most trusted profession by the general public compared to medicine, which is often ranked third or lower

(Chaperon, 2010; Ham, 2016; Odishoo & Vezina, 2014; Olshansky, 2011). Despite this ranking, nursing appears to fall under the authority and power of institutions. Espousing the positives of being the most trusted profession, Olshansky (2011) suggested that nursing should use this consistent performance as a reason to acquire a seat 'at the table' where health care decisions are made. Nurses could contribute a strong voice that drives institutional reform and practice, highlighting the knowledge of the profession.

Others, such as Odishoo and Vezina (2014), warned that the nursing profession must be cautious when promoting its consistent ranking as trusted. Dependency upon the history of a positive public image, founded on trust, can result in a disservice to the profession. This can potentially overlook positive outcomes that nursing can achieve for patients after developing knowledge guided by evidence. Nurses instead should use their position as a platform to promote their knowledge and contribution to safe patient care with positive outcomes.

**Advancing the profession for better patient outcomes**

To build power within an institution nurses must demonstrate their contribution and ultimately value. This includes demonstrating the capacity to lead and facilitate positive patient outcomes. Kopinak (1990) and Donelan, DesRoches, Dittus, and Buerhaus (2013) appealed to nurses to make it known to the public and other health care professions, who they are and their capabilities. This should include informed knowledge and the ability to produce better care. It is proposed that by embracing these strategies nurses can begin to shift the power of institutions and authorities, across the health care sector, and advance the profession to achieve better outcomes for the public. Hallett and Fealy (2009) further support the view that nurses should take action. Self- belief, commonly seen in other professions such as medicine and law, enables nurses to embrace their own capacity and harness their power (Hallett & Fealy, 2009). This can be done by building knowledge through CPD and its application in practice.

Provision of health care occurs in a state of constant evolution and instability. A health care facility is driven by the need to retain its approval to operate. This is complicated by performance measures that constantly increase the demand to

achieve more for less. Lees (2016) suggested that such changes contribute to the disempowerment of the nursing profession by increasing workloads and constantly changing environments. Embedding change is a complicated process with past experiences impacting on the future. Research conducted in the United Kingdom (Lees, 2016) and the United States (Shafer and Aziz (2013) identified that during periods of change nurses report increased feelings of pressure. Nurses need to be cautious that during these times they do not ignore the advancement of themselves and their profession, which is created through CPD that builds knowledge.

Lees (2016) convincingly argued that institutional change and power is enhanced when transformation is accompanied by positive managerial behaviours, transparency and education with comprehensive consultation throughout and ongoing support. This view was supported by Lacey et al. (2017) and Shafer and Aziz (2013) who also identified that engaging front-line nurses significantly improved patient outcomes and successful change. These insights are invaluable when considering mandated CPD and its subsequent implementation. If nurses fail to trust each other, attempts to bring about change may be faced with peer resistance because of past experiences with institutions. Likewise, lack of management support or pressure to prioritise the facility over nurses' educational needs can negatively impact upon their ability to effect change and improve patient outcomes from CPD.

Exploring nurses' responses to institutional power and change Brooks (2009) provided experiences of nurses working in aged care. Research revealed that an institution focuses upon the provision of health care with minimal cost and maximum benefit to the facility. This use of power was explained as disempowering patients and nurses and as a common practice prior to aged care reform (Brooks, 2009). Health institutions are also businesses and therefore their focus is on productivity and costs.

Such experiences shared by Brooks (2009), Shafer and Aziz (2013), Lacey et al. (2017) and Lees (2016) carry warnings for nurses to be vigilant to maintain patient safety at the forefront of change and not to become so guarded that they damage their own path to power. Health care institutions will focus on the ability to

continue to offer service with a key requirement to generate income or achieve a cost neutral status. However, these approaches may be counterproductive to the nursing profession's desire for social advocacy. This situation requires that nurses speak the truth to those institutions that hold power and demonstrate their value to the institution's financial goals through the use of contemporary knowledge.

Providing a local perspective Madsen (2009) investigated the impact of the power of the Australian Government in the provision of health care at a community level. The research revealed a failure of government to consult with specialist nurses in the field when developing the business model. This oversight resulted in increased workloads for nurses and a failed model of health care (Madsen, 2009). Such overt omissions of nursing input in public policy demonstrated a lack of power of the profession. It is the government's role to fund and direct health care, but a nurse's scope of practice and responsibility to the community requires social advocacy. Nurses have a duty to ensure patients are provided care in an effective manner, not an approach that is focused on minimum financial expenditure. Knowledge of best practice and advances in practice offers nurses an avenue to counter proposed change and to benefit patients.

**Nursing's hidden and under-acknowledged power**

The literature on power frequently presents nursing as dominated or suppressed. D'Antonio, Connelly, Wall, Whelan, and Fairman (2010) looked at nursing and power differently. They acknowledged that there is a history of oppression and gender bias accompanied by restrictive approaches. But nurses were advised that powerful nurses generate opportunities for change for themselves and the wider professional group (D'Antonio et al., 2010). A sign of power is the capacity to embrace opportunities where knowledge and skills can be applied to patient care. Such commentary creates opportunities for CPD to counter the power of culture and institutional power.

While many proposed nursing is constrained by hierarchy and the power of others, D'Antonio et al. (2010) reported that nurses are powerful and hold many roles and positions previously thought unsuitable for them. Leadership and

management of institutions of health and regulatory bodies involve nurses. Nurses in these positions contribute to the profession and the institutions in which they work and practice. The navigation of difficult complex paths in the provision of health care is traversed daily by nurses, with a negotiation of the real and ideal across many levels and in many roles (D'Antonio et al., 2010). These nurses should be called upon to lead the profession, as the experts drawing upon contemporary evidence to demonstrate knowledge as a means to acquire power.

### 2.2.2 Social power

Social power (i.e. power arising from and exerted within the social field) can impact on the actions, decisions and behaviours (Bourdieu, 1992) of individuals. A social field is a dynamic environment where individuals come together with pre-existing beliefs and positions to collectively focus on accomplishing the same goal (Bourdieu, 1991). Under the NMBA standards for practice (Nursing and Midwifery Board of Australia, 2016e) the common focus of nurses should centre on the provision of care to maximise patient outcomes. Social power, like institutional power, exerts influence that can be seen across health care settings around the world.

When considering social power, the foundational work of French and Bertram (1959) explained that social power varies according to influences that underpin different forms of power. This relationship between power and influence occurs in a dyadic relationship, both significant to the other but viewed from different positions (French & Bertram, 1959). This is a crucial perspective when considering social power. Power is not stagnant and is unable to be held and used to influence another without the 'other' partaking in the interaction. This is an insightful interpretation of power with acknowledgement of multiple influencing elements. Within the dyad are two points of view, one that determines the behaviour of the agent who exerts power and the other that decides the reaction of the recipient of the behaviour. These aspects are unpacked in this research into Critical Care Registered Nurses (CCRNs) CPD and promulgated throughout the findings and discussion.

Power related to knowledge is viewed from multiple perspectives. This is evident in the work of philosophers Bourdieu and Foucault. Bourdieu (1991) broadly viewed knowledge as a form of power in the social setting. Foucault (2000) is said to have refuted the view that knowledge is power. Instead, according to O'Farrell (2005), Foucault focused on the complex relationship that exists between the two. The distinct perspectives of power by Bourdieu and Foucault are important and influence the way one observes power. I ascribe to Bourdieu's belief that knowledge is power, and that relationships and interactions pivot around this premise, in the social setting.

Accepting that power is viewed differently, French and Bertram (1959) encouraged consideration of what determines the behaviours of an agent, who exerts power and the aforementioned reactions of the recipient of the behaviour. This differentiation of power and how it is viewed by different individuals is important, accounting for the effects of social power. The philosophical writings of Bourdieu as previously mentioned influenced this doctoral research in the analysis of the findings and in the perspectives presented in this chapter, as the literature is reviewed and presented.

Power is commonly unseen or overlooked as an integral component of social interactions. Borthwick, Boyce, and Nancarrow (2015) explained that it is when power is exerted and imposed upon others and is accepted as legitimate or taken for granted, that power relationships become obscured. This explanation assists in understanding and explaining power as an undercurrent of society, with power often obscured from sight in social settings and relationships.

The ability to exert influence over others, which can occur with power (Schira, 2004) does not have to be perceived in a negative light. A valuable warning about power is provided by Sepasi, Abbaszadeh, Borhani, and Rafiei (2016), that power is not, and should not be thought of as a stagnant phenomenon. If power is stagnant, then inertia is created. This inertia can create potential pathways for corruption and destruction (Sepasi et al., 2016). This view may suggest how cultures with stagnant power create negative perceptions of power among individuals.

In embracing CPD and knowledge to move away from inertia, negative elements of power can be countered. This contributes to minimising the corruption and destruction often associated with imbalances of power. The ability to exert influence over others can and ought to occur through the sharing of knowledge and peer teaching in the day-to-day social interaction of nurses. Sharing of knowledge and power creates opportunities for control and opens up the possibilities to create positive change in the profession.

**Social influence of power**

Contributing to power as a means to create social change, Pratto (2016) proposed that power is not an agent but rather a component of a social relationship and interaction. Using social change theory, Pratto (2016) drew the reader's attention to the notion of power between individuals. When one individual has something, for example knowledge, that another individual wants or needs then the individual has power over another. This is a critical point to consider when reflecting upon the nursing profession's mandate of CPD. A nurse who gains knowledge also gains power in the social environment. This is what Bourdieu (1991, 1992) refers to as social capital. The sharing of knowledge creates opportunities for social relationships founded on respect to be built. As the knowledge is shared the power in the relationship becomes balanced with nurses spreading social capital.

When power is accepted and embraced it can act as a resource (i.e. capital) to achieve goals. Continuing the call to embrace power as a means for nurses to advance themselves and their colleagues, McKinnon (1999) called for an increased awareness of nurses' contributions to patient care. This was accompanied with a recommendation that nurses drive growth in their own capabilities and contribute knowledge at an interdisciplinary level to augment their own personal power. Despite calls to embrace power little appears to have changed. Fackler, Chambers, and Bourbonniere (2015) recently echoed the plea, stressing the positive impacts for nurses, patients and the cultural environment of the workplace when power is embraced. CPD is one means by which nursing can achieve this power by engaging in knowledge building and embedding sharing in practice.

Raatikainen (1994) argued that the attainment of goals is underpinned by power and with nurses undertaking a self-assessment of their abilities and quality of nursing care. Not only does the literature promote acceptance of power for the individual, it has gone further and illuminates what characteristics a powerful nurse will hold. Raatikainen (1994) identified that nurses with power were more likely to be motivated and receptive to advances in evidence and practice. Such nurses were reported to be more knowledgeable and able to act consciously toward goals with collaboration. In contrast, when nurses felt powerless they were less receptive to change, had lower confidence and felt they had less impact on patient care (Dawson, Stasa, Roche, Homer, & Duffield, 2014; Raatikainen, 1994).

The concept of powerful is influential in the outcome of CPD activities. The attributes of 'powerful', motivation and confidence (Raatikainen, 1994) enhance engagement with CPD. It also supports nurses to advance themselves, their colleagues, policy and patient care. In advancing policy, positive outcomes can be seen in the social setting, thus producing social power for the group and in turn the profession.

Power is not without risk and as such a balanced understanding is needed. When individuals are equipped and capable of seeing both the benefits and risks associated with power, caution and care can be applied to the use of power in a social environment (Peltomaa et al., 2012). Nurses in the workplace face multiple facets of power. This makes it essential for nurses to have an awareness of their own power and the capacity it affords toward achieving goals and objectives. Peltomaa et al. (2012) encouraged nurses to identify and utilise power as a resource that assists nurses individually and collectively to achieve their goals. The achievement of knowledge and performance related goals through CPD advances nurses toward acquiring social capital and power.

Some of the most influential features of social power are seen in the literature over the past twenty to thirty years. This literature formed the foundation for more recent literature and thus is important to explore. Persons and Wieck (1985) contributed to the understanding of social power by presenting the view that all individuals have some level of resources and therefore a level of power. Power

in a social situation is dynamic, held by the individuals whose resources are perceived as the most desirable at a point in time. While power has no ability to exist within itself it can permeate a person's life and career (Persons & Wieck, 1985). This acknowledgement of the interdependence between individuals for power to exist is integral to the social settings in which nursing is practiced. Knowledge when viewed as a form of capital becomes a source of power and a resource to create change.

Persons and Wieck (1985) also explained the complexities of power and associated responsibility. As power is linked to knowledge there is an inherent responsibility for the holder of power, in the social environment, to share their knowledge. Social interactions are based on the sharing of knowledge. When individuals share their knowledge in a reciprocal way, power becomes disseminated across the social group (Persons & Wieck, 1985). The NMBA has built this responsibility into their model of CPD. Nurses are expected to return from CPD and disseminate their new knowledge into their workplace to hopefully build a pattern of reciprocal sharing across nurses. The literature cautions nurses (Persons & Wieck, 1985; Sepasi et al., 2016) that when knowledge is not disseminated, social power creates an imbalance and negative cultures can begin to develop.

**Dynamic state of social power**

The non-static nature of power explains the differences seen across different settings of a profession, and even across different professions and the literature. The social setting of the critical care nurse (CCN), and all nurses, is complex and differs from field site to field site and from nurse to nurse, impacting on multiple perceptions of social power. Janss, Rispens, Segers, and Jehn (2012) supported this view, highlighting the variance of power in different settings. In one group the individual may feel powerful while in another powerless, or inexperienced. In a newly formed team, or with the introduction of new members, the distribution of power traditionally aligns with expectations of team members (Janss et al., 2012).

Drawing from health care professionals Janss et al. (2012) explained how hierarchical structures, shared responsibilities and unwritten rules of power and

control contribute to action and behaviours. Those professions considered powerful may not be the holder of power in multidisciplinary teams. The interdisciplinary nature of the teams carries an increased risk of conflict and power and the perception of social power can influence the effectiveness of conflict resolution and thus overall effectiveness of the team (Janss et al., 2012). These interactions and actions greatly influence the social culture of the team and positions of power.

While comprehensive research exists and continues to identify the impact of social power on individuals and professions, not all of the literature believes that the intent of the research can be achieved. Pratto (2016) cautioned that the true extent of social power will remain elusive if the misconceived and poorly defined concept of power continues to exist. Until addressed, contributions to the literature will remain unable to elicit the true impact of power. Consequently, Pratto (2016) argued that any awareness and strategies to navigate power, including in the local social arena, will not be achieved until power is more clearly defined. It is true social power needs to be better understood, but to suggest that a final definition or criteria can be developed ignores societal change. It is societal change that contributes to the current views of social power, which will continue to evolve with society. Knowledge underpinning practice exists in an evolving state. Therefore, nurses need to continue to embrace and share knowledge to maintain and advance their position in the social space.

**Generating social power**

The literature offers extensive insights into what contributes to the generation of social power and its impact upon nurses and other professionals. Across social power literature is the application of the theoretical positioning of Pierre Bourdieu highlighting the influences of social power (Borthwick et al., 2015; Hu et al., 2015). Bourdieu presented the concept of capital, as an acquired form of power that can be seen in knowledge, habitus and individual dispositions, which are evident across a field and in the social space of the professional. The position of an individual within the social space is dependent upon capital held by different individuals. Complexity is associated with distinctive forms of capital that are apparent in separated social spaces, and these may be in the same profession

or across different professions (Bourdieu, 1977, 1991, 1992; Bourdieu & Wacquant, 1992; Hu et al., 2015 Gallego, Monteith and McColl, 2015).

Aligning with Bourdieu's perspective of the use of capital to generate power is knowledge. Knowledge is available to nurses through engagement in CPD activities and through peer sharing. Painter (2010) and Peltomaa et al. (2012) encouraged the nursing profession to engage with knowledge as a means to overcome the gaps in evidence that underpin professional practice. Persons and Wieck (1985) called for knowledgeable nurses to function in the day-to-day role that requires decision making to produce positive outcomes for patients. This is used to highlight that nurses are placed in a powerful position enhanced by knowledge (Persons & Wieck, 1985).

Despite the promotion of knowledge as power in the literature there appears to have been limited impact. More than three decades ago, Persons and Wieck (1985) told nurses that power will not be bestowed upon them and that to gain power nurses needed to want power. To gain power nurses need to build capital and demonstrate their capital in the field. It appears from the literature that the profession of nursing remains reluctant or unable to embrace power today. Mandatory CPD was implemented in Australia in 2010, with a continuing void in the literature as to its impact on the profession of nursing and nurses, and their perception of power and its acquisition. This absence extends globally and to other disciplines.

CPD is not simply an avenue for nurses to gain knowledge and capital; CPD also offers opportunities for networking. Networking was identified by Persons and Wieck (1985) as an avenue for nurses to gain power, both professionally and personally, and to influence their environment. Networking offers avenues for nurses to share knowledge and generate influence while distributing power and capital amongst their colleagues.  Again, there is a void in the literature to explain if and how nurses are using networking as a source of power.

Networking requires skills as does the acquisition of power. These skills must be acknowledged to promote change across the profession. Randle (2003) presented essential insights and direction for the body of literature and the

profession of nursing to enhance the acquisition of power. Central to the work of Randle (2003) is promotion of self-esteem as a core element that is integral to a nurse's ability to accept, acquire and build power. Self-esteem is a major predictor of behaviour and the ability of nurses to function. Those nurses with a healthy self-esteem are more likely to engage in knowledge gaining activities and therefore provide greater patient care than those with lower self-esteem (Randle, 2003). Despite this valuable insight, care must be taken as the literature does not appear to share similar viewpoints with little research published about the relationship and impact of self-esteem upon CPD/knowledge acquisition.

The social environment and related elements of social power are significant when considering the fragility of self-esteem of all individual's (Randle, 2003). Intuitively though, it would seem possible that the sharing of knowledge and CPD activities can build self-esteem in some environments but may not yield such positive experiences in others. Networking requires self-esteem and confidence, qualities the profession of nursing must embrace and promote amongst members.

Promoting power in nursing is not only about promoting the profession. Social power for nursing also involves improving processes and ultimately benefits patients and the community (Sepasi et al., 2016). Sepasi et al. (2016) illuminated the use of power by nurses to not demonstrate superiority but instead to offer better work environments and processes. Singh, Pilkington, and Patrick (2014) supported this view with individuals holding power seen to demonstrate higher levels of productivity. This greater productivity was attributed to sharing of power and dissemination of responsibilities. These nurses also reported that their feelings of empowerment developed into self-efficacy and had a sense of impact (Singh et al., 2014).

Attributes of decisiveness, self-control, self-esteem and confidence are positive attributes of power poorly acknowledged within the literature about the nursing profession. Instead, the nursing literature is inundated with abuses of power (Janss et al., 2012; Tame, 2012; Walrafen, Brewer, & Mulvenon, 2012). CPD may be an avenue for nursing to change this perception and representation. The dissemination of knowledge as a means to distribute power and build self-esteem throughout the profession may present power in nursing in a new light.

As seen in the literature addressing institutional power, nurses shared many accounts of feeling powerless in their environment. Sepasi et al. (2016) did not dismiss these accounts but called for nurses to open their minds and look for positive attributes of power, and what they can acquire and hold. Nurses and professionals are encouraged by Sepasi et al. (2016) to understand and view power, previously mentioned, as multilayered. Amongst multiple layers of power are strong social relationships. To embrace power amongst social relationships nurses are encouraged to increase their awareness of basic human interests and attitudes.

Ideally as a collective group nurses would be able to combine their power and begin to create a cultural shift in the social setting and the wider profession. Knowledge acquired in CPD can be used as a source of power, building nurses' confidence and creating a safer social setting for sharing of knowledge. Through open minds power can be seen as a source for change and acceptance instead of something that leads to being controlled by others.

Fackler et al. (2015) supported this view proposing that a nurse's power is acquired through their knowledge, experience and degree of self-confidence. Delving deeper Fackler et al. (2015) explained that nurses attributed power within the social environment of the workplace as a tool to build relationships and advocate for patients. This occurred with a conscious effort to improve patient outcomes, guided by knowledge.

Fackler et al. (2015) research also revealed that those nurses with more experience carried a greater sense of power. While this seems logical, it is an important concept as it nurtures the acceptance of social power being related to experience that can be shared across peers in a positive fashion. The ability to share knowledge, views and opinions, and provide support to colleagues contributed to nurses feeling powerful within the social setting (Fackler et al., 2015).

While it may be that some nurses might seek opportunities to abuse power evidence from recent research shows the opposite. Fackler et al. (2015) reported that feelings of power left nurses with a greater sense of self and this resulted in

greater motivation to share knowledge and expertise that contributed in a positive fashion to the social environment of the workplace. This re-enforces the positive impact of engaging with and sharing of CPD upon patient outcomes and the social culture of the workplace.

**Caution about social power remains**

Despite positive discussion and encouragement to embrace power the profession of nursing continues to view power cautiously. Is this due to a lack of understanding of power, or does it relate to the past in nursing? The literature offers some explanations as to potential reasons. Nursing has a sensitive past and present. The intent has been to generate knowledge for the means of moving social power forward in the nursing profession.

Nurses' resistance to accepting power or using the term 'power' has been portrayed in the literature. Peltomaa et al. (2012) shared accounts of nurses preferring to view responsibility over power. This is explained further with accounts promoting a personal and professional accountability to be responsible for standards of practice. However, nurses did express feeling powerless over the professional standards that guide their practice (Peltomaa et al., 2012). These reports of feeling powerless against the regulatory body is supported by Painter (2010) who found that nurses felt managed by the system instead of being able to contribute to and manage the system that governed them. Similar feelings have been revealed in the findings of this research toward the mandated standard of CPD.

Despite limitations in embracing  power over the past two decades, Peltomaa et al. (2012) showed that the nursing profession is changing. With the entry of new graduates into the profession a greater willingness among junior nurses to accept power has been observed. Experienced nurses are more likely to report feeling that their power resides in their goals and capacity to provide care (Peltomaa et al., 2012).  This is a pleasant change as it shows that nurses are moving slowly toward change.

Research into paediatric intensive care nurses (Mahon, 2014) identified that trust was considered a core element of teamwork and negotiating power. However,

those considered to be in middle and upper management or removed from the bedside were considered to have power over those nurses who participated in the research. Of great interest is that nurses felt that respect and a power balance were shared with the medical team but not with nurses in middle and upper management (Mahon, 2014). This is valuable exposing the internal fracturing perceived by some in the nursing profession. This work has also contributed positively, highlighting the possibility of knowledge sharing by nurses that contributes to nursing's navigation of social power.

**Time to embrace social power and what it offers nursing**

The literature illuminates a need to move forward and for the nursing profession to advance and embrace power. Through the acceptance that power exists in all relationships and is an interpersonal construct that highlights the significance of other participants in an interaction, nursing's capacity to embrace power will be enhanced. Power is a give and take, generally achieved through one individual having something the other does not (Hewison, 1994; Pratto, 2016; Sepasi et al., 2016).

Nurses can complain about lack of power, but this does little to change the situation. Nurses must actively seek power. Schira (2004) encouraged nurses to have a positive self-concept and recognise and communicate with peers about the future of nursing. This becomes the first step to gaining and using power. Schira (2004) cautioned the reader that expressing and believing in the positive aspects of nursing is not denying the issues and concerns that exist, but instead constitutes an important professional perspective. An openness to practice and the importance of change to practice from knowledge acquisition implies that CPD is essential for nurses to enhance their level of power.

Schira (2004) believed that lack of power among nurses is not a reflector of reality, with nursing being a powerful group. Instead, perceived lack of power results from a failure to recognise the advances of nursing. Both individuals and groups of nurses recognise and cultivate power to enhance patient safety, optimise patient care and outcomes, and implement and drive policy that

supports both nurses and patients (Schira, 2004). CPD and the generation of new knowledge drawing on advances in practice create power for nursing.

## 2.3   Social accountability

The social responsibility of nurses surrounds the provision of safe care influenced not only by knowledge but structures of power. A nurse, as a professional, has to be socially accountable for ensuring that their practice meets the needs of the community in which they practice (Australian Nursing and Midwifery Council, 2007, 2009). One avenue is through engaging in CPD related to the context of their practice, for example intensive care, in essence demonstrating social accountability.

This section of the literature review presents a balanced representation of knowledge that surrounds social accountability. This is complicated by some key limitations. The body of literature to date has taken a narrow focus with only a few professions discussing social accountability. To date the dominant focus has been from the perspective of educational providers. Despite these restrictions valuable understandings are presented to guide the nursing profession. This literature is helpful in developing an understanding of mandated CPD as it relates to this research.

Social accountability has many aliases, such as social responsibility and social responsiveness and advocacy, which are often used interchangeably (Fleet et al., 2008). Care must be taken when exploring the literature to safeguard that the term used by the author aligns to the terms embraced by the wider literature. The literature of social accountability is distinctive with an openness to embrace variations and definitions as they apply to different professions (Boelen & Wollard, 2009; Goldman, Reeves, Lauscher, Jarvis-Selinger, & Silver, 2008; Woollard, 2006) avoiding the need to achieve a one-size-fits-all definition. This inclusive approach to definitions facilitates greater depth in current understanding and knowledge, even though the area is under researched.

The definition of social accountability used extensively in the literature (Boelen & Wollard, 2009; Sandhu, Garcha, Sleeth, Yeates, & Walker, 2013; Woollard, 2006) embraces an educational position perspective. Boelen and Heck (1995) defined

social accountability as "the obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve" (p. 3). This definition has been influenced by the authors' connection to medical schools. However, it can also be applied in nursing, both as a profession and as professionals.

The use of a definition that applies to both education and practice carries risk. There is limited research around social accountability in practice, and therefore the definition holds more rigour in the area of education research and literature. Similarly, there is a risk that research reports do not clearly outline how they use the term 'social accountability' to explain their findings. It is evident that educating and practising worlds are different, and the literature is reviewed with this awareness.

Heller, Heller, and Pattison (2003) moved beyond the narrow focus of medicine and created a definition intended to encompass and be applied to all professions in health care. In a more broader definition, Heller et al. (2003) proposed that social accountability was the recognition of the public as central to need. The areas of knowledge, experience and evidence together are used to meet the needs of the community. This definition is more appropriate for both education providers and clinicians alike, with the community being central and influencing actions of the professional. This definition is seen in elements of the NMBA and the mandate of CPD, with a need for development that reflects the context in which the nurse practices (Nursing and Midwifery Board of Australia, 2016d).

Outside of the area of health, The World Bank cited in Malena, Forster, and Singh (2004) has contributed to defining social accountability broadly as the "approach toward building accountability that relies on civic engagement, i.e., which it is ordinary citizens and/or civil society organisations that participate directly or indirectly in exacting accountability" (p. i). This definition is ambiguous and difficult to apply, a critique supported by literature (Boelen & Wollard, 2009).

Countering The World Bank's broad approach, Boelen and Wollard (2009) suggest that social accountability is the commitment to respond and meet the

health priorities of society. This definition is much simpler and therefore more likely to be embraced; however, it does not outline whose standards, expectations and perceptions. Such absences create ease of use by health care professions with regulatory bodies who can use their standards and expectations to generate a model of CPD. The definition provided by Boelen and Wollard (2009) does share commonality with that of Heller et al. (2003). This highlights the variances of definitions and a preparedness to share elements of similarity while embracing difference for different needs.

In an arena where multiple terms are frequently used Boelen and Wollard (2011) wisely remind us to distinguish social accountability from social responsibility and social responsiveness. Fleet et al. (2008) echoed the call for clarity and encourage caution in the use of common terms used incorrectly, or as if they were interchangeable. For Boelen and Wollard (2011) social responsibility references the awareness of duties required, whereas social responsiveness refers to engagement in action that meets social needs. Social accountability is different, it forms the justification for the scope of actions undertaken and anticipated outcomes (Boelen & Wollard, 2011). This position can be applied to nurses and mandated CPD. A nurse must understand their professional responsibilities, that is, a responsibility to society, and address their educational needs by sourcing appropriate knowledge and skills, demonstrating social responsiveness, and finally justifying their actions taken, thus proving social accountability. These steps are seen in the NMBA guidelines but poorly transitioned into reality.

Not all literature suggests that social accountability is as specific as definitions suggest. Malena et al. (2004) argued that social accountability has no intention of referring to a specific manner of accountability. Instead, it is cleverly proposed by Malena et al. (2004) that social accountability encourages individuals and corporations to see social as an approach for extracting accountability. This is achieved by not attempting to replace other forms of accountability. Instead, it places all forms of accountability as a complement to achieve improvement (Malena et al., 2004). Social simply becomes the guide to measure and defend our actions.

In exploring definitions, cautions are provided in the literature. Solbrekke and Englund (2011) advised that social accountability should not be confused with professional responsibility. Professional responsibility is a concept that exhibits a clear explanation of a responsibility to individuals and public interest. It requires professionals who base judgements on science and experiential knowledge along with professional ethics. However, cultural differences, policy contexts and the interests of stakeholders influence professional responsibility and how it is viewed (Solbrekke & Englund, 2011). Social accountability complements professional responsibility to strive beyond the good intentions and well-meaning of action and focuses on taking action that has a significant impact on the health care environment and positively impacts on individuals health (Boelen & Wollard, 2011) as driven by societal needs.

The literature of social accountability is further bolstered by Boelen and Wollard (2009) highlighting institution responsibility. Institutions, such as the NMBA, are called upon to evaluate their social accountability by the conceptualisation, production and justifiability of their actions for the society they serve. Social accountability is complex and twofold, involving altruism and integration. Altruism focuses primarily on societies wellbeing while integration is integral in the social canvas (Boelen & Wollard, 2009). There is no point focusing education on a societal need if that knowledge is never then integrated into society. Likewise, there is no value in nurses engaging in CPD if the knowledge acquired fails to be applied to practice.

It is apparent that current definitions and understandings of social accountability are complex. However, definitions do intersect, and this allows a threaded resemblance to exist and be seen across all definitions. The difference of definitions ensures that each profession is able to apply social accountability to their professional behaviours.

**Application and interpretation of social accountability definitions**

Challenges to the concept of social accountability exist. Woollard (2006) challenged socially accountable practitioners asking what is it that makes one socially accountable? Woollard (2006) further asked where is the balance

between objective and subjective? Where is the balance between responsibilities to individuals and responsibilities to society as a whole? Where is the balance between social engagement in reform and independence? It is these questions that influence and guide the balance of health professional education in its current state. It is also these questions that a nurse should be considering in their approach to knowledge acquisition and CPD.

Discussing the application of social accountability to education, Woollard (2006) proposed that in fully engaging students medical schools are better positioned to produce graduates that practice their craft and influence society. This can also be applied to nursing degrees and continuing education. Supporting this position is Fleet et al. (2008) who argued that socially accountable CPD involves all aspects of health care. And this includes the consideration of patients and the wider community's health care needs when planning and engaging in CPD by the professional RN.

Calls for a socially accountable profession span the literature (Ho et al., 2008; Malena et al., 2004; Woollard, 2006). This call is underpinned by an expectation that the community is provided for in a safe and effective fashion. This is supported with an increased reference to social accountability, as a foundation element in the effective delivery of health care (Ho et al., 2008; Malena et al., 2004; Woollard, 2006). Discussions across the literature of social accountability emphasise its importance, with a focus on three key themes: achieving improved governance, increased effectiveness, and generating empowerment.

Valid concerns are raised that education can be influenced by businesses such as health care providers and universities. Woollard (2006) asked what determines the focus of learning. It is insinuated that education providers are pointedly guided by service indicators. As a consequence this may result in a failure to address the priorities of society in which health care professionals are educated and practice (Woollard, 2006). Woollard (2006) is not alone in these concerns. Leinster (2011) was apprehensive about the absence of societal influences in curricula, with a preference instead given to institutional productivity.

Leinster (2011) called on education success to be determined by measurable outcomes observed at a societal level. Education providers are called upon to prioritise the capabilities of students and graduates over institutional productivity when determining educational strategies and content delivered (Leinster, 2011). The prioritisation of productivity is obvious when health care institutions promote hospital competencies, required for institutional accreditation, as CPD. The goal of the institution is increased productivity and decreased risk, not the generation of new knowledge and advancing practice of the individual practitioner.

**Social connection integral to social accountability**

Integral to social accountability is the individual's expectation that health professionals are willing to embrace accountability. Questions are presented in the literature asking what it means to be accountable today (Chouinard, 2013), with the democratic meaning of shared responsibility shifting to one of control, regulation and compliance. Thus, the traditional elements of accountability are often becoming lost amongst policies and regulation. Chouinard (2013) argued that myth and ceremony ultimately lead us to a culture of compliance with uncritical engagement in a ritual of accountability. Chouinard (2013) cautioned professions and professionals that a greater distance between people and professionals evolves as interactions become more performance based with compliance monitoring. Consequently, professionals and community have less of a relationship to each other and accountability is lost (Chouinard, 2013). This raises questions. Has the NMBA's approach to mandated CPD in its current format, where it can be influenced by institutional offerings that target greater productivity, create greater distance between nurses and public need? Possibly, and therefore this becomes an important focus for nurses.

Social accountability is not simply aimed at the individual practitioner. Professional associations and regulatory bodies also need to lead the way. Solbrekke and Englund (2011) presented a need for professionals to be competent, balance responsibilities, and embrace accountability. Professional associations are called to encourage social trustee values and be prepared to impose sanctions or de-registration on those who fail to meet professional standards (Solbrekke & Englund, 2011). The NMBA are obligated to monitor

nurses' CPD and act accordingly, using disciplinary action on any nurse who fails to comply with their intention of building knowledge related to the context of a nurse's practice.

To be socially accountable the profession must then defend its actions. The NMBA have not publicly defended or explained their decision to broaden the scope of acceptable forms of CPD. This greater inclusion allows nurses to move from personal knowledge needs to corporate driven education. The NMBA and nurses who use this as their CPD, must now be prepared to be accountable to the public for their actions and demonstrate safe patient care guided by their CPD.

Contributing to the depth of literature about social accountability in medicine, Helm (2012) drew attention to other aspects of life both professionally and personally that centre on social accountability. The complexity of social accountability is explained by Helm (2012) who presents two perspectives to an individual: *inner* and *outer*. An *inner* perspective offers an individual the ability to take ownership for their actions and hold themselves to account. The *outer* perspective reflects societal norms, and these may not reflect that of the inner perspective (individuals). With the two elements of *inner* and *outer* Helm (2012) questioned the level at which we, the professionals, are held accountable.

This is an important question addressed in this research, that of CCN's approach to CPD. Does the model achieve what the NMBA promised the community? Or do nurses address their need to be accountable to *inner*, self, or *outer*, society, or both or not at all, and simply tick a box to be eligible to earn an income?

As a professional a nurse is required to conform to societal expectations associated with the profession. Their behaviours and actions are demonstrated by showing professionalism. This involves a civic engagement with social responsibilities through an essential body of knowledge and skills, both for the profession and the society it serves (Solbrekke & Englund, 2011). However, Solbrekke and Englund (2011) raised a concern that professionalism has moved from a societal focus to a more self-interest focus, where the generation of

knowledge is paramount. This echoes Helm's (2012) concerns about what drives nurses and their CPD.

**Competing demands impact on social accountability**

The evolution of control mechanisms across western societies in the last twenty to thirty years has created a movement in decision making away from society and towards government (Solbrekke & Englund, 2011). This movement, away from societal control, creates a significant risk for social accountability. Solbrekke and Englund (2011) convincingly argued that governmental oversight has brought a need to demonstrate accountability with greater transparency that is evident under a predefined economic goal. This arises from concerns that governmental and external stakeholders need to meet key service performance indicators and demonstrate fiscal responsibility (Solbrekke & Englund, 2011).

A movement towards fiscal responsibility comes with great risk and cost to collegial standards as defined by professions. Solbrekke and Englund (2011) advised professions and professionals to be vigilant that governmental accountability does not overwhelm professional responsibility and social accountability. Fiscal responsibility is seen with institutions promoting productivity driven education. If nurses are not cautious their CPD will not generate new knowledge and address their educational needs. Instead, nurses risk feeding institutional productivity and power, while ignoring the power of knowledge acquired during addressing their own professional needs and positively impact patient safety.

The concerns proposed by Solbrekke and Englund (2011) are not supported or challenged by others in the literature. This provides a space for nursing to contribute to this discussion. Achievement of increased productivity, decreased hospital waiting times and shorter admission periods may look impressive for governments at election time. However, there must be more to nursing's contribution to health than a high throughput of patients. Nurses need to be knowledgeable and not simply productivity machines that address numbers on a waiting list. High productivity is achieved in factories where little change occurs from object to object: patients are not objects. No two patients in health care are

the same. Nor should we be encouraging nurses and the profession to be caught up in the political push for accountability throughout employer competencies. Nurses have their own personalised educational needs. It is only when these needs are met that nurses will meet their social responsibility and social accountability.

Social accountability is neither a simple movement nor a simple task. Such accountability makes regular reference to society and the community in which we are situated. Leinster (2011) questioned the extent and need to address global health in social accountability asking: 'where is the line drawn?'; and, 'where does the measure of social accountability stand?'. Acknowledging conflicting motives and altered society needs across communities, Goldman et al. (2008) encouraged investigation of local, state, national and international health care needs. Despite uncertainty as to the breadth of social accountability, both Goldman et al. (2008) and Leinster (2011) agreed. The social accountability movement requires a cultural change involving multiple stakeholders to define individual roles and collective responsibilities. Only then can a sustainable partnership that serves the needs of the community, be it locally, state, national or global, begin.

To achieve this momentum and movement to a wider view of social accountability, input must be obtained from many key stakeholders. In the world of health care there is a longing for a better system where priorities and expectations are achievable. Unfortunately, today we continue to have mismatched objectives that fail to intersect to facilitate change. Consumers desire high quality, affordable health care and health care professionals should strive for greater knowledge to guide the decisions made in the provision of health care. This occurs alongside policy makers and institutions with the aim of accessible care that is cost effective (Boelen & Heck, 1995). To achieve this aim all stakeholders must work together to define success, otherwise they will be left in a row-boat that simply goes around in circles. Malena et al. (2004) proposes that only through obtaining and disseminating knowledge, mobilising public support, and advocating and negotiating change can better service and empowerment of nurses occur.

The core values to achieve social accountability are presented by Boelen and Heck (1995) as relevance, quality, effectiveness (cost) and equity. These core values can be applied to socially accountable CPD of nurses, and other professions. Different societies have different needs. Relevance directs movement beyond one model towards more personalised models that address the main concerns. Ranking of need does not render the lesser priorities as irrelevant, but places greater emphasis on health areas most prevalent.

The application of evidence inclusive of social, cultural and consumer expectations generates quality. By focusing on the greatest needs impact can be achieved and resources optimised in a cost-effective manner inclusive of equity for all, regardless of geographical location (Boelen & Heck, 1995). Nurses need to strive for a high level of knowledge achieved through CPD that relates to the common needs of the community they care for. While education in the less common areas of health can be beneficial, focus should centre on the priorities of health as they relate to the workplace.

**Social accountability in health care CPD**

The literature does provide evidence of the connection between social accountability and CPD. In research undertaken by Thompson and Davis (2008) the challenges in providing CPD that are both socially accountable and evidence-based are revealed. Thompson and Davis (2008) explored CPD models and their response to societal needs. The research identified that despite the social contract between medical professionals and society being implicit in the concept of CPD, there was no explicit statement of this in any CPD initiatives surveyed. The research found that when initiatives for CPD were driven by the medical profession and government the involvement of society was more consultative than in the form of a partnership (Thompson & Davis, 2008).

Thompson and Davis (2008) identified potential limitations surrounding the belief that professional CPD meets with the requirements of social accountability. In what should not be surprising, given the history of involvement, it was identified that private corporations such as drug companies contributed and drove CPD, making it a commercial instead of socially accountable venture. In response to

the results that presented a failure of socially accountable CPD, recommendations were made that CPD be evidence-based and respond to the needs of the profession based on the needs of society (Thompson & Davis, 2008). Unfortunately, there has been no follow up to assess if any changes eventuated. For the nursing profession it is not clear as to whether this advice has been observed or ignored in their current model.

In the face of movement towards greater social accountability the literature does present some insightful suggestions. Lindgren and Karle (2011) advised that social accountability within health care should not be an assumed expectation. Health professionals are reminded that social accountability like other expected professional behaviours is predominantly acquired in times of learning (Lindgren & Karle, 2011). Consequently, Lindgren and Karle (2011) recommended that social accountability be evident in all levels of education so as to avoid being lost throughout professional life. This must include CPD as nurses comply with the NMBA mandate.

Social accountability has multiple challenges across multiple dimensions. Pollack (2009) in his discussion of social accountability proposed that there are two dimensions: internal and external. The internal dimension references the relationships that exist within the same organisation. External interactions are those that include stakeholders including those that service and access services delivered by  organisations (Pollack, 2009). This situation is seen in nursing where daily interactions occur with both internal and external sources throughout the course of the day. Pollack (2009) proposes a need for caution with regards to who we are socially accountable to and to what level, if we are to truly address societal needs.

## 2.4   Continuing professional development

A profession is expected to continue to advance knowledge and practice. CPD is a fundamental means of meeting the mandate of being a professional. Knowledge can be perceived as power (Bourdieu, 1991), and has the ability to effect practice change within the workplace. The NMBA mandate expects that

nurses will acquire and apply knowledge in their workplace. To understand the mandate the literature surrounding CPD will be discussed.

The body of knowledge surrounding CPD centres on the development and delivery of CPD activities. There is limited research into the area of perceptions and approaches toward CPD, especially for nursing. The literature that does exist was predominantly published over ten years ago but remains applicable today. With a focus on recruitment and delivery of CPD programs, from a marketing perspective, the research supporting the effectiveness of CPD in achieving practice change is limited. Australian literature has invested in exploring the needs of rural and regional practitioners and ways to deliver CPD using advances in communication technology.

CPD is a popular term commonly used interchangeably with continuing professional education in the literature. Amongst professional groups CPD is used as a tool and method to update knowledge and skills (Alberta et al., 2013). Lifelong learning is commonly used to discuss CPD or the continued education of professionals beyond their original qualifications (Davis, Taylor, & Reyes, 2014), while staff development is used to define further education from an organisational and institutional prospective (Gallagher, 2007). The distinction between terms is often vague but the underlying theme is that education is continuous.

Adult learning theory and reflective practice underpin CPD, directing the trajectory the individual takes (Bennetts, Elliston, & Maconachie, 2012; Schön, 1983, 1987). The development of CPD educational programs is heavily linked to adult learning theory, which guides the structure of the offered programs and courses. Professional regulatory bodies have applied reflective practice to CPD as a means of guiding the educational needs of individuals to implement the generation of knowledge and skills into practice (Bennetts et al., 2012). However, the efficacy of this approach is not clearly evident in the literature.

CPD is not new to nursing, with the importance of continuing education presented by Florence Nightingale in 1859 (Gallagher, 2007). Continuing education in nursing, and across the world, is defined as education that occurs after initial

qualifications have been obtained that lead to registration with a professional regulatory body. Further learning opportunities through CPD are  designed to present and consolidate knowledge and skills that enhance patient outcomes (Gallagher, 2007). Growth of knowledge and skills is required to provide protection to the public, which Bennetts et al. (2012) explained can only be achieved by ensuring a competent workforce

**CPD creates opportunity for growth in nursing**

The body of knowledge surrounding CPD has frequently proposed that CPD is a method to bridge the gap between evolving evidence and a need for health care to rapidly implement changed practice. Bartels (2005) focused on the importance of CPD in nursing, rightly stating that nurses can no longer ask what they can do for patients. Nurses must ask: what difference can I make, and how can I give my patient maximum value with minimal risk to optimise outcomes? Nurses need to move with the rest of the industrial age from a group of doers to a group of thinkers (Bartels, 2005), but as a profession is nursing prepared and capable of making this change?

Bartels (2005) not only shared these concerns but encouraged the profession of nursing to make use of the knowledge that exists to optimise practice. Nurses are called upon to no longer be dependent on the organisation to bring about change. Instead, there is a call for nurses to drive change by implementing their CPD into practice. Bartels (2005), for example, called upon nurses to drive responses to evolving health care needs of society and use education as their primary resource. CPD offers nurses opportunities to acquire resources, and to shift the perception of powerless to powerful and be strong proponents of social accountability. It is up to nurses to determine their willingness to invest their energy and generate a shift in the profession's perception.

Amongst the literature addressing CPD are areas not yet explored or supported. This highlights the restricted scope and limited depth of knowledge to address the complexity of the concept of CPD. Two significant gaps that present in the literature are the perceptions of nurses and other professionals toward CPD, and evidence to support changes to practice driven by CPD (Alberta et al., 2013;

Draper & Clark, 2007). Such absences in knowledge extend globally and highlight vital areas that require urgent attention. Research into these areas will contribute to the support and refinement of mandatory CPD by regulatory bodies and further reveal the impact of CPD upon the care needs of society.

**Can CPD improve practice?**

Discussions surrounding CPD and its adoption by regulatory authorities frequently state that through CPD positive practice change will evolve. This position is taken despite a lack of substantial evidence to support these beliefs. Alberta et al. (2013) and Lee (2011) provided insights into the reported impact of CPD and identified that  variables in organisations and workplace culture determine the success of CPD in changing practice. Adding further complexity are variables in the motivation and ability of individual practitioners to effect change. Collectively these aspects have contributed to the difficulty in evaluating changes in practice (Alberta et al., 2013; Lee, 2011). Despite this issue regulatory bodies, like the NMBA, continue to mandate CPD under the umbrella of public safety.

Research into the effectiveness of courses and educational conferences offered to practitioners has yielded disappointing results. Despite the abundance of educational opportunities; research has revealed that while formal education contributes to an increase in knowledge and skills there is no evidence of benefits for patients (Chipchase, Johnston, & Long, 2012; Clancy, 2000). This failure to impact patient outcomes has been attributed to a failure of educational course based learning to meet the needs of a rapidly evolving complicated clinical arena (Davis et al., 2011). However, for Ellis and Nolan (2005) limitations of the effectiveness of CPD can be attributed to a failure to consider the differences that exist in the expectations and values of those taking the course and their professional roles. This is valuable, highlighting that practitioners need to invest and consider the CPD undertaken. Instead, of picking the easiest or most convenient option.

Covell (2009) supported by Draper and Clark (2007) responded to critics of CPD and its impact on patient outcomes. The link between nurse's CPD knowledge

and patient outcomes is difficult to explain in theory. However, current evidence does demonstrate that patients have better outcomes when cared for by knowledgeable nurses. Critics were cautioned against being so quick to attack the legitimacy of CPD (Covell, 2009; Draper & Clark, 2007). Clancy (2000) recommended that CPD be granted its standing due to the heavily weighted acceptance that development of knowledge and skills can only be beneficial to patients.

Social influences and workplace culture contribute to influencing the effectiveness of CPD. Ellis and Nolan (2005) wisely illuminated that when individuals feel coerced or forced to undertake CPD negative feelings can occur in response. These negative experiences contribute to failing to acknowledge the relevance of CPD to the workplace. As a consequence reports from nurses portray negative or little impact on practice due to social influences (Ellis & Nolan, 2005). Lee (2011) was able to identify the impact of peers upon perceptions as a significant influence on the ability to effect change from CPD. Lee (2011) acknowledged that many peers were unaware of the influence they had on others attempting to instigate practice change. Managers however tended to be more focused on the organisational resources required to effect change than individual practitioners. This was termed the 'clash of cultures' by Lee, emphasising distinct differences between those engaging in CPD and the organisation seen to be inhibiting application of CPD acquired knowledge (Lee, 2011).

In the absence of hard evidence Chipchase et al. (2012) and Davis et al. (2011) proposed that while CPD commonly involves one-off interactions with new material the benefits for patients and practice change are possible. However, change is shown to be most effective when there is situational learning with multiple interventions over time (Chipchase et al., 2012; Davis et al., 2011). In earlier research Draper and Clark (2007) challenged individuals to consider CPD in the context of its use in practice. Guided by the literature nurses need to engage in CPD that targets practice needs. This will contribute to the profession generating better patient outcomes from knowledge using evidence-based instead of opinion-based decision making.

**Nurses' perceptions and responses to CPD**

The literature draws attention to differing views associated with different roles. This is evident when nurse line managers view CPD and its subsequent implementation as the responsibility of clinicians. This expectation occurs in the presence of a limited understanding of the support required and provided to staff to effect change (Lee, 2011). While managers believed that the responsibility remained with clinicians, they did acknowledge that constraints hindered the process. These constraints were seen to focus on a limited ability and time to practise new skills in the rapid pace of the clinical environment, that was seen to hinder implementation of innovation into practice (Lee, 2011). This mixed message of the expectation to act but acknowledging significant constraints highlights the challenges for nurses to create change and promote patient safety.

Perceptions toward CPD are influenced by others but can also be influenced by the individual's past and beliefs. CPD has been regularly proposed as a technique for improving individual self-worth, achieved through the generation of competence, with skill acquisition and knowledge used to build confidence in self and in the provision of patient care in an environment of rapid change (Alberta et al., 2013; Lee, 2011).

Amongst the limited exploration of nurses' approaches to CPD is quantitative research by Drey et al. (2009), which explored practicing nurses in three National Health System Trusts in the United Kingdom and their approach as practitioners. Over two-thirds of nurses in these trusts undertook CPD for career progression. A little over twenty percent of participants in the research reported only mandatory institutional training in the same period (Drey et al., 2009; Gould, Drey, & Berridge, 2007b). An important finding was a decline in commitment to learning across a nurse's career. Nurses expressed a tendency to engage even less in mandatory competencies and CPD and thus potentially were no longer adequately prepared to provide safe care in a changing health care system (Drey et al., 2009). This research highlighted risks for the NMBA in assuming nurses will engage with CPD, with evidence from United Kingdom colleagues indicating that despite mandatory CPD nurses are still failing to engage.

Research from Nigeria provides a slightly different perspective to the understanding of nurses' perceptions about CPD. Research by Alberta et al (2013) reported that nurses perceive CPD as valuable after having to complete mandatory CPD every three years. The other side of this issue showed that sixteen percent of respondents believed they had the required level of knowledge and skills to practice nursing and did not need to participate in CPD. Worth noting was the revelation that the majority of nurses in this study had registered for the first time in the past five years (Alberta et al., 2013). This raises concerns, the clinical world changes rapidly and preparatory courses are not capable of teaching the nurse all they need to know for the duration of their career.

Career progression and protection of registration are reasons nurses frequently cite for engaging in CPD (Alberta et al., 2013; Drey et al., 2009; Gould et al., 2007b). Despite this fact, nurses could identify the role that CPD played in providing and maintaining safety for both patients and nurses. Many nurses see CPD as a means of maintaining skills or career development with a limited focus on knowledge but believed CPD to be valuable (Gould et al., 2007b). The perceived self-value that nurses achieved from CPD is an important element that contributes to motivation for further CPD. Research by Gray, Rowe, and Barnes (2014) reported that motivations for and engagement in CPD is more likely to exist in individuals when they feel valued and supported.

Not all responses and perceptions toward CPD are positive. Nurses in the United Kingdom expressed resentment at the institutional expectations placed upon them to undertake a substantial portion of CPD in personal time (Gould et al., 2007b). Such resentment centres on a perceived failure to acknowledge personal/family commitment, and limited support from a facility. Nurses argue that it is the facility that benefits from increased practitioner knowledge with improved service delivery and cost cutting, and yet there is no leave or funding support for nurses (Gould et al., 2007b). This view is not uncommon and contributes to the overall attitude of nurses toward CPD.

A positive culture for CPD will not just arrive or exist in nursing without a substantial investment to change the culture from within the profession. Nursing needs to be guided by evidence not only in practice but as the profession moves

forward. This includes being alert to the focus of nurses' CPD and ensuring patient safety and career progression is equally balanced. Similarly, nurses need to remain vigilant to not moving away from CPD due to resentment that arises from institutional barriers. Much can be learned by the nursing profession from the literature surrounding CPD.

**Sociocultural influences surrounding CPD**

The literature has identified multiple motivations that underpin nurses engaging in CPD. In research conducted by Lee (2011) individuals reported competition as a key driver for CPD. However, it was not clear if this competition was related to career advancement or a drive to influence practice change. Research into Australian midwives conducted by Gray et al. (2014) also highlighted a competitive need to be the best midwife, in the eyes of the mother, as a motivation to engage in CPD and skill development. This need to be the best acts as a driver to build knowledge and motivates nurses to seek out and engage with CPD activities that build knowledge and performance. This hidden factor is important, as it emphasises public perceptions about nurses and midwives.

An area with limited research is nurses' approaches toward CPD. Nigerian nurses (Alberta et al., 2013) attributed mandatory renewal of registration and subsequent employment as the main reason and motivation for engaging in CPD. Only fifty percent of Nigerian respondents cited professional responsibility or interest as motivational factors to engage in CPD. Desires to improve knowledge and skills also rated poorly as motivational factors (Alberta et al., 2013). These findings are not unique and show connection to the findings of this research.

Further research by Davis et al. (2014) identified other reasons for nurses to engage in CPD. It was revealed that this engagement was a desire to keep the mind active, address curiosity, and obtain new knowledge that facilitates the delivery of high quality care. Interestingly, this research was also able to reveal that nurses valued the challenge of implementing knowledge into practice and that self-motivation plays an influential role in engagement with CPD (Davis et al., 2014). Building on this body of knowledge Gray et al. (2014) additionally revealed the impact that peers have on nurses and midwives. Peers triggered

motivation to engage in CPD and maintain competence. Nurses and midwives reported that friendships, feeling valued and being a part of the team all played a positive influence in the motivation for engagement of CPD (Gray et al., 2014). These insights are invaluable for regulatory bodies achieving their intent of public protection. Such motivational elements need to be embraced and used to extend the standard of CPD to one which enhances patient outcomes.

It is unfortunate that the literature reveals feelings of isolation experienced by nurses that engage and attempt to share their CPD experiences (Lee, 2011). Nurses reported that sharing knowledge and skills gained from CPD is more ad hoc, unstructured, of rare occurrence and not a requirement of their work environment or profession (Lee, 2011). This culture of limited sharing contributes to silos, preventing practice change from CPD gaining acceptance and prevents others from experiencing the benefits of CPD.

Negative perceptions and feelings surrounding CPD are common not only within the literature but within everyday professional practice. The cultural environment and social influences play a significant role in the adoption of CPD among nurses and other professionals (Gould et al., 2007b; Hughes, 2005; Lee, 2011). The influence of workplace culture is demonstrated in the literature with reports of individuals concerned with the perceptions their colleagues and peers have when they engage in CPD, or attempt to share their CPD within their practice. Individuals often fear being labelled as trouble-makers or report experiences of managers obstructing attempts to implement change resulting in feelings of frustration, isolation and exhaustion which have a negative impact on further pursuits of CPD (Gould et al., 2007b; Hughes, 2005; Lee, 2011). These accounts are not questioned in the literature and little is offered to minimise their negative impact.

Nurses in the United Kingdom and Australia have expressed concern and frustration with a reflective model of CPD, citing the difficulty that exists in not knowing what you do not know (Gray et al., 2014; Hughes, 2005). Hughes (2005) rightly states that nurses are at risk of engaging in the wrong CPD or avoiding CPD altogether due to poor understanding and poor self-evaluation using reflective models. Australian midwives holding dual registration have identified

that it is difficult to undertake self-assessment of skills they are not using on a regular basis (Gray et al., 2014). CCNs in Australian regional hospitals face a similar situation. With less exposure to complex critically ill patients, self-assessment of complex knowledge and skills becomes difficult for regional nurses to identify and address.

The literature provides insights into the ease with which technology can be used by nurses in CPD. Research into Australian nurse's experiences with the internet for the development of knowledge validate the barriers the internet plays in accessing CPD. McKenna and McLelland (2011), for example, identified that over a quarter of participants in their study found navigating the internet for knowledge difficult and over sixty percent were not comfortable accessing databases. With online registration for conferences and online or face-to-face education; this research highlights a major barrier to nurses accessing knowledge for practice. This is only one study, but there is limited evidence that supports or challenges this situation, making these insights invaluable for the profession.

Expanding on a nurse's capacity to resource and apply literature Nesbitt (2013) explored nurses' abilities to access evidence-based practice from journals. Findings revealed that few nurses are comfortable accessing and appraising evidence for practice in journal articles. Thankfully research by Nesbitt (2013) went beyond identifying if nurses could understand journals, and found that with the implementation of journal clubs nurses were able to implement knowledge into practice. Research in this area raises discussion and creates knowledge about the need for nurses to be supportive of each other around technology. Using groups to build knowledge and skills to resource evidence in the workplace contributes to patient care in an inclusive manner.

**The role of regulatory bodies and CPD**

The NMBA has adopted CPD as a form of nurses maintaining competence through continued education (Australian Nursing and Midwifery Council, 2007, 2009). Regrettably, what has been implemented by the NMBA leaves the image of a rowboat full of nurses, each doing their own thing, attempting to move the

rowboat along the river. Instead, of a smooth paddle down the river of knowledge their disorganised approach creates a whirlpool for patient safety.

In order to achieve the desired goal of improved patient safety through CPD Chipchase et al. (2012) strongly encouraged regulatory authorities, in this case the NMBA, to monitor and endorse particular programs or organisations to provide education. This support is lacking in Australian nursing with the NMBA allowing nurses to undertake almost carte blanche CPD which appears to be in direct opposition to the available literature.

The NMBA model requires that nurses engage with reflection and monitor and guide their own learning. While responsibility of the practitioner is clear, and it is reasonable to expect them to take some responsibility, the NMBA assumes that nurses understand reflective practice. Chipchase et al. (2012) highlighted that in order for practitioners to achieve successful CPD and provide greater protection for the public they need to continue to engage in self-reflection.

Additionally, nurses need to allocate time to practise their skills, seek feedback and access evidence. All of this occurs while reflecting on practice and learning to source education opportunities that are evidence-based and appropriately targeted (Chipchase et al., 2012). This is a significant task to expect any individual to achieve, let alone one who is new to nursing or unfamiliar with reflective practice and its principles. This creates further cracks in and disjointed rowing of the 'boat' that nurses are attempting to paddle to achieve patient safety.

**CPD in Australian nursing**

Australia is contributing to the knowledge of CPD. This not only benefits Australian nursing but the profession worldwide. Unfortunately, only limited research into Australian nurses and CPD has been completed with few articles available (Katsikitis et al., 2013). This highlights that this doctoral research is not alone in its concern for the NMBA model, with two other studies completed in recent years, although addressing similar concerns. Moving beyond the mandate of twenty hours of CPD annually, Katsikitis et al. (2013) were driven by a concern that nurses were not professionally engaged or aware of the decision making required to achieve CPD.

Katsikitis et al. (2013), using quantitative research, revealed nurses were unable to describe the motivations behind the board's mandate for CPD. Most respondents indicated that most of the focus for CPD was hospital competency based with a concentrated focus upon areas of advanced life support and wound management. Education offered within work hours by the institution preceded conferences and workshops as valid forms of CPD. While this has provided significant insights into nurses' understanding of CPD there was no discussion around motivational influences. This research focused on identifying nurses understanding of board-mandated requirements of documentation and what constituted CPD (Katsikitis et al., 2013).

Reflective practice is integral to the CPD framework adopted by the NMBA with the NMBA assuming nurses understand and are competent using reflective practice. This flawed assumption is highlighted by Katsikitis et al. (2013) whose research identified that despite Australian nurses stating they understood reflection on their learning, they had difficulty articulating the reflective practice role within the new framework.

While research from the United Kingdom and Nigeria identified managers as suppressors of change generated from CPD (Alberta et al., 2013; Gould, Berridge, & Kelly, 2007a; Gould et al., 2007b; Hughes, 2005; Lee, 2011), Australian research has presented a brighter picture. Australian nurses expressed feeling comfortable returning from CPD to implement change (Katsikitis et al., 2013). This difference in perceptions could be attributed to culture but also to the research participants.

In Katsikitis's (2013) Australian study, most participants undertook CPD within the health care institution. Therefore, it is reasonable to assume their colleagues had also been exposed to similar education. It is also possible that resources from within the institution had been allocated, making a workplace culture appear more receptive to change (Katsikitis et al., 2013). Regardless of the importance of the manager's position and the positive influence a manager can have CPD and practice change cannot be ignored.

Historically CPD was viewed as an employee benefit. The tides are turning and there is greater expectation on nurses to fund and maintain their own CPD. Nurses, including CCRNs, in Australia have a wide scope of practice, with changes in practice and knowledge occurring at a rate greater than they can often maintain (Covell, 2009).

## 2.5   Conclusion

Power, social accountability, and CPD are weaved throughout the literature, both explicitly and implicitly. Current literature reveals overt absences in knowledge and understanding of approaches taken toward CPD, and the effectiveness of CPD for practice. The NMBA has embedded CPD into their continuing competency framework, presenting a need for a greater understanding of CPD to justify its use. The absence of measurable outcomes from CPD is a need that requires widespread research and investigation but is not the focus of this research.

This research addresses a significant practice area of need and examines nurses' approaches toward socially accountable CPD. The methodology uses a constructionist philosophy incorporating the theoretical perspective of critical social constructionism and the methodology of critical ethnography.

# Chapter 3

# Methodology

## 3.1 Introduction

The opportunity to observe individuals as they engage with normal life events is a privilege that accompanies research. Through observation researchers are offered openings to develop new thoughts and understandings that create opportunities to generate new knowledge. Qualitative research explores the experiences and stories of others through the sharing of experiences (Denzin & Lincoln, 2011) with the intent to generate a better understanding of people, their lives and the world.

This research has been situated in constructionist philosophy using the theoretical perspective of critical social constructionism and the methodology of critical ethnography. Guided by critical social constructionism and critical ethnography the research embraced opportunities to construct meaning inclusive of cultural influence. The use of critical perspective occurred in response to the findings of this research. It is not intended to present nurses as an 'oppressed group'. In its place, the critical lens was applied to illuminate the findings in order to create conversation and change, where appropriate, and contribute to the knowledge of Continuing Professional Development (CPD).

This chapter discusses the philosophy of critical social constructionism and critical ethnography as used in this doctoral research.

## 3.2 A theoretical perspective of social constructionism

## 3.2.1 Evolution of social constructionism

Social reality is constructed and influenced by constant negotiations and constructions of reality, influenced by experiences occurring in the social world (Berger & Luckman, 1966). Using communication as a tool, individuals construct the world in which they live. Through communication with others we complain,

share joys and life activities along with sharing our struggles and accomplishments (Gergen, 2015).

The sharing of experiences and communicating with others allows the construction of social reality to occur, and different realities to form. An example is how my family has constructed their reality of my undertaking a Doctor of Philosophy from their social interactions with me. They have developed an understanding of doctoral research from my experience and their observations and perspectives taken from our conversations. I too have constructed a reality of doctoral studies. My reality is based upon my experiences and that of others who have shared their reality of successfully obtaining a Doctor of Philosophy. It is my constructed reality, it is not absolute, and it is not the same or shared reality for all candidates. But, it is the reality that I share with significant others, such as supervisors, examiners and family. Through sharing my reality I have influenced their meaning and understanding (i.e. socially constructed) of doctoral studies.

The seminal works of Berger and Luckman (1966) triggered momentum for the social constructionism movement, influencing how social constructionism is seen today. Berger and Luckman's approach was derived from the work of Alfred Schutz (1899–1959), influenced by Edmund Husserl (1859–1959). In the late 1990s and early 2000s widespread acceptance and adoption occurred with social constructionism acknowledged as a theoretical perspective separate from constructivism (Holstein & Gubrium, 2008).

Despite gaining independent acceptance, social constructionism is often confused, misunderstood and misused, mistakenly and interchangeably with constructivism (Burr, 2003, 2015). This is most likely attributed to their interconnected past. Social constructionism embraces the development of phenomena relative to social contexts whereas constructivism explains the individual meaning-making of knowledge in a social context. The application of both theories is also different. Social constructionism is an accepted sociological concept and constructivism is more commonly accepted as a psychological concept (Burr, 2003, 2015; Chisholm, 2012). This clarification is important as it explains the theoretical influence of social constructionism in this research. This research embraces the sociological position where meaning is generated from

interactions, in which more than one person must be present, contributing to social meaning.

To differentiate further, Burr (2015) argued that radical constructivist psychology is where "each person perceives the world differently and actively creates their own meaning from events. The 'real' world is therefore a different place for each of us" (p. 21). Whereas social constructionism argues that the way we see the world is influenced by social forces that are structural and interactional such as culture, history, and the position that each individual holds with their views of the world (Burr, 2015). Chisholm (2012) explains social constructionism as a developed form of critique, with the intent of transforming the oppressing effects of the meaning-making processes in social interactions. Central to both Burr (2003, 2015) and Chisholm's (2012) explanations is centrality of the inter-relational quality, content, and context.

Definitions of social constructionism carry distinctive foci but each shares a commonality, or as Burr (2015) explains, a family resemblance. Social constructionist theory has and continues to emerge from a progressive dialogue of philosophers, researchers and others who apply the theory (Gergen, 2015). As a result, it has evolved into a cluster of approaches with no single dominant position but shared assumptions of language, knowledge and reality (Berger & Luckman, 1966; Burr, 2003, 2015; Chisholm, 2012; Holstein & Gubrium, 2008).

Many would argue that the evolutionary positioning of social constructionism can dilute its usefulness, rigour or relevance to research. However, the postmodern era has shown that there is value in appreciating and accommodating that ever-shifting development and sophistication of thought, as our understandings of the world and people within become more complex, sophisticated and nuanced. Hence, I would argue that it is this evolutionary shift that ensures that such theories maintain relevance and applicability to research and life today.

### 3.2.2 Epistemology and ontology

The core tenets of social constructionism are underpinned by epistemology and ontology. Traditionally they are treated separately. However, Crotty (1998) proposed that epistemology and ontology are unable to exist alone and instead

are positioned side-by-side informing theory. To say that something is what it is regardless of our understanding or labelling is objectivist epistemology and is rejected by constructionists, including myself.

Epistemology and ontology are abstract principles that guide theoretical positions. Epistemology provides a philosophical position for which decisions related to forms of knowledge are possible, ensuring that knowledge is both adequate and legitimate to inform what it means to know (Crotty, 1998). Epistemology seeks the relationship between the inquirer and the known (Denzin & Lincoln, 2011), studying the nature of knowledge and how we come to know the world (Burr, 2015). Ontology is the study of being, concerned with what it is, and inquiring about the nature of its existence, and the nature and structure of reality (Crotty, 1998; Denzin & Lincoln, 2011). In other words, ontology is a discursive account of '*what it is*'.

Epistemologically, social constructionism rejects the stance that the truth is 'out there' waiting to be discovered. Instead, the truth is taken as a co-construction arising between the differing realities of individuals. In engaging with the world, understanding of an individual's reality finds meaning. Meaning is not discovered, but rather, meaning is constructed. This epistemological '*knowing*' accepts that different people will construct different experiences for the same phenomena (Crotty, 1998).

Holstein and Gubrium (2008) cautions of great harm when we assume, believe or accept that research can or should identify the objective universal truth. Attempts to identify universal truths encourage thought toward the "fatalistic status quo" (Holstein & Gubrium, 2008, p. 15), naturalising aspects of existence that are inevitable and ought to be challenged and changed. Contributing to the evolution of knowledge and remaining abreast of social influence, social constructionism provides a lens to challenge the presenting circumstances, exploring what is and how it came to be. This acceptance of more than one truth adds to the credibility of social constructionism and its acceptance as a valuable theoretical position used in research (Holstein & Gubrium, 2008).

Through social interactions, relationships and experiences we create our own version of reality. Ontologically, reality is contextual and socially relative and therefore many realities can exist simultaneously (Berger & Luckman, 1966). Our perceptions and experiences of real phenomena are brought to existence and then shaped as a product of the language we then share with others (Burr, 2015). In constructing our reality, we also construct our knowledge and meanings derived from social interactions. These are held in the mind. Thus, ontologically and epistemologically, social constructionism establishes that reality and meanings are not unique in nature. Instead, they are constantly negotiated realities with different meanings (Berger & Luckman, 1966; Spencer, Pyryce, & Walsh, 2014). As we think or talk about the world we begin to represent what it is to us. Thus, through discourse and interaction with others, we create and construct our accounts of the world (Burr, 2003, 2015).

A social constructionist embraces that knowledge and as a result the meaning of reality is contingent on human practices. Through interactions with others and the world we co-construct knowledge and meaning that is transmitted and developed within an essentially social context (Gergen, 2015; Hosking, 2008). During the construction of meaning the objective and subjective elements become interwoven and difficult to separate, existing together and central to meaning. It is this construction of meaning that is explored in constructionism (Fish, 1990).

As individuals we are all different. As a result, we have the capacity to construct different understandings, critiques, analysis and co-constructions to form a perspective that contributes to a common shared standard. For social constructionism, reality cannot be constructed from meaning and '*truth'* without the mind. Therefore, meaning is not discovered but constructed (Gergen, 2015). This constructed meaning by individuals can differ even when referencing the same phenomena. This explains the different ways people interpret and construct meaning from the world in which they engage. A key influencing element of constructed meaning is culture. Nursing culture includes but is not limited to learned behaviours, specific language (medical/nursing terminology) and patterns of thoughts and perceptions (Scott & Marshall, 2009). Social

constructionism fosters a critical spirit to examine the impact of culture on how the world is seen and perceived by the individuals who live within it (Crotty, 1998).

Social constructionism is acceptance of multiple realities and holds that all accounts are legitimate. This position is underpinned by the understanding that an individual's perception and view of reality is influenced by their experience and position within society. When an individual shares their perceptions and reality with others, they contribute to the social construction of events of those involved in the social interaction. There is no ultimate truth and reality to find and share. Instead, there are many different versions of reality and it is these versions we seek to find.

Those that claim that social constructionism is contradictory perhaps have not understood the relationship between realism and relativism, as viewed by social constructionists. A meaning that is socially constructed, therefore relative, doesn't imply that it is not real. Crotty (1998) suggests that instead of comparing 'realism' against 'constructionism' it ought to be contrasted to 'idealism'. Idealism is the philosophical view that real is confined to our minds, consisting simply of ideas, which is more aligned with a social constructivism perspective. Burr (2015) proposes that "through social interactions and relations with others, each of us develops a system of dimensions of meaning, or 'constructs'" (p.22). As members of society, culture and social groups much of our understanding is shared with others. Relativism is an important concept of social constructionism; therefore, it is discussed in greater detail in section 3.2.4.

### 3.2.3  Social constructionism to critical social constructionism

From social interaction and the subsequent generation of meaning social constructionism has evolved, providing a continued relevance as a theoretical position. It is agreed that social constructionists seek to identify, understand and explain the generated meaning between individuals (Gergen, 2015; Holstein & Gubrium, 2008). Social constructionism also seeks to identify, explain and create opportunities for change, using critical perspective.

A critical perspective aims for further advancement of social needs and embraces a practical aim (Haslanger, 2012).  That is, it should be helpful to those committed

to furthering social justice through the research question asked. Critical theory is not intended to convince non-believers that there is a problem. Nor is its aim to prove that there is only one belief. Critical theory is a resource to answer a question and to address a concern (Haslanger, 2012). Through questioning and critique the world is offered a lens, such as critical social constructionism, that can be used to generate progressive social change (Holstein & Gubrium, 2008).

Critical social constructionism arises from a critical theoretical perspective (Hosking, 2008). Critical theoretical orientations traditionally focus on power inequalities seeking to expose the related status quo (Holstein & Gubrium, 2008). Caution must be exercised by the researcher to not assume an individual, group or culture is oppressed. Likewise, the researcher must exhibit care to not overlook the influence of power (Hosking, 2008). Social constructionism initially influenced this research but moved towards critical social constructionism as the findings revealed the subtle, pervasive presence of power.

Critical social constructionism makes power explicit, treating health care as a political and contested site, while centralising the importance of engaging with people as humans. Rather than simply applying theory, researchers engage with theory to draw understandings and influences from many disciplines (Latimer, 2008). Drawing from widespread theory enhances the development of understandings from multiple perspectives and creates greater insights.

The field in which research occurs is a complex arena where boundaries are determined by the researcher and caution needs to be exercised. The researcher, if unaware, may apply a field that is restrictive and may inhibit the constructed understanding. If a researcher approaches the field with the belief of oppression, freedom or political undertows the field becomes set, and the research becomes biased (Latimer, 2008). The researcher therefore sees a reality of oppressed individuals that may not feel oppressed, which prevents the researcher from revealing the reality.

Latimer's (2008) point of the researcher determining the field in critical social constructionism is vitally important for a researcher determining the field, and expectation creates an inability to reveal what is occurring and why it occurs. The

ability to identify connectedness, and create understanding becomes lost, with a risk of the participants becoming confused. Or as Latimer (2008) so bluntly expressed, "cultural dopes" (p.157). It is after all the intent of critical social constructionism to identify how people constructed their reality, what brought them to their perceptions and ultimately why.

Founded in the theoretical position of social constructionism, many participants revealed that their choices for CPD were driven by elements of power and cultural influence. These shared realities provided with an opportunity to extend the research beyond what occurred, to the identification of the underlying influencing elements. Thus, taking the theoretical influence from social constructionism to critical social constructionism seemed a more organic process to explore the positioning of participants.

Power is viewed as an ongoing, relational construction that can open and close possibilities. Power is not thought of as one-way or uncontested (Hosking, 2008). While power contributes to a political arena and shapes realities, critical social constructionism approaches the individual as a person, not as collective groups or oppressed victims (Latimer, 2008).

To elicit change and create avenues for forward movement, as explained by Latimer (2008) "we have to get inside nursing" (p. 158). To do so, we need to understand nursing and understand its cultural context and social practices. Over considerable time this can be achieved by observing and learning about nursing, but it is best learned on the job by being a nurse. As a nurse I know nursing, not as everyone knows nursing, but as *I* know nursing. This means that when I am with other nurses we share a commonality. We have a core set of shared beliefs and experiences. This affords a connectedness and creates a shared space. This space allows the ability to connect with other nurses, move deep into their realities and explore what brought them to such realisation.

### 3.2.4 Realism and relativism

As a Critical Care Nurse (CCN), I find the area of philosophy challenging. I am used to pragmatic and analytical aspects of life heavily influenced by the scientific positivism realm. The aspects of 'I see A' because of 'what is occurring at B' is

embedded in my being. Yet I also see capacity for multiple realities and for things to be relative and influenced by others. Human physiology is influenced by illness, but the experiences of an illness can be starkly different between individuals. This ability to see both is where I find myself on the spectrum of realism and relativism. This ability to move in both directions is dependent on my perceived reality which is contextually determined.

The realism-relativism spectrum is intensely debated in the literature. Some literature refers to relativism as anti-realism (Nightingale & Cromby, 2002). In this research the term 'relativism' will be used to identify its separate position independent of realism. Debate about the alliance of social constructionism to realism or relativism would place it at both ends of the spectrum as well as between (Andrews, 2012; Freeling & Parker, 2015; Gergen, 2015; Haslanger, 2012). This capacity to be placed along and in the middle of the spectrum is achieved with the belief that there can be an independent reality, a pathophysiological process of illness. But there is denial that there can be direct access to the reality (i.e. the experience of the illness). Instead, a representation of reality, not a reproduction of the social phenomena is achieved. This allows the middle, or subtle realism position to be possible (Hammersley, 1992).

Multiple accounts of perceived realities are accepted under the positioning of relativism in critical social constructionism. It is proposed that to be a relativist is denying that the world exists independent of our images of it. In addition, a relativist embraces multiple realities, influenced by individuals who have the capacity to generate multiple realities side by side (Kirk, 1999). I refute the belief that a critical social constructionist must be a realist or relativist, aligning myself instead with an ability to move along the spectrum dependent upon the context. Gergen (2015) supports this position suggesting that one must guard against foundationalism to "sealing ourselves off from other possibilities" (p.200) where voices are silenced. Declarations of real and absolutes close options for dialogue, and the multiple realities are consequently hidden and unable to be revealed. This would amount to the antithesis of critical social constructionism.

Critical social constructionism has been questioned for challenging realism and querying reality (Andrews, 2012). But it does not have to be one or the other,

rather it can be both. Realism can have a biomedical perspective of 'what is' accompanied by a unique interpretation of the individual's collection of experiences. An example is a person with Stage IV terminal cancer, but who expresses gratitude for this diagnosis as it makes them a better person.

The usefulness of findings under a relativist approach have been questioned (Hammersley, 1992). If multiple realities are all legitimate and are found without preference of one account over the other, how can there be a contribution to knowledge? It has even been proposed, by opponents to relativism, that relativist research does not contribute to knowledge in a meaningful way and therefore its use is limited, if not obsolete (Hammersley, 1992). What Hammersley overlooks is the immeasurable value in understanding different perspectives. When individuals present their reality as it is, new understandings and knowledge are established including that of the suppressed and overlooked.

The position or positions that one takes on the realism–relativism continuum are important aspects when considering the research and the findings. To sit as a realist would indicate I do not influence the findings and what is reported. Clearly this is not true. Just as a relativist argues that there is no right or wrong, multiple realities allow for truth to exist in all forms (Andrews, 2012).

As the researcher, I place myself in the middle of the spectrum, constantly questioning my influence in the research. I remained acutely aware of my feelings, beliefs and perceptions of the topic, careful to limit the impact of my views of the constructions with participants. Likewise, I explore the realities shared, guided by the theoretical positioning of social constructionism, as a contribution to knowledge that may potentially benefit the profession of nursing.

The acceptance of multiple realities being shared, leading to change, is supported by Haslanger (2012). Haslanger explains it is not until the different perceptions of reality are shared that there is hope for positive change to occur. This point is pivotal in critical social constructionism's acceptance of the forms of relativism with different accompanying realities. With both relativism and realities, effective change can be brought about.

### 3.3 Methodology

A methodology provides a lens used to acquire knowledge of the world. Providing methods and theory for which to explore the topic (Denzin & Lincoln, 2008; Leavy, 2014), and is guided and aligned with the theoretical perspective. As such, critical ethnography was an appropriate methodology for this research because of its strong congruency with critical social constructionism.

#### 3.3.1 Critical ethnography

Steeped in extant anthropological history, ethnography is naturalistic research that seeks the descriptions of life to understand social reality on its own terms (i.e. 'as it really is'). Ethnography brings with it a history of revealing culture and developing knowledge of practices and behaviours. It is important that ethnography as a methodology is clarified here from methods of ethnography. Ethnography is often used to describe how data were collected, the methods, instead of the theoretical underpinnings of the methodology, the plan (Holstein & Gubrium, 2008; Wolcott, 2008). It is my intent to discuss the methodology of ethnography in this chapter, followed by the research methods in chapter four.

The beginnings of ethnography can be traced back to the Chicago School of Ethnography, 1917 to 1942. Anthropologists built a significant body of knowledge using ethnographic methodology to explain culture and the world, as it was locally and in far off distant lands. Today the methodology of ethnography is shared by many disciplines as we live in an observational society where individuals seek to explain what is occurring around us (Atkinson et al., 2007; Gobo, 2008). Ethnography has been used widely across nursing and health care research to reveal the culture and behaviours of the individuals within.

The anthropological history of ethnography aligns with investigating the foreign and unknown. It seeks to understand patterns and behaviours and is often undertaken by those who are not familiar with the area of research. A sociological approach seeks to understand patterns and behaviours, placing a greater emphasis on aligning the findings to theories to explain the phenomena. The ethnographer embarks on their research with a cognitive aim to identify the

natural attitudes, social conventions and everyday behaviours as they are socially constructed (Gobo, 2008).

Fundamental to ethnographic research are the terms of '*emic*' and '*etic*' which refer to the positions of individuals involved and the view of the beholder. The term '*emic*' is used to reference the insider's view of the world that is held by those who live within it. In obtaining the '*emic*' view the researcher can attempt to explain why participants do what they do. There is not one '*emic*' perspective for there are multiple versions of reality, when versions of the '*emic*' are combined understandings of behaviours can occur. An '*etic*' perspective is external, the social scientific perspective of reality. Through ethnographic methodology, using both '*emic*' and '*etic*' perspectives, ensures a thorough collection of data (Fetterman, 1998).

Ethnography offers opportunities to explore why people do what they do. This includes exploring social interactions, behaviours and perceptions that exist within teams and communities of people in the chosen environment (Oliffe, 2005; Reeves, 2008; Roberts, 2009; Roper & Shapira, 1999). Methodologically, ethnography is founded upon observation and fieldwork. The researcher is required to develop a presence within the field. Of course, not all fields can be lived in and this requires the researcher to establish a presence. Here the ethnographer opens him/herself to all experiences, gains insights from participants and develops an understanding of what is occurring (Wolcott, 2008).

Researchers need to be cautious when applying ethnographic methodology to their research. While observation is core to the ethnography, not all research participants and topics can be observed, but the research can remain ethnography based (Wolcott, 2008). This is supported by Angrosino (2007) who noted that it is possible to use data collection techniques typical for ethnography in ways that do not require participant observation. It is suggested by Angrosino (2007) that in some research participant observation would not yield the data conventionally intended in ethnography.

The ethnographic methodology approach to research is commonly undertaken by those who are unfamiliar with the research field. It is argued by Gobo (2008)

that if the researcher is familiar with the area they are unlikely to see the fundamental social structures upon which culture and society rest. But it is this insider perspective, the '*emic*', that has allowed unobstructed access to nurses in intensive care and resulted in this research topic/question being developed. It was through seeing nurses' behaviours and attitudes toward CPD that the research question emerged. The *'etic'* was achieved by taking the research to an area outside the researcher's professional location (i.e. clinical field sites where no past interactions existed).

Having an *'emic'* perspective allowed the research participants to share a common understanding and knowledge of the world of an intensive care nurse. This understanding could only be gained by the outsider after months or years of observation (Wolcott, 2008). Even then the shared experiences of caring for critically ill patients could never be truly understood as the researcher would have observed but never grappled with the experience. This insider experience of the researcher as an intensive care nurse provided great insights into the day-to-day experiences of participants. It was this shared common ground during interactions that enabled participants to use terminology and intensive care language that did not require in-depth explanation and instead revealed a shared reality. Significantly, common ground existed between researcher and participants that would not have been possible if the researcher was not an intensive care nurse. This lends strength to the research and contributes to the researcher's ability to draw on the multiple realities of participants.

Ethnography must draw on theory to guide the research and the approach taken, including the methods adopted under the umbrella of ethnography. Ethnography seeks the '*what'* and when, influenced by the theory of social constructionism that seeks the '*how'*, and this produces research that describes the '*what'* and *'how'* of nurses' approaches to socially accountable CPD. Placed together social constructionism guides ethnography, to look at and hear activities through which everyday individuals produce the orderly, recognisable, meaningful features of their social worlds (Holstein & Gubrium, 2008).

### 3.3.2 Evolution of ethnography – critical ethnography

The evolution of research methodologies has resulted in the extension of ethnography to critical ethnography. Critical ethnography draws on cultural studies using a critical pedagogy that theorises social structural constraints and human agency (Atkinson et al., 2007). This critical methodology aims to identify the relationships between structure and agency to create opportunities for empowerment of the researched. A critical ethnography takes a political stance and makes explicit its aim to change the world. This paradigm has been influenced by the works of Pierre Bourdieu, deeply rooted in sociology (Atkinson et al., 2007), and falls under the post-modern umbrella of ethnography (Gobo, 2008).

**What it is**

Moving beyond the aim of identifying the social world for how it is, critical ethnography is the intent to create opportunities for change. Critical ethnography thus approaches research with a resolve to bring the events of everyday life to the forefront in order to bring about change (Jones & Watt, 2010). The overarching goal of critical ethnography is to free individuals from sources of repression and domination. Critical ethnography requires insights into the production and mediation of wider structures that produce change, and as a consequence, is both hermeneutic and emancipatory (Atkinson et al., 2007).

Critical ethnographers take a political stance, sometimes seen as radical, making explicit their intent to highlight a need for change (Atkinson et al., 2007). Critical ethnography however does not oppose traditional ethnography. Instead, it provides a more direct approach to thinking about the relationships among knowledge, society and political action. Ethnography offers a powerful means to critique culture and the role of research within it. For the critical ethnographer the ability to be scientific and critical is embraced and considered a strength (Thomas, 1993).

Critical ethnography should not be confused with critical theory. Instead, critical ethnography is conventional ethnography with a political purpose (Thomas, 1993). Conventional ethnographers commonly speak for their subjects to an

audience of peer researchers. A critical ethnographer focuses upon giving power and authority to participants as they communicate on their behalf about the research topic. Consequently, critical ethnography proceeds from an explicit framework that modifies consciousness or invokes a call to action and attempts to use knowledge for social change. A conventional ethnographer studies culture with the purpose of describing it. Critical ethnographers do so to create opportunities for change. Conventional ethnographers recognise the impossibility, even undesirability, of research free of normative biases, believing that biases are to be repressed. Critical ethnographers instead celebrate normative and political positioning as a means of invoking social consciousness and societal change (Thomas, 1993).

**What it does**

The critical ethnographer takes the research beneath the surface and questions the proposed wisdom disrupting the existing state of affairs. This produces enquiries about taken-for-granted assumptions, bringing to light the underlying and obscure modus operandi of power and control. A critical ethnographer moves from 'what is' to 'what could be' (Madison, 2012). This movement permits the identification of what is happening and provides opportunities to expose shared rhetoric. This action is undertaken with core recognition of the need to be ethically responsible to those that live in the reality (Jones & Watt, 2010).

When research is undertaken to bring about change there is often the thought that the cultural group is marginalised and in need of representation. This is not always the case and requires ethical care. Critical ethnography draws upon the expressions of social groups to identify what occurred that resulted in social control and the creation of power imbalances as a means to illuminate and correct (Madison, 2012; Thomas, 1993).

Care must be taken when applying critical ethnography to research. The postmodern ethnographies, such as critical ethnography, dispute the authority of the objective participant observer, and often criticise classical ethnography for being realist, impersonal and falsely neutral (Gobo, 2008). Classical

ethnographies entitlement to say, 'I know what it is because I was there' is called upon to be dismantled.

The style of analysis and discourse of critical ethnography remains connected to conventional ethnography. The core rules of ethnographic methods and analysis share commonalities while being distinct from each other. Conventional ethnography refers to the tradition of cultural description and analysis displaying meanings by interpreting meaning. Critical ethnography references the reflective process of choosing between conceptual alternatives and making value laden judgements of meaning methods to challenge research, policy and other forms of human activity (Thomas, 1993). Critical ethnography therefore draws on descriptions and interpreted meaning to form critique and suggested change of the social world.

## 3.4  Using critical ethnography as methodology

A critical approach to research requires that the researcher's position is overt and stated. The researcher, activists, participants and other audiences contribute to the research as critical participants. The critical researcher must take ethical responsibility for his/her own subjectivity (Jones & Watt, 2010).

I entered this research acutely aware of my position as a CCN. I had worked in a metropolitan unit where the tone of discussions, between nurses, toward the implemented CPD changed. As a nurse, I was concerned with the approaches being taken, for I was confused, as were others, by the processes of the impending changes related to CPD. I talked with other nurses, and I did not understand the model or its underlying intent before embarking on this research.

I hold strong views on employers that promote meeting the mandatory CPD of the Nursing and Midwifery Board of Australia (NMBA) by completing the institutions mandatory competencies. I view the hospital mandated employee competencies such as hand hygiene, fire training, occupational health and safety and clinical skills, such as medication administration or basic life support, as a requirement of employment rather than CPD that posits new or expanded knowledge. I am astutely aware of my position surrounding the need for new knowledge that can benefit patients I care for, to be considered CPD. Self-

awareness of my views was essential to protect the perceptions of my participants from becoming lost under my own views and beliefs or obscured.

Acknowledging feelings generated by observing and being in the social world of research must be acknowledged by the researcher (Thomas, 1993). Critical ethnography is complex requiring multiple voices, multiple subjectivities and multiple meanings (Jones & Watt, 2010). This requires deep reflection with articulation and ownership of beliefs, feelings and experiences of the research remaining at the forefront of the analysis. Subjectivity in critical ethnography is an interplay of self with those within the research field. If it was all about my experience this would be an autobiography.

Critical ethnography demands positionality and awareness on the part of the researcher that his/her actions in studying and representing people and situations are acts of domination. Positionality forces the researcher to acknowledge their own power, biases and privileges just as they denounce the power that surrounds the subject and field (Madison, 2012).

Positionality is sometimes understood as reflective ethnography (Wolcott, 2008). This requires consideration and accountability for our research paradigms, our positions of authority and our moral responsibility related to representation and interpretation of the social group. Important questions of positionality need to be addressed in reflexive ethnography. In particular the use of the research, that is, who ultimately benefits and who gives the authority to make the claims we do about what we have been witness to? The background and the history of the ethnographer also need to be clarified. Do they share commonality with the social group, or do they have no past connection to the research topic (Madison, 2012)? This awareness is embraced to protect the research and findings from the researcher.

Critical ethnography is heavily entrenched in the dialogue with others. This is driven by our concern for others. Ethnographic positionality should not be confused with subjectivity, which is a domain of positionality. But positionality demands we project our attention beyond our individual or subjective self. Instead, we attend to our subjectivity in relation to and in our interactions with

others. We are subjects in dialogue with others to co-construct meaning from multiple perspectives (Madison, 2012). Madison (2012) contends that "critical ethnography is always a meeting of multiple sides in an encounter with and among others. One in which there is negotiation and dialogue toward substantial and viable meanings that make a difference in others' worlds" (p. 10).

Critical ethnographic reflection examines culture, knowledge and action. It broadens the capacity to see, hear and feel expanding horizons and make choices. Critical ethnographers describe, analyse, open up hidden agendas to scrutiny, exposing power centres and assumptions that inhibit, repress and constrain. As individuals we live in a world where reality is taken for granted. This taken-for-granted world often seems too confusing, powerful or mysterious to delve beneath the surface. It is complex and difficult to see clearly and address the fundamental problems of social existence experienced on a daily basis (Thomas, 1993).

### 3.4.1  Ethical aspects of methodology

Critical researchers acting ethically have a responsibility to uncover injustices and challenge power. Care must be taken to not label a group oppressed if they do not believe they are oppressed (Madison, 2012). Research objectivity is a potential and dangerous illusion. Critical ethnography allows a researcher to commit to uncovering accounts that may reveal further questions. This provides depth and richness that can be found lacking in other research (Jones & Watt, 2010).

Critical ethnography begins with an ethical responsibility to address unfairness or injustice in a lived social field/domain. The ethical responsibility that is identified as the motivator for a critical ethnographic approach references a sense of duty, commitment and passion for compassion to enhance the lives of those individuals in this world/domain (Madison, 2012).

Critical ethnography demands the critique of the notion of objectivity as well as subjectivity (Madison, 2012). This critique demands that care be taken to avoid passing perceptions and feelings as fact. This includes ensuring that researchers are positioning conclusions that have convincing theoretical and empirical

linkage. Through exposing the researcher's positionality, we allow accessibility and transparency while welcoming vulnerability to judgment and evaluation. This provides ethical responsibility for our own subjectivity as researchers and our political perspectives, resisting the trap of self-centeredness or presenting an interpretation as if free of 'self' with no accountability for consequences and effects (Madison, 2012).

Fieldwork is complex and personal experience is aligned with the philosophical positioning and theoretical framework of the research. Our intuition, senses and emotions are woven into who we are as individuals and researchers. These are inseparable from the processes of data collection. As researchers we invite the ethics of accountability and take a chance in being proven wrong (Madison, 2012).

## 3.5    Conclusion

Critical social constructionism with critical ethnography underpin the exploration of the research topic. It is core to this research to identify the approaches and perceptions of the Critical Care Registered Nurse toward CPD and social accountability. Critical social constructionism provides the avenue to explore 'how' nurses achieve this, while critical ethnography provides the 'what'. This researcher aligns with the ethical requirements of researcher positioning. The intent is to bring positive change to a system of mandatory CPD that has a distinct mismatch between the rhetoric and reality. It is also viewed as having greater potential than what is currently being achieved.

This research needed to do more than describe how it is. A critical methodological approach provided the scaffolding to achieve this. The combinations of critical social constructionism, the exposing of power, with critical ethnography, the experience, the ability to ask what may be, contributed to possibilities of change. This research goes beyond explaining the situation as it is and creates thoughts of what could be.

In the next chapter, the methods will be discussed with a particular focus on congruency with the methodology.

# Chapter 4

# Research Design and Methods

## 4.1  Introduction

The design and methods of this research are grounded in the philosophical stance, theoretical perspective and methodology discussed in the previous chapter. This section of the thesis identifies and justifies the research processes used with detailed explanations of the techniques applied and the setting in which the research was undertaken (Crotty, 1998). This research embraced the complexity, details and contexts that surround the engagement of Critical Care Nurses (CCNs) with Continuing Professional Development (CPD).

The research design emerged with refinement of the data collection. Qualitative research embraces a non-linear approach more aligned with a circle, with continual examination and interpretation of the data to make decisions that guide the research in moving forward (Polit & Beck, 2012). Some decisions were made early on, such as the application of social constructionism and ethnography and the use of a collective case study design plus methods (e.g. interviews), to collect the data. Other insights and decisions, such as moving to a critical analytical lens, occurred only after gaining of insights from participants and greater understanding of the phenomena.

This chapter will present the choices and decisions made about design, sample, setting, rigour and ethical issues, providing an audit trail for a researcher to follow, which also speaks to the rigour of the study.

## 4.2  Design: A collective case study

The applied research design was a collective case study influenced by the naturalistic approach of Robert Stake and Helen Simons. A naturalistic collective case study was adopted to unravel the complexities of one demarcated entity in a real-life context (Abma & Stake, 2014; Simons, 2012, 2014). A collective case study engages more than one participant (i.e. case), and can involve more than

one field site (i.e. institution) (Stake, 1995). This research was a collective case study that involved twelve participants and three health care institutions/field sites.

A collective case study is not defined by methodology or methods but rather its singularity plus the concept and boundaries of the case (Flyvbjerg, 2011; Simons, 2014). Ragin and Becker (1992) describe the singularity and boundaries as the '*casing*' of the study. The singularity of this collective case is the CPD model that has been mandated and implemented by the Nursing and Midwifery Board of Australia (NMBA). The boundaries of the case are as follows:

1. **Participant Boundary**: Registered Nurses (RNs), twelve participants, who worked in critical care areas. Inclusivity involved currency in practice and registration requirements of the NMBA.

2. **Health Care Facility Boundary**: Three Intensive Care Units (ICUs) accredited as level two acuity by the Victorian Department of Health. The standards for acuity are formulated by the College of Intensive Care Medicine of Australia and New Zealand (2011) guiding patient admissions and related care within each ICU. Each ICU was situated in a public hospital that had capacity for over 200 hundred patients and a minimum of six beds per unit.

3. **Location Boundary**: Geographical locations of the regional health care facilities. Specifically, the townships in which the health care facilities were located had populations greater than 30,000 people and each was located within 300 kilometres of Melbourne. This boundary of distance refined the participants from the field sites to nurses likely to experience similar geographical barriers. Specifically, the barriers experienced when accessing formal CPD opportunities that are predominantly offered in metropolitan locations.

4. **Conceptual Boundary**: CPD is the conceptual boundary, which sets the focus of the research and creates a frame that influences the approaches taken to investigate the subject area (Simons, 2014).

The naturalistic collective case study design is emergent, being shaped and re-shaped as a greater understanding of underlying issues that surface, ensuring a

deeper discovery of meaning as perceived by the participants (Abma & Stake, 2014; Simons, 2012, 2014; Stake, 2000). This does not mean that the research retains a fixed philosophical or theoretical perspective throughout. Instead, it creates opportunities for greater depth in understanding ways in which RNs in ICUs view mandatory CPD. This research design evolved and progressed during the period of the research, influenced by the participants and their shared experiences. The movement of the theoretical perspective in this collective case design, from an interpretative perspective to critical interpretative analysis, arose directly from the alignment of the methods with the methodology.

A collective case study is intensive and embraces the richness and variance that occurs with the inclusion of more than one case or participant. This approach yields depth, exposing views with the power of detail that creates opportunities to illuminate the complexity of the CPD policy mandated by the NMBA (Flyvbjerg, 2011; Simons, 2014). Drawing from participants' experiences, the intertwined relationships that exist between perceptions related to CPD and the regional critical care environments, expose and construct the context of the case (Flyvbjerg, 2011). The intent of this collective case study was to build an understanding of the aspects that influence a CCN's approach to CPD that complies with the NMBA mandate, which in turn informs the profession moving forward.

Abma and Stake (2014) warn that this emerging approach in research can result in universalism with a shift in the focus of the research from the case itself to the identification of general and universal patterns. Protecting the research from this universalism was paramount to the researcher retaining the uniqueness of each case and the collective case study. This required vigilance to maintain focus upon nurses and their perspectives and experiences of CPD.

A case may be simple or complex, it may be a nurse or a nursing ward, or it may be the adoption of CPD into a profession. Complexity of the case arises in social sciences as individuals/people who are part of the case. Each individual is part of a society and is multifaceted. A case evolves from the bounded system it exists within while including aspects that are semi-fluid in nature, and each individual is unique and different despite common attributes. Therefore, to address these

challenges, it is important to clarify the conceptual elements and interrelationships of the case. The case must be specific, complex and functioning. Thus, the focus on CPD has been narrowed using the boundaries of the case to centre upon CCNs that work in regionally located ICUs and their adoption of the NMBA model of CPD.

## 4.3   Methods

### 4.3.1   Recruitment process

Recruitment of participants commenced after receipt of ethics approval. First contact with potential participants of the health care facilities began with a printed and emailed flyer that advertised this research and invited participation. In negotiation with nurse unit managers, in each of the three locations, the researcher visited each field site and spoke to potential participants as a group.

These group interactions involved the researcher providing an explanation of the research verbally and in written format, using plain language information statements. The introductory session also created an opportunity to answer any questions that potential participants raised about the research. Printed plain language information statements and consent forms, were provided to all potential nurse participants for them to consider in their own time. Stamped self-addressed envelopes enabled participants to return their consent at a later date, if they wished to partake in the research after further contemplation.

Indication of interest to participate was raised by some potential participants during private, one-on-one conversations, separated from colleagues, ensuring confidentiality of participants. Those who agreed to participate were required to sign a consent form prior to any negotiation of time or place for interviews.

### 4.3.2   Participants

Twelve Division One RNs participated in this research from three regional Victorian ICUs. Four participants partook from field site A, six participants from field site B and two participants from field site C. All twelve participants were currently working in their local area either in a part- or full-time capacity. Positions

held by the participants included nurse unit manager, nurse researcher, nurse educator, CCNs, clinical nurse specialists and associate nurse unit managers.

The gender of the participants consisted of one male and eleven females. In Victoria, Australia, there was a total of 68,036 RNs in 2016, of which 60,494 were female and 7,542 were male, meaning that nine percent of the Victorian nursing workforce is male (Nursing and Midwifery Board of Australia, 2016f). This equates to one male to nine female nurses. This research has a one to eleven ratio of male to female participants, which is slightly lower than Victorian statistics, yet comparable and expected.

The age of participants ranged between twenty-six and fifty-five years of age, with the majority of participants in their mid-forties. All participants had undertaken further education in the speciality area of critical care nursing. This is in addition to the initial education which led to registration as a nurse. This further scholarship occurred in the form of postgraduate study. Among participants further qualifications were obtained in two ways. Six participants had undertaken their extended training within the hospital setting, commensurate to delivery of education within nursing at the time (Patrick & Lavery, 2007). The remaining six participants had undertaken university study to obtain a postgraduate certificate or diploma in critical care nursing. This mixed exposure to education is common in nursing because of the relatively recent shift, past twenty to thirty years, of preparatory training from hospitals to education in universities.

### 4.3.3  Setting and time

Eight health care institutions were identified as potential sources of participant recruitment. This choice of settings was guided by public registers outlining the patient capacity of each ICU. Looking for similarities across field sites narrowed the possibilities for suitable settings. Ultimately three ICUs were identified as preferred field sites.

The data collection period extended over four months was brought about by the timing of ethics approval from the Ethics Committee of each field site. Each field site was attributed a label and they are referred to in this research as field site A, B & C, reflective of the order in which the data collection was undertaken.

### 4.3.4 Ethics approval

Ethics was first submitted and obtained from the university Human Research Ethics Committee (HREC) of original doctoral enrolment and then extended after transfer of study by the HREC of the current university (Appendix A). Following ethics approval contact began with the chosen health care facilities ethics department to explore the potential of this research occurring in their facility. Health care HREC committee representatives suggested that support be gained from department managers, the Director of Nursing and the Director of Hospital Research. This was a requirement at all three sites and accompanied all submissions for approval to the relevant HREC committees.

Participants that expressed interest in the research were required to read the plain language information statement (Appendix B) and sign the consent form (Appendix C) prior to interviews occurring. All participants were provided with a copy of both the plain language statement and the consent form for their own records and were also given the opportunity to have any questions answered before interviews proceeded. In addition, participants were verbally reminded that they were able to withdraw their consent at any time, without any negative repercussions. No one withdrew.

### 4.3.5 Data collection

The interviews conducted in this research were influenced by Kvale and Brinkmann's (2009), and the methodological influences of critical ethnography and theoretical perspective of critical social constructionism. Thus, the words shared in interviews were considered for their subcultural and cultural connotations as well as their literal meaning (Atkinson et al., 2007; Fetterman, 1998). The researcher draws from experiences and perceptions as they are portrayed by the participant to construct meaning. This new understanding and meaning is a co-construction, unable to be created by the researcher alone and dependent on the disclosed beliefs and views of participant's (Atkinson et al., 2007; Koro-Ljungberg, 2008; Kvale, 2014; Kvale & Brinkmann, 2009).

Influenced by social constructionism, interviews are a tool that can facilitate the formation of social meaning. By focusing the interviews upon the CPD activities

of participants the underpinning influences of social processes and contexts can be unveiled (Koro-Ljungberg, 2008). Therefore the interviews sought to extract from participants what they know, in the way that they know it, inclusive of social contexts (Atkinson et al., 2007).

The success of interviews as an effective research method is dependent on the interviewer's ability to listen and convey to the participant that they have been heard (Kvale & Brinkmann, 2009). Guided by this approach the researcher would regularly reframe what the participant had said, in the newly co-constructed meaning. This created opportunities for the participant to realise how they were heard and also contributed to accuracy in perceiving the constructed meaning of each participant. Probing and further questioning by the researcher elicited greater depth in the newly co-constructed meaning.

Equally important to the success of the interview is rapport between the participant and interviewer. A strong rapport facilitates depth and a genuine exchange with openness. Comfort levels of participants with the researcher define the depth of knowledge and experiences shared (Atkinson et al., 2007). The researcher drew on her personal experiences as an intensive care nurse, sharing experiences where appropriate and demonstrating shared common ground, and this was effective in facilitating trust. When participants exposed sensitive cultural patterns of behaviour, such as negative workplace behaviours, the researcher also provided reassurance about confidentiality of the participant and the field site. This included highlighting that each interview was a part of a collective case study approach, not a single individual case or field site.

Kvale and Brinkmann (2009) explain that an interviewer can take many approaches but is influenced by his/her predilections of how knowledge is acquired. Using the example of a '*miner*' and a '*traveller*' Kvale and Brinkmann (2009) suggest two epistemological conceptions of interviewing as a process to collect knowledge (i.e. a miner), or a process to construct knowledge (i.e. a traveller). Drawing from their work, this research was conducted using the epistemological position of a traveller. As a traveller, the researcher embarked on a journey to identify CCN's approaches to CPD using the conversations with participants along the way to construct knowledge. The travelling route was

planned but participants created unexpected twists and turns along the way in the content they shared, and the knowledge and understanding constructed (Kvale, 2014; Kvale & Brinkmann, 2009).

In this research, semi-structured interviews were well suited to the traveller's journey. A semi-structured interview offers the guidance and ability to explore a broad range of topics in which the researcher is interested (Minichiello, Aroni, & Hays, 2008). Using this approach, the questions for the interview are designed around topics, but did not require exact phrasing or fixation of words or order of questions across interviews. Minichiello et al. (2008) explains that this interview approach allows scope to be created, facilitating the exploration of participants' perceptions and consequently a more detailed construction of participants' reality.

The use of open-ended questions requires care, as Kvale and Brinkmann (2009) caution the researcher to be sure to not give specific opinions on a topic and risk biasing the participant. Guided by this, as the researcher, time was taken to become aware of the researcher's own beliefs about the topic to be sure to limit influencing the participants.

An interview guide, as suggested by Jamshed (2014), was used across all interviews. The interview guide created a form of consistency in the phrasing of questions across participants. This was also found helpful, as a deeper meaning was constructed across participant interviews and in the process of analysing the findings.

Due to the duration of data collection, four months, an interview guide facilitated consistency in the researcher's approach to the interviews across a considerable period of time. From each interview the researcher began to construct new knowledge and understandings of the topic. It was important to reflect upon these new insights but also remain consistent in interview questions. Failure to do so would have meant omission of the participant's valuable insights.

The interviews for this research were conducted at a time and place that was chosen by the participant. This decision, to allow the participant to select the time and place of interview, was in response to the researcher wishing to acknowledge

the importance and value of the participant's time and contribution. The interviews were conducted in a range of different locations including private offices, public spaces such as coffee shops, parks and participants' homes.

The interviews commenced with the participants sharing information about their professional life, such as age, past nursing experiences, qualifications and current workplace and distance of home from current employer. After gaining insight into the participant and their level of experience questions moved on to CPD. The first questions in this area allowed participants to explain what CPD meant to them, how they defined it, and their views on and engagement with CPD. This included asking about the factors that influenced their choices around CPD. Only after these areas were addressed did questions about their response to the NMBA mandate of CPD enter the interviews. This structure was important, as it allowed participants to gain comfort and develop a rapport with the researcher. This then created an opportunity for the researcher to obtain insights into the participant's perceptions of CPD prior to addressing professional expectations.

### 4.3.6  Rigour

Qualitative research is commonly undertaken embracing some degree of acceptance of relativism. Accepting multiple views does not allow qualitative research to be judged using the same criteria and approach as quantitative research (Ryan-Nicholls & Will, 2009). Assessing rigour in qualitative research must include consideration of the methodological and theoretical perspective to approach the area of inquiry in the research that has been undertaken (Cho & Trent, 2014). Rigour in qualitative research draws from the four areas of credibility, transferability, dependability and confirmability (Lincoln & Guba, 1986). These areas have been embraced as a framework to achieve rigour in this thesis.

**Credibility**

The truth of the topic is found within the human experience determined by lived experience and perceptions of the participants. In ethnography the truth is assessed in terms of the researcher's reflection on the research process (Ryan-

Nicholls & Will, 2009). The determination of truth lies within the plausibility of the claim. No knowledge can be countered as certain, but knowledge can be assessed based upon the "likely truth" (Hammersley, 1992, p. 69). Credibility is the ability to recognise participant experiences within the study in the findings and interpretations (Cho & Trent, 2014). Credibility can be achieved with triangulation, peer debriefing, and member checking, all which were used in this research (Lincoln & Guba, 1986).

Triangulation of data is an integral element of achieving rigour and validity in findings (Taylor, Kermode, & Roberts, 2006). Houghton, Casey, Shaw, and Murphy (2013) explain triangulation as a means to achieve completeness of data and confirming data. In this research, triangulation occurred by obtaining data from more than one field site and from different roles within the nursing profession. This diversity in nurses' roles, within the ICU, and geographical locations opened the research findings to multiple perspectives and assisted in achieving depth of data, which is key to rigour. The participant pool was also sheltered from one another with no pre-existing interactions. This allowed the findings from the three independent locations to be compared and combined. This added depth to the collective case study and assisted in identifying data saturation during the data analysis with observation of recurrent themes and experiences across participants and field sites.

Peer debriefing was embraced by the researcher throughout the doctoral study. Engaging in conversations with supervisors contributed to maintaining an openness to the data, and remaining congruent to the theoretical and methodological positioning of the research. Lincoln and Guba (1986) espoused that through exposing thoughts, views and actions, as the researcher, to professional peers the inquirer is "kept honest" (p.77). The experience of supervisors brought different perspectives to the research and facilitated an opening of my mind to further possibilities and occurrences.

Embracing the opportunity for feedback from peers and supervisors meant two pilot interviews were conducted. These occurred prior to the interviews with research participants and involved two CCN colleagues who volunteered their time and support. With their consent the interviews were shared with supervisors

for honest and constructive feedback. This experience contributed to the development of interview skills and was an integral part of achieving rigour in the research (Kim, 2010).

The pilot interviews generated exposure for the researcher to the role of asking questions for conducting investigative research. Furthermore, it offered an opportunity to test the questions and contribute to establishing rigour. During the pilot interview questions were tested, modified and confirmed as appropriate for use with participants. Pilot participants provided feedback around the research topic and the questions posed during the interview. They confirmed that the questions were clear and lacked ambiguity, creating an opportunity to provide their personal perspectives.

Member checking is encouraged to retain credibility of research, providing an opportunity for participants to confirm or refute co-constructions formed during interviews (Lincoln & Guba, 1986). The opportunity to refute a constructed understanding of the researcher was integral to this research, attaining true and accurate insights and descriptions. Throughout the interview process participants were provided with co-constructions of the discussion and asked to confirm or correct the accuracy or inaccuracy in the understanding that the researcher had formed about their views. This was important to me as a researcher, as I wanted to remain true to the participants' views.

**Transferability**

Qualitative research acknowledges that generalisations are rarely the goal. The inquiry emphasises the phenomena in the natural environment with less control over conditions found in quantitative research (Ryan-Nicholls & Will, 2009). Thick descriptions in the findings are used to provide transparency and detailed contextual information allowing the information to be compared to the work done by others (Cho & Trent, 2014). To build rigour and enable transferability, if appropriate, or replication dense descriptions are threaded throughout the thesis. These are provided to allow others to see the path that has been taken in this research with explanations as to why this path was chosen over another.

As a researcher I make no claims that the findings of this research are reflective of Critical Care Registered Nurses (CCRNs) other than those that participated in this research. The findings provide a window and a foundation on which other research can be based and wider exploration and development of knowledge surrounding nurses and CPD can occur.

**Dependability**

Using transparency of decisions throughout the thesis, from chapter one where my position as a nurse was concerned with policy of mandated CPD to the methodology and methods where I have outlined my theoretical perspective. In doing this I have created a window to view my approach to the research and allowed the reader to be a travelling companion along with me on my research journey. My positionality on CPD, critical social constructionism, critical ethnography and the realism/relativism continuum has been transparent for the reader. In doing this I invite the reader and possible critics to discover this research from my perspective. I acknowledge other paths could have been taken, but they would not have aligned with my views and beliefs of the world. I am not infallible, but in embracing the credibility of research rigour I have worked towards a robust thesis. Rationales for decisions are offered throughout my work.  This allows those that do not share my views or opinions to see the way that I have come to such positions and decisions (Houghton et al., 2013) and travel with me.

Reflexivity using personal contributions is threaded throughout the thesis. These contributions are important as they acknowledge that the researcher was part of the research (Houghton et al., 2013).  Influenced by theoretical positioning of critical social constructionism the findings of the research as a co-construction were made with participants. The interpretations and discussion chapters use these co-constructions to shed light on the experiences of CCNs with CPD.

The reader of the findings views them through my analytical lens. This included having supervisor feedback on the data analysis  (Cho & Trent, 2014). This guidance continued to open my mind and assisted in revealing knowledge and insights. These have been presented in the findings and discussion chapters as co-constructions between the participants and me.

**Confirmability**

Sandelowski (1986) suggests that "confirmability be the criterion of neutrality in qualitative research" (p.33). This is only achieved when auditability, truth, value and applicability are established. Embracing subjectivity qualitative inquiry embraces the complexity of the researcher being involved with the subjects but requires a process of reflection. Reflection refers to the act of rigorously examining how researcher involvement effects the data collection, analysis and consequent dissemination of information. This deep reflection prevents the researcher from becoming too enmeshed or too disillusioned and cynical. Awareness of positionality prevents results from becoming romanticised or demonised and instead allows a true reflection of the reality provided by the participants (Thomas, 1993).

Seeking to expand knowledge and understanding the researcher embraced all nurses' views. To achieve deeper and more comprehensive understandings participants were asked to clarify their view and provide more detail. This use of reflective research promoted a larger view with interpretations that produce new insights. This approach also builds trust and credibility in the findings (Thomas & Magilvy, 2011) which is important for the rigour of the research.

**Potential Researcher Bias**

Using a self-critical lens the researcher must look at their own preconceptions and how these affect the research (Cho & Trent, 2014). This approach has been embraced throughout the research. The researcher is aware and has disclosed, from the beginning, that as a CCN great concerns are held toward the model of CPD implemented by the NMBA. These concerns are compounded by the approach many RNs take to completing their CPD requirements. It was these concerns that were the catalyst for this research. Within this acknowledgement of my views is the belief that this does not apply to all nurses. It also accepts that not all nurses will share this view, nor do they have to. In fact, the researcher welcomed nurses' views that were in stark contrast to her own. This broadening of knowledge and understanding is important as it allows me to grow as a human and to understand my research question more fully. The researcher has

endeavoured to make it clear when her opinions are offered to ensure that the reader is able to make their own determination as to what influence they may or may not have had on the interpretation of the data.

## 4.4   Thematic analysis

Analysis of the research data were undertaken using the processes provided by Braun and Clarke (2006), an interpretative process to make sense of the data (Guest, MacQueen, & Namey, 2012) and to ascribe meaning (Trent & Cho, 2014). During thematic analysis meaning is a socially constructed interpretation where multiple interpretations are to be expected and interpretations are influenced by a researcher's predilections, the research question and the approaches undertaken in thematic analysis (Thorne, 2000; Trent & Cho, 2014).

Thematic analysis is described by Braun and Clarke (2006) as flexible. This flexibility does not mean that it is not without structure and boundaries. Thematic analysis is a method used to identify, analyse and report themes (patterns) within the data to organise and highlight the richness of data. The researcher plays an active role in the analysis process. The themes arise from the researcher's thoughts on the data and the links created by the researcher's understanding of the data (Braun & Clarke, 2006; Guest et al., 2012).

A theme captures something important about the data in relation to the question and reflects a patterned response or meaning in the data. A theme can be determined by size or by repetition throughout the data; these elements also contribute to the flexibility of thematic analysis (Braun & Clarke, 2006; Marks & Yardley, 2011). The decisions about what constituted a theme in this research was guided by the research question, the researcher's epistemological and theoretical positioning and the data provided by the participants.

A thematic analysis can be undertaken inductively, using the data to guide the interpretation and meaning generated; or deductively, where the data is used to confirm or negate a research idea or hypothesis (Braun & Clarke, 2006; Guest et al., 2012). This research utilised inductive thematic analysis, with codes and themes derived from the text data. Inductive thematic analysis is encouraged when the focus of the research, nurses' perceptions toward CPD, lacks

evidentiary depth in research and knowledge of the phenomena (Guest et al., 2012; Vaismoradi, Turunen, & Bondas, 2013).

Guided by epistemological perspectives of constructionism, thematic analysis seeks to theorise the sociocultural contexts and structural conditions that influence the accounts of the participants (Braun & Clarke, 2006; Burr, 2003, 2015; Thorne, 2000). Methodological approaches to critical ethnography are influential in the thematic analysis process. The data is explored for cultural insights with exploration of inconsistencies and contradictions to illuminate conclusions about what is happening and why (Thorne, 2000).  A thematic analysis should serve to enhance the overall quality of the data (Guest et al., 2012).

It is acknowledged in a thematic analysis that interpretations are socially constructed and meaning is conferred with the possibility for multiple interpretations. It was the researcher who determined the topic of research, designed and asked the questions at interview, and conducted an analysis of the data. Therefore, the findings of the research are gathered, filtered and shared through the lens of the researcher (Trent & Cho, 2014).

Braun and Clarke (2006) outlined six steps of thematic analysis.

- The first step requires familiarisation with the data through reading and re-reading the data, noting any initial ideas.
- The second step involves the initial generation of codes across all of the data in a systematic fashion with collating of data relevant to each code.
- The third step collates codes into potential themes with the associated data.
- In the fourth step, themes are reviewed for rigour and validity of the research. During this stage themes are checked for their ability to reflect the coded content contributing to the development of a map for the findings.
- The fifth step defines and names themes incorporating ongoing analysis to refine themes and to ensure the overall story of the data is reflected in the themes generated.

- The sixth and final phase is the production of a report with vivid and compelling extracts from the data (Braun & Clarke, 2006).

Following Braun and Clarke (2006) the first step undertaken was familiarisation with the data by listening and re-reading of interview transcripts as previously outlined. The second step, the initial generation of codes occurred using the following process. Each printed transcript was divided into three columns. The middle column contained the typed text of the interviews with both the interviewer questions/comments and the responses of the participant.

The right side of the page determined the space in which to write key words/subheadings that described the comments at that point of the interview made by the participant (i.e. coding). This included both explicit and implicit terms and centred on simply placing a word on what the participant was stating, for example, cost or fear of peers. The intent of these words/subheadings was to provide key guidance to the experiences being shared. The right side of the transcript was completed for the entire interview.

The analysis then moved to the left side of the page where broader themes in the form of subthemes were assigned as they arose from the comments on the right side of the page, for example, financial influence or peer influence. The subthemes written on the left side of the page were then written onto small post-it notes in preparation for the next stage of analysis process. This process was supported by Braun and Clarke (2006), Marks and Yardley (2011)  and Trent and Cho (2014), who all suggested the use of columns to assist in coding the data.

Braun and Clarke (2006) third and fourth step requires searching for themes to refocus the analysis to a broader level of themes rather than codes. The codes and data are sorted into potential themes using visual aids. Post-it notes were sorted into related groups and assigned an overarching title that explained the themes that had been elicited from the data and grouped together.  These were then placed on to a large A3 page with the key theme/phrase encircled by connected sub-themes.

Each A3 sheet with the wider themes was photographed to provide a document that could be safely worked on, without losing the fragile state of the post-it note.

To facilitate a collective case study, each transcript analysis was typed into a word document. In the word document the broader themes/phrases were typed as a title in a table and the related themes were then typed below each relevant title. This process was repeated for each transcript to develop a collection of themes as they emerged in the collective case study.

Only after all interviews were analysed, post-it noted, photographed and typed were they compared for similarities and differences entering what Braun and Clarke (2006) describe as step five: defining and naming themes. The similarities of themes were noted including noting the number of times a theme was identified in other case studies to contribute to the collective case study. Differences in themes across case studies were compared, taking care to analyse accounts to facilitate the construction of a greater understanding from the findings. While the participants each contributed to the collective case study, field site comparison was undertaken to assist in constructing understanding of the ICUs. This allowed commonality in each field site and across sites to be identified and the highlighting of the unique elements at each field site that were identified as having an influence on nurse's approaches to CPD.

The process continued with data analysis of identified themes and consideration of connection and disconnect between themes. This was achieved by looking at both common and unique themes as they were illuminated in the findings aligning to step six of Braun and Clarke (2006) process, that is, producing a report. This process facilitated the refinement of the final themes which would then be interpreted using the theoretical writings of Pierre Bourdieu to provide interpretation.

## 4.5   Ethical considerations

Ethics is founded on the principles of right and wrong (Leavy, 2014), drawing on moral theory to provide a framework for ethical decision making based upon a tetrad of principles (Harrowing, Spiers, Kulig, & Kipp, 2010). The principles of autonomy, beneficence, non-maleficence and justice are all essential elements that require consideration and application in social research (Artal & Rubenfeld, 2017; Harrowing et al., 2010; Jelsma & Clow, 2005).  Ethics not only incorporates

the tetrad of principles; ethical research requires an approach that is well designed and will generate findings that are useful to the body of knowledge (Jelsma & Clow, 2005).

Qualitative research participants were known to the researcher through the use of interviews. Participants are often invited for their specific qualities and experiences related to the topic of research, in this case CCNs. A core component of qualitative research is the relationship between the participant and the researcher, contributing to an increase in ethical risk (Jelsma & Clow, 2005).

The principle of autonomy centres on the right of the individual to make decisions about their own lives and infomed consent (Jelsma & Clow, 2005; Traianou, 2014). A means for achieving autonomy is consent. Consent should not be considered as endless, where it can be obtained once and is not required again. Consent of participants must be both obtained and retained throughout the research (Jelsma & Clow, 2005). Integral to this is the researcher carefully examining what is required for informed consent, with consideration of the depth of information that is supplied and the associated understanding of the participant (Traianou, 2014).

Qualitative research carries with it the issue of confidentiality. Ethnographic research founded upon cultural and community issues carries a risk that participants may be identified and stigmatised (Jelsma & Clow, 2005). As such action is taken to protect participants and safeguard confidentiality throughout the research. One way that privacy of participants is protected is by replacing participant names with pseudonyms (Traianou, 2014). All transcripts were de-identified at the time of transcription to facilitate maintaining confidentiality. The data for this research has remained in locked files with password protection for all electronic files.

The ethical principle of beneficence centres on wellness of participants. The goal of research is to not change the life of participants but where appropriate, services should be offered to participants (Jelsma & Clow, 2005). This research carried a small probability of beneficence for which participants were offered support via Life Line and the Employee Assistance Program, should any support strategies

be required in their life. Participants were also advised at the time of consent and at interview that they were free to cease their participation in this research.

Non-malificence is core to ethical research and focuses upon the minimisation of harm. The researcher needs to create a field of trust and openess to elicit the experiences of participants. The presentation of findings of the research carrry a risk of harm to participants. A researcher should consistently engage in reflexivity to remain objective. This can be achieved with the guidance of experience colleagues (Jelsma & Clow, 2005). Harm while able to be minimised can never completely be avoided (Traianou, 2014).

Harm can occur to participants when their participation is exposed. Protection of participant identity extends from the recruitment phase through to the dissemination of findings. The dissemination of findings carries a risk that participants will be identified and be exposed to potential negative repercussions from individuals with power. It must be acknowledged that this risk is always present despite best efforts to provide identity protection (Harrowing et al., 2010). Dissemination of findings also carries with it a risk of embarrassment or humiliation for participants.

The ethical principle of justice considers power relationships between the researcher and participants. This includes participants from vulnerable populations and the researcher has an obligation to ensure all participants are not disempowered or exploited. The researcher flattens the power differential so that participants can freely exercise choice regarding their decision to continue involvement in the research (Jelsma & Clow, 2005). Participants and the researcher had no prior relationships and no known future professional or personal relationships. However, the researcher acknowledged a position of power in portrayal of participants' perceptions and insights. Embracing reflexivity the researcher took great care to remain true to participants and has used narratives throughout the findings chapter to portray their insights.

To ensure participants are protected from exploitation, a researcher must be able to articulate direct benefits that may arise from the generation of new knowledge for those that participated in the research (Harrowing et al., 2010). This research

intends to inform the profession of nursing, nurses that the NMBA registers and the wider global community through dissemination of these findings about the use of CPD in the nursing profession. Such insights are important with limited, previous research conducted in this area despite widespread adoption of CPD worldwide and in other health care professions.

Guided by the ethical tetrad the consideration of ethics in research is complex and requires consideration beyond who will participate in the research. Ethics must occur with the formation of the research question and be embedded throughout the research process. During the application of theory, methodology, methods, data analysis and presentation of findings care must be taken to minimise the risk of harm and ensure participants are represented accurately and with integrity (Leavy, 2014).

As a critical ethnography this research provides a critique of practice and behaviours which Madison (2012) advocates necessitates great ethical care. As critical ethnographers, researchers are often driven by feeling a need to act morally and make a difference in the world. The emphasise on 'critical' means the intent is to encompass moral action, embracing a sense of duty to do good (Madison, 2012). To achieve this we share our findings as a means of inviting the ethics of accountability and the risk of being proven wrong (Harrowing et al., 2010; Madison, 2012).

All research must be undertaken with the approval of the HREC and using the standards for human research (Artal & Rubenfeld, 2017). This research was undertaken with the approval of the relevant HRECs who were provided with an outline of the research topic and the research design. This research required ethics approval from the university, and three independent health care organisation ethics committees.

This research was considered low risk by HRECs; nevertheless, it was acknowledged that harm, although highly unlikely, could arise from the research. To minimise harm all participants were provided with a plain language statement and offered opportunities to ask questions to ensure they understood the intent of research. Participants were advised in the plain language statement and at

interview that they had the right to withdraw from the research, or could retract any comments they made at any point prior to the interview being conducted and at any time up to the final aggregation of the data.

To mitigate harm and ensure support for all participants, accompanying the plain language statement was a debriefing statement. In the debriefing statement, all participants were advised of contact details of the researcher and support services such as Life Line and the Employee Assistance Program.

Informed consent both written and verbal was obtained from all participants prior to the interviews being undertaken, all of which were older than twenty-one years of age. Participants were considered capable of making informed consent based upon their capacity to practice as RNs under the NMBA standards.

The privacy of participants was paramount to the research and all participant identities have been protected by assigning pseudonyms. To protect the identity of the one male who participated in the research, four of the pseudonym names chosen for the research are common for males and females. All interviews were held in locations of the participants choosing to facilitate privacy. No indication was given to participants at each field site as to how many participants were involved or interviews that may have already been conducted.

A vigilant approach was applied throughout the presentation of the findings. Care was taken to ensure that the participants' voices and insights gained through the researcher were accurately portrayed. Throughout the interviews participants shared their experiences of CPD, underlying influences of workplace culture and associated behaviours were revealed. These findings carry the potential to create disharmony in the workplace and require ethical care to protect participants from potential harm. As a means of protection field sites in this research have each been assigned a pseudonym.

With the dissemination of findings in this thesis and in future publications and presentations, the participant's privacy, confidentiality and identity will remain paramount. The ethical responsibility to share the findings as a socially constructed understanding is a responsibility that has been embraced and embedded throughout the research.

## 4.6   Conclusion

This research applied a collective case study approach to explore the research topic of CCNs and their approaches toward CPD. Through collective case study, multiple perspectives are drawn together to deepen the level of knowledge generated and associated understanding.  The collective case study comprised twelve nurses from three similar ICUs located across Victoria, Australia.

Guided by the epistemological and theoretical positioning of critical ethnography and critical social constructionism interviews were conducted with each participant. Using semi-structured interviews participants shared their realities. As a CCN, the researcher and participants both shared familiarity with the role of the nurse in this environment and patient care requirements. This shared experience facilitated rapport and created a greater depth of sharing between participants and researcher, as common ground was already established.

The data arising from interviews was analysed using thematic analysis to explain how nurses approach socially accountable CPD. This chapter has explained the steps that were taken in thematic analysis, building rigour in the research. Underpinning all research are ethical principles of autonomy, beneficence, non-maleficence and justice and these principles are integral to conducting ethical research and minimising harm to participants.

In the next chapter the findings of the research are shared as they emerged from the thematic analysis. The findings are presented in a style to ensure that participants' voices are heard and experienced by the researcher during interviews, using thick descriptions and quotations.

# Chapter 5

# Findings

## 5.1 Introduction

The findings provide detailed in-depth accounts that illuminate the cultural influences surrounding each nurse. Each Intensive Care Unit (ICU) has its own unique culture and influences determined by Registered Nurse's (RNs) and other health care professionals that practice in the unit. Boud and Hager (2012) advocate that "nothing effects learning more strongly and unconsciously than the everyday circumstances of work" (p. 24) including the nature of work, and associated challenges and opportunities that drive learning. During the interviews the circumstances of work were openly discussed by nurse participants. The insights revealed highlight the complexities that influence behaviours and expectations in the workplace and the impact upon the nurses' approach to and decisions surrounding Continuing Professional Development (CPD). These cultural influences have both covert and overt components inherent within the context of each participant's field site.

This chapter reveals the themes as they emerge from the data. Each theme carries sub-themes that have been included to demonstrate both the richness and depth of the data. Nurses' accounts are used to expose how they approach and perceive social accountability through CPD. The themes presented are:

- CPD and navigating workplace environment
- CPD the front-line of isolation
- Personal insights underpin CPD
- Obscured motivations of CPD
- Professionalism of CPD
- The CPD model lacks professionalism
- CPD providing the way forward
- Organisation and profession mismatched in CPD
- Light at the end of the tunnel

Thick descriptions, with verbatim accounts, capturing grammar, tone and content from participants are presented in *italic* indented sections throughout this chapter. Thick descriptions are used in ethnographic research to present field experiences and make explicit the patterns of cultural and social relationships within context (Holloway, 1997). Pseudonyms are used to protect the identity of participants. Any other identifying elements, for example, reference to health care facilities or geographical location have been removed.

## 5.2 CPD and navigating workplace culture

The culture within the ICU has revealed itself as a key influential factor that guides the decisions and approaches of nurses toward CPD and the dissemination of that knowledge acquisition. Each ICU is unique, but similarities are shared across ICUs allowing sub-themes to arise. Nurses participating in the research spoke of cultures that:

- created fear and vulnerability;
- contributed to frustration and a widespread resistance to change;
- lacked consideration of the personal investment required in CPD; and
- had variable degrees of acceptance to exposing and sharing knowledge.

Nurses' approaches to CPD were found to be guided by the expectations embedded in the ICU in which they worked.

**A culture of fear and vulnerability**

A sub-theme described by participants related to feelings of fear that underpinned a resistance to change in the workplace. Morgan talked openly of a culture of resistance to change from nurses being scared and fearful for a variety of reasons.

> *Scared of change. I still reckon it all boils down to the change factor. Scared of extra work, scared of the unknown, scared of change, got too much other stuff to do to worry about it. They're busy. They are busy, look they're flat out. They're up there today – I'm sifting through trying to find now who can be enrolled in what*

*and they're not interested. People aren't interested in taking on anything extra, they are there to do their job and go home and that's it. They don't want to overload because they do have to learn … Then I try and nurse them through it and if they can't do it, they will not do it.* (Morgan)

As Morgan highlighted, the fear of the unknown can lead to nurses disengaging with opportunities of advancement and learning. Being afraid can lead to feelings of vulnerability. Kim shared a response to the behaviours of colleagues and the cultural environment which contributed to her feeling frightened and attacked.

*I think it's a fight sometimes. There are such strong personalities and maybe I'm a sensitive sort of person. I'm a very strong personality and character, it's more I'm trying to protect myself because I'm feeling frightened or attacked.* (Kim)

For Kim knowledge became a way in which she could shield herself from perceived attacks by her colleagues. CPD allowed her to build confidence and minimise her levels of fear. This aligns with the concept that knowledge is power. As explained by Bourdieu (1991) knowledge in a culture becomes a form of capital.

Kaylah also explained that she regularly engaged in CPD with the intention of building new knowledge. This motivation was based on a subsequent ability to provide current evidence-based care to her patients. However, she did not disclose her CPD activity to colleagues, instead making a conscious decision to remain silent about changes in practice.

*That could be a bit different or that's a bit old school, but I thought no I'm not going to say anything … some of the things that I do now I had people go 'what's wrong with it the way it is?'.* (Kaylah)

The behaviours of the majority are often influential on the level of comfort and security felt and experienced by nurses in the local setting. Experiences of unfair criticism, feeling ostracised and being negatively labelled were common. For

Kaylah and Kim these experiences led to feelings of vulnerability in the workplace.

In attempts to avoid feeling vulnerable Alysha revealed that she was cautious with some colleagues. In a senior position, colleagues commonly sought her advice and professional opinion and Alysha felt a need to protect her image.

> *It depends on who's asking. If it's one of my peers and I don't know,* [I would say] *'oh I don't know'. But if it's a junior nurse you think, hell I probably should know that. I'll just go look it up, saying, 'yeah leave that with me'. Like sometimes a junior nurse will come with something, I'll say 'I don't know', but it depends what it is. If I think maybe I should know it, then I'll check it out.* (Alysha)

Kim also admitted to feeling a lack of emotional security in the workplace. The vulnerability arose from a lack of recognition of the contribution she provided.

> *Maybe, once in a while, you could actually let me know if I am actually doing something right because all I feel, like I'm being told each time I come into the office, is everything that I'm doing is wrong. I doubt myself enough, how is it that I never seem to be doing anything right even though I do overtime, I do extra shifts, do extra requirements that are not paid for. There's got to be some sort of balance I suppose.*
>
> *I don't feel like I have to get a pat on the back all the time but if I've done something okay then maybe once in a while learn to tell people, not just me but others as well, because it does help with morale for the staff.* (Kim)

This pattern of behaviour with colleagues is more critical than supportive, or positive, and impacts upon nurses and their feelings of fear and vulnerability. For Kim the drive to CPD stems from a need to overcome self-doubt. Feeling the lack of a protective workplace Kaylah's response is to remain silent and avoid drawing attention to herself and new knowledge. Alysha responds in a defensive way, placing barriers between herself and others exposing potential knowledge

deficits. These nurses worked within one unit with the culture surrounding CPD having a diverse but direct impact upon behaviours.

**CPD resistance builds frustration in the workplace**

Emerging from the data, frustration was evident with colleagues' perceived resistance to change. Kaylah had worked most of her career in metropolitan high acuity ICUs. In the smaller regional unit, she felt like an outsider and it was therefore difficult to suggest where changes in practices might occur. Negative responses from colleagues impeded her career and created dissatisfaction with her work.

> *Because my careers on hold and there's nothing. This* [ICU] *is so general. Like there's not much here that stimulates me. At the moment I'm on hold.* (Kaylah)

Levels of frustration were revealed across all three field sites. Taylor and Jessie shared colleagues' resistance when changes to practice were suggested.

> *If something's more simple, I think people are more likely to do it. If we complicate things, people get their backs up and want to keep the old way because it was easier.* (Taylor)

> *Sometimes they actually say, 'are you trying to teach us to suck eggs and stuff?'.* (Jessie)

Trish presented a different perspective irritated at nurses and management that want her to engage in education and change practice. Guided by past experiences Trish practices and draws upon previous knowledge and understandings.

> *… sometimes things really hadn't changed.  You know, yeah, I knew all that.* (Trish)

Feelings of frustration and disappointment extended to management. Kim felt let down by the organisation, believing there is a greater need to support and

empower nurses. This dissatisfaction impacted her ability to share knowledge with her peers.

> *Well it's an in-service for part of my CNS* [Clinical Nurse Specialist Role]. *It's part of my requirement so they don't really care what it is as long as it's something that has some sort of direction. I approached the clinical nurse consultant and said to her 'this is what I'd like to do, do you think' and I gave her a copy and she said 'yes, I think that would be good'. It's something different.* (Kim)

Frustration existed across ICUs with attempts to share knowledge and implement practice change being dismissed by colleagues and management. The ability to positively influence nursing's culture is made harder and more difficult when it is perceived, rightly or wrongly, that colleagues are not invested or interested.

### 'It is my time' resistance

Nine of the twelve participants disclosed that they had a high level of engagement and passion toward CPD activities. However, three nurses presented a different but equally invaluable perspective.

Trish believed strongly that the Nursing and Midwifery Board of Australia (NMBA) should grant credit for the effort invested to physically relocate to locations where CPD activities are held. Trish passionately advocated this position.

> *… they don't classify that. That's a whole eight potential points* [eight hours]. *I haven't got time. If that was a four-hour course and it took me a day and a night to do. I haven't got time to do another four and a half of those per year.* (Trish)

**Degrees of acceptance**

Engagement with and dissemination of knowledge was influenced by the culture of the ICU with variable degrees of acceptance seen across field sites.

Field site A participants spoke of a culture that collectively encouraged and supported fellow nurses. This environment of peer encouragement facilitated nurses sharing their knowledge and embracing further opportunities of CPD.

> *… we are always talking to each other, debriefing, about patients and events, looking for learning and sharing when returning from education.* (Leah)

Kathy, a colleague of Leah's, explained that the culture was evolving in a positive fashion. And this created a belief that as a result nurses became more involved in the sharing of their education with colleagues.

> *We were expected to give in-services on evidence-based practice, and our unit had an expectation that we looked at any literature and brought things* [new knowledge] *back.* (Kathy)

Kathy highlights the ability of a culture to move from resistance to acceptance. In cultures where resistance was considered high, reluctance existed toward sharing knowledge and creating changes in clinical practice. Consequently, rightly or wrongly, participants felt the likelihood of achieving desired changes was low. Jamie's words are powerful, explaining why the attempts to create change stopped.

> *Sometimes it's difficult, because sometimes things are so ingrained in a workplace that you actually – it's very, very hard to change.* (Jamie)

**Isolation has a tempering effect**

Within an ICU subgroups and cliques form guided by shared values and beliefs. Despite being surrounded by others, nurses did reveal feeling secluded. In

response behaviours were modified to minimise perceived potential and actual emotional harm.

By 'temper' Kaylah is referring to her disposition or state of mind, around a sense of calming and dulling her behaviours.

> *It* [feeling vulnerable] *tempers me. It really tempers me because I suspect I've got quite a reputation here for being a pain in the arse. Because I keep asking 'why do we do that?' or, 'has anybody thought about that', you know?*
>
> *Yeah, but it definitely tempers me, I know you can't be too in people's face. Because it's* [the ICU] *somewhere that I think some people do know and realise too that they're not perhaps as involved or as engaged, yeah. So, to really just put it up there in their face is a bit confronting. So, I temper it which they probably can't believe that's tempered. They go 'Oh my God'.* (Kaylah)

This excerpt from Kaylah highlights that behaviours were modified but not completely hidden, just tempered.

Feelings of being alone were also attributed to a lack of support from management to encourage CPD and new practice. Kaylah admitted she also felt a need to soften herself around management.

> *… so, when you come in you go 'oh, so – oh how come they do that that way? Have you ever thought of doing that?' I've set up a – in the first year there were so many things that I saw that I felt mm, that could be different or that's a bit old school, but I thought no, first twelve months I'm just not going to say anything. So, I didn't and then after twelve months I approached the nurse manager and asked her* (whether she) *would be open to me setting up a clinical practice group, just where we would once a month get together and just talk about clinical issues, just ask questions about what we're doing and if it – just simple stuff.* (Kaylah)

The decision to wait twelve months to talk to management about ideas highlights the vulnerability and adaption of behaviours in nurses. Perceived resistance contributed to a belief that there needed to be some degree of withdrawal or alteration of behaviours. Driven by a need to conform to the majority and avoiding being labelled and thus feel included and safe, behaviours/adjustments are made.

**When it's safe to share**

In an environment where nurses felt safe, participants stated there was a comfort in sharing knowledge, strengths and deficits. In such cultures education was able to be used to advance safe practice with dissemination of knowledge across peers. This contributed to what was described as a positive culture of learning.

Feeling safe in her workplace Kathy admitted, with a light tone and laughter in her voice, that she had many gaps in her knowledge.

> *Um, well now that I am doing this role yes. I can find lots of flaws that I need to work on. On the ward, um yeah, yeah, I do a bit of both I suppose. If there is something I say, 'oh I don't know a lot about that', or 'I have forgotten it more than likely because we don't use it much', I'll go and do a little bit extra.* (Kathy)

Whilst this attitude of Kathy's is refreshing it is not unique. Leah, a senior nurse, sourced knowledge from colleagues, nursing and medical staff including nurses that she considers junior.

> *Yeah, the thing is that we've got the most experienced staff on night duty. There are only a group of four or five like your CNS's* [Clinical Nurse Specialists] *and that around you, some of them, most have had longer experience than me. Even though they are not* AUM (Associate Unit Managers) t*hey have got more general experience. You've got your students, sometimes they are even a good recipe, they are doing the most up-to-date content.* (Leah)

This willingness to expose limitations in knowledge was attributed to two core aspects by Leah and Kathy. First, an acceptance and self-confidence that as nurses it is unrealistic to have an in-depth understanding of all areas; and second, the culture of the workplace that supports nurses learning by sharing knowledge.

## 5.3 CPD the front-line of isolation

A strong theme that emerged from the data was feeling isolated. These perceptions were attributed to an absence of like-minded nurses in the local environment. In response nurses used CPD opportunities to be with other health care professionals that valued and invested their time in CPD. During such interactions participants described feeling *motivated* (Kaylah), *inspired* (Kathy) and *energised* (Leah).

A causative element in feeling isolated was geography. Geographic distance can be a barrier to interacting and connecting with other ICUs and critical care nurses (CCNs). Travel became a given condition to counter feelings of separation. However, innovative approaches and investments over time to bring CPD to their local area, were also used to address loneliness. In the following sections the power of nurses is revealed, highlighting the use of CPD to overcome feeling isolated.

*Alone in my workplace*

When colleagues did not share similar views toward education or its significance to currency of practice, some participants described feeling like an outsider in their workplace. In response CPD was embraced, creating opportunities to mix with other like-minded CCNs.  A change in workplace for Kaylah brought with it a dramatic shift in culture towards CPD. This contributed to feeling in a minority and isolated.

> *I view [clinical site] as not very progressive, not forward thinking and maybe it's just the unit I work in and the people that work in it. I understand that there are different times in everybody's life where you are going to be more career focussed or not. I've seen that throughout my career with different friends going through their*

*life stages, but at some point you have to be engaged in your profession.*

*There are too many people here* [that think] *that it's a job. It's just a job. It's a shift-working job that fits into their lifestyle, which is terrific; but I despair that we're all classed as registered nurses and professionals because we're not. So, I find that really frustrating whereas in the city where I worked and that of course was only one reference point. You had a bigger cohort of people who were very interested in their career and questioning practice, interested in research and doing further education.*

*So, you had all those influences and so it was a really uplifting environment to work in, whereas I don't. There are some terrific people here, don't get me wrong. But there are not enough of them and I find that brings me down a bit. But I just go, 'Oh my goodness'.* (Kaylah)

The difficulties in establishing a connection with colleagues contributed to a sense of loneliness.

Despite feelings of being alone in the workplace, Alysha also felt some connection outside of the ICU. The adoption and engagement in CPD and knowledge acquisition is one strategy nurses use to access or retain positions of respect. This approach decreases feeling alone in the workplace by highlighting their personal and professional value to their peers. Alysha believed that CPD afforded her knowledge, that support her retaining seniority and a position of respect within the health care organisation.

*There is a fair bit of respect given to us out there on the wards. We're lucky to have that respect.* (Alysha)

Insightfully, Alysha viewed respect as something that is given, a privilege not a guarantee.

*Creating CPD opportunities to overcome isolation*

Minimising professional and geographical isolation nurses embraced and utilised innovation. The organisation of CPD created an opportunity to change perceptions of their peers. Alysha talked about why she contributed to the local conference.

> *How can we supply good quality education to our nurses in* [clinical site] *without them having to leave* [the local area]. *Because I know many of them have got young families. I've been there, and I know what it's like. You can't get away. We're expected to do this education. How can we get it to them, good quality stuff not just the competencies we do? But ICU stuff that they'll really get some benefit from.* (Alysha)

This innovative approach highlights how nurses are not only thinking about their own CPD, they are thinking of their colleagues.

> *A lot of people who might attend our conference would be intimidated to go to Melbourne* [capital city] *and they would think, oh I won't be able to get anything out of that it'd be over my head. Here they might say 'okay we can do that and it doesn't look too intimidating for them'.* (Alysha)

This approach highlights the sensitivity of nurses to colleagues. It also exposes variances in comfort levels of nurses that may act as a barrier and stop nurses from engaging in formal CPD and education.

Describing attempts to bring nurses together, Kaylah explained the development of clinical practice groups.

> *There was some really good interest in it. I, from the beginning, said it has to have a different chairperson every twelve months, because you can't have just one person doing this and making it their baby. So, after fourteen months we handed on to a new chairperson, which was great, so it must be a bit over two years*

*now that we've been running that. So that's quite good and positive, but there is still that – some of the things that I do now I had people go 'what's wrong with it, the way it is?' I kind of go I can't believe that attitude of why change, when it's just about engaging in new ideas so I find that really hard work.* (Kaylah)

Within Kaylah's experience there is also sadness and a desire for more nurses to be open to change. However, as Kaylah explains, change takes time and is hard work.

*Role modelling CPD to others, it is my professional responsibility*

Acceptance of a professional responsibility to role model behaviours was seen in the findings. A need to make overt their own personal and professional investment to education and knowledge acquisition was discussed.

*I think in my role, it's really important that I lead by example so the education should be non-threatening, it should be relevant and in a supported, safe environment.* (Jordan)

Using personal experiences participants were able to share knowledge in a way that created a supported environment and minimised feelings of isolation among colleagues.

Alysha admitted that she wanted her fellow nurses to embrace new knowledge and address their own personal needs. Alysha shares her knowledge, role modelling, in the hope that it fosters knowledge growth across her fellow nurses.

*I don't know that they do. No, they do, they know that they need more education, but I don't know that they can see whether they actually see something they've missed out on. I wish they did and we try. So, there is a huge area that they don't get to see. We try to pass on some of that knowledge, but you can't pass it all on.* (Alysha)

With more nurses engaging in CPD and engaged in learning activities the perception of being surrounded by like-minded people improves. Thus,

contributing to a decrease in feelings of isolation and nurses' role modelling the use of CPD for peers.

*Having like-minded people around helps*

Responding to feeling isolated nurses utilise coping strategies and seek out CPD. This included making connections with others outside of the workplace. Kathy enjoyed external CPD acknowledging a willingness to "open up" during activities and that CPD lead to feelings of satisfaction.

> *That was really good. There were only five of us with one teacher. Intimate, we got to really open up and talk and I didn't feel embarrassed or that I asked any stupid questions or anything like that. So, engaging, I suppose.* (Kathy)

Feeling comfortable and satisfied, the desire to engage in further education and build knowledge with learning grew. Leah's experience features the commitment to travel and make a connection with others while gaining knowledge, at both small and large events.

> *It was three short talks, very focused, focused sessions. Even though we travelled to Melbourne in the afternoon and then travelled back.* (Leah)

For Jordan the need was greater than simply being surrounded by like-minded others. There was a desire to maintain an awareness of what research and practice was being undertaken across the state, the country and in the global community of critical care.

> *I like to go to a relevant conference every year. I'm a member of the College of Emergency Nursing and the ACCCN (Australian College of Critical Care Nurses), so the two professional bodies for the area that I work in. So, through that I get all the regular emails and I get the journals with both of those organisations … good networking, bouncing ideas off the other educators and hearing what's working well in other hospitals and what*

*challenges they're having. The networking is really important.*
(Jordan)

Not all nurses like the same format of education. Hence diversity in the offerings of CPD activities is important. Jordan shared the many benefits, particularly satisfaction and inspiration she receives from attending conferences.

> *I love the annual conferences. I must say I just love that interaction and the networking and I usually come away really inspired just from going to those conferences. I love being in the same room as others… that inspires me.* (Jordan)

Alysha also found that conferences were a strategy to remain connected to the wider critical care community.

> *I like to attend an* ICU *conference at least once every two years, if not every year. So, that I know what's being talked about, research level, what's actually happening. Or I talk to people. I have a good conversation with people who have been to the conference to find out what's happening.* (Alysha)

Building on the ability to liaise with others Kaylah was aware of the value provided when engaging in CPD to maintain her professional responsibility.

> *I feel a really strong responsibility to belong to the nursing profession. … they always have the calendar of events coming up and things that aren't advertised that you can attend, so you're in the loop. … I also try and get a couple of conferences a year, because not only do you get the content, but you get the networking. Particularly because of* ICU *and how long I've been in it, I know a lot of people in the industry so going to those, not only is it social but you get to talk to people about what they're doing. Yeah, so I find that really valuable.* (Kaylah)

Not all CPD was directed toward the local patient group and care provided. Regional nurses recognised the benefits of attending CPD directed toward

nurses working in higher acuity ICUs. Satisfaction and pride was observed in participants that belonged to a social group that improve practice in their local setting.

> *An* ICU *conference a couple of years ago, we went to that and there was stuff that came out that was presented at that. That really changed all our practice up here. There's some really new cutting-edge research.* (Alysha)

The ability to implement CPD into practice is a positive experience for nurses. Participants spoke of these experiences with pride and satisfaction.

*Connecting beyond my workplace*

Caring for acutely ill patients can be complex. During unfamiliar events, feelings of isolation arose due to a lack of support from nurses familiar with the situation. One strategy used was communication technology at the bedside.

> *You have the physicians there explaining things to you. You can ask 'why are you are doing this?' Now that it's a lot more controlled, you can ask, 'why are you doing this?' and 'what's this do?' and all the rest of it.* (Kathy)

Such a need to be connected with other institutions is not unique. Leah would actively seek educational opportunities at other health care facilities.

> *I had seen different things advertised and asked to be on their mailing list and now they send me listings.* (Leah)

This willingness and ability to engage and connect with other health care providers demonstrated the resourcefulness of regional CCNs. Despite a willingness to travel, few metropolitan hospitals extended training invitations to nurses in regional areas.

> *More input from metro places, that would be nice. Once a month. Even if it is a teleconference.* [It's about] *accessibility and that you know there is something there.* (Leah)

Leah felt that such a connection would facilitate professional growth. She also viewed the use of technology as a means to create a larger collective group of CCNs, beyond the local workplace.

> *With the technology that is available now, it's still really hard. Despite the advances in technology the option to videoconference and so forth is limited.* (Jordan)

The reluctance to offer digital CPD using technology is clearly having an impact upon regional CCNs. The participants expressed a hope that this issue is addressed by the providers of education for CCNs.

*The impact of travel and cost on overcoming isolation*

The participants of this research have been open that travel did not create an unwillingness or inability to undertake valuable CPD. Many participants accepted that the barrier of travel was an associated outcome of their decision to live in regional and rural areas of Victoria.

While cost was not a barrier it did require careful consideration in nurses' decision making and choices about CPD.

> *There's a lot you have to do in your own time and I've accepted that.* (Jordan)

> *It does when you have to pay for everything, the travel.* (Kathy)

> *Even though it might be for three-to-four hours it's a full day thing that you have to plan your life around. You have to commit.* (Leah)

The investment in CPD, when value is seen, was overtly evident. However, there was a conscious awareness that having to prioritise CPD could mean limitations on practice.

> *It would have to, we are stuck in our old ways.* (Kathy)

Kathy's description of stuck in 'our old ways' expressed sadness and regret. In deeper conversations with Kathy and other participants it became obvious that it is not always travel that is a barrier for nurses. Having experts come to the local area was also a challenge.

> *It's hard because you have a small core group, we never get*
> *anyone down. It seems hard to get them down* [to the local area]
> *for focused stuff.* (Leah)

The challenges that surround bringing CPD to them only exacerbate feelings of isolation and disconnection from the professional group.

## 5.4   Personal insights underpin CPD

As individuals we are influenced by our perceptions and beliefs. Our insights into a situation permit a view that may be unique or shared. A common thread amongst most participants was that you can't know everything, and it is vital to be exposed to changing knowledge and practice. Others believe that their years of experience and previous exposure have provided them with knowledge and protection in their practice. In this theme the data from participants will surround participant's insights about why they and their colleagues engage and do not engage in CPD.

*My role provides me with the CPD I need!*

Rapid changes in health care, in particular critical care nursing, were recognised by many participants as a core rationale for engaging in CPD. Yet a minority of participants were of the belief that not much in health care or nursing changes. It is the insights and perceptions of nurses that have been shown to impact upon approaches toward CPD.

Trish felt her previous experience equipped her to deal with most areas in her day-to-day role.

> *So, I have to do her* [supervisor's] *job up to five to six weeks a*
> *year when she goes on holidays.  So, I attend meetings and look*
> *at rosters and that sort of thing.   I'm an AUM* [Associate Unit

> Manager] *so I'm actually filling her role when she's gone, and we sort of found something in there one day that if you're acting out of your role it's a point an hour, so we thought, excellent.* (Trish)

Trish, was not alone in using her employment as CPD. Morgan, believed her role and CPD were connected and addressed her educational needs.

> *So, the vast majority* [of CPD] *is actually done through employment; I'm a little bit different because I'm a research coordinator. We have a three-day conference every year to start with, so I get a lot of points from attending that. Also, constantly having to read journal articles and continually educating* [myself] *that way. But the vast majority of my points are gained just from the competencies up there as well because I continue to do my advanced life support, my basic life support. I do all their competency on the website, the epidural competency and stuff like that.* (Morgan)

Trish and Morgan provided an approach to CPD that was one of a minority view. Though not resistant to change, these participants highlighted a preparedness to continue with the status quo, which may well be the perspective of other nurses outside this research.

*Perceptions of self*

An individual's personal insight into their performance has an influence over the decisions they make about most things. A pattern across the data revealed that a nurse's past clinical experiences influenced their perceptions about their current education needs.

> *I certainly did a lot more* [CPD] *when I lived in Melbourne, it was a high acuity hospital, so I went off and did education.* (Trish)

While perception and insight drives some nurses to CPD others are of the belief that that they can handle any new situation. Using her experiences from past

employment years ago, Trish felt reassured that limited education was currently required.

> *They* [the equipment] *are very user friendly. The rep will come down but I'm sure people will be going off to centres to learn about them.* (Trish)

Not all colleagues have the same reliance on machinery or company representatives for education. Participants at the same field site, who had also previously worked with such equipment, had already explored external opportunities for education.

*Guided by personal insight*

Eryn, viewed the introduction of haemofiltration (a kidney filtration machine) into the unit as a trigger for CPD, to refresh her knowledge and provide safe patient care.

> *They're sick patients, they can deteriorate very quickly. You need to get them on* [to the machine] *now. So, I don't want to have any flaws. I don't want to put myself in a situation where I am compromised.* (Eryn)

Approaches to education vary among nurses. Insight and reliance on past experiences clearly plays a significant role in how nurses perceive their current level of performance.

## 5.5   Obscured motivations of CPD

Nurses in this research responded to the Board mandate as an incentive for registration rather than a motivational element to change behaviours. The sub-themes below outline what the participants explained as motivational influences upon their engagement with CPD.

*Intrinsic and extrinsic influences*

Participants were intrinsically and extrinsically motivated to engage in CPD. During interviews the reasons for engaging in CPD were varied, the most common reasons being:

- a need to meet the NMBA mandate for registration;
- protection of self from others;
- protection of the image of a critical care nurse (CCN);
- maintaining a connection with colleagues and like-minded nurses; and
- a need for personal satisfaction and the pleasure gained from learning.

The most common motivation as to why nurses engaged in CPD revealed extrinsic motivation of registration with the NMBA should they be audited.

> *So, **if** I get audited, it's **not** when I'm audited. Do you know what I mean? So, if I get audited, I know I'm doing my professional development and I know I'm doing the right thing. I know I'm focusing on the right area, so I'm doing relevant ongoing CPD points. So, why would I put too much excess time and energy into that when I'm time poor?* (Jordan)

Jordan's use of '*if*' in regards to auditing is powerful. This motivational element of needing to engage in CPD in case of an audit was not only held by Jordan. Kaylah talked about why nurses engage in hospital competencies and programs promoted by the hospital despite seeing little value in such activities.

> *I think the Board or the hospital organisation, they see it as a way to get you to do it, because then you can say 'well it's towards my CPD'.* (Kaylah)

Kim, like Kaylah and Jordan, is motivated to ensure she can maintain her registration and her employment.

> *At every time of the year we have to tick that box!* (Kim)

A key motivation in CPD when discussing the NMBA is to maintain registration. Most participants acknowledged CPD as providing knowledge. The connection to the NMBA shifts the focus from knowledge to maintaining registration and financial security.

*Motivated by the NMBA – a need for evidence*

A need to satisfy the NMBA with evidence of CPD has been a conscious component and motivation guiding nurse's engagement in CPD. Across participants the discussion revealed concerns and an emphasis on being able to provide such evidence.

Kathy had shifted her focus from external education to activities undertaken in her paid employment, counting these as CPD.

> *To be frank and being in this role, acting up in it, um, I have looked into it a little bit and it counts as my CPD anyway. Before this I was doing things and putting them in a folder …* (Kathy)

This attitude of easiest option is not unique. In changing their focus nurses acknowledged that there was a shift from personal learning to one of NMBA satisfaction. The shift from education to maintaining registration has been revealed as a significant motivational element.

*Motivated to build knowledge*

Not all participants were prepared to accept their employment requirements as CPD. Instead, motivation to engage in CPD was fostered by an intrinsic enthusiasm, underpinned by an innate need to build knowledge and grow as a professional. Taylor's view was common among participants, explaining her perspective of CPD.

> *… there's actual development. I feel like most of the time you actually get some new/more knowledge out of that. It's actually developing, not just staying the same, or 'not just refreshing'* (knowledge). (Taylor)

The distinction between 'new knowledge' and 'refreshing' is a contentious issue among nurses. This will be discussed in section 5.9 of this chapter.

*Patient or nurse? Who is the motivator?*

Some participants acknowledged a need to use CPD to guide practice and provide the public with protection. Patient safety was not the dominant motivational factor when approaching CPD. Protection of self and registration were a greater focus.

> *It's a personal – yeah, put myself in a situation where I'm not going to be compromised or my patients or my staff.* (Eryn)

> *I need to make sure that I'm on the ball so that I know nobody can question or anything like that.* (Kim)

Protection of self was prioritised over addressing education specific to patient care.

## 5.6   Professionalism of CPD

The theme of professionalism in nursing and CPD was noted in the data. Participants raised issues and concerns which created self-doubt and questioning of nursing's ability to be considered a profession. This theme surfaced in discussions of CPD and nurses owning and driving their own learning.

Guided by observations of colleagues, participants revealed an absence of a strong sense of being professional. This criticism extended beyond colleague's behaviour and included the regulatory body of nursing in Australia. Fears were shared that the NMBA model of CPD risked professional standing, and consequently that of the profession and their future. The following sub-themes contain a plethora of descriptions to help in illuminating these concerns.

*Knowledge, the connection to professionalism*

Concerns raised by many participants, centred on the apparent lack of investment and changes in practice from CPD activities.  This perceived absence

of professional investment was highlighted to have a negative impact on the professional environment and the image of nursing as a profession.

Positive work environments were suggested to be contagious. Kaylah talked passionately about experiences in such workplaces.

> *… people who are interested in their career and questioning practice, interested in research and doing further education. So, you had all those influences and so it was a really uplifting environment to work in.* (Kaylah)

Embracing opportunities to acquire knowledge from CPD is seen as a way to professionally advance, as nurses. For Kaylah this is accomplished through knowledge generation and acquisition.

*Being accountable – I'm a nurse*

Concerns were raised in the data as to whether nurses have the ability to meaningfully engage in self-reflection and self-assessment.  The participants were not intending to offend their colleagues but to raise an area in which they are deeply concerned. Jessie, a senior nurse involved in overseeing colleagues, explained what contributed to this perspective.

> *… too many people actually didn't push themselves or would look towards what's best practice or other things. Quite a few people would tend to do just what they were taught. I actually think continuing education is really mandatory. I probably think it needs to be a little bit more in career development mode, because sometimes what can be countered is just maintaining what you're doing without really advancing or questioning what you're doing.* (Jessie)

The NMBA CPD model is built upon a nurse's insight, reflection and their ability to acknowledge limitations and the education required. Trish raised a concern as did others that their colleagues may not be prepared to ask for support from peers to achieve the model.

> *It depends on whether the people that are struggling and need*
> *help are going to stand up and take responsibly to do that.* (Trish)

Accountability extends beyond asking for assistance and requires nurses maintain their own records. This motivation is lacking, with a reliance on records maintained by employers if audited.

> *I know one or two who have been audited. I'm sure, look I know*
> *that the information is actually there. Like they record our things*
> *that we do upstairs, all our competencies and stuff it's all recorded*
> *there. I can just drag it off a system if I need to.* (Alysha)

The dependency on health care providers to keep records compounds the level of concern in some participants. Use of hospital competencies was a contentious topic among participants with mixed perceptions, and will be discussed in section 5.9 of this chapter.

*Professional accountability and CPD*

Over half of the participants voiced concerns about nursing as a profession. However, there was a distinct preparedness among participants to accept the accountability associated with a profession. Alysha shared how her need to be accountable and provide safe care influenced her approach to CPD.

This responsibility felt by Alysha extended from herself to her colleagues.

> *Especially as an ANUM you've got to know that you're talking*
> *about because a lot of doctors come through, they don't know.*
> *So, if they look at you and if you don't know and if I don't know I'd*
> *be looking to see and get them to ring a consultant, otherwise I'll*
> *give them advice and say 'but if you want to check with the*
> *consultant'. Yeah, it's a fair bit of responsibility.* (Alysha)

Alysha called for nurses to accept that it is more than the task associated with the employment role that makes you a professional.

*They're goal driven. It's like come on guys. I know you are doing*
*stuff, but can you excuse yourself and come because you need*
*to be there. There's so much knowledge and so much you can*
*learn and when she's only a student she needs to learn but that's*
*what you need to do.* (Alysha)

Alysha's reference to promoting experiential learning highlights a desire to change the profession. The participants spoke of a longing for nursing to move from task orientation to knowledge growth and changes in behaviour and practice.

*Embracing Continuing Education – a nurse's responsibility*

As required of the professional, the participants openly accepted their responsibility to embrace continuing education.

*Oh, that's part of my role for sure.* (Alysha)

CPD was viewed as more than formal learning with opportunities for informal learning common and easily accessible.

*I don't think we put it* [CPD] *in black and white or actually think*
*about it like that. So, no and I don't know that, you know,*
*sometimes there's some fantastic learning experiences on the*
*rounds and people don't always appreciate it. Some of the nurses*
*will walk away from a round and not listen …* (Alysha)

The overlooked and omission of highly valuable and pertinent education, related directly to the patient group by nurses can be connected to the NMBA model of CPD. The NMBA model requires nurses to provide written evidence of their learning. This has added complexity to the situation with nurses viewing learning as formal and overlooking valuable experiential experiences. Responding to the need of written evidence nurses are moving to formal and trackable CPD and hospital/employer competencies to satisfy the NMBA. This will be discussed in section 5.9 of this chapter.

## 5.7 The CPD model lacks professionalism

*Where is the professionalism?*

Some participants viewed nursing as a profession. Others strongly questioned the right to call nursing a profession. When asked why nursing was a profession, participants found it difficult to qualify and express what nursing did to qualify it as a profession. Those questioning nursing as a profession believed that the struggle to retain a professional image could be attributed to the failure of nurses to embrace the ongoing educational requirements expected of a professional.

> *There are not enough people who are career focused. There are too many who are just coming to work, doing their job and going home. They're blue-collar workers and that's their attitude. There's nothing wrong with that, but don't call yourself a professional nurse if that's going to be your attitude to your working life and your career. … at some point, you have to be engaged in your profession. There are too many people here* [who think] *that it's a job. It's just a job. … but I despair that we're all classed as registered nurses and registered professionals because we're not. So, I find it really frustrating.* (Kaylah)

The disappointment was unmistakeable in Kaylah; both her voice and body language gave support to her words. Kaylah was sad that colleagues and other nurses, who for various reasons, refused to engage in the professional role of the nurse as she viewed it.

*Failing grade*

The NMBA's approach to CPD as a professional requirement is not viewed as successful among participants. Participants have been highly critical of the CPD undertaken by many nurses, after witnessing the damage that the current approach has had on the nursing profession.

The disappointment of participants was evident in both voice and body language revealing a disheartening and tiredness at attempts to instigate change

themselves. These feelings are exacerbated by nurses observing little or no change since the implementation of mandatory CPD in 2010.

> *I don't think it's changed a lot to be honest. I think people are just skating through and hoping that they don't get audited. There's a lot of people, a lot of girls here that have young families that wouldn't be doing the hours to be honest, particularly if they're on nightshift. There's no way, no way in the world they'd be getting the hours which is disappointing.* (Alysha)

The disappointment towards nurses failing to engage in learning contributes to negative perceptions amongst participants. This cumulative approach adds to the fatigue experienced in those nurses that see the value in CPD.

*All about image*

Criticisms toward the NMBA model of CPD were identified in the data. One such criticism surrounded the protection of the image of the nurse. Participants' beliefs about the motivations of the NMBA mandatory CPD were telling.

> *Protecting the profession, them rather than us. (*Trish)

Such scepticism about the NMBA motives questions if the image of nursing is more important than the betterment of the profession to the regulatory body.

> *I can't even think of what it's called. But this training to do with aggressive people is just mumbo jumbo. It doesn't make any sense. It doesn't seem relevant. I've got no idea why we're doing it. It's them* [employing organisation] *covering themselves I think. I don't know. But it's CPD.* (Trish)

Trish's experience of training that she called *'mumbo jumbo'* creates questions for the mandated model of CPD, especially when she is then prepared and permitted to count this as mandated CPD. The NMBA mandates that nurses engage in CPD to demonstrate that nursing meets its professional requirement of education.

Participants strongly criticised the adopted model. Trish criticised the type of training that can be counted as CPD, Kaylah felt a minimum of twenty hours per year was too restrained. This was supported with commentary about the ease with which twenty hours could be achieved, with a few days at a conference and/or a few articles researched.

> *One of the things I find with the registration bodies is their requirement to do twenty hours per year, which I just go 'well that's laughable!' Twenty hours is seriously easy and also part of me goes I'm insulted that as a professional I have to prove that I'm doing twenty hours … But I do understand that. That is the way of the world and that within any profession you're going to have that group and you're going to have people who are engaged. So, you have to come to some sort of arrangement, so I understand that.*
> (Kaylah)

Whilst accepting that the NMBA has to set a standard, other criticisms arose. The standard set by the NMBA has been challenged by some, like Kaylah, believing that the model contributes to harming the profession. These views are expressed in the next section.

*We're being dumbed down as a profession*

A criticism of participants is that the NMBA, as the peak professional body, has not succeeded in demonstrating the strengths of the nursing profession. A contributory factor is the critique around recording CPD, as expected by the NMBA. Words such as 'ridiculous', 'pointless' and a 'dumbed down' approach to learning were frequently observed in the transcripts of participants.

Concerns exists about the level of professionalism and the broad scope of what the NMBA considers acceptable CPD has been criticised.

> *I think nursing, nursing talks about being a profession but we're not. We're not. We have a long way to go and part of that is you have a Board that says it's okay to put down hand hygiene as thirty-minute CPD. That standard is so incredibly low that it is not*

*doing anything to progress the profession. I don't know, except to say that if they really got strict about it then they'd have to deregister half the bloody nurses.* (Kaylah)

The NMBA model of CPD has blurred the lines between continuing education and mandatory employer training and competencies. The majority of participants in this research were not comfortable and opposed the blurring of lines and what is seen as opening Pandora's box.

*I don't think mandatory training should be continuing education because to me continuing education is about improving what skills you've got, expanding knowledge. Not just ticking boxes, and a lot of mandatory training is ticking boxes. So the hospital can go to accreditation agencies and say all our staff have attended their fire training, all our staff does. So, if that goes through and it gets counted in training, but to me its continuing professional development is actually – if your profession is nursing, what have you done to improve your scope of nursing practice?* (Jessie)

The declaration of participants as representatives of the nursing profession was clear. CPD needed to be of a professional standard, not to fit the employer, but to fit the needs of the individual and the profession.

*That to me is demeaning nursing. So, if I look at other professions, alright, I'm sure they wouldn't have to do those demeaning things and they wouldn't be included in their PD, their CPD hours.* (Jamie)

*CPD evidence and the Board*

Many participants were concerned at the lack of evidence to support nursing as a profession, in particular, ongoing education.

*I think we should have the drive to do it* [nursing] *ourselves. But I don't know that everyone does. How do you, nobody really looks*

> *at it, it will only be the odd one that is audited. If you are only doing*
> *it because you get audited, well yeah.* (Leah)

The desire from within nursing for a stronger stand was widespread with many participants echoing Leah's thoughts. There was a broad level of support for the NMBA to revise the current model, placing a greater emphasis on the evidence of CPD provided by nurses.

*Professional behaviour toward CPD is lacking*

Amongst nurses that embraced CPD there was bewilderment as to why colleagues did not see the value associated with the development of new knowledge. As professionals, participants understood that nursing is measured by more than its bedside manner, with examination of its contribution to evidence and associated improvements in patient outcomes significant factors.

The participants, such as Alysha, believed colleagues lacked professional behaviours about education.

> *Before people would wander off and do bits of pieces* [work] *and*
> *handover. If you had a busy patient you would say, 'we need to*
> *care for the patient' or 'we won't go to that* [in-service] *today'. But*
> *now you don't get a choice, you go to that education session*
> *because it's starting to be that important.* (Alysha)

By employers and management forcing nurses to engage in CPD the absence of professional responsibility remains. Nurses should be seeking educational opportunities not being told to go. A unanimous view across participants was that CPD requires more than the annual ticking of a box instigated by the NMBA, with the current poorly conducted random audit.

*All about attitude*

One of the areas of criticism surrounded the reluctance across individuals and groups of nurses to embrace change and evolve their practice. Kaylah shared an experience that occurred after returning from CPD that offered new insight and understanding into the provision of care for various conditions.

*I had people go 'what's wrong with it the way it is?' I kind of go I can't believe that attitude of 'why change?', when it's just about engaging in new ideas.* (Kaylah)

The disinterest in change has impacted on those that engage in CPD, creating barriers that deter nurses from sharing knowledge and embracing the advancement of a profession. As Kaylah showed, nurses who disseminate new knowledge are simply asking colleagues to engage in a discussion as professionals.

## 5.8 Organisational and profession mismatch in CPD

A theme arising from the data concentrated on a mismatch between participants, the profession and colleagues. This issue was often revealed with associated frustration and explanation. Frustration arose out of experiences with colleagues and those who continued to resist engaging with CPD activities. These feelings of frustration were not limited to nurses and were attributed to the developed model of mandatory CPD by the NMBA. Participants were unable to identify their own values within the implemented NMBA model. As a consequence, participants described the current mandated CPD model as belonging to the regulatory board, not members of the profession.

*Different worlds – theory versus reality*

Participants described a distance from the NMBA suggesting that the Board and nurses exist within different worlds. It was suggested that the NMBA does not understand the reflective approaches applied by nurses in their day-to-day role. Such a mismatch was presented as reflective of an absence of practicality in CPD of the NMBA.

*I hate the idea of sitting down and writing that sort of reflective thing, but you know yourself where your strengths are … I reflect myself on my practice. I will be doing something and think, 'yeah shit I need to get on top of that', but I don't sit down and write something out, no I don't. And I don't know anyone who does.* (Leah)

Feeling disempowered participants raised concerns that there was no avenue for them to voice discontent. Kaylah gives the example of recording CPD to highlight this issue.

> *If you were audited you've got to present it in a certain way. Seriously, that would be like writing an essay. I keep a list of what I've done, but I don't go through and go this is what my learning objectives were. This is what my learner outcomes were. Like I couldn't care less. I'm just there. I'm taking it in, I'm making notes while I'm there, yeah like please. That kind of thing makes me mad because how is that going to benefit me? It's not. It's just going to prove to them that I've thought about it and so that makes me just like, oh for God's sake.* (Kaylah)

> *It's bloody obvious and is it really going to make any difference if say, for example, there's one person who's going to a conference because they have to get four hours CPD. Then there's another person who's going because they want to learn and because they've gone, 'I really need to know more about haemofiltration'. Is it going to make any difference if those two people sit down and write it up? Not really, why not just provide the tax invoice and certificate of attendance.* (Kaylah)

Such a mismatch between the world of nurses and the NMBA creates a further 'us and them' divide. As frustration builds it contributes to disharmony in the profession and acts to inhibit unity.

*Powerless to change colleagues*

Accepting differences in beliefs toward CPD, participants continued to talk of their frustration and an absence of power to achieve widespread acceptance and change. Leah felt helpless and despondent by her inability to exert professional change.

> *… there needs to be something, people should be encouraged. I think we should have the drive to do it ourselves.* (Leah)

146

Failure of colleagues to embrace learning intensifies feelings of helplessness. For Kaylah, her disappointment arose when colleagues failed to engage in a conference specific to ICU provided in Melbourne.

> *I thought this year it's here in Melbourne. This is fantastic. This is such a great conference. There'll be a lot of interest … when it all came down to it there are only two of us going … there are only two people from this unit and there must be sixty nurses … what do you do?* (Kaylah)

Unfortunately, Kaylah is not alone. Jamie talked of frustration at the lack of adoption of knowledge and change in practice. In a deflated tone, Jamie talked of attempts to change colleagues' attitudes toward education and practice change in the unit.

> *A little bit hard sometimes. It takes a little bit of a drive to do it* [create change]*, but you do have to try* [and] *pick who you talk to. Also, there needs to be a little bit of planning. If you just walk in and say, 'I reckon we should do this', you won't get very far, but if there's something there which says it makes it easier they sort of buy in a little bit.* (Jessie)

The acknowledgement of resistance to change appeared to exist across all field sites in this research. This was despite this research being informed by participants who expressed a strong belief in the attributes of CPD.

*Change the registration standard please*

Even though nurses were resigned to having a limited impact upon their colleagues embracing CPD, it was suggested by participants that the NMBA is in the position to effect change. Using the CPD model of the NMBA as an example, participants talked of their support for mandated CPD. But they also felt disconnected and unable to provide direct feedback to the NMBA. Alysha felt the NMBA is rigid.

> *I think PD* (professional development) *should be stuff that's actually relevant to your work, to my ICU rather than just the general hospital.* (Alysha)

Alysha's reference to role specific professional development is an important area raised by others. As previously alluded to, the ability to use employer mandated competencies is contributing to the frustration of many participants. This concern of professional development related to the area of practice was important to ICU nurses.

## 5.9 An ineffective political rowboat

An overarching theme that arose from the data was a model of CPD that is ineffective. An image has been created of a rowboat being paddled at different rates and force. And instead of progressing further, it simply moves in circles creating a whirlpool action. In this section a model that is yet to be understood, lack of education and failure of the CPD model will be discussed, as presented by the participants.

An area of concern, identified in the analysis of the interviews, was an overt lack of understanding around the intention of the NMBA's model. The accounts of participants were consistent, suggesting that nurses remain unaware of the rationale of the NMBA and the associated intrinsic expectations of the CPD model. Instead, nurses attempt to make the best of the situation and implement the model from their perceived motivations.

*A model yet to be understood*

All participants openly disclosed that they had their suspicions about NMBA reasoning and could not confidently state the underlying rationale of the model. This uncertainty had extended from the time of implementation in 2010, to the time of interview. No participants were aware of the Continuing Competency Framework that underpinned mandated CPD, with the intention of protecting the public through a competent workforce (Australian Nursing and Midwifery Council, 2009).

The suggested reasons for mandatory CPD are outlined below:

> *… accreditation and ticking the boxes.* (Leah)

> *So, it recognises that over time you can de-skill, you can lose knowledge and it recognises that and actually makes the individual accountable for their own ongoing confidence I suppose as a registered nurse.* (Jordan)

> *I think a lot of other professions as in* [not just nursing] *are going that way.* (Eryn)

These responses raise concerns about a potential serious issue for the NMBA. The Board is most likely unable to attend its intended goal of public protection, if nurses think that it is about *'ticking boxes'* or as Jordan suggesting, addressing *'deskilling'.* These findings were reflected in research by Katsikitis et al. (2013) with Queensland nurses also unable to rationalise the implementation of mandatory CPD by the NMBA.

*Education of the model – has it been forgotten or overlooked?*

Concern and confusion surrounded what is considered acceptable CPD and the way CPD should be approached. While the twenty hours of CPD commitment was clear, the focus of such CPD and the rationale remained elusive. As such many participants explained that in their view this contributed to an approach that was overshadowed by a need to tick the box.

Left with little guidance nurses described directing their focus toward adopting an *'if I am audited where is my evidence'* approach. Kathy shared her reality about CPD after the implementation of mandatory CPD.

> *It took me a couple of years to get my head around it. Looking back, it was kind of dismissed by a lot of people. They didn't comprehend it. They didn't take it on board, the mandatory bit. It did take a few years to get my head around it. In the last few years it has become more important as people were audited.* (Kathy)

Kathy's experience and that of others highlights the slow uptake of CPD across nursing and the response to being audited. Jordan, with similar experiences, believed that the point of mandated CPD had been lost.

> *I felt that the whole point of it was lost a bit. The talk I guess gave me the impression that people were just attending something just so they could get the hours rather than approaching it from the point of view that it's something that's important, that I keep up to date on or that I refresh in. So, I think the whole point gets lost a little bit because people were hours focused.* (Jordan)

This lack of understanding was not unique. Alysha reflected on the implementation of the NMBA model and her thoughts and those of her colleagues over the five-year period.

> *I don't think it was well documented at that stage. It just said twenty hours of education. I think most of us thought that meant formal education. We just heard 'twenty hours' and thought better get to some conferences. It was word of mouth. There are lots of nurses like me and there are still nurses who don't know exactly what it means.* (Alysha)

This absence of communication has arisen in participants' accounts of their own approaches to CPD and those of their colleagues. In discussing their conversations with other nurses, all participants felt a little lost within the implemented CPD. It is not that nurses are unable to engage in knowledge building CPD. It is that the NMBA have not communicated their intent and desires to its registrants.

*Misunderstanding of the NMBA's intent for CPD*

As previously discussed, participants were unclear as to why mandated CPD had been implemented. Delving deeper into the rationale for mandated CPD, Trish, Eryn, Jamie, Jessie and Morgan provided more detailed insights.

> *To keep us educated I suppose. So, we're competent, protecting the profession. Them* [the NMBA and] *then us. Probably logistics, everything is getting more legal these days.* (Trish)

While Trish viewed it as a legal requirement she interestingly placed the needs of the profession, the image and the registration body, above those of the nurses, the professionals. Eryn also shared a belief that it was about image, and the wider professional reputation.

> *I think a lot of other professions, not just nursing, are going that way, to be accountable. Show other people that we do know what we're doing* [pause] *I don't know what their motivation is.* (Eryn)

Expanding on Eryn and Trish, Jamie suggests that it was accountability that brought nursing into line with other professionals.

> *I thought it was great, because it helps us be in line with other professionals, other professionals who have to do it and not just in health, but they have to do it.* [To] *aid employers and educators and managers with underperforming staff. To bring us in line with other professionals.* (Jamie)

> *But they're still not asking for evidence of it, right? Is it about keeping standards up in nursing? Is it to assist in the nurses that are underperforming to have evidence that they are underperforming? But I can't imagine they'd go down that track though.* (Jamie)

Jamie talked passionately about bringing nursing into line with other professionals, but then the tone changed as self-questioning about why mandated CPD had been brought into play. Morgan offered a more pragmatic insight.

> *I thought it was purely and simply just to show that we were current with our practice and education. I really had no other thoughts behind it, only that they were trying to justify the*

151

> *professionalism of the role. I suppose so they could prove to other*
>
> *organisations that we do, do it. I really don't know.* (Morgan)

Such powerful contributions from participants exposed not only a model that is not understood, but a desire to know the reasons mandatory CPD was implemented by the NMBA. The reality as Morgan put it '*I really don't know'*, coupled with feelings of uncertainty as Jamie explained with '*I can't imagine they'd go down that track though'* contributes to widespread caution amongst nurses.

While it was identified that some nurses were unsure of the intent behind mandated CPD, there was also evidence of misunderstanding that created fear. Jessie described experiences of colleagues who were randomly audited.

> *She turned around and was very threatened by this audit request*
>
> *coming through. She actually, culturally thought someone had*
>
> *dobbed her in to look at her clinical skills and what she was doing*
>
> *to maintain them. She got really panicky about it, so we had to sit*
>
> *her down and go through stuff.* (Jessie)

For nurses to experience such a reaction from a random audit highlights the absence of communication and education from the NMBA about its processes.

*A growing indifference to CPD*

Indifference to CPD and the NMBA mandate grows from lack of education, communication and understanding of the model. Similarly, nurses are unable to own their CPD and professional standing as there is an apparent lack of uniformity in the expectations of CPD resulting in nurses disengaging. Alysha shared her indifference.

> *I'm indifferent to it all to be honest, just because it's not.  I don't*
>
> *think it was well, it wasn't well delivered when it came in and I don't*
>
> *think it's been improved on particularly since. So, I think the idea*
>
> *is good. I think ongoing education is necessary there's no doubt*

*about that. But I think there's got to be ways, maybe if they delivered something, what they actually want. So, I would know what's acceptable.* (Alysha)

With a distancing of registrants from the regulatory body, nurses are approaching CPD in survival mode, ensuring an ability to maintain a wage.

*It is vague, yeah. No not totally. All I really understand is they just want to know what professional development we're doing to keep our registration active.* (Morgan)

A growing distance and indifference extends throughout the profession and creates a culture surrounding CPD that will eventually require change. As nurses disengage the model will have less impact on both the profession and the patients that nurses are responsible for.

*Overlooking of CPD opportunities*

Frustration often leads to disengagement and creates a culture that is difficult to change. As nurses continue to address the model in their own way, the main objective becomes lost. But irritation was also directed toward the NMBA. Trish's perspective was unique in this research but very important for depth of understanding.

*I think within certain areas of the hospital and probably most hospitals we've got a lot of online competencies we have to complete. A lot of that is quite relevant to our areas so a lot of people are probably keeping up to date in that way. If I'm a nurse and I just come on and potentially I worked on a medical ward and I know how much is changed and why do I need to be forced to go and do this. Often, you're learning – new physicians come along, new nurses and everyone teaches everyone and you're learning all the time on the job.* (Trish)

Trish strongly believed that the NMBA does not consider her role and the learning that occurs there. It was interesting that bedside learning is discounted as an acceptable form of CPD, according to her interpretation of the NMBA model.

Such views of mentoring and peer learning as excluded from possible CPD was not uncommon. Many participants raised the concern of how this would be recorded.

> *Not really no. I suppose it's not classified that it's you know, if a doctor came up to me and explained something to me and I think oh yeah, I learnt something there, where do I log that, that I had a ten-minute lecture on something and it's a CPD, you know.* (Trish)

This view contributes to the discovery that for nurses the NMBA has failed to outline what is and is not considered CPD effectively.

*Clinicians versus 'hackademics'*

While embracing CPD Jessie was furious at what was viewed as the mismatch between Jessie's philosophy for education and CPD and the components that underpinned the NMBA CPD model. Jessie brought this topic of documentation of CPD into the interview, voicing a deep resentment toward the NMBA. After observing and assisting colleagues who had been audited Jessie revealed a belief that nurse's individuality and opportunities to prioritise CPD are being overridden by the NMBA. Jessie powerfully supported this stand by saying:

> *I suppose I actually just* [became] *more frustrated with them when they were trying to get nit-picky. I thought it sounded like hackademics and administrators trying to get me to say something that they wanted to hear in a way that they wanted to hear it, rather than what actually me, as a clinician, would do.* (Jessie)

The resentment is exemplified in the word '*hackademics'* and the use of words to distance Jessie as a clinician from the administrators of the NMBA. This disconnection between nurses and the NMBA creates a 'them' and 'us' culture.

This divide is suggested by Newton, Henderson, Jolly, and Greaves (2015) to maintain the fractures within the profession of nursing and inhibit change.

*Hospital competencies as CPD – an insult to nurses' intelligence*

A core criticism of the NMBA model of CPD has been the acceptance of hospital and employer competencies as CPD. Raising this topic with participants drew passionate responses with different views. The most common response amongst participants was that while competencies are an essential component of employment, they often fail to meet the CPD requirements of a CCN.

> *We have the stuff the hospital mandates that you have to do, but a lot of it is totally irrelevant. I read journals, I go to education, I travel and attend ACCCN* (Australian College of Critical Care Nurses) *education sessions.* (Leah)

Leah is not alone in the view that they are irrelevant and hence directs her education for CPD elsewhere. But there is anger at the ability of nurses to claim employer competencies as CPD.

> *Oh my God, don't even start me on mandatory competencies!*
> (Kaylah)

This topic triggered a passionate response, not only evident in her words, but in her tone, raised and firm and her body language, emotive and more use of her arms than previously during the interview.

> *It's insulting my intelligence to do basic mandatory competencies at graduate nurse level. It's insulting. I'm masters level educated. I've been a nurse for thirty years. Don't ask me every twelve months to do falls training. Oh, there are so many of them that make me, simple drug calculations. Like please, when was the last time I ever had to count a drip rate? Seriously, I think it was 1989.* (Kaylah)

> *It's just so insulting, hand hygiene. Look, I can understand it from an organisational point of view and it's the way of the world. If you*

*come to a new hospital it is orientation. Make everybody sit it to begin with so that you can say this is our standard. This is what we expect of you. But don't make people do it every year. It's like a red rag to a bull to me. If it's a skill that I don't use very often then absolutely, I have no hesitation in putting my hand up to say I'd like to do my ALS* (Advanced Life Support) *every twelve months, which I religiously do because I don't resuscitate every day. But you know, hand hygiene, falls, pressure injury, that's undergraduate. They're* [competencies] *developed at undergraduate level. It's insulting to me.* (Kaylah)

This depth of rationale from Kaylah highlights annoyance at the hospital but also the NMBA who accept such things as CPD. Jamie also questioned the appropriateness of such activities.

*Some of them are really insulting. It's not graded for knowledge level so a first-year nurse out will have to do that. Right, and so would a thirty-year nurse out with loads of experience have to do the same thing. There's no grading between.* (Jamie)

With a lack of variation, hospital competencies serve the employer. Alysha distinguished between hospital and CPD competencies using the influence they exert on her performance as a CCN.

*I know that it's relevant in many ways. But for me if I'm going to do PD I want to be doing stuff that's actually relevant to my actual role. Education needs to be. You need to be doing stuff that's relevant to your work. Because there are lots of Mickey Mouse things you can do that'll give you the hours. But are they really helping us as ICU nurses? Probably not.* (Alysha)

This acknowledgement of the place of hospital competencies is important. They are part of the nurse's employment after all. However, as Alysha and others have indicated they offer little to the professional development of the CCN. Taylor provided an insight into how nurses often approach such employer

competencies. This insight was shared by others and contributed to the strong positions and beliefs held by participants.

> *It's ridiculous, how is that professional development? I think that's just professional being. I can tell you everyone has the answers to the fire training saved on their hard drive. There's hardly even any brainpower in a lot of it.* (Taylor)

This admission to the storage of answers highlights the dangers of accepting such activities as CPD. It also reveals the lack of respect given to hospital competencies by nurses. It must then be asked is the NMBA prepared to continue to accept such activities as CPD? The participants of this research suggest the Board should not.

*Time for change – nurses expectations of CPD*

It is known to nurses that the monitoring of CPD occurs through a random audit process. This is revealed as having no impact on many participants in regard to the approaches they undertake or the CPD they engage with. As we are aware from the findings to date, it simply directs nurses toward CPD that has some tracking or paper trail attached.

In response to the current approach, nurses voiced a desire for yearly submission of activity. Alysha shared her thoughts highlighting the element of luck that currently surrounded the provision of evidence to the NMBA.

> *I think if we had an audit, that we got audited every year and we had to put in our hours that would work better. At the moment it's just good luck isn't it.* (Alysha)

This reference to good luck at not being audited was shared by others. Of the participants in this research only one revealed they had personally been audited by the NMBA. Some were even unaware of colleagues who had been audited. As such participants suggest, a change to move to annual evidence would also shift ownership of learning.

> *I think the onus for education should be with the people, they're*
> *the ones that know their deficits. I think we need to be audited*
> *because that way we actually would be responsible and you'd*
> *have to say okay these are my hours.* (Alysha)

Many participants shared similar suggestions. Currently the NMBA require nurses to tick a box that indicates CPD has been undertaken in accordance with minimum standards (Nursing and Midwifery Board of Australia, 2016d). Participants were critical of this approach, suggesting it is not an accurate way to monitor currency in knowledge and competency of nurses.

> *You're a Board with a certain amount of responsibility to make*
> *sure you've seen this. Because you've given their registration to*
> *this person and you're going with a tick* [the] *box* [approach] *I think*
> *it needs to be policed more.* (Kim)

Despite widespread concern about the '*tick the box*' approach, it was suggested, by more than a few participants, that the current approach has been a strategic decision. It was hinted that this minimal approach was adopted to avoid dealing with an issue too large for the NMBA to effectively manage.

> *So it's thousands of school teachers, sonographers,*
> *radiographers they have to, right, they have to provide evidence.*
> *I don't think it would hurt. I really don't think it would hurt nursing,*
> *but the thing is who is actually going to look at it and what's going*
> *to be the outcome? So if they wanted to bring something like that*
> *in, like there's how many thousands of us, what admin clerk is*
> *going to look at it and they're going to go, oh she's only got 18*
> *hours here, really? What are we going to do? Are we going send*
> *her a letter and tell her to do two more hours of something?*
> (Jamie)

The majority of participants called for a system that requires annual submission of CPD activity. This was acknowledged as not assuring accuracy or effectiveness of the education undertaken, but it was seen as an improvement. It

was suggested that such a change may assist in increasing the profession's response to CPD and advancing practice.

## 5.10  Light at the end of the tunnel

*CPD positive movement for nursing*

The nurses contributing to this research were unmistakably passionate about education and took pride in their profession and career. Their positions and views however create concerns for nursing and the potential to devalue nursing amongst those within and outside the profession.

The identity of the nursing professional was important to all participants. The professional associations and connections highlighted nurses' ability to engage with colleagues locally and intra state, as well as nationally and internationally. These connections have been a contributing factor in nurses feeling a sense of belonging and taking pride in their profession.

> *… so, you're in the loop. From a political point of view, you get to be part of what's going on at a political level in your profession, because you read the – not so much the peer review journals but the peer magazine type stuff on their websites. Of course, you get emails from them constantly about what's going on, so you're in the loop.* (Kaylah)

The mandatory focus on CPD has been appreciated by some as a positive move for the profession. For Jamie, there has been a positive change since the implementation of mandatory CPD.

> *I see it* [nursing] *as a profession. I think more so now, yes. There's more avenue to grow in that profession now than what there was years ago.* (Jamie)

Jessie shared the perception of change occurring over time and from a position of seeing change within a profession as well as within the workplace.

*Some individuals will do it* [CPD] *quite willingly, others don't. You've got to drag them. … but as one of the ladies said, they don't realise there's a professional obligation for them to do things, it just sort of slips [sic] their mind a little bit.* (Jessie)

*I think people have moved now to acknowledging it is part and parcel of being the nurse, you do have the professional side to maintain so they will. They don't whinge or bitch about it, they just do it. But again, it's about what they're doing, because they know that they can actually sometimes just tick boxes, get the hospital based stuff and that counts.* (Jessie)

Jessie's experience is powerful and demonstrates the changes that are occurring within nursing to embrace professionalism. CPD has become one means for nurses to do this and change is being noted.

## 5.11 Conclusion

The contributions of the participants in this research have highlighted common views and provided unique insights into the opinions and concerns for them and anecdotally the wider nursing profession regarding their views about CPD in nursing. What is clear from these narratives is that approaches to CPD do not align with the idealistic expectations of the NMBA in providing protection to the public.

While the participants agree that new knowledge will have a positive impact through a flow-on effect to patients, this is not the reason that nurses shared their engagement with CPD. For this group of nurses, the decision to engage or otherwise in CPD was strongly influenced by the culture of the workplace and their perceptions of the culture of acceptance towards CPD within nursing. What is clear is that participants find engaging in CPD provides them with protection from their colleague's critiques, as well as acceptance and an opportunity to be with like-minded nurses. While the NMBA has a CPD standard the nurse participants dismissed the standard as inappropriate, stating that it undermines both the individual nurse and the profession as a whole. The participants were

resolute that the current model is fundamentally flawed, and they do not see it as being professionally credible.

# Chapter 6

# CPD Through the Philosophical Lens of Bourdieu

## 6.1 Introduction

Australian nurses are obligated to undertake a minimum of twenty hours of Continuing Professional Development (CPD) annually. The legislated governance board, the Nursing and Midwifery Board of Australia (NMBA), mandated a model of CPD which provides nurses with a broad set of guidelines. This has created extensive variability in how nurses interpret, and subsequently comply with the mandate. The decisions about and approaches toward CPD for nurses are rife with considerations that impact even the simplest of questions, such as 'what?', 'where?', 'when?', 'who?' and 'how?' As a result, nurses undertake a balancing act between addressing the regulatory body's requirement to retain registration, while navigating the complexities of their local practice and clinical environment, satisfying their personal and/or professional goals related to CPD.

This discussion chapter uses the philosophical writings of Pierre Bourdieu to explore the complexity and balancing act taken on by Critical Care Nurses (CCNs) as they meet the mandate of CPD. While Bourdieu did not conduct research in the area of nursing, his philosophical writings are increasingly used to explore relationships between individual nurses, and the structures and social spaces they inhabit (Carter, 2014). Bourdieu's writings provide both a theoretical and practical lens from which to examine the CPD of the CCNs in this research.

Bourdieu's research and philosophical writings investigated the breadth of society to demonstrate the necessary unity of theory and research, and exposed the issues of the day as they were (Jenkins, 2002). This chapter starts with an explanation of the fundamental elements of Bourdieu's theory as it relates to the CPD of CCNs. The chapter progresses to a deeper discussion regarding doxa, specifically the orthodoxy of professionalism, CPD and power. The chapter

prepares the reader for the subsequent discussion chapter that explores rhetoric and reality using the positions of orthodoxy and heterodoxy.

## 6.2   CPD and Bourdieu's field

Pierre Bourdieu explains his concept of 'field' as a setting where agents and their social positions are located. An agent's positioning in the field is influenced by a series of complex manoeuvres and struggles in response to resources and/or incentives; and the ability of individuals to access both (Jenkins, 2002).  Fields can be defined by multiple factors, with housing, intellectual differences and education, employment, power, social class, and status and politics just some of the common influential factors identified by Bourdieu. Variations across a field occur when individuals and institutions attribute different values to elements, thus contributing to a difference in fields (Bourdieu, 1991).

Boundaries of fields move,  this is seen with CPD across the different Victorian Intensive Care Units (ICUs) in this research and noted in the different perceptions and responses shared by the participants. Bourdieu's philosophical writings explain that the challenges occurring within the field lead to altered boundaries. This is commonly motivated by an individual's need for self-preservation or to improve their own position with respect to defined capital (Bourdieu, 2004; Bourdieu & Wacquant, 1992), which in this research is CPD.  A field is similarly influenced by external forces, such as politics and structures, with the NMBA being such a force. These external elements can be either embraced or rejected by a field. This complex state of struggle and manoeuvring results from a need to gain control over the social field by agents and reflect the social majorities views (Jenkins, 2002).

To understand the field of a Critical Care Registered Nurse (CCRN) the setting requires a description to present the mental blueprint. An understanding of the field also compels elucidation of overt and covert professional expectations. These are exposed through rituals and behaviours of nurses within the ICU where they practice. An ICU is designed and functions differently from other areas of health care. Unlike other clinical areas, such as medical and surgical wards, the ICU is not readily accessible to visitors and other health care staff. The type and

location of doors to ICUs, for example, are designed to limit public access with staff within the ICU, controlling entry and admittance to the unit.

Once inside the ICU there are more boundaries that mark and define the field. Individuals are presented with a series of single rooms separated by walls with large glass sliding doors or aligned bays separated by curtains. Nurses can be seen at each bed-space to provide one-to-one patient care. While variations in settings are seen across units, commonality exists. The architectural design is taken from a panopticon. ICUs commonly have a nursing and medical desk located in a central position. From this position staff can survey patient rooms or beds, monitor patients and observe fellow staff and visitors given access.

As you look into a single bay or rooms you will see a bed surrounded by equipment. Each bed-space has a monitor that often beeps to gain the attention of the nurse. This is attached to moveable pendulums that hang from the roof. A number of intravenous pumps have fluids bags and lines attached to the patient. A ventilator may be located at the bedside and if the patient is of higher acuity there may be other machinery such as kidney dialysis machines or cardiac support devices. The patient is often lost to the visitor's initial view, hidden among all the equipment. The view for the CCRN is anecdotally known to be different. To the CCRN the patient is the first thing they see. The nurse mentally notes the physical position of the patient, their level of consciousness and the equipment that surrounds the patient's bed. Observations then move to the staff located in the bays and rooms around the nurse. Combined, this first view informs the experienced professional of many aspects of patient care. Thus, the staff working in the unit create and build the field.

Observation of patients' rooms reveals nurses in clinical conversations with other health care team members, each with different roles and scopes of practice. The CCRN is usually asked for their input into the plan of patient care (Flannery, Ramjan, & Peter, 2016; Nathanson et al., 2011). Using the scope of practice of the CCRN and building upon earlier identified guidelines and goals by the health care team (intensivists, surgical or medical specialists and the CCRN), the CCRN is observed making decisions about the care provided. This includes the

regulatory management of supportive technology such as ventilators and infusion pumps.

While it is common to have a hierarchical division between doctors and nurses in the ward setting (Liberati, Gorli, & Scaratti, 2016), this is usually less overt in the ICU. This diffusion or even absence of hierarchy can be attributed to the time spent together and relationships developed across the disciplines. Intensivists and medical staff are present in the ICU throughout the day and night, working closely with nurses, developing an understanding of each CCRN's capacity. This fosters development of trust between nurses and doctors (Flannery et al., 2016; Tume, Scally, & Carter, 2013). Trust then facilitates a greater opportunity for collaboration in the provision of care. This includes confidence in the ability of the CCRN to make decisions aligned with the goals set for patient care (Tume et al., 2013).

The setting of the ICU to an outsider may appear to have a significant influence over the field. To those comfortable inside the walls of an ICU, higher stakes are at play and it is these stakes that influence the field, especially in relation to CPD. Nurses working in critical care areas undertake strategic manoeuvring and planning targeted at ensuring a secure and sustainable social position within the field.

Within health care CCRNs are commonly viewed with respect and considered a support system for ward nurses when questions, clinical concerns or challenges that arise in less acute clinical areas. It is a common occurrence for Registered Nurses (RNs) working on wards to seek guidance and input, into care delivery, from intensive care nurses. This can be a simple phone call to gain reassurance or it may involve asking the ICU nursing staff to review a patient (Green & Edmonds, 2004; McIntytre et al., 2012).  This collegial context contributes prestige and respect to the social field of the critical care nurse (CCN), from those outside the CCN group.

Among the CCRN's group respect and prestige are awarded differently. Knowledge remains a powerful commodity easily challenged within the social field of an ICU. When a CCRN shares knowledge with nurses working on wards

there is a tendency for passive acceptance of this knowledge (McIntytre et al., 2012). However, knowledge and information shared amongst other experienced CCRNs is habitually questioned and challenged.

When changes to practice are suggested nurses sometimes have a tendency to resist the adoption of new practice. For some nurses, resistance to change is linked to a simple need to understand the new practice and evidence, while fear can drive questioning and opposition from other nurses (Montani, Courcy, Giorgi, & Boilard, 2015). The impact of fear is significant and occurs in many forms. The requirement to add new skills may be seen as difficult or impossible for some nurses; others may contest or resist change out of a need to remain in their 'comfort zone', leaving things as they are. The element of fear is known to drive challenges and questioning in a potentially obstructive fashion. These behaviours arise in an attempt to maintain comfort and a perceived symbolic position (Hannes et al., 2007; Montani et al., 2015).

CPD and the knowledge it affords to nursing is not always accepted in the profession. The state of flux surrounding the acceptance of CPD contributes to challenges of dominance and subordination and the complexity of achieving balance within the social field. The acceptance of CPD is variable among individuals and the location of practice, influenced by the views and positions within the social field (Kemp & Baker, 2013). The embracing of new knowledge places an individual in a position of being the learner; for some nurses this can be seen as a vulnerable place, no matter how brief the duration. Vulnerability can occur in various forms. But it may result from nurses exploring their own knowledge and performance leading to recognition that improvement is needed. While this sounds easy, for some nurses it can create exposure, particularly if it involves disclosure to colleagues of knowledge deficits (Kemp & Baker, 2013).

When vulnerability occurs, an opportunity may exist for individuals or groups of CCRNs to alter their position within the field's dominance. The movement of groups from dominating to dominated can occur easily with practice change. Imagine nurses working in an ICU that have worked together for fifteen years. Content with navigating day-to-day practice, their experience lends them to perceive change as unnecessary. Within this unit sits a subgroup of nurses that

166

regularly engage in CPD. Motivated by their CPD this group offers suggestions of new or altered practices that can benefit patients. This subgroup, conventionally the minority, starts to implement change or new practices.

The NMBA mandate of CPD offers this small subgroup knowledge and power and encourages the use of contemporary and evidence-based practice. The majority that overlook opportunities for education, believing they are comfortable in practice, start to become vulnerable. The minority, using the knowledge gained from CPD, start to lead change in practice and this change extends to other nurses. Those previously hesitant to change may now begin to embrace and promote change. As nurses shift, the minority group increases in size and becomes the new majority. This shifting of positions challenges and changes the balance in the field, especially when the majority have previously been resistant to change.

The position of CPD within the social field of nursing is determined by the value attributed to CPD by nurses. Unlike a game of football or a debate where the number of players on each side is balanced, a social field is not evenly balanced. A social field's balance is determined by the positions and views of the individuals that exist within the field. When the field has more individuals who embrace CPD and as a result change their practices, the field reflects this trend and vice versa. The state of the field is determined by the individuals within and this means that when individuals change their stance or new individuals enter, the state of the field can alter. This fluid state adds to the ongoing state of tension within the field and the constant state of movement that occurs within the boundaries.

## 6.3   CPD and Bourdieu's habitus

Pierre Bourdieu explains that habitus is influenced by predetermined dispositions that sway individuals to act and react subconsciously in quite specific ways (Bourdieu, 1991), for example, views and perceptions concerning the value of education. Some CCRNs appreciate CPD whilst others do not or will not. Bourdieu did not search for a universal explanatory principle. In providing a localised principle, Bourdieu provides practical transferability and application of his philosophical writings (Robbins, 2000). This qualification provides important

clarity around the use of habitus. The predetermined dispositions that Bourdieu references give rise to practices, perceptions and attitudes consistent with but not consciously coordinated or governed by rules. The dispositions that contribute to habitus are inculcated, structured, durable, generative and transposable (Bourdieu, 1991). Each feature requires an explanation and application to the CPD of nurses.

Inculcated dispositions are generated over time and influenced by the individual's first exposure to traditional practices and or perceptions (Bourdieu, 1991). An individual's exposure and experiences, over their lifetime, with education and learning, further acts as an inculcated disposition and influences the approach to CPD at a subconscious level. Despite a disposition being significantly predisposed early in life and by the social environment, dispositions continue to be influenced throughout life. The workplace environment and culture effects inculcated dispositions, with values, such as the belief in lifelong education and CPD, able to be swayed by colleagues. Workplace environments (i.e. social fields), can reinforce the importance of CPD when colleagues are invested and receptive to learning and change. Likewise, in work environments where CPD and knowledge generation are not accepted as worthy, former dispositions may be questioned by the individual and adapted to match those of the current workplace.

Inculcated dispositions are not consciously used to guide action and behaviour, adapted to meet societal needs. Individuals possess an inherited concept of society. This is modified by the individual in order to generate a new concept appropriate for their condition and experiences (Robbins, 2000). It is our past experiences that continue to have an active present which influence practices in a more reliable fashion than rules and explicit norms (Bourdieu, 1992). The combination of past and present experiences allows individuals to navigate the field and conform to habitus.  This can be seen in the way nurses openly embrace or silently approach their CPD mandate across different ICUs.

Dispositions produced are structured and inevitably reflect the social conditions in which they were acquired. Bourdieu provides the example of table manners and social class, to explain structured dispositions, with differences seen

between classes that become ingrained and carried throughout life (Bourdieu, 1991). Education and knowledge acquisition share similarities to the table manners example, with the drive for knowledge and growth embedded in many across their life, influenced by the social setting.

Due to the deep-rooted nature of structured dispositions, Bourdieu (1991) reminds individuals that dispositions are durable and remain with the individual for life. Dispositions operate in a way that is preconscious and not readily amenable to conscious reflection and modification. This can be observed in nurses that have been encouraged or discouraged to embrace learning and change throughout their lives which impacts their future beliefs and behaviours surrounding learning. This may subconsciously alter the disposition and influence an individual's habitus and that of their social environment, particularly when combined with exposure to strong influences that may encourage embracing or rejecting CPD early in their career.

Finally, dispositions are generative and transposable, capable of creating practice and perceptions across fields other than where they originated (Bourdieu, 1991). This means that the values and beliefs of nurses toward CPD may be influenced by other factors in their lives. CPD is driven by nurses who seek to be proactive and independent, directing their learning to seek out opportunities to extend their practice knowledge. Nurses' previous life experience affects their ability to achieve such directed learning.

This can be appreciated through the participants driving opportunities in their lives. Leah, who holds an arts degree, used dispositions gained from previous experiences to support her 'mid-life' career change. Leah entered the nursing profession with skills and values of personal independence and ownership of personal growth and she used these to be successful in nursing. These dispositions allowed the generation of new practice through a career change. And they were transferrable from her previous career into the changes now applied to the profession of nursing and CPD.

Habitus can be seen on one hand as the way that individual's become themselves, developing attitudes and dispositions and on the other hand, the way

that agents engage in practice (Webb, Schirato, & Danaher, 2002). A nurse's habitus disposes the individual to a desire to improve patients' health outcomes. This improvement comes about from activities and perspectives that reflect contemporary knowledge which are culturally and historically valued in the nursing field. Thus, the habitus of embracing new knowledge and practice is often subconsciously influenced by the field.

Habitus also affords individuals with a sense of how to act and respond in situations of daily life, orientating actions and tendencies but not strictly determining them. Habitus provides individuals with a sense of what is and is not appropriate in the social game (Bourdieu, 1991). Nurses can be seen to respond to their habitus in discussions, disclosures and their approach towards CPD. Some nurses are openly transparent in their perceptions of CPD while other nurses are more reserved or cautious.

Bourdieu's writings on habitus have described how the social conditions in which dispositions are instilled influences similarities and differences observed across individuals. This gives rise to a habitus that is reflective of social conditions (Bourdieu, 1991). Examples of this are seen in the participants' stories and experiences where their backgrounds present different perspectives and views on CPD. Nurses are able to attribute their views to their past and to apply these insights to their present. One participant that exemplifies this is Kaylah, who had previously worked in a large metropolitan hospital, and attributed this to her valuing of CPD. In the metropolitan ICU the social conditions instilled a drive for knowledge through CPD. Kaylah then moved to a regional area and found a vastly different field. In a conscious response she reduced her pursuit of CPD in the regional area so as 'to not cause trouble'. Kaylah perceives that in her current social environment there is a resistance to change, repercussions of which include overt, negative barriers and consequences directed towards nurses that openly engage in CPD and encourage practice change.

A habitus embodies the attitudes we inherit but it does not constitute an incentive that conditions expected behaviour. We do not regulate present actions to a future goal, as our actions are not purposeful. Instead, they are continuously adapted to allow future goals to be achieved (Robbins, 2000). But, habitus can

be used as a strategic calculation based on past efforts related to an expectation or objective. This requires the individual to carefully navigate the field and to do or not do, and to say or not say in order to be successful (Bourdieu, 1992). It is this careful navigation of the field, influenced by habitus, that has been illuminated in using Bourdieu's philosophical writings of field, habitus and capital.  In illuminating the field and habitus we are able to develop a greater understanding of the reality and the rhetoric of CPD for regional CCRNs. The identification of different forms of capital that influence nurses' commitment towards CPD is also possible.

## 6.4   CPD and Bourdieu's capital

In the social field and habitus instrumental elements exist and in their own manner influence. Bourdieu's writings present variations of capital present in society. Capital can be economic, symbolic, social and cultural assets (Bourdieu & Wacquant, 1992).  The aspects of capital are diverse and varied, shaped by the habitus and field. Among the types of capital presented by Bourdieu is economic capital (i.e. material wealth, money, stocks, shares, property), cultural capital (knowledge, skills, qualifications), and symbolic capital (prestige, honour) (Bourdieu, 1991; Bourdieu & Wacquant, 1992).

Capital provides the ability to trade and exchange one form for another. This is seen with the reward of a qualification, that is, knowledge, for a higher salary. Capital may also allow the individual or group to achieve social gain through associated prestige and respect for the different types of capital. Within the social field capital is a contributing facet in the complex manoeuvres and struggles that take place (Bourdieu, 1991). When capital is used for a non-financial benefit, it might be seen as a commodity. Individuals then trade forms of capital to navigate social complexities, contributing to a field of power (Bourdieu & Wacquant, 1992).

When individuals or groups view others as having more capital than they possess, they are said by Bourdieu (1991) to submit to capital. This submission which is unintentional contributes to the creation of symbolic power (Bourdieu, 1991).  This can be seen in social fields where nurses view other nurses as having a higher level of contemporary knowledge than themselves or others. This

subconscious creation of symbolic power is influenced by the field and the dispositions of habitus.

In fields where the majority of nurses embrace CPD the symbolic power associated with CPD can be apparent. Participants of the research demonstrated this when they expressed a common thread of desiring acceptance from colleagues. Those nurses deemed to have increased knowledge from CPD were described as highly respected with participants sharing how they wanted others to view them as one of those nurses. That is, nurses are unconsciously submitting to the symbolic power acquired by colleagues.

Capital and its associated symbolic power can only be exerted on a person who is predisposed by their habitus to perceive it. Not all individuals will perceive power associated with knowledge and others may simply ignore potential power influenced by their dispositions (Bourdieu, 1991). The symbolic power of CPD can be seen in nurse participants' perceptions and experiences influenced by their colleagues and the social field.

Bourdieu's research and philosophical writings around education are comprehensive with Bourdieu sharing his philosophical view on the influence of cultural and symbolic capital (Webb et al., 2002). Bourdieu highlighted that capital has multiple forms and exists within a field, contributing to  the representation of power in a field (Bourdieu, 1991). Capital as Bourdieu (1991) explained, "act(s) like a trump card in a card game" (p. 230) defining chances for profit or gain in a given field. This extends to other fields in which capital represents power. Bourdieu also disclosed that the volume of capital in the social space contributes to the success of the cultural field (Bourdieu, 1991).

Using this philosophical perspective, we can start to appreciate the capital attributed to CPD by nurse participants and the field. As seen in the findings nurses do not engage in CPD for financial reward. Nurses are investing in CPD for the capital benefits it offers them. This capital has multiple facets, some being prestige and respect, others being symbolic power; and for some nurses it is capital that affords protection.

The value of cultural capital is attributed by the social field (Bourdieu, 1984; Webb et al., 2002). For example, a professional qualification is a form of social capital. Cultural capital can be seen to be measured in three ways: its relationship to the individual, its relationship associated to objects, and its relationship to institutions.

In nursing, there is a mixture of perspectives which is predisposed by the form of training. Those that have been nurses before the 1990s in Australia were hospital trained, with university training only gaining momentum from the early 1990s. Numerous hospital trained nurses later went on to undertake a Bachelor degree; but for some nurses both their nursing and intensive care training occurred within the formal hospital system. This blend of preparation contributes to mixed perspectives of capital that a university qualification and ongoing formal education affords. As a result, nurses have different relationships which may be connected to formal education and ongoing knowledge acquisition. The variances in relationships extend towards the NMBA that is driving mandatory CPD, and through associated historical influences such as health care institutions and their role in educating nurses.

As Bourdieu emphasised, capital is multifaceted and cultural capital is not alone in its influence over nurses' perceptions and approaches toward CPD. Symbolic capital encompasses prestige and respect from within and outside the social field. This leads to further symbolic capital, with individuals already afforded respect and prestige in receipt of more (Bourdieu, 1984, 1992, 2004). Symbolic capital has a tendency to be overlooked by individuals within the social field, with the risk that it will be perceived as an individual's reward, rather than something earned or learned (Webb et al., 2002). The illusive nature of symbolic capital, coupled with its recurrent omission, contributes to its high desirability with individuals eager to be offered such capital from their peers (Bourdieu, 1984, 1992). This view is seen across research participants with a mutual expression of the desire to be recognised, respected and held in a prestigious position by others in the field.

Symbolic capital may be given and removed by colleagues. The individual then needs to navigate the social setting to maintain a hold upon their given status. The ability to hold or lose symbolic capital makes it even more valuable and

powerful (Bourdieu, 1984, 1992). This was acknowledged by participants and shared by Alysha, who was awarded prestige and respect from colleagues inside and outside the field.

> *Because there's a fair bit of respect given to us out on the wards. We're very lucky to have that respect and it's not to be … I think they think that we've done more education.  I think that's part of it. A lot of it is because of the respect shown to us by our consultants so that flows on and our consultants, you know,* [consultant's name] *showed so much respect towards his nurses that it actually does flow on to the whole hospital.* (Alysha)

Alysha accepted that while she was afforded this respect she was unable to assure its continuance. In attempts to maintain her status she openly engaged in CPD and shared her knowledge among colleagues.

The qualities of symbolic capital provided by Bourdieu allow exploration of the findings of this research, providing the opportunity to look beyond the rhetoric of nurses engaging in socially accountable CPD to the reality of nurses' CPD. The concepts of respect and prestige should not be underrated. As participants explained these qualities are valuable with some participants prepared to go to substantial lengths to hold and protect.

Alysha feared that symbolic capital would be removed if she acknowledged her limitations to some colleagues. This included refusing to disclose an inability to answer a question, due to lack of knowledge, in front of junior staff. Instead, she would seek information and hide what she perceived as her knowledge deficits from her colleagues. Kim revealed that while she engaged in CPD she did not disclose this to her colleagues, believing they were not receptive to CPD, or that it was viewed as an attempt to be 'better than them'. These two experiences presented perceived realities, with nurses being cautious and wary of exposing knowledge and practice. By applying Bourdieu's philosophical perspective and investigating nurses' accounts it is feasible to unveil social fields of power and the complex state of CPD in nursing.

CCNs work in a field that requires careful navigation of the habitus to achieve or acquire capital. In a clinical field and habitus that embraces new knowledge and practice, CPD affords capital in a way that encourages nurses to embrace change. Unfortunately, not all fields and habitus are open to new knowledge and maintaining contemporary practice. Where new knowledge and practice change are viewed as a threat or unworthy of investment, CPD can be regarded as a hazard creating instability within the social field and habitus. Kim shared experiences of colleagues questioning CPD being used as a means to be granted access to rewards. Traditionally rewards, such as promotion and project positions, are awarded to nurses who have worked within the workplace for longer periods than Kim.

The cultural and symbolic power attributed to knowledge is determined by the field and habitus. For nurses, there are two distinctly different, yet connected, fields in play. The first being the local environment which is heavily influenced by the individuals that practice within the field. The second is the wider professional field of Australian nursing which is influenced by the NMBA and its mandate for CPD as a way to maintain yearly renewal of registration. The presence of interconnecting/interrelated fields was made evident by participants, who referred to a disconnect between the NMBA, policy and professional standards, and themselves and their colleagues who are active clinical practitioners.

Nurses shared that while CPD was highly valuable they remained unaware of the motivations of the NMBA in setting the standard and implementing monitoring of mandatory, annual CPD hours. This deficiency of understanding surrounding the NMBA motivations impacts the nurses' approach to CPD. Nurses engage in CPD for many reasons. Despite patients benefiting from nurses having contemporary knowledge, they are not a driving force behind nurses' CPD choices. For nurses the field of power is complex with the reality being a different game of 'needs based' to that of the rhetoric espoused through the games the NMBA plays as 'public protector'.

## 6.5 CPD and Bourdieu's doxa

Elements of field, habitus, capital and power cannot be interpreted as if they are one-dimensional. Each is influenced by principles that Bourdieu labelled doxa. Doxa refers to the uncontested acceptance of daily lifeworld, often the most fundamental beliefs that are viewed as core. The field articulates these beliefs and traditionally accepts them as inherently true and essential. Doxa attitudes involve an unconscious submission to the conditions that are arbitrary and conditional (Bourdieu & Wacquant, 1992; Webb et al., 2002).

Doxa addresses the natural and social that appear as self-evident. It is distinguished by Bourdieu as separate from orthodoxy and heterodoxy, which implies that beliefs and awareness are shared (orthodoxy) or antagonistic (heterodoxy) (Bourdieu, 1977). The application of orthodoxy and heterodoxy to the research findings afford the ability to move beyond the fundamental doxa position and analyse findings. As  Bourdieu (1977) stated:

> Language is real, practical consciousness, it can be seen that the boundary between the universe of (orthodox or heterodox) discourse and the universe of doxa, in the twofold sense of what goes without saying and what cannot be said for lack of an available discourse, represents the dividing line between the most radical form of misrecognition and the awakening of political consciousness (p. 170).

This research provided an opportunity to generate discourse and reveal what occurs subconsciously for the nurse participants and the wider nursing profession. This research exposes the reality and rhetoric surrounding CPD, the NMBA and its nurses by using Bourdieu's positions of orthodoxy and heterodoxy.

Bourdieu's philosophical position proposes that society has agreed values and principles. These are often unspoken but provide the boundaries for behaviours and conduct (Bourdieu, 1992; Bourdieu & Wacquant, 1992; Webb et al., 2002). An example of a core value or principle is education, with knowledge viewed as positive and something all should strive for. But not all within society share this value. This gives rise to a heterodoxy, where challenges to the status quo of doxa and beliefs of orthodoxy occur. It is with the exposure of heterodoxy that the

evolution of views and opinions can occur. This creates opportunities for growth in a society. Nursing, as a profession, is perceived to openly embrace ongoing education. However, this is not universally applied or agreed to by nurses. In the case of mandated CPD many nurses challenge the approach of the NMBA. This heterodoxic viewpoint thus creates an opportunity for reform both among individual nurses and the regulatory board.

Doxa, orthodoxy and heterodoxy offer a way to understand CPD. Through using Bourdieu's orthodoxy and heterodoxy positions we are able to illuminate the reality that exists within the nursing profession as it co-exists with the rhetoric espoused by the professional body. In the following chapter orthodoxy and heterodoxy are discussed in greater detail including the orthodoxy of professionalism, CPD and power that underpin the NMBA model. To expose the rhetoric of the NMBA model and elucidate the reality for nurses Bourdieu's concepts of field, habitus and capital in relation to CPD will be explored.

## 6.6   Interconnectiveness between CPD and Bourdieu's philosophy

Pierre Bourdieu's philosophical writings of habitus, field, capital and doxa offer many insights and the ability to identify connections between them. That is, the connections between the objective social structures of institutions and ideology, and the everyday practices of what people do and why they do it.  Bourdieu's philosophical positioning is key to understanding the potential for social accountability of CPD in the nursing profession.

CPD standards in nursing are determined by the NMBA and nurses must decide to abide by the expectations or risk not being able to register. This means being unable to be employed as a nurse in Australia. The choices made by nurses are influenced by diverse factors that vary across individuals and also share commonality. Using Bourdieu's theoretical frameworks of habitus, field, capital and doxa we can clearly see the elements that influence nurses in their approaches to meet the mandated CPD requirement of the NMBA.

## 6.7 Conclusion

A Bourdieusian approach allows the exploration and explanation of the interrelatedness of social positions, resources and cultural competence that exist when change is occurring (Husu, 2013). Bourdieu's philosophy gives rise to the interaction of the concept 'power' in the enactment and enforcement of CPD. Power is generated when there are challenges to the status quo that exist within habitus, capital and the field that occur (Collyer, Willis, Franklin, Harley, & Short, 2015). This shift in power can alter the social field and symbolic capital and this will be explored in greater depth in the next chapter.

# Chapter 7

# Bourdieu's Positioning Exposes the Rhetoric and the Reality of CPD

## 7.1 Introduction

Bourdieu presents two opposing positions, orthodoxy and heterodoxy, to expose the tension between maintaining the status quo and a range of challenges, which may or may not lead to change. In using the positions of orthodoxy and heterodoxy to discuss and examine perceptions of and approaches to Continuing Professional Development (CPD) it is possible to discern the rhetoric from the day-to-day reality of current CPD practices. The evidence from this research argues that there is a significant discrepancy and disconnect for Australian Critical Care Nurses (CCNs) between the realities of everyday practice, and measured and tangible outcomes of CPD envisioned by the Nursing and Midwifery Board of Australia (NMBA).

This disconnect questions the level of confidence in CPD for nursing staff, seeing this educational framework as not providing a protective role for patients. With this in mind and using the work of Bourdieu; the rhetoric or orthodoxic position is held by the NMBA as the governing and registering body, whilst the reality or heterodoxic position is held by clinical nurses in relation to their day-to-day practice. These tensions reveal the myriad of variables at play and the complexity of governance and social accountability in both nursing registration and practice.

Prior to discussing the accounts of nurses undertaking CPD, and the marked divide that exists between nurses and their professional body, we first need to clarify aspects of Bourdieu's writing. Building on the aspects of Bourdieu's theory, discussed in the previous chapter, this chapter will begin by defining orthodoxy and heterodoxy.

## 7.2  Orthodoxy and heterodoxy

*Orthodoxy* is core values and beliefs articulated through fundamental principles essential to societal function and deemed inherently true. Orthodoxy can be considered as the traditional knowledge base providing an overriding status quo within the given field which by its usage becomes accepted and often preserved in protocols and practice documents (Bourdieu, 1977; Webb et al., 2002). *Heterodoxy* looks to challenge the status quo by questioning beliefs and values within a particular field. This challenge to the orthodoxic position promotes different thinking, closer scrutiny, encourages the potential for change and further promotes participant involvement (Bourdieu, 1977; Webb et al., 2002).

Orthodoxy and heterodoxy cannot exist alone. They have an inherent relationship which encourages society to continually examine its structure, providing a vehicle for recurrent revision of shared values (Webb et al., 2002). Without heterodoxy, orthodoxy has no capacity to evolve and reflect fluctuations in society. Without orthodoxy, society does not take specific positions to accept and guide daily life. Exposure of heterodoxic challenges allows the social field to re-examine societal values, and where appropriate, adopt newer, revised, shared values into the core orthodoxy (Webb et al., 2002).

The findings of this research illuminated three common themes including professionalism, CPD and power. Underpinning each theme is orthodoxy, that is, core values and beliefs adopted by practitioners to be inherently true. The NMBA applies the orthodoxic principles of professionalism and power as a tool to influence nurses' adoption of CPD requirements. Also revealed in the findings are the challenges of CPD standards in Australia. These challenges in and of themselves demonstrate a heterodoxic state of values and beliefs. The participants' perspectives of CPD served their patients by improving patient outcomes and their own needs as practitioners, enhancing career satisfaction. Hence it would seem that the heterodoxic position taken by practitioners valued CPD in a more pragmatic manner. This finding is supported by nurses seeking CPD opportunities that provide new knowledge and address their professional needs, while also viewing the mandated model of CPD as failing to embrace the overall diversity of the profession.

Discourse has a significant role in heterodoxy. It facilitates questioning of beliefs, values and expectations assumed within orthodoxic positioning (Bourdieu, 1977; Webb et al., 2002). Arising from discourse is the questioning of and challenge to the current status quo and production of what Bourdieu (1991) refers to as "a transparency of common sense" (p. 131). This challenge provides an opportunity to scrutinise, add meaning and consider change by looking to integrate and encompass previous tacit and often repressed practices which have been unveiled during orthodoxic discourse. Through interviews with participants the heterodoxic practices of nurses in relation to the NMBA's mandate became apparent and more clearly understood.

The heterodoxic position for nurses was exposed through robust and vibrant conversations. Nurse participants have been openly critical and challenging of the NMBA model, CPD standards and the public portrayal of the profession by the NMBA. Trish viewed the model as being driven by a need to protect the professional image of nurses rather than nurses themselves. Kaylah attributed a *'need for some arrangement'* to address those nurses who were not invested in continued learning. Leah viewed the public portrayal of nurses and CPD as a means to addressing a lack of drive among nurses and to fix the perceived *'image'* problem. The use of power by the NMBA and the organisations that employ nurses is viewed by practitioners as serving institutional needs, approving health care delivery, and meeting regulatory requirements and legislation rather than the needs of the profession. The identification of nurses in a heterodoxic position to the regulatory body illuminates the multiple challenges the NMBA and the success of its policies face.

## 7.3   Orthodoxy – rhetoric

It is important here to explain the orthodoxic principles that have influenced the adoption and use of CPD within the Australian nursing profession. Orthodoxic principles are the foundation of core beliefs and views, reflecting the social and inherent value within a field (Webb et al., 2002), in this case nursing. Society, often subconsciously, embraces the orthodoxic principles of professionalism and endorses the NMBA to manage the registration of nurses. Embedded in regulation of a profession are the orthodoxic principles of professionalism that

hold an expectation of expertise, supported by CPD and power. This section will examine these principles in relation to CPD and power as applied to the profession of nursing.

### 7.3.1 Professionalism

At the core of social expectations is an inherent orthodoxic principle that health professionals are experts in their field (de Bruijn, 2012; Hill & Mulvey, 2012; Sullivan, 2005). Accepting this orthodoxy, society then endorses each profession with the ability to self-regulate their discipline through independent regulatory bodies using government endorsement. The professional registration body, empowered by society, sets and monitors professional standards. The Australian public places its trust in the NMBA to ensure that registration is only available to nurses capable of delivering the highest quality and safe nursing care. Thus ongoing self-regulation of the NMBA is contingent upon the continued demonstration of expertise and actions that address the interests of the society by which it is endorsed (Adams, 2016; Sullivan, 2005).

Historically, the label of 'professional' was only associated with those that had completed formal higher degree education, research and had social influence (Adams, 2016; Sullivan, 2005). This view was reflective of societal beliefs and was influenced by social prestige, class and opinions of the day. Over time, these principles and values have changed, as they have for nursing (Fullbrook, 2004). The orthodoxy of professionalism today reflects the evolving values of society related to what constitutes a professional.

Today most occupations and careers are considered professional in nature and have some form of self-regulation and overseeing body. Modern society applies the term 'professional' to athletes and trade-based workers, such as painters, plumbers, electricians, landscape gardeners and fitness trainers. While not historically considered professionals, each has been valued in society for their contribution and expertise. With changes to societal views, many, if not all, of the aforementioned are now referred to as 'professionals'.

Nursing has long argued for their status for and fought hard to be viewed as a profession. The movement of nursing from a calling, to a trade, to a profession

was one that required a change in societal perceptions and beliefs about the role and capacity of a nurse (Fullbrook, 2004; McIlwraith, 1983; Tierney, 2012). Societal views of and opinions on professionals have shifted, which has often arisen out of the need to protect the community and society as a whole. As a result, the community benefits from this evolution with diverse groups of professional bodies regulating professional conduct and creating protection for the community.

A key orthodoxic principle of 'professional' is that individuals and groups hold specialist knowledge and/or skills. This often requires some level of formal education leading to a qualification to practice (de Bruijn, 2012; Hill & Mulvey, 2012). This inherent view by society – that professionals hold specialist knowledge and skills – contributes to protecting the title of 'professional'. Leah's perspective of her colleagues as experts and professionals was influenced by their level of '*knowledge*' and '*experience*' with an appreciation for knowledge sharing.

At the core of health care professionals' practice is the requirement of "placing the best interests of patients at the centre of everything" (Barnhoorn & Youngson, 2014, p. 545). This aligns to the orthodoxy of 'professionalism' where experts maintain and expand knowledge and skills to remain relevant and contemporary. In nursing and health care, it is imperative for patient safety that nurses remain current in their knowledge and skills. This is complicated by the rapid evolution in knowledge (Al-Abri, 2007; Blumenthal & Hsiao, 2015). Participants acknowledged the need for currency and a professional connection. Conferences were a common tool for participants to build contemporary knowledge. Jordan, for example, engaged in conferences for *'networking and to bounce ideas off others'* while Alysha explained that she would be *'inspired'* and wanted to know more after hearing from others. So, it would seem logical that CPD activities are one way in which nurses remain abreast of changes in health care, and enhance their knowledge and skills.

The literature surrounding the definition of professionalism remains elusive, with no single agreed upon statement (Birden et al., 2014). Despite this absence of consensus, it is generally accepted that core values, such as knowledge and

expertise, are integral to the term 'professional'. It is these core values that are fundamental to a continued acceptance by the community, providing the foundation on which nursing has built its acceptance, respect and acknowledgement as a profession. And this respect includes how nurses view each other. Professionalism was viewed strongly by Kaylah who felt that without continuing education nurses were simply '*doing shift work that fits into their lifestyle',* but if this was widespread it would have a negative impact upon the professional standing of nursing.

Nurses entering and continuing to practice under the umbrella of professionalism have a duty to be socially accountable to patients and their families. Social accountability exists in a fluid state with a dynamic relationship, but where one individual must hold the higher position. This can only occur with a mutual agreement that one party, the professional, is delegated influence over the form of action taken (Pollack, 2009), in this situation CPD. To work towards accountability the nurse must engage with the community in which the nurse practices. This was seen with nurses actively investing time and energy into a local nursing conference to address the educational needs of local critical care nurses and share knowledge to improve the care provided to those in the local community admitted to intensive care. By engaging in education that related to community needs the nurse becomes situated in that community and can therefore address community development (Malena et al., 2004).

As professionals, nurses must ensure that their knowledge is fundamentally sound and aligned with contemporary evidence that underpins best practice. Nurses working in critical care, like all other nurses, have a responsibility to ensure that patients and their families are provided with the highest standard of care using the current evidence available. For Eryn, working with critically ill patients meant she needed to engage in education to remain contemporary and avoid '*putting myself in a situation where I am compromised*'.

Through CPD nurses can acquire knowledge that embraces the needs of the community in which they practice. With socially responsible CPD, currency in evidence-based guidelines and clinical practice, nurses achieve a basic professional mandate and responsibility. In doing so nurses can avoid the

'rhetorical' elements of CPD which seek to tick the box by encompassing all of those none essential activities that fall outside of direct patient care. This requires that nurses engage in CPD that focuses on the wellness of others and works toward positive patient outcomes (Woollard, 2006). Some nurses are embracing patient needs in their CPD. Eryn, Jordan and Alysha were driven to engage in CPD by their need to provide the highest level of care guided by current evidence for their patients. As previously mentioned professionals are expected to maintain expertise and currency in their area of practice. CPD activities provide this opportunity to maintain and develop knowledge.

## 7.3.2  Continuing Professional Development (CPD)

The orthodoxy of professionalism and CPD fit together as interconnected loops. The recognition that CPD activities enhances performance and positively impacts individuals is widely accepted in the literature (Boud & Hager, 2012; Crouch, Page, Wright, & Jackson, 2015; Fleet et al., 2008). The ability to enhance performance has been a core principle and value influencing the adoption of CPD. Despite widespread acknowledgment of the value of CPD there is agreement across the literature (Alberta et al., 2013; Chipchase et al., 2012; Clancy, 2000; Crouch et al., 2015; Davis et al., 2011; Davis et al., 2014; Draper & Clark, 2007; Lawton & Wimpenny, 2003; Wilcock, Janes, & Chamers, 2009) that the full impact of CPD on patients and practice is not clear.

The ongoing education of professionals has been given many labels. Lifelong Learning, Continuing Education and Adult Learning are common examples. Each of these labels, rightly or wrongly, is used interchangeably with CPD to reference education post original training/qualifications. Lack of a consistent term can be confusing and carries a risk of undermining the fundamental importance of ongoing education in a world where knowledge rapidly changes (Davis et al., 2014; Gallagher, 2007). While the above terms are often used interchangeably in the literature, in this thesis the term 'CPD' has been applied.  This provides consistency with the mandated approach of the NMBA and legislation of health care professionals in Australia.

The principle of knowledge to underpin safe nursing care in the community is key to the adoption of mandatory CPD by the NMBA. Thus, mandated CPD has become an approach used by regulatory bodies to achieve such protection (Bramley, 2006; Katsikitis et al., 2013; Lindley, 1997). The capacity to safeguard the community is determined by the standards within the mandated model of CPD and, importantly, the commitment of nurses across Australia to the mandate. While not understood by many participants Jamie was hesitant but suggested mandatory CPD to be motivated by *'keeping the standards up in nursing'.*

The NMBA, as the regulatory body, holds a social contract with the community that is built upon the orthodoxy of professionalism. This contract provides assurance that the community is cared for by Registered Nurses (RNs) whose knowledge is current and best practice. To fulfil their social contract, the NMBA has embedded mandatory, socially accountable CPD into a continuing competence framework, as a protective mechanism for the public (Australian Nursing and Midwifery Council, 2009).

Today the NMBA uses mandatory CPD as a conduit to achieve currency in knowledge and practice amongst the nurses it registers. The NMBA has developed a contract between the nurse and the public with the NMBA acting as the monitor, regulator of practice behaviours and disciplinary agent when necessary. When the public interact with the nursing profession, under the orthodoxy of being a professional, the public entrust that the nurses providing care have met the agreed standards to ensure public safety.

The orthodoxy of CPD holds that professionals assess their knowledge, with the intention of identifying strengths, absences and or deficits. Focusing on deficits, targeted CPD provides scope for improvement in praxis and enhanced practice outcomes (French & Dowds, 2008; McCormick, 2010; McMahon, 1998). These principles are reflected in the NMBA model and CPD (Australian Nursing and Midwifery Council, 2009). Responding to a changing acuity of the workplace Alysha shared that after attending CPD specific to identified needs for herself and colleagues *'it really changed all our practice up here'.* This ability to connect CPD to knowledge deficits and implement into practice highlights the importance of CPD tailored toward the individual.

The orthodoxic principles of CPD emphasise that these activities must go beyond the revisiting of knowledge. New knowledge must be acquired or developed (Bartels, 2005). In other words, knowledge maintenance is viewed as insufficient whilst knowledge expansion is an expected and critical element of CPD. As such, effective CPD demands that professionals pursue knowledge that enhances their understanding and improves practice. Many participants believed strongly in this position. Jordan, Kaylah and Kim, for instance, felt that the rehashing of knowledge through employer competencies was simply a way to *'tick a box'* and not CPD.

The acquisition of knowledge while important is not the only element of CPD. A key element is that of evaluation. That is, the knowledge obtained in CPD must also be subjected to measurement and appraisal. Therefore CPD activities undertaken by professionals must be able to demonstrate changes in thinking, knowledge or practice (McCormick, 2010). Measuring changes in thinking and behaviours may not be as easy as it would seem. A common thread in participants was experiencing resistive colleagues. For example, Trish was resistive to travelling to engage with new knowledge due to the impact upon her time. Taylor felt that nurses were more likely to *'get their backs up'* when things were thought to be complicated or require personal investment. For Jessie the experience of sharing new knowledge with colleagues was in response to behaviours and attitudes that reflected *'being taught to suck eggs'*. Such experiences highlight the challenges in creating a shift in the thinking of some nurses.

In the 1960s and 1970s research identified that health care was moving at a rapid pace with knowledge taught in initial training believed to have a five-year half-life (French & Dowds, 2008). Evidence on which today's practice is grounded, that is, changes on a daily or weekly basis resulted in 'current' knowledge often being outdated within a year. Therefore, it is imperative that a commitment to and consistent effort in learning be undertaken to merely 'keep up' (Barriball, While, & Norman, 1992; Drey et al., 2009; van Baal, Thongkong, & Severens, 2016). It is through current, researched knowledge that validated evidence is provided to confidently change the way nurses engage with practice. This allows the

demonstration of nurse's capacity to the health care community and creates avenues for nurses to display their true power, knowledge base and skills, which can often go unseen.

### 7.3.3  Power

Bourdieu explores the *field of power* as a metaphor for the way in which individuals conduct themselves within the culture they inhabit. Power may be viewed as governmental regulation (for nurses this can be the NMBA), or as capital, that takes many forms (e.g. social, knowledge, financial). For Bourdieu capital is presented as a source of power that affords influence over social, cultural and even symbolic events in individual's lives (Webb et al., 2002).  CPD is a form of knowledge capital, affording knowledge and influence with a diverse impact on nurses. The NMBA exerts power over nurses, stating that CPD must be undertaken to continue their employment.

Power within a culture has a significant influence on group behaviours. This research highlighted this power with nurses like Alysha, Kathy and Kim using their position in the workplace to share knowledge with others. Using the requirement of sharing knowledge and providing education these nurses were able to disseminate knowledge to their peers. This perceived power was used to share knowledge but it is also capable of eliciting positive and negative outcomes for those around them. As a result, the individual's level of self-esteem and comfort within the group is often determined by their alignment to those with power. If the individual shares similar views and beliefs to those with power, they contribute to the majority who hold power. Kaylah highlighted the impact of colleagues on their willingness to share knowledge. When surrounded by those that embrace knowledge and change Kaylah would share her knowledge openly. However, when colleagues were resistive they would ask '*what's wrong with how we do it now?'* This in turn created sensitivity about whom she could reveal her knowledge to, so as to protect herself from any negativity.

The impact of power can be observed in nurses exposed to workplace bullying. Negative use and abuse of power can have a direct impact upon self-esteem and results in withdrawal and isolation of nurses (Randle, 2003). Cultures of negative

behaviour can only survive when the majority of the social group conform to such behaviours. Thus it is the majority that has the power to determine behaviours and standards (Hutchinson & Jackson, 2015).

Bourdieu references power and the cultural field, exploring the risks and benefits as defined by the field. The value attributed to both risks and benefits is proportional to the values and beliefs of the cultural group and the values placed upon assets (Jenkins, 2002). Education can be a valuable source of power, but its significance is determined by the merit placed on education by the nursing profession. Kaylah talked of the influence of the field, and how the behaviours and attitudes of others caused her to '*temper*' and alter her own actions. This change in behaviour was to withdraw and to not challenge current practice using the evidence she had gained in recent CPD.

A professional with current and or extensive knowledge is often highly regarded by colleagues. Alysha attributed the level of knowledge to the *'fair bit of respect given to us out there on the wards. We're lucky to have that respect'.* It is not uncommon for nurses on the ward to seek support or guidance from their intensive care colleagues. When such knowledge is shared, power is often generated. Power does not have to indicate a state of ultimate control. Power often references the ability to influence or guide a group's behaviours toward the accepted norms of the majority. Individuals however are not always under the control of the majority, with personal views and perceptions influencing their acceptance of power (Schira, 2004). This is seen with nurses deferring to others for guidance and through the sharing of knowledge to guide practice.

Supporting the belief that knowledge is power, nurses are encouraged to embrace experience and knowledge, promoting sharing among peers (Palanisamy, 2015). Such sharing of knowledge occurred during in-service education sessions (Kim), in talking about new knowledge acquired in recent CPD (Kathy) and through '*fantastic learning experiences on the rounds'* (Alysha). In embracing this form of power nurses can create a profession in control of its future. The support for nurses to build and embrace power as an advantageous source to be used in achieving goals through sharing knowledge extends across

the literature (Fackler et al., 2015; McKinnon, 1999; Peltomaa et al., 2012; Pratto, 2016).

Power dynamics exists in the social world because of pre-existing perceptions and influences. This often extends to interactions between individuals with one party normally prepared to abide by the decisions and directions provided by the other (Bourdieu, 1984). Research into hierarchies entrenched in medicine and its specialities demonstrate there is often reluctance among individuals, health professionals included, to challenge specialists in other fields. Palanisamy (2015) exposed unwillingness among practitioners to question the expert, even in the presence of concerns for potential patient harm. This insight highlights the complexity of social power in health care. Acquisition of new knowledge may carry risks in the local setting and this can create a reluctance for nurses to challenge practice with new understandings due to social hierarchies.

It is through social acceptance of the value of knowledge and capital that individuals acquire power (Bourdieu, 1991; Webb et al., 2002).  As Bourdieu (1991) explains, knowledge creates the possibility for symbolic power, an invisible form of power. Consequently, opportunities to create change can be slowed or missed. Symbolic power can only occur with "the complicity of those who do not want to know that they are subject to it or even that they themselves exercise it" (Bourdieu, 1991, p. 164).

CPD and knowledge are commonly unseen or less acknowledged sources of power. For example, Trish illustrated how bedside education is often overlooked as a valid form of CPD. The suggested reason for Trish was attributed to *'where do I log that; that I had a ten-minute lecture on something and it's a CPD'*. The power of the nursing profession has often been under acknowledged and utilised as a result. Power can be built and held from demonstrating knowledge by highlighting the impact upon patient outcomes achieved through the application of evidence (Pelc, 2009; Stuart, 1986; Tierney, 2012).

Moving further into Bourdieu's approach is the relationship between power and habitus. Orthodoxy and heterodoxy create a lens from which the interconnection of power and habitus can be illuminated. Social space exists with a defined field

of power, with expected behaviours and beliefs for those individuals within the field (Bourdieu, 1991). In nursing the field is set by the NMBA, employers and the wider community. The NMBA is a key source of power, setting the field and expectations of behaviours for registration. The health care organisations that employ nurses are contributors to the field, with their own performance criteria and rules for employment. The local community is also a powerful contributor to the field. Their power lies in their ability to determine the NMBA's continuous right to regulate the profession on behalf of the community. Within this complex state individual attitudes and behaviours and how they come to be who they are, can be influenced by all of the above sources of power.

Within the field of power for nursing are internal hierarchical structures, which divide nurses into groups, acting as a hindrance and negatively impacting their ability to gain ground against institutional power (Ballou, 2000; Pelc, 2009). Power is gained through a cohesive approach and unity. The collective number of nurses far outweighs any other profession in a health care institution. Therefore, one would think sheer numbers would afford power. However, without cohesion amongst nurses this is lost (Ballou, 2000; Pelc, 2009). When the group is fragmented, the power is lost. Accompanying this weakness is a missed opportunity to demonstrate the widespread benefits of knowledge application, with the profession neither united nor internally supportive (Pelc, 2009).

Extending the discussion of power, Bourdieu uses habitus in a unique way, defining habitus as "dispositions which incline agents to act and react in certain ways" (Bourdieu, 1991, p. 12). Through exploring attitudes and dispositions and engagement in practices within a social setting habitus and sources of power become known. In habitus beliefs, ideas, choices and practices are guided but not fully determined by the social structure. Alysha and her colleagues' approaches to bring CPD to the local arena is an example of how nurses are influencing the practices in their field. In doing so they have created a safe space, attempting to remove '*intimidation*' that may be associated with larger conferences, and highlighting the value and impact of learning for their colleagues.

The individual is equipped with the power of agency and choice. Agency, however, is subconsciously influenced by habitus. In habitus an individual develops a rarely articulated sense of rules that become second nature, resulting in subconscious action and decision making (Collyer et al., 2015). Habitus is further influenced by objective structures (institutions, social relations and resources) that in time become embodied and internalised, influencing agency subconsciously (Husu, 2013).

The workplace is a social environment subjected to both institutional and social power. Therefore, determinants of power can be unique to the area with distinctive power relationships influenced by individuals and culture. A strong sense of power can be connected to nurses in social settings including their relationships with other nurses and physicians. These feelings of power act to motivate nurses to engage with or resist knowledge building and sharing, and social interactions within the workplace (Fackler et al., 2015; Skei, 2008) in the form of CPD. These aspects of habitus are important when considering the influence of power on behaviours and practices of nurses. Individuals engage with power at a subconscious level, often not recognising it for its impact upon the field and behaviour. The impact of workplace power is considerable for nurses like Kim. The decision to engage in CPD is driven after a conscious realisation that '*I need to make sure that I'm on the ball so that I know nobody can question me'.* Such comments highlight underlying influences for some nurses to engage in CPD out of an attempt to protect them from negative workplace behaviours.

The term 'field' for Bourdieu refers to the social space where individuals question and contest norms, intent on gaining a position with power to create change or have control. The field is always fluid (Collyer et al., 2015). In most situations, the field is founded on history, responding to challenges that arise from the differences across individuals, groups and institutions. To build power, Persons and Wieck (1985) promote the approach of 'know and be known' for nursing. Power is lost with the hiding of abilities and knowledge, with opportunities missed for professional recognition or power. By embracing CPD and the accompanied knowledge and self-confidence, nurses build their capacities and make visible to

the field (institutions, professionals and patients) the profession's true potential (Persons & Wieck, 1985).

Power acquisition through making visible capacity needs to include all stakeholders with which nurses interact. Nursing holds considerable power with its patients, built upon a history of well documented trust, being the most trusted profession year after year (Ham, 2016; Odishoo & Vezina, 2014). This position should be utilised for nursing to gain further power by highlighting that the profession can be trusted due to its specialised knowledge. Nursing is both an art and a science. Power can grow when nurses embrace scholarship, evidence, knowledge, skills, critical thinking, competency and accountability. It is these skills which save lives and allow effective outcomes, and trust simply facilitates the process (Odishoo & Vezina, 2014).

The individual's or institution's position and degree of power within the field is determined by dispositions, objective measurements and institutional factors such as education and qualifications (Husu, 2013). As individuals within the field change; the field in turn responds and changes to form a habitus reflective of its members (Husu, 2013). Thus power within the field is rarely fixed.

Social power is often linked to action, although social groupings, social dynamics and the environment add complexity to the actions taken, as others are involved. In social environments power dynamics and decision making is embedded and aligned with unspoken social expectations. The impact of power in social groups is moderated by variables such as interpersonal concerns and cultural influences (Scheepers, Ellemers, & Sassenberg, 2013). This is seen in the experiences of participants sharing their knowledge. Alysha moderated her sharing of knowledge dependent upon with whom she interacted. Kaylah altered the way in which she spoke about new practice when colleagues appeared resistive and resentful of her behaviours. Morgan felt safe to share her knowledge as did Leah, because they both felt that their colleagues were receptive to altering their practice.

Feelings of power and empowerment are not personality traits; they are cognitive processes shaped by the social space in which the individual or group resides (Singh et al., 2014). When nurses have high levels of self-esteem, decisiveness

and self-control they are more likely to feel powerful. This contributes to feelings of safety in expressing their views and to being more receptive when decisions and views are challenged by peers. These aspects are integral and dependent upon the social environment and contribute to power that exists within the field (Sepasi et al., 2016).

The field is a structured system of social positions ranging from individuals to institutions. These internal structures have control and power over the occupants in the field (Jenkins, 2002). However, power within the structure is not always clear. For example, the general public have the power to choose (through elections and representation) the politicians who legislate the authority and membership of the regulatory body, which then determine the standards and discipline for breaches by professionals such as nurses. Yet members of the general public may be unaware of their position of power because of its indirect nature.  Nurses also have an ability to influence the power of the NMBA by challenging the orthodoxy of positions. Nurses too, like the public, may be unaware that they hold this position of power. Overlooking their influence extended to the nurses in this research, with a common thread of nurses not being sure what influence they had over the NMBA decision making about CPD.

Capital is a significant feature across Bourdieu's work because of its ability to generate power. However, capital can only be effective or real when the field is prepared to acknowledge positions of power (Movberg, Lagerström, & Dellve, 2012). In social fields, for instance, capital has been observed to influence interactions between individuals (Collyer et al., 2015). Capital can take many forms (e.g. social, cultural and symbolic), providing recognition and respect due to it being socially attributed but not produced by the individual.

Capital is a recognised form of power when individuals within the field respect such capital. This was evident in the comments made by participants with an individual's level of knowledge influencing the level of respect given by peers. Alysha believed respect was given to intensive care nurses by those working on wards. This respect became a driving force for Alysha to maintain a high level of knowledge. As such, knowledge and education is a form of symbolic capital that acts as a means to acquire power from respect (Bourdieu, 1991). The

achievement of higher status in the perception of others is cultural capital. This form of capital is often associated with those with more experience and is built and developed over time (Collyer et al., 2015). The influences of symbolic capital and cultural capital can be seen in nurses' approaches toward CPD. Prestige and respect are identified as key motivational elements underpinning some nurses' engagement with CPD. When we see respect of colleagues and the power that knowledge brings as reasons nurses engage in CPD, a reality is revealed which fails to reflect the mantra of the NMBA's education for social protection.

Building capital across the field is important, as it creates opportunities for individuals to acquire power and influence others. This can be observed in nurses recognising and supporting their colleagues through sharing knowledge and encouraging CPD to generate power within (Persons & Wieck, 1985). In doing this a nurse demonstrates their capacity and builds capital among their peers. The NMBA rationale for mandatory CPD is to provide nurses that have current knowledge, who are capable of providing high level care and who are socially accountable. This research reveals that the suggestion that nurses engage with CPD for patient safety is more rhetoric than reality.

## 7.4   Heterodoxy – the reality

The underpinning principles outlined in the orthodoxy of professionalism (i.e. CPD and power) are used to contrast the reality for nurses who participated in this research. In this section Bourdieu's state of illusio; subjectivism; social capital; cultural capital; habitus; and reflective practice are used to reveal the rhetoric. An alternate reality for nurses' actions is disclosed, as well as the challenges that exist and act as a barrier for the NMBA to achieve its raison d'être of public protection.

Underpinning the disconnect between rhetoric and reality is a divide between core values of the NMBA and the nurses it registers. This situation is exacerbated by poor communication and guidance from the Board. The NMBA's core responsibility is to monitor the registration of nurses. Prior to national registration the professions had core professional representation and a voice through the Australian Nursing and Midwifery Council (ANMC). National registration for

nurses saw the dissolution of the ANMC. Some may say that Australian nurses are without a nursing professional body, with the NMBA undertaking a more regulatory approach. With appropriate structures in place, the profession might begin to work towards a collective ideal of practitioners, academics and governance leaders in nursing, instead of the current state of heterodoxy.

### 7.4.1 Games the NMBA and its nurses play

In his book, *Logic of Practice* (1992), Bourdieu explains how deconstruction of acts allows the review of events and practices. It is during this approach that questions arise that are not commonly asked by those involved in the game. This is attributed to the close familiarity that individuals have, where behaviours appear innate. Explaining what is meant by 'game' Bourdieu uses examples of sport and games where rules are a tool that explain how all individuals play the game.

A game has a predetermined set of rules and actions that are carried out in day-to-day life. Each rule or action has an intended objective aimed at achieving success and winning the game. Bourdieu is explicit in his writing. He explains that while a game has a field, rules and clear stakes, in social fields the products of a long and slow process of empowerment are games **in** themselves **not for** themselves (Bourdieu, 1992).

Individuals in the social field do not enter the game as a conscious act. People are said to be born into the game (Bourdieu, 1992) with their involvement and degree of investment determined by the outcomes at stake: the illusio. Suppositions are made prior to engaging as to the stakes associated with the social game and the value from playing (Bourdieu, 1992). Individual players are taken into the field and at times oppose each other competitively. Cohesiveness and competition are guided by the pre-determined level of agreement of the players and shared belief, in this case orthodoxy. An individual will engage in the game when it is viewed as worth playing and this acknowledgement is the determinant of their involvement.

While acknowledging the stakes, not all individuals enter the game on the same side. Individuals can hold different beliefs and values but the stakes of day-to-

day life require that they engage in interactions where rules and objectives are heterodoxic to their own (Bourdieu & Wacquant, 1992). Nurses participating in this research shared experiences revealing a state of illusio. For these nurses the focus was to maintain registration; the risks are high if they are noncompliant with the rules of the game, that is, mandatory CPD. Failure to be compliant results in an inability to renew registration, earn an income and maintain employment as a RN. As a result, nurses ask themselves how they can best exist within the game and remain uninvolved, tick the boxes and not incur any penalties.

The decision about how to play the game varied across nurse participants. Some participants partake, staying closer to the rules than others. The majority of participants viewed the NMBA mandatory CPD requirement as simply part of the game, that is, a requirement to be ticked on an annual basis in order to maintain registration and employment as a RN.

Thus a game exists between the NMBA, nurses and the public where the field is set but the way the game is played is overtly different. Through mandated CPD the NMBA has created a field where the primary rule is to 'comply to remain a nurse', founded upon a need to protect the public. Nurses do not disagree that protection of the public is essential. But, not all nurses share an aligned doxa with the NMBA and its mandated model of CPD.

Nurse participants disclosed that the stakes of the game are not always about public protection. Often the CPD model is viewed, by participants, as a high stakes requirement to maintain registration, employment and income. Participants rationalised this in many ways. For Taylor it was '*stature and a professional thing, even doctors do it'.* Whilst Jamie, Leah and Kim suggested it was more aligned with 'formalising CPD activities, using evidence as proof': a means for the NMBA and employers to meet their requirements.

The power of such comments from nurses creates an opportunity to critique the NMBA. For example, is the NMBA playing a game of its own, and placing the reputation and standing of the profession at stake? The NMBA do appear, on the surface, to conform to the professional standards of ongoing education with mandatory CPD to build expertise. However, the model implemented is poorly

understood and too easily exploited by nurses who can play the game without breaking any rules. The capacity to easily manipulate the model, as seen in nurses like Morgan, use their employment as CPD. Morgan explained that *'the vast majority of my points are gained just from the competencies up there (the Intensive Care Unit (ICU))'*. This was accompanied with an acknowledgment that it did not build new knowledge or skills but met the requirement of twenty hours annually and allowed renewal of registration.

Viewing CPD as a figurative penalty 'stick' used to maintain registration; nurses play the game and the state of illusio remains. Participants shared multiple approaches toward CPD that allowed for maintenance of registration. While most participants shared experiences of engaging with new knowledge this was not seen across all nurses. In Trish's situation, the stakes of registration are high. Navigating the field and the rules within, Trish finds relief in what she described as a *'loophole'* whereby she easily fulfilled CPD requirements without performing anything other than what was required of her by her employers. Within the NMBA approved CPD activities is an employment related role of covering a manager's leave. Trish counted five to six weeks of annual leave cover, where her employment required that she act in the position of her supervisor as her CPD. Despite acknowledging the absence of new knowledge being generated, Trish's approach to CPD highlights the heterodoxic state that has moved away from gaining public protection.

The stakes of the game are high for Trish. As a mother of two she requires her job to make ends meet. The time required for Trish to travel to locations that offer CPD impacted her family life. The incentive for compliance is high, that is registration, therefore employment. But the rules are vague and therefore behaviours push the boundaries of the standards implemented by the NMBA. Unfortunately, Trish is not alone in this manipulation; other participants were happy to count meetings, and filling the roles of managers during periods of leave as their CPD. This raises serious questions about the NMBA model of CPD being anything more than rhetoric and thus unable to provide a regulatory framework for public safety.

Navigating the boundaries of the game does not mean there is no appreciation of the value of CPD and ongoing education. These behaviours are a reflection of actions taken when the stakes are high, and rules are open to interpretation. It is common in human nature for some individuals to take the path of least resistance. However, the current model of CPD is likely to fail with nurses' actions not aligned with the intention of the game.

As with any situation, when the rules and boundaries are pushed, resentment can arise. Those participants who valued CPD opposed, even resented, the lack of constraint put in place by the NMBA. Rules that permit the use of employer competencies as acceptable CPD constituted a core area of concern for several participants. Nevertheless, to maintain the illusio nurses disclosed that, if audited, they would claim their hospital competencies as CPD. The stakes of maintaining registration are simply too high for nurses to not engage in the illusio.

This acceptance to conform to the illusio was not simply among those participants less invested in CPD or focused on meeting the twenty-hour requirement. Jamie regularly invested in professional development and reported an average in excess of forty hours of knowledge building CPD in a year. Despite the commitment to education Jamie admitted that no records were kept of these activities. If an audit was conducted by the NMBA, then certificates of hospital competencies would be used if other evidence could not be easily found. The ease of finding evidence of hospital competencies make their use appealing and meets the NMBA standards. Jamie acknowledged that the stakes of CPD and registration are essential for financial viability. For many participants, the necessity to maintain registration was high and the current NMBA CPD standards create another game for nurses.

The need to maintain the illusio and play the game was openly shared through nurses' discourse. Nurses across field sites understood that some colleagues did not invest in CPD as they had. The acceptance of in-house hospital competency standards to meet mandatory CPD requirements was considered a contributing factor to nurses' resistivity. Approaches to and incidences of using employer training eases the increased financial impact for regional nurses. Jamie revealed that the financial burden of CPD includes the cost of driving, road tolls and

carparks are substantial, as well as the time impost. These are issues that most metropolitan RNs do not incur.

It is natural for nurses to consider the personal impact of engaging in CPD. This includes evaluating the value obtained from CPD and their need to maintain registration. However, these behaviours create doubt in the nursing profession's ability to support and sustain the NMBA intention of public protection. When nurses approach CPD to maintain registration, a discrepancy arises between nurses and the NMBA. The NMBA implemented CPD to protect the public, and nurses approach CPD to maintain registration. This absence of commonality and clear heterodoxic state corroborates that the NMBA has a rhetorical model that is unlikely to achieve public protection.

The NMBA is positioned as a regulatory body, answerable to the public and the government. The Board is not designed to protect nurses. Its purpose is to ensure the public are provided with effective care by professional nurses. In setting up the national registration in 2010 the then ANMC developed a continuing competency framework. The framework became the initial structure for the implementation of mandatory CPD to ensure a competent profession of RNs that delivered safe, effective, evidence-based care (Australian Nursing and Midwifery Council, 2009).

In setting the initial standards for CPD the ANMC stated that effective CPD activities are those that lead to a change in practice and involve active learning of new skills or knowledge (Australian Nursing and Midwifery Council, 2007, 2009). The guidelines clearly stipulated that mandatory continuing education and/or employer competencies should only be counted when learning with new knowledge and skills has occurred (Australian Nursing and Midwifery Council, 2009).

This 2010 requirement of new knowledge stands in stark contrast to the expectation laid out by the NMBA in 2016. The latest guidelines related to CPD clearly establish that nurses *are* permitted to count mandatory activities and/or employer competencies, if they are perceived as being relevant to the context of practice. The guidelines provide no stipulation that new learning or new skills

acquisition must be achieved for activities to be counted (Nursing and Midwifery Board of Australia, 2010b, 2016d). This difference is profound, but commonly overlooked. Hence it has opened up the possibility and actual engagement of 'playing a game' of convenience rather than meaningfully expanding public safety and evidence-based practice.

This rhetoric by the NMBA must be challenged. The reality of CPD practised by nurses reveals a significant gap which leads to workplace tension, between the realities of everyday practice and rhetoric contained within the NMBA framework for professional development. Failure to challenge this rhetoric has the potential to be derogatory in terms of protecting the general public, by providing the highest and most consistent professional development standards possible.

NMBA mandated CPD was implemented in response to Federal Health Care Legislation (State Government of Victoria, 2009). The CPD requirements for nursing are not as stringent as those of other health care disciplines. Other disciplines in health, such as medicine, have worked to refine their standards for CPD. Each refinement has resulted in increased standards with more robust criteria and a requirement to provide evidence of worthy CPD action. This is accompanied by regular auditing of staff annually (Medical Board of Australia, 2010, 2016).

The profession of medicine refined what are considered appropriate forms of CPD. At the same time the NMBA elected to modify its language, increasing a nurse's ability to interpret the requirements. Why did this occur? Does the NMBA believe that the original requirements were too demanding? Did nurses not adhere to the standards or complain? Is the NMBA aware that it is unable to achieve its intent, or that there is a disparity between the spirit of the standards and how they are met? This research has not sought to answer these questions. However, the research findings strongly suggest that nurses are not approaching CPD as the NMBA intended. The manipulation of such lax CPD requirements offers less than ideal protection or value to the general public.

Bourdieu argued strongly that  inalienable value was important, saying the value is intrinsic to the individual and not subject to the values of the market (Webb et

al., 2002). This point is valid when looking at the tensions highlighted between the rhetoric and realities of CPD. As the model currently stands the value of professional development gets lost in both the NMBA rhetoric of CPD and current interpretation of CPD by nursing staff. The profession of nursing is playing a game with rhetoric, presenting CPD as a safety and competency strategy to protect the public. The reality shows that nurses and the NMBA are not aligned in their beliefs toward CPD. Nurses also do not understand the NMBA's intention behind implementing mandatory CPD. The risk exists that, for nurses, CPD will continue to reflect an annual ticking of a box at renewal of registration. Meanwhile the community believes CPD in nursing expands knowledge and improves safety in health care.

### 7.4.2   Identifying and pushing the boundaries

Bourdieu uses the concept of subjectivism to explain social reality. Subjectivism is a perspective that social reality is produced through thoughts, decisions and actions of individuals (Webb et al., 2002). For Bourdieu subjectivism occurs for the individual after they first come to know themselves in terms of the world which they view as oppressing them. This is often accompanied by a state of apprehension about the lived experience of the individual and others and forms knowledge of the social world (Bourdieu, 1991).

It is this knowledge of the social world that when coupled with a desire of knowing self, an individual decides to challenge their social world or allow it to continue as is. Those that seek more often are driven by the belief that others live within the world they wish to inhabit. Bourdieu (1992) used the example of believing the grass is greener for others. This is a subjective assumption made on the premise that the individual assumes another situation is more agreeable or appropriate than their current situation. Bourdieu (1992) explains that the desire for a more satisfying social world, or greener pastures, is not triggered by the experience the individual is having, but occurs when their own situation appears to offer little in the way of help or change.

Bourdieu rationalises that when situations and circumstances appear as barriers to achieving the goal, individuals start to consider how things could be. As a

strategy individuals often explore the limits of the situation to determine boundaries and realms of possibility (Bourdieu, 1977). This exploration of the subjectivist view of a situation can result in driving change and evolution for the better (Bourdieu & Wacquant, 1992). By unpacking the heterodoxy values and beliefs of the nurses in this research, opportunities for change and the evolution of CPD in the profession of nursing arise.

Subjectivism, as presented by Bourdieu, is visible in participants' feelings and perceptions of CPD and the NMBA approved model. Participants shared situations which they described as hopeless and where a way forward or change was not evident or obvious. When participants looked to other professions, such as medicine and allied health, the grass appeared to be greener.

This suggests a state of envy amongst nurses believing that other professions are more invested in CPD and thus more amenable to change practice. In response nurses actively sought ways to create professional investment and cultural change in colleagues. This can be seen in bringing local CPD opportunities to nurses. Alysha believed that colleagues viewed large metropolitan conferences as *'over my head'* and therefore avoided these opportunities. In response Alysha lead the local conference with the hope that colleagues would think '*okay we can do that, and it doesn't look too intimidating*'. This desire to bring change to the social setting is not only beneficial for Alysha's colleagues: it fulfils her need to change the world in which she lives to one that supports her desire for learning.

From discussions and interviews with nurses about CPD, professionalism arose as an area of concern. This is exacerbated by dissatisfaction surrounding the willingness of the NMBA to accept employer competencies as CPD. Nurses, like Kaylah, believe that the profession of nursing is being damaged by devaluing knowledge required to be a RN. Instead of a focus on knowledge, critical thinking and clinical reasoning, in Kaylah's view, the focus of the profession is moving toward a greater emphasis on tasks. Drawing on her perceptions and experiences, Kaylah revealed how she often looked to other professions and their standards and judged nursing against those. By engaging in these behaviours, Kaylah and nurses like her are exploring the limits of nursing's mandated model

of CPD, considering the possibilities of higher standards and a more refined model. When the subjective possibilities are considered, boundaries can be identified, obstacles start to become clear and this creates opportunities for change.

Current thoughts about CPD in nursing can be attributed to the increased level of frustration and resentment at current structures within the profession. A common issue arising in this research was resentment towards the NMBA and fellow nurses for not pushing the boundaries and challenging the status quo. This was apparent when participants discussed their feelings about nurses they believed did not engage in CPD. These nurses are suggested by Kaylah to be protecting themselves and engaging in a disservice to the profession.

The proposition made by multiple participants is that the NMBA may have deliberately chosen the current model. It was suggested that the ability to do no more than required prior to mandatory CPD implementation may have been the intent of the NMBA. Morgan suggested it was *'to justify the professionalism of the role'* while Jessie was more sceptical, suggesting it was all about *'hackademics and administrators'* getting nurses to do it their way. The inclusion model and acceptable forms of CPD triggered a passionate response from Kaylah: *'it's just so insulting'.* Taylor echoed these thoughts and explained the acceptable forms of CPD as *'ridiculous, how is that professional development?  I think that's just professional being'.*

The decision to have broad inclusion criteria, including employer competencies, was suggested by participants to be related to a need to limit the work associated to monitoring the large number of nurses. For Jamie the questions were *'who is actually going to look'* at the CPD and *'what's going to be the outcome'* for those that do not meet the standards? Jamie went on to suggest that the NMBA approach was in response to many nurses who would or could not meet the criteria at the time of registration renewal had the standards been higher. From this perspective most participants challenged the NMBA and its boundaries, recommending a more rigorous process surrounding the CPD.

The influence of subjectivism is fundamental to the evolution of supporting change. This was observed amongst those participants that desired a better system of higher standards for the profession, which did not constitute all participants. Some were happy with the ability to use employment requirements as their CPD. For those that wanted more change I believe their desires do not arise out of a need for greed or promotion, or indeed a need to exert power. Instead I propose that they stem from a deep melancholy about the profession to which they belong. Kaylah exemplified this in her despondent comments that '*nursing was not a profession*' as it appeared to her. Kaylah argued that the need to apply mandatory CPD standards highlights the lack of investment from nurses to be a professional and a need for regulatory drive to create such behaviours illuminates lack of drive amongst nurses. These values and beliefs highlight a need for change in nursing with participants calling for a model that meets their professional expectations and ensures the protection of nursing as a profession.

### 7.4.3  Nurses power and the disempowered NMBA

Decisions made by individuals in relation to CPD are intertwined and heavily influenced by multiple factors. The state of illusio influences choices about CPD made by nurses and the occurrence of subjectivism creates questioning and room to explore change. Societal influences and their impact upon nurses and CPD and the capital that exists within a social context has evolved as key influencing factors in nurses' approaches to socially accountable CPD. Looking at each ICU's culture toward CPD assists in setting the scene in which nurses need to exist within and navigate.

Field site A described CPD as an accepted and embraced activity that was welcomed into the workplace and had influence over nursing practice. CPD was seen as a form of valuable social capital. Those nurses that engaged in CPD were spoken of in respectful tones and described feeling respected by colleagues. Participants that did not engage in CPD that built new knowledge instead chose to utilise employment requirements that spoke positively of those that engaged in CPD and welcomed the knowledge they brought to the unit. The unit did not appear to have a power struggle between those engaging in new knowledge and those prepared to use easier means to meet their CPD. Nurses

felt safe to share their knowledge which contributed to a positive workplace culture. This could be attributed to the majority of participants describing an ICU with staff committed to finding and sharing new practice.

In stark contrast, field site B was described by participants as an environment with internal struggles to acquire and hold power and define the symbolic capital associated with CPD. At this field site knowledge was a highly valued commodity on which position, reputation and standing were well established and built. Nurses at field site B believed that while the majority of nurses engaged in CPD some did not. This variability created a series of complexities which impacted upon the types of capital and those reported to have capital. The power exerted from nurses that did not engage in CPD was considered significant. Some participants at this field site even revealed their hesitation in disclosing CPD activities to their colleagues due to negative responses that surrounded potential change. This created a divide and was accompanied by challenges of symbolic capital associated with CPD. When such a challenge exists, the habitus moves into a state of flux, creating a divide between those who do and those who do not value CPD.

Field site C was markedly different again. Here the social norms were described by participants as being in a state of evolution. Participants described a slow movement towards valuing CPD and the acceptance that it can bring positive change to practice. While the nurses in the field were prepared to evolve, it was nonetheless portrayed as moving in a guarded fashion. Resistance to change remained evident and caution surrounded the discourse on CPD. Although there was change, views about accepted behaviours and expectations were explained in a way that illuminated a state of concern and hesitation that alternative motives were at play. This was explained by one participant as nurses questioning why they were encouraged to engage in particular CPD opportunities. Some nurses had even questioned whether suggested CPD was because others thought they could not do their job.

Diversity of capital attributed across field sites is important to identify. Even given variables in culture, each venue had shared core values and beliefs. This commonality in the face of diversity adds rigour and strength to the findings of

nurses' perceptions and approaches to socially accountable CPD. The depth of the heterodoxic position of nurses in relation to the NMBA adds to the value of these findings, which supports the argument that nursing has failed to embrace the current model of CPD.

Lack of capital attributed to CPD by nurses can be attributed to failure to embrace the mandated model. The reasons nursing has failed to embrace CPD are many and varied. Some nurses simply do not perceive value in CPD while others see the value and capital of CPD, which is encouraging for the profession. However, the same cannot be said for the NMBA mandated model. This view is supported by participants who shared experiences and perceptions of CPD that highlighted that symbolic capital is found by nurses when they engage in CPD.

The NMBA promotes idealised rhetoric of a profession surrounded by and accepting of CPD. The participants shared experiences that revealed a far from supportive culture in nursing, and regional nurses' experiences of feeling isolated from CPD in their community were common. Kathy, a senior nurse in her unit, talked about her isolation locally with experienced staff working permanent night duty. For Alysha and Jamie, the isolation was geographical. Both nurses talked about their isolation from peers who also shared a passion for positive change in practice based on evidence. This strong desire to be exposed to CPD was high across many of the participants, with barriers to access creating a yearning that was accompanied by sadness and frustration directed at the profession and the NBMA.

The participants were able to identify the symbolic capital of CPD and multiple uses of power. For some participants CPD was a protector that buffered colleague's challenges while they engaged with other colleagues as they shared their knowledge. Other participants described the respect they were able to achieve from colleagues resulting from their CPD activities. The symbolic capital of CPD should not be overlooked. For Alysha, the motivation to continue to engage in CPD surrounded a need to ensure she was well thought of and respected professionally. This was achieved by continuing to portray her image as knowledgeable and maintain her position in management, a primary focus for her CPD. However, Alysha did acknowledge that her CPD activities would be

perceived by patients as a secondary benefit. Others, such as Jordan and Taylor, both engaged in CPD after observing colleagues and aspiring to reach their performance levels. It is valuable insights like these that highlight how nurses can be motivated to acquire capital and associated benefits.

The social power attributed to CPD is evident upon hearing participants' experiences. As explained by Tame (2012) clinical environments have long been known as conflicted sites, either accepting or strongly opposed to change that occurs from learning. This conflict occurs in response to the individuals that exist within the culture, and collective values that determine what is valuable and what is not. The expected behaviour and attributed value to CPD is often set by the majority (Robbins, 2000). This is evident in this research through participants revealing their cultural intricacies that highlighted both the acceptance and resistance to new knowledge and practice change from CPD.

The NMBA and the orthodoxy of being a professional declare that CPD is highly valued and embraced. In reality, the social environment determines the value placed upon CPD, which does not always match the ideal. In nursing, while the public are considered, nurses approach CPD guided by their cultural field, and the benefits and opportunities that CPD can provide in their local area. This continued state of illusio serves to develop workplace culture. However, it also highlights that nurses are not engaging in CPD out of a primary need to meet the needs of the community. Instead, the influence of capital results in nurses undertaking CPD for a very different game, which is not influenced by the mandate of the NMBA.

### 7.4.4 Symbolic violence and CPD

Bourdieu's concept of power is multidimensional. Capital is not only symbolic but heavily influenced by one's social environment. The power of symbolic capital has an influence on the individual, with cultural capital and habitus directly impacting upon an individual's practice and decision making. The NMBA is required to function at a national level. Nurses however are required to navigate a local habitus to achieve acceptance on a day-to-day basis within the workplace.

The navigation of habitus has a significant impact on perceptions of and approaches to CPD for nurses.

Symbolic, cultural and social capital are heavily influenced by challenges that exist within the habitus and the agreed orthodoxic principles of the cultural group (Webb et al., 2002). The habitus influences responses toward those that do not conform to the proposed social norm. This often occurs in the form of symbolic violence, which refers to non-physical violence that occurs in a symbolic way, for example, denial of resources, exclusion from discussion or treating individuals as inferior (Webb et al., 2002).

The presence of symbolic violence can influence individual behaviours, interactions and perceptions of a cultural group/society due to a perceived or presented power imbalance between individuals and groups. The existence of symbolic violence can relate to an individual or group of individuals that are dominated and disadvantaged (Jenkins, 2002). Participants in my research shared personal experiences of symbolic violence in response to their engagement in CPD. These included perceived, targeted isolation from colleagues to public interrogations about why they practised in that fashion. Nurses also shared use of CPD as a tool for protection from acts of symbolic violence within the field. The utilisation of CPD as protective was explained as arming the individual with knowledge that allowed the answering of public interrogations in a confident manner.

Symbolic violence creates vulnerability and caution, which often results in hesitation to share knowledge and skills gained through CPD. These experiences are important as they underscore the reality of CPD in nursing. It is only when the reality is exposed that the rhetoric can be uncovered, and action taken for change. The concept of emotional violence in nursing is well documented (Tame, 2012; Walrafen et al., 2012; Weinand, 2010), resulting in a hostile workplace. The experiences of nurses engaging in CPD have revealed an environment of isolation and vulnerability. This is supported by literature which states that up to fifty percent of nurses have been exposed to such feelings at a point in time in their career (Walrafen et al., 2012).

The NMBA has focused on bringing knowledge and evidence into practice through CPD. Some participants presented an alternative motivation with CPD, offering a strategy for protection from symbolic violence within the field. Kim and other participants, from all three field sites, spoke about hostile workplaces. For Kim, knowledge and personal self-worth gained from CPD were key to counteracting attempts from colleagues to exert power over and humiliate others like Kim.

In sharing her experiences Kim highlighted a foundation of protection that guided decisions made about CPD. As a result Kim and others gained knowledge and experience to create a strategy to navigate workplace culture. In a symbolically violent workplace, as shared by participants, an influential factor for engaging in CPD was an attempt to shift the balance of power. With colleagues who shared an interest in CPD, participants explained how CPD became a tool to gain power and change culture.

Kim was not alone in these feelings; the majority of participants in this research shared experiences of symbolic violence. Symbolic violence in nursing was described by participants as being isolated from colleagues and like-minded nurses. Participants were also labelled as troublemakers or difficult when talking about their CPD activities, and then viewed as different and considered someone to be cautious around.

Causes of symbolic violence in nursing have been attributed to years of oppression experienced by nurses (Weinand, 2010). After being rendered powerless, it is proposed that nurses, as professionals, have sought opportunities to gain power. As nurses have historically struggled for power they have also fought amongst themselves (Farrell, 2001; Weinand, 2010). This impact of culture on nurses' CPD choices highlight a dramatic shift away from the NMBA raison d'être.

Navigating symbolic violence in the field impacts nurses. In order to manage stressful situations nurses are reported to utilise emotional intelligence. Emotional intelligence provides a buffer from occupational stress by providing individuals with an array of emotional and social competencies that can be used

on a day-to-day basis within the cultural field (Khodadady & Hezareh, 2016).  Kim and other participants have, for example, embraced CPD as a form of emotional intelligence that facilitates them remaining within the workplace.

The NMBA have publicly promoted that nurses engage in CPD with a motivation of gaining knowledge to increase the quality of nursing care (Nursing and Midwifery Board of Australia, 2016g). Kim and other participants openly disclosed their vulnerability in the workplace, confirming that their approaches to and motivations for CPD are not aligned with those of the NMBA. The participants shared that the strategy of engaging in CPD for protection from symbolic violence worked and resulted in improved self-value and confidence in the workplace. This was validated by reports that peer critique and judgement decreased after colleagues became aware of the individual's participation in CPD activities. This highlights power through social and symbolic capital connected to knowledge in nursing.

The connection between CPD and symbolic violence has also been identified in other nursing research. Tame (2012) explored perioperative nurses' experiences of horizontal violence after engagement in CPD activities. After disclosing engagement in CPD to colleagues; nurses in Tame's study reported being negatively judged and openly obstructed within the workplace because of their engagement in CPD.

Tame (2012) reported that a key contributing factor in symbolic violence related to CPD creating competition among colleagues. This theme has also been identified in the findings of this doctoral research. Participants shared that they remained guarded about their newly acquired knowledge and were reluctant to share amongst all their colleagues. The degree of hesitation related to the culture of the workplace that would judge them.  When the decision was made to share knowledge a key determinant in this decision was the social position of the individual they shared the knowledge with. Exercising caution was required with careful consideration of the individuals involved in the interaction, and their role and standing within the workplace.

Emotional intelligence became a strategy for coping that allowed Alysha to share her experiences of engaging in CPD. Having an astute awareness of the requirements to navigate the cultural field meant Alysha, like others, only shared knowledge and deficits when she deemed it safe to do so. The risks of symbolic violence are significant, creating reluctance amongst nurses to share their CPD and acquired knowledge without first undertaking a process of cultural and field evaluation to deem the risks to their social status. The behaviours and practices of the societal group toward CPD influence social capital and contribute to the development of habitus.

## 7.5  Conclusion

This research clearly demonstrates a significant disconnect between the NMBA's intent, related to mandatory CPD and CPD activities undertaken by practicing Registered Nurses. The rhetoric espoused by the NMBA is at odds with day-to-day realities of clinical practice. Participants' experiences and approaches surrounding CPD presented multiple discrepancies from the espoused motives of the NMBA mandated model of CPD. The influences for nurses to engage in CPD are vast and varied, often driven by the need to develop or protect their own self and the position they hold within the field.   Amongst such influences remains a connection to patient safety; but the greatest motivation for CPD decisions comes from the local environment and workplace, not the profession's regulatory body. This disconnect places the NMBA model of social protection with an educated and current professional group in grave danger of being irrelevant to its practitioners.

The complex and interrelated influences were revealed for each participant and while some remain unique to the field site in which the nurse practices, most were seen in some way across all field sites in this research. The influence of capital and power over CPD is phenomenal. The NMBA was typically seen by participants as a regulatory body that needs to be appeased, but the driving force of CPD comes from the local field. The impact and influence of colleagues to encourage, support or hinder the dissemination of knowledge and create change in practice is considerable. Within the habitus of the field individuals alter their behaviours to limit harm, to avoid being labelled or isolated or to simply avoid

attention. For some nurses their colleagues' behaviours entice them toward CPD, with knowledge providing a protective buffer and creating empowerment. For others CPD is about maintaining a position, and respect and power that those in the position get to hold. CPD and social accountability are acknowledged by nurses. It is accepted that patients benefit from the additional learning that occurs in CPD, but patients' needs are not driving nurses to engage in CPD. The influence of peers and rules of the local field along with the need to be registered and employed carry far greater importance and motivation for nurses as they choose the way they will engage with CPD.

To achieve its raison d'être the NMBA needs nurses to invest in CPD that is directed towards building new knowledge. The NMBA is battling deeply ingrained behaviours that are complex with many underpinning factors. These can only be overcome by shifting the balance of power. The NMBA power position is significantly diluted according to participants in this research. The NMBA model of CPD is simply idealised rhetoric that can be summed up as an ineffective political rowboat, caught in a whirlpool and doomed to sink if immediate rescue efforts are not made. To create this shift major change needs to occur in nurses' willingness to embrace knowledge and change. And the NMBA, as the regulatory body, has a responsibility to lead this change.

# Chapter 8

# Conclusion and Recommendations

## 8.1   Introduction

The engagement in learning by or through formal and informal opportunities contributes to knowledge and the provision of contemporary, evidence-based nursing care. Within the clinical area of intensive care, best practice reflects the rapidly expanding knowledge base that exists and is therefore in a state of constant flux and change. Patients and families within the Intensive Care Unit (ICU) place an immeasurable amount of trust in nurses to *know* and *do* what is best to optimise outcomes. This requires that nurses remain cognisant of evolving evidence that underpins decision making in practice. In addition to patient safety, current knowledge and evidence-based practice; Continuing Professional Development (CPD) can contribute to the recognition, power and status of nursing as a profession. Therefore, nurses need to engage in CPD and knowledge acquisition, irrespective of whether it is, or is not, a mandated requirement for registration as a practitioner.

Unfortunately, the current mandated requirements of CPD in nursing do not serve or benefit the public well. This is evident by nurses achieving their required CPD through employer competencies such as hand hygiene, fire training and manual handling. Such tasks were presented by the participants of this research to offer little in the way of further knowledge development and because of this carries little social value. The implementation of mandatory CPD in 2010 by the Nursing and Midwifery Board of Australia (NMBA) was promoted as widespread change across the profession that would enhance patient safety and the nursing profession (Australian Nursing and Midwifery Council, 2009). However, a cultural shift across the profession towards universally embracing CPD to improve patient care has not yet been achieved.

The intent of the Australian Nursing and Midwifery Council's (ANMC) continuing competency framework was for nurses to expand and extend knowledge in ways

that would improve patient care and outcomes and indeed the profession of nursing (Australian Nursing and Midwifery Council, 2007, 2009). Original expectations required new knowledge acquisition and prohibited the use of annual employer competencies. However, the standards for CPD have been broadened to such an extent that the effect has ultimately been to render them ineffective in meeting the goals of extending a nurse's knowledge base, which was the premise of implementing mandatory CPD in the first place (Nursing and Midwifery Board of Australia, 2010b, 2016d). As a result, today's model of mandated CPD is easily manipulated, leading to exploitation resulting in unmet educational potential.

The current mandatory CPD model requires significant amendments. The nursing profession needs to examine the CPD criteria and communicate much more clearly the standards that need to be met. A Critical Care Nurse (CCN), or any registered nurse (RN) for that matter, should only be allowed to claim newly acquired and/or extended knowledge as their CPD. Activities required by the employer must not be able to be claimed. For example, online fire training, whilst imperative for patient safety, does not meet the criteria of new knowledge and RNs need to refresh their knowledge annually. Instead, fire training addresses workplace occupational health and safety requirements and therefore should not be eligible for CPD.  CPD should build knowledge in nurses that influences the outcomes of patients on a regular basis. With positive patient outcomes nurses can demonstrate their impact and acquire power within the health care setting.

The focus of mandated CPD needs to remain relevant to contemporary evidence and advances in health care, particularly in light of rapid knowledge change in our contemporary health care practices. This standard of CPD would most likely contribute to nurses achieving better patient outcomes. Exploitation of accreditation requirements through promotion and usage of employer competencies as CPD must stop. This is especially so when the public is fed the rhetoric that all nurses are engaging in education that builds contemporary knowledge. This rhetoric is not supported or reflected by reality.

To say that all nurses exploit the model is unfair and untrue. It is equally unfair and untrue to say that all nurses take the easy option of counting employer

competencies as their CPD. Indeed, this research has shown that many nurses engage in CPD in order to extend current knowledge as well as build new knowledge in order to enhance patient care, wellbeing and safety. Participants have also highlighted that many struggles exist within the nursing profession that could act as obstacles to engaging and sharing CPD. There are also challenges within institutions and with employers that may impact upon CPD and its practice. Nurses do want to be acknowledged for their contribution to health care and respected by their colleagues within and outside their discipline. Public acknowledgement and acceptance of CPD is one way that nurses can begin to build capital.

Current CPD literature focuses on how to engage individuals in CPD rather than the overall impact of CPD. In contrast this research explored the approaches of nurses that work in regional ICUs to reveal how they think about and engage in CPD. This change of focus has revealed valuable and insightful research findings with commentary about these areas of concern. The findings highlight an openness of nurses to learning, but the motivations for learning may not be what the original conception of CPD expected. Patient care remains at the forefront. However, the decision about which CPD content to engage with is guided by a myriad of conceptions, motives and personal issues for nurses including employment considerations.

This research began from the researcher's insider, emic perspective, as an ICU nurse observing colleagues' responses to the introduction of mandatory CPD. After many years of working in ICUs it became apparent that the system of mandatory CPD was not meeting its potential. In the beginning nurse colleagues engaged in regular conversations about how they might achieve their mandatory hours, unsure of the requirements and what could or could not be counted as CPD. This concern quickly faded due to a lack of clear understanding of the standard to be met. In some ways many nurses felt that meeting the mandatory requirements was merely 'ticking a box', meaning they could easily find normal duties that met the criteria for CPD. This approach is not seen as adding value to *who* they are as nurses or *how* they practice. This was the view amongst participants who choose to use and record their employee responsibilities as

CPD activities, thereby adding no new knowledge, skills or practice to the level of competency as a RN.

I strongly believe that what we as nurses ought to consider worthy CPD must be beneficial to the profession and to our patients. CPD must generate knowledge and change, and it must be decided by the nurse, not the employer. A nurse needs to determine their own learning needs to ensure they can provide the highest standard of patient care.

Mandatory CPD has potential but it has been troubled by a poor understanding among nurses and subsequently is open to exploitation. The intent of the model has also been harmed by the ease with which employing institutions have exploited the requirement for learning to serve their own purposes. Most education offered by employers is centred on addressing their needs, increasing productivity, addressing accreditation standards and minimising cost and risk (Brekelmans, Maassen, Poell, Weststrate, & Gueurder, 2016; Pool, Poell, & ten Cate, 2013). CPD that is most beneficial is not really tailored to the needs of the institution and employer: it targets the individual – the nurse.

Change in the professional is enhanced through the use of reflection to evaluate current performance and knowledge, identifying areas for growth (Fleet et al., 2008; Fowler, 2014; Gray et al., 2014; Rolfe, 2002). Reflective practice supports the orthodoxic principles of professionalism, accepting and embracing the development of new knowledge, and CPD (Australian Nursing and Midwifery Council, 2007, 2009; de Bruijn, 2012; McCormick, 2010). The NMBA model supports nurses engaging in reflective practice to identify their CPD activities and encourages them to identify areas that require improvement. However, through the promotion of possible forms of CPD the NMBA continues to allow the use of mandatory employment requirements as CPD (Nursing and Midwifery Board of Australia, 2010a, 2010b, 2014, 2016a, 2016g). The blatant allowance of employer requirements, such as hand hygiene, manual handling, basic life support, bullying and harassment awareness and fire training, does not address the professional growth of the nurse and safer, improved patient care. The employer competencies are typically about workplace productivity and employee safety and taught in undergraduate education in preparation for employment.

Such requirements do not bring new advances to practice and health care. Until this problem is addressed, and a greater emphasis is placed upon CPD linked to personal reflection, the model of CPD is unlikely to achieve its intent of knowledge gain and professional development which are foundational to public protection.

Approaches and choices of nurses' about CPD have been poorly explored in the literature. Research and attention has instead centred upon the most effective ways to deliver CPD that engages those attending. This research has scrutinised the CPD of regional intensive care nurses. In doing so it has presented new insights and understanding about how these nurses perceive and approach CPD. This has been undertaken incorporating the available literature, critical ethnography, critical social constructionism, with the data and theoretical works of Pierre Bourdieu, to understand the Critical Care Registered Nurse (CCRN) and CPD from the perspective of the nurse.

This concluding chapter presents the strengths and limitations of this research, which are integral to understanding the impact of the findings. The chapter also shares understandings that have been developed and featured throughout this research by drawing together CPD, the CCRN and implications for the profession and the regulatory body, the NMBA. The chapter culminates with a summary of the conclusions and recommendations for the nursing profession and recommendations for future research.

## 8.2   Strengths and limitations

All research has strengths and weaknesses with debate and critique. What is evident from the wider literature (Denzin & Lincoln, 2008, 2011; Houghton et al., 2013; Leavy, 2014) surrounding qualitative research is that what is perceived as a strength by some may be considered a weakness by others, and vice versa. Each decision in research design creates potential benefits and potential trade-offs that may be contested. For example, whilst qualitative research has a recognisable strength in depth of findings, it trades-off the potential of a large sample size, and vice versa for quantitative research design (Denzin & Lincoln, 2011; Leavy, 2014). The value of qualitative data is obtained through exploring in-depth, participants' experiences and beliefs.

**Significance**

The qualitative approach taken in this research was a strength. In an area where little was known and understood, exploring the approach of regional CCRNs to CPD has created awareness among these research participants. Through qualitative interviews intensive care nurses have contributed by revealing their perceptions and approaches toward CPD. With valuable contributions nurse participants have permitted the activities of and approaches to CPD to become visible. This research has also identified the meaning of mandated CPD across research participants (Denzin & Lincoln, 2011) .

**Philosophical congruency**

The core strength of this research is its strong alignment to philosophical underpinnings of critical social constructionism and critical ethnography. The critical paradigm of research is often challenged for its consideration that the research target audience is oppressed (Hosking, 2008; Madison, 2012; Thomas, 1993). I do not suggest that nurses are oppressed but rather the research embraces the critical paradigm to illuminate CPD in the profession, rather than fulfilling a need to free it from its chains.

**Philosophical positioning**

The main critique of critical social constructionism centres on the acceptance of multiple realities (Freeling & Parker, 2015; Gergen, 2015). This critique raises concerns and begs the question that if multiple forms of knowledge surround one topic, how can research activity, such as this one, be considered accurate? I believe the ability to embrace multiple realities is not a weakness of social constructionism but a strength. Being open to multiple realities allows protection of what Gergen (2015) described as "sealing ourselves off from possibilities" (p. 200). If we narrow our view to only one reality, then we risk missing valuable insights provided by others and fail to view the world through their reality with all the intricacies it holds for individuals. The findings of this research are reflective of the social interactions and social construction of knowledge that embraced multiple realities resulting from interactions between the participants, myself and my research mentors.

To make a generalised statement that these experiences reflect all nurses is to say all nurses are the same and this is simply not the case. Not all nurses work in the same social environments, nor do they have the same life and employment experiences. Combining multiple realities builds depth to the knowledge base and permits greater understanding. Thus, it is not the intent of this research to say that the findings reflect all nurses. Instead, the research presents a reality that was socially constructed and reflects the nurses involved. To my knowledge, these findings present the first insight into Australian nurses' perceptions and approaches to socially accountable CPD, and therefore deserve careful consideration as the profession continues to build knowledge in this area.

Realists may argue that this research is weakened by the adoption of social constructionism and its acceptance of the existence of multiple realities, questioning its contribution to knowledge. However, this research provides more than a snapshot of one cultural environment's construction of knowledge, capturing the construction of knowledge across three geographical locations. While work environments and professional groupings are the same, geographic locations and thus possibilities for influencing cultural difference allow for a wider interpretation of results. Capturing the perceptions of nurses across the state lends weight to the validity of results. The commonalities and diverse data collected across participants means that data can highlight multiple realities with both commonality and uniqueness of groups. The results were also interpreted drawing on all three sites, adding strength to the findings of perceptions and approaches toward CPD with commonalities revealed across sites.

**Emic perspective**

Critical ethnography has a long history of observations including the time it takes the researcher to learn the culture and observe what is occurring before asking questions (Atkinson et al., 2007; Gobo, 2008; Jones & Watt, 2010; Madison, 2012; Wolcott, 2008). As a CCN, as the researcher I am an insider, familiar with the environment and broader culture, social norms and behaviours being researched. This is similar to many nurse researchers today. The argument that only outsiders can conduct valid research due to a perceived objectivity is refuted by Hammersley and Atkinson (2007) and has held over time (Styles, 1979).

Instead, the insider and outsider position is promoted as the role an ethnographer can have in the field and differences in the types of information they have immediate access to (Hammersley & Atkinson, 2007).

This positional insider view led to the research question with years of observing how nurses talk about and engage with CPD. When an ICU nurse talks to their peers they share commonalities. As an ICU nurse and researcher, the rapport that developed with the participants enhanced the flow of discussion. Participants did not need to explain medical terms or care as this was a pre-existing shared knowledge. This created an opportunity to gain insights during interviews that may have been different than those obtained if the researcher was a nurse from outside of an ICU or came from a different background. Despite sharing a common grounded understanding of nursing and ICU practices the local social field remained unique and unknown to the researcher. This was acknowledged by presenting an etic perspective for the researcher.

It is emic perspectives of the profession that allow nurses to talk about and share knowledge with other nurses. This depth of knowing, that is, sharing a professional language, being familiar with events and commonality can only be understood by being a nurse. This insider knowledge and perspective contributed greatly to the development of this research project. Despite this commonality, it was never taken for granted as being the same by the researcher. At the forefront of the researcher's thinking was that while each ICU and CCN nurse's experiences are familiar, they are also unique and different. This was a strength in this research.

**Rigour**

Rigour in research is sought by making decisions that are right for the research topic chosen (Houghton et al., 2013). These decisions are influenced by philosophical underpinnings and the researcher's own beliefs and positions. This alignment between researcher and philosophical positioning is vital in achieving congruency (Atkinson et al., 2007; Denzin & Lincoln, 2011; Madison, 2012).

To achieve congruency and strength in research alignment must extend across researcher, research topic, methodological approach, theoretical positioning, and

analysis and interpretation of the data (Richards & Morse, 2013). This strength from aligned thinking allows the data to be interpreted by the researcher and others using similar perspectives. Critical ethnography and critical social constructionism have been used in this research as a way of thinking that assists in understanding the data from these positions. This approach allows the construction of meaning inclusive of cultural influences (Atkinson et al., 2007; Berger & Luckman, 1966; Holstein & Gubrium, 2008; Hosking, 2008), and with a critical lens to create conversation and real possibility for change.

**Data collection**

The use of semi-structured interviews was a positive attribute. All research is open to critique, review and examination for researcher bias. To limit this bias I spent a great deal of time to ensure my positioning, views and beliefs were clear when conducting the interviews. This was important, as I did not want my views and beliefs to impact the findings of this research. The use of open-ended questions was a purposeful choice to limit my influence on participants' responses.

The interview questions were focused and considered to limit researcher bias. Questions were often presented using: "tell me about your experience with…? or "what do you understand by…?" or "why do you think that may be?". This approach offered participants opportunities to interpret the researcher's questions as well as to explain their views. The researcher when sharing perspectives also used phrases such as "I wonder if…", or "what do you think are the influencing factors?". A structure for interview questions had been developed and used in pilot interviews prior to the collection of data to ensure consistency across all interviews.

**Differences in field sites**

The inclusion of three different field sites, located significant distances apart, facilitated the identification of different ICU social norms and behaviours and their relationship to CPD. Those working in these sites have little interaction professionally and they are included within separate health care networks across Victoria. These geographical barriers contribute to the strength and value of the

findings. The replication of stories and accounts across nurse participants and field sites highlights commonalities that may exist across the profession, not just the sites. While the findings reflect those of research participants, they are revealing. When several participants, from different field sites, share the same or similar experiences, they provide more confidence that commonalties are widespread amongst CCNs.

**Differences in roles of nurses**

A further strength is the inclusion of nurses from different roles, not that a comparative approach was sought, but rather if there were similar perceptions held by nurses, regardless of their employment responsibilities. Participants from each site ranged from nurses who provided daily care at the bedside, to nurses from management, education and research. This inclusive approach assists in obtaining diverse perspectives, with nurses from different roles and positions within the ICU contributing their experiences and views of CPD. Such commonality in experiences strengthens both the findings and new knowledge acquired about nurses and CPD.

**Participant pool**

This study was conducted using regional CCNs from three different geographical field sites which might be perceived as a weakness. This group of nurses and their experiences reflect their environment, values and beliefs. However, the findings of this research cannot and should not be applied to all nurses. Metropolitan ICU nurses may present very different findings to their regional counterparts. Likewise, nurses from other areas of practice may offer different insights. This limitation to regional ICU nurses, however, was a deliberate choice. It allowed for a narrowing in the scope of the research, because the design did not presume to represent the total population of RNs or CCNs. It also created a foundation for further research.

This research provides insights into an area rarely explored in Australia, that of intensive care nurses from regional Victoria. This creates a new understanding and new knowledge about this group of nurses in these locations and CPD. Thus, the findings are a reflection of the participants, highlighting their tendency to have

a predilection to invest in CPD to build knowledge. This may have contributed to a bias in the findings. Only a few participants were nurses that did not engage in CPD. It is reasonable to assume that nurses who perceive little value in CPD may have thought there was limited value or benefit to them in participating in this research. As a consequence, it is acknowledged that their views may not have been fully addressed by this research.

**Previous research and literature**

The phenomena of this research has had limited exploration in the literature. This absence makes it difficult to compare, support or refute the findings of this and other research. This is a limitation for this research. However, this research provides fertile ground to support further contributions to our understanding of nurses' approaches using socially accountable CPD.

**Limitations acknowledged**

This research was not without its limitations and it is important to acknowledge them for what they are. It is strongly believed by the researcher that not all limitations are a negative or a critique of the research. Limitations are viewed as acknowledging what simply existed and occurred throughout the research. This is important to provide transparency in the research and indeed the findings.

Acknowledgement of research limitations are integral when considering the final research findings which point to potential changes needed in the nursing profession. However, it is believed that despite the limitations of this research the findings are important for the wider nursing profession, holding significant value and importance for the profession to move forward.

## 8.3   CPD for nurses

This research has presented insights into ICU nurses' approaches and perceptions of socially accountable CPD. The NMBA implemented mandatory CPD to provide public protection through a workforce of knowledgeable and current registered nurses. This research highlighted that participants are aware of the value attributed to engaging in CPD and the importance of ongoing

education for knowledge growth and safe practice. However, caution must be exercised as there are possible games being played by some nurses, health care providers and the NMBA in relation to CPD. These games may place the public and their safety at risk, particularly if nurses are not achieving the CPD that has been promoted to the public of knowledge acquisition and implementation into practice.

The themes that emerged from the data highlighted that most nurses do invest in CPD and create professional growth. The data supports that nurses engage in learning to advance their knowledge and then look for ways that their new knowledge can be used in practice. Such attributes of learning are not unique to nurses but are desired professional traits. It is this willingness to invest in professional growth that presents hope and promise for the nursing profession's future to deliver exemplary and contemporary care.

This research creates optimism for the nursing profession and the embracing of new knowledge. A change in social behaviours and expectations is possible through the use of CPD across the profession. At field site A, for example, the reported embracing and welcoming of new knowledge and changes to practice was refreshing. Knowledge was seen as a source of power that should be shared among all nurses rather than few. This approach to knowledge and CPD creates a space where nurses are not navigating for control or power amongst themselves. Instead, nurses are working together, sharing their knowledge with the intent of empowering colleagues who in turn can empower them with new knowledge – a collaborative rather than competitive approach. This is the social norm the nursing profession needs to embrace and promote the mandatory CPD model.

Associated with negative elements of social norms and power is a constraining and sometimes oppressed advancement of the profession. When those that hold social and institutional power attempt to enforce the status quo, the nursing profession risks becoming stymied and thus finds it difficult to move forward. In an environment of social vulnerability, Bourdieu referenced symbolic violence (Bourdieu, 1977; Jenkins, 2002; Webb et al., 2002), with individuals restricting access to resources, or judging others and responding in a non-physical nature.

These types of behaviour were highlighted by participants with experiences of isolation, extensive critiques, workplace duties allocation and, as Kaylah revealed, her colleagues labelling her a *'pain in the arse'*. These behaviours disempower the nursing profession and present power in a negative light, instead of the position that creates opportunities for recognition of the contribution nurses can make to the health care industry.

To protect themselves from acts of symbolic violence and a negative culture the participants responded strategically. CPD and the knowledge it offers, capital, have become a tool for nurses to navigate possible harm and with new knowledge used if colleagues challenge practice. This approach by nurses was described as removing or addressing elements of vulnerability that exist within the workplace. The personal empowerment gained by nurses from CPD should not be overlooked and should be promoted across the profession to highlight how CPD offers more than new knowledge it can create growth, both personal and professional.

The participants perceived knowledge as a form of power. Knowledge also contributed to confidence within the workplace and extended outside of the ICU. Participants valued the respect from those outside of the ICU and attributed this to their level of knowledge which allowed them to hold a unique position among their peers. This external source of respect was very important to some participants and constituted a key driver in continuing to engage in CPD.

The knowledge obtained from CPD activities should ideally be disseminated within and across the workplace. In sharing knowledge across the workplace nursing practice may be more effective and change, where appropriate, can be implemented to benefit patients. However, change is not always well received in nursing (Tame, 2012). It is unfortunate that some or many nurses, depending on the workplace, are perceived as being resistive to change. CPD brings new knowledge and the power to create change and demonstrate to those in health care hierarchy the value that nurses can provide through patient outcomes. Until such change arrives, CPD is at risk of remaining as a tool that helps nurses survive the social field, instead of being embraced for the social capital and symbolic and social power it offers.

In the nursing profession the NMBA holds all regulatory and policy power. Today in Australia nurses lack a national professional representative body, as they did when the ANMC existed, other than their union or speciality groups. The absence of such national representation was identified by some participants, who were unsure where they could raise concerns for the profession, or where they could have their voices heard as a member of the profession. Through national registration, the NMBA has created, unintentionally, a one-way model of communication between regulation and nurses. Opportunities for direct feedback from nurses are limited and often lost or determined by the priorities of the NMBA. When opportunities are available, they often occur without nurses being aware they exist.

This lack of communication between the NBMA and the nurses it registers is extended into the CPD model that appears to be not clearly understood by nurses. As a result, policies are often misunderstood and/or poorly used and as a result, ineffective. When asked about the mandated CPD policy, most participants' responses highlighted that the understanding of hours, twenty hours annually, was clear but uncertainty surrounded what is and what is not desired or counted as CPD. Of noteworthy concern was that participants were unable to voice the NMBA's intent of public protection that underpins mandatory CPD. This absence of an understanding toward building knowledge to enhance patient care is deeply concerning and contributes to idealised rhetoric.

The participants' accounts supported the statement that most nurses welcome learning and new knowledge. But there is concern about what learning is best to engage with. As a professional discipline, nursing needs to continue to advance and achieve high quality care and standards. This cannot be achieved without a significant investment from nurses toward CPD activities that builds new knowledge to be used in practice. The nursing profession as a whole needs to view knowledge as a positive attribute that brings change and advancement, which when highlighted within health care creates power for the profession and significantly contributes to improved patient outcomes. Approaching CPD to 'tick a box' is not helpful to the profession and leaves nursing stuck in a rut, in the

same position and with the same behaviours, and minimises valuable opportunities to acquire power in health care.

The NMBA has intended that the knowledge acquired through CPD be used to improve patient outcomes (Australian Nursing and Midwifery Council, 2007, 2009). While most nurses acknowledge the value of CPD, much of their motivation to engage in CPD does not directly relate to patient care. With the NMBA connecting mandatory CPD to registration, many if not most participants focused upon needing to remain registered and employed. This approach in relating mandatory CPD to registration has traction. However, the poor implementation of the mandate has resulted in nurses failing to understand the intent to change patient outcomes through knowledge. The connection of CPD to registration has created a stick, with potential for punishment, not a carrot, which offers incentives. Despite the risk of punishment, loss of registration if a nurse fails to comply, participants revealed there is little concern about this occurring. Instead, some participants in this research acknowledged a comfort in continuing their current approaches, using employment competencies as CPD, while they awaited an audit request from the NMBA for evidence of their CPD. Random audits as punitive sticks should not be the driving factor to engage in ongoing professional education. Nurses need to be motivated by patient safety and the positive aspects that new knowledge from CPD can bring to their profession.

The NMBA's unique approach in monitoring via random audit has been questioned by many participants. Questions were asked as to why nursing would not embrace practices that align to other health care professions which require evidence of CPD at each renewal of registration. This preparedness to embrace higher standards and demonstrate CPD supports the importance of CPD to the profession. Currently participants reported that they will look for the evidence if and when asked, thus being prepared to play the game, all the time remaining within the rules.

Some participants also challenged the NMBA requirement of a written reflection to accompany their CPD. Underpinning the challenge was a belief that it was insulting to experienced nurses. These participants were confident and stood firm in their position that they had the ability to reflect without taking the time to

document their reflection. Such comments are valid points. The validity of a reflection is hard to judge, as it is often a very personal process (Bagay, 2012) and what determines the validity of someone's reflections on learning, and if it addressed their previously identified need.

The NMBA's model of CPD was criticised by participants. These criticisms highlight the rhetoric and reality of CPD in nursing. Participants have been critical of what the NMBA will accept as CPD. This is evidenced by nurses refuting the validity of employer and workplace competencies as CPD, such as fire training, manual handling and hand hygiene, and their concerns for what their acceptance means for the wider profession. The participants in this research have increased their own standards to those that promote learning and contribute to feelings of self- and professional worth and respect. Many refused to accept employer competencies as true CPD or acceptable learning.

Current standards have left participants expressing feelings of belittlement and being unprofessional. In seeking refined standards, participants wish to see the exploitation of employer's mandatory competencies as CPD prohibited, instead seeking CPD that builds knowledge for the nurse and the profession. In calling for a new standard, some nurses have aspirations of raising the bar for the profession and moving away from what is perceived as accommodating the lowest common denominator. Some participants were calling upon the NMBA to implement a new CPD model that reflects their vision of the profession and creates the prestige and respect that nurses deserve.

## 8.4   Implications for the profession

It is time for nurses to embrace knowledge that generates power and creates control over the future of the profession and its image. CPD that addresses societal needs and is socially accountable is a way for nurses to demonstrate their actual contribution within health care while providing the highest level of care to the community. The NMBA mandate of CPD for social protection is not a perfect model and individual nurses are not currently in a position to have significant influence over the model set by the NMBA.  However, the acceptance

of and embracing CPD and the knowledge it affords is within the control of nurses and the professional group.

The current model of CPD in Australia reflects the standard that has been set for the profession. There is always room for refinement and improvement, just as other health professional bodies have done. This research provides evidence that most of the participants, that is nurses, generally wanted change and an increase in standards. In raising CPD standards an opportunity is created that may enhance the impact that nurses have in health care. Raised standards can also assist the NMBA in achieving its intent of public protection with nurses focused on building personal, targeted, new knowledge to apply in practice and benefit patients. This change will not be easy and requires significant investment by the profession. Such change will require widespread consultation of nurses, rigour in decisions, and a well delivered and informative education campaign. All of which centres around the need for enhanced standards for the profession and address patient safety and outcomes for the community nurses care for.

The NMBA is called upon to lead the profession of nursing. This includes facilitating change in traditional behaviours and attitudes of nursing to education and change. Mandatory CPD could be used by the NMBA as a model and method to facilitate such change. This may include mandating CPD as only new or extended knowledge that occurs external to employing health care provider's requirements.  This new knowledge can then be promoted as a way to effect change in practice and nursing care. A widespread demonstration of the impact of nurses can assist the profession in gaining recognition and power from others in health care. The profession of nursing needs to embrace the power of knowledge. CPD may be the key to acquiring greater respect and power for nurses.

Participants in the research, as previously mentioned, revealed that currently CPD in nursing has become a game which many nurses play. Some nurses engage in CPD, while others do not. The point is that the model of CPD has not been embraced or accepted by all the research participants and it is possible that this mirrors its disjointed acceptance across the nursing profession in Australia. The current CPD model perpetuates the game for both the NMBA and nurses. It

appears that many nurses tick a box, playing the game, saying they have engaged in CPD that aligns to the NMBA's expectations. The NMBA asks for no evidence of this beyond ticking a box, or a random audit. The NMBA advises the public that nurses have engaged in CPD. What is of concern here is that there is limited evidence of activity beyond the nurses that are audited and provide evidence: remember that this evidence can include fire training and other employer requirements. The current field upon which the game is played for both nurses and the NMBA must change. The NMBA is the only entity with the ability to change the field and the rules. Until changes are made the public is potentially at risk from nurses who have failed to build their knowledge base.

The NMBA role is regulatory, to register nurses, to manage those that underperform and to be a peak governmental body. They cannot be the professional representative for the profession as well as the regulator. Under national registration and professional restructuring, the ANMC ceased being the advocating body of the profession. This or a similar body needs to be reformed to allow regulation and professional advancement to be separately managed. This would add value and strengthen the profession, providing a more consultative body that nurses themselves can approach with professional concerns, resulting in changes on the national stage that enhance standards and care for all. It is logical for nursing to have such an accountable body. After all, medicine has maintained their medical association that acts as the ANMC previously did for nursing.

Current standards of CPD are set for all nurses regardless of area of practice or years of experience. To say a newly graduated nurse and a nurse of ten years working in an ICU should have the same standard reduces expectations and makes little sense. The NMBA has within its power the ability to present a scaffold of standards for nurses related to areas of practice and time within the profession. It is reasonable to think that a more experienced nurse should meet a higher standard than a novice. This move from a minimal standard to a scaffolded standard creates a driver for enhanced performance. It also attributes respect to nurses for their growth as professionals. These standards could be aligned with CPD. A CCN's role is significantly different to that of a nurse on a surgical ward

or a mental health nurse working in the community. This should be acknowledged within the NMBA framework and this issue was highlighted by participants.

## 8.5   Summary of conclusions and recommendations

Nursing is a profession that is highly respected and offers great opportunities for those within and those for whom we care. Knowledge underpins a nurse's role and for the CCN remaining abreast of rapid changes is crucial to patient safety. CPD offers one avenue to achieve this, and this has been mandated by the NMBA.   However, many challenges exist for mandatory CPD and nurses are required to face these challenges and respond. Some are easier to address than others. For the regional CCN, culture is not the only challenge. Others are often financial and geographical, and these challenges are significant and often difficult to overcome.

The findings of this research support the following conclusions and recommendations.

- I conclude that the engagement with formal and informal CPD, by CCN, is influenced by the behaviours and social norms of the workplace and the degree of personal investment toward professional learning and growth.
- I conclude that the current CPD model of the NMBA and its inclusive nature has rendered it easily manipulated by both health care institutions to achieve their accreditation requirements and nurses who believe that the provision of education is the responsibility of the employer, not the nurse.
- I recommend that the profession of nursing form a peak professional body whose responsibility and focus is to represent and advance the profession of nursing.
- I recommend that the NMBA review the model of CPD and implement refinements that narrow the scope of permitted CPD. In this should be the raising of expectations of what is acceptable above those currently in place. The NMBA is also counselled to require that all nurses provide an annual record of CPD activities at the time of renewal or registration, removing the option to tick the box and allowing the audit process to occur from submitted documents at registration.

- I recommend that nurses working for more than three years are no longer able to count employer mandated competencies as CPD. Such activities should only be permitted if they address a new scope of practice.

- I call on all nurses to come together and accept knowledge as a tool that can be used to promote the profession and raise its standing. I ask nurses to also promote the profession with positive examples of CPD in practice.

In the above recommendations, there is a request that the standard of CPD be raised in the profession. I acknowledge this will not be welcomed by all nurses. I believe strongly however that nurses that choose not to engage in CPD and fail to meet required standards are free to leave the profession. The NMBA should not be afraid of these individuals leaving. Instead, it should be viewed as a means to ensure that those nurses dedicated to high quality safe care, that is socially accountable, remain in the profession.

Our profession should not lower its standards in order to accommodate the lowest common denominator. Nursing should do everything in its power to be the best. Those that are most vulnerable through illness deserve the best care possible. Substandard care provided by a nurse that lacks congruency to contemporary practice is not appropriate. Life is too precious and errors in health care are too high as is. By applying these elevated standards, the profession can work towards building respect both within and outside of the profession.

## 8.6  Recommendations for further research

This research has created knowledge in an area previously not explored. In doing so it has generated opportunities for further inquiry. There are many areas of CPD that require further study to develop a more comprehensive understanding. This research has presented insights into nurses' perceptions and approaches toward engaging in CPD. From this new understanding many new questions and interests have arisen which will be explored in future research and publications.

It is proposed that further research should be undertaken with exploration outside of the critical care arena. This could involve larger scale research across Australia applied to various practice areas. Using the findings of this research it is also proposed that similar research be undertaken with nurses in metropolitan ICUs.

This would assist in identifying similarities and differences that exist between nurses in different geographical settings.

I believe that research should be conducted into how changes in practice are undertaken in nursing. This has been partly addressed in this research with a focus on nursing that engages in internal power struggles. These tensions often inhibit change and contribute to strategic behaviours between and among nurses. The influence of CPD and nurses upon practice change is an important area to understand, as it will assist in understanding the wider impact of CPD.

It is also proposed that CPD be evaluated for its effectiveness. Despite wide-spread adoption across professions the impact of CPD remains elusive. For such reliance on public protection CPD should be investigated for its true impact on practice. This is an area which is of great interest, as it supports the notion that CPD can effectively contribute to improve patient outcomes.

## 8.7   Closing comments

This research started from a conversation with a supervisor where I expressed my confusion and concern about what was occurring around me in the nursing profession. The process hasn't been easy, nor was it expected to be. I started as a clinician, not a researcher. I entered this research oblivious to the deficits within the literature surrounding the impact of CPD. This has created many challenges. I have learnt about research and current knowledge from many different areas as I searched for information. The highlight of this research has been interactions with participants. The information they shared about their experiences and the co-construction that occurred to provide insight into their perceptions and approaches toward CPD have been amazing. From here the opportunities for further research in this area are endless. I look forward to continuing to explore this area with my newfound set of research skills that I can build upon and develop.

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# Appendix A HREC Approval

**VICTORIA UNIVERSITY**
MELBOURNE AUSTRALIA

# MEMO

| TO | Ms Joanne Finn | DATE | 04/11/2015 |
|---|---|---|---|
| | CC Professor Kris Martin McDonald | | |
| | Dr Phil Warelow | | |
| | College of Health and Biomedicine | | |
| | Victoria University | | |

FROM    Associate Professor Deborah Zion
        Chair
        Victoria University Human Research Ethics Committee

SUBJECT    Ethics Application – HREC Approved Application External to Victoria University

Dear Ms Finn,

Thank you for submitting this request for ethical approval of the project entitled:

*Federation A14-004:*    *"Australian regional critical care nurses attempt to achieve social accountability through continuing professional development"*

*(Project approved by Federation University HREC).*

The proposed research project has been accepted and deemed to meet the requirements of the National Health and Medical Research Council (NHMRC) 'National Statement on Ethical Conduct in Human Research (2007)' by the Chair of the Victoria University Human Research Ethics Committee. Approval has been granted from **4 November 2015 to 4 November 2017**. Any variations to the protocol must be approved through the original approving HREC and notified to VUHREC.

Please note that the Human Research Ethics Committee must be informed of the following: any changes to the approved research protocol, project timelines, any serious events or adverse and/or unforeseen events that may affect continued ethical acceptability of the project. In these unlikely events, researchers must immediately cease all data collection until the Committee has approved the changes. Researchers are also reminded of the need to notify the approving HREC of changes to personnel in research projects via a request for a minor amendment. It should also be noted that it is the Chief Investigators' responsibility to ensure the research project is conducted in line with the recommendations outlined in the National Health and Medical Research Council (NHMRC) 'National Statement on Ethical Conduct in Human Research (2007).'

On behalf of the Committee, I wish you all the best for the conduct of the project.

Kind regards,

**Associate Professor Deborah Zion**
Chair
Victoria University Human Research Ethics Committee

# Appendix B Plain Language Information Statement

| **PROJECT TITLE:** | Australian regional critical care nurses attempts to achieve social accountability through continuing professional development |
|---|---|
| **RESEARCHERS:** | Professor Kristine Martin McDonald<br><br>Ms Jo FINN |

As a registered nurse, nurse educator or nurse unit manager working in a regional level 2 critical care environment you are invited to participate in research related to Continuing Professional Development (CPD). The research project will investigate the perceptions and approaches of nurses to the Nursing Board of Nursing Midwifery mandated CPD.

This plain language information statement contains details about the research project and explains what participation involves, allowing you to make an informed decision as to whether you choose to participate. The research will form part of the PhD studies of Jo Finn who is a critical care nurse and academic. Dr Jenene Burke supervises Jo's studies.

Should you wish to participate in the research, please complete the attached consent form and return it to Joanne Finn in the enclosed envelope.

**Background:**

On July 1st 2010 the newly formed Nursing and Midwifery Board of Australia adopted a continuing competency framework for registered nurses when renewing their registration. A component of the continuing competency framework mandates that nurses annually complete 20 hours of mandatory CPD.

This research will study the perceptions and approaches to CPD of registered nurses, nurse educators and nurse unit managers who work in regional Victorian level II critical care environments. It aims to develop a greater understanding of

how nurses have interpreted mandated CPD and what nurses are undertaking as a means of meeting this requirement.

Research participants have been selected from nurses who work in critical care environments and have indicated their willingness to participate.

**What will participation involve?**

Each participating nurse, nurse educators and nurse unit manager will be invited to complete one interview that will not exceed one hour. During this time the researcher will ask questions about participants' approaches and perceptions to CPD, as well as demographic questions related to work and educational background. Interviews will be audiotaped. The conversation during the interview will form the data of the study. Interviews will be conducted at times and locations that are mutually agreeable to suit the participant and the researcher. Participants may choose to amend their responses within two weeks of interview.

Participants may request a summary of research findings after the awarding of the Doctor of Philosophy by Federation University.

**Privacy, Confidentiality and Disclosure of Information**

Only the research team (Joanne, Kristine) will have access to participant responses during data collection. All data derived from the interviews will be de-identified with no reference to the clinical facility or geographical location. Participant's names will be referred to by pseudonyms during the data analysis phase. Interview responses will be analysed and interpreted for insights into each nurse's interpretation and approaches to the newly mandated CPD requirement.

The results of the research will be used in the publication of a doctoral thesis and other appropriate media such as research journals and conferences. All data will be kept in locked files for a minimum of five years before being professionally shredded or permanently deleted. No identifying information will be used in any publication arising from the research.

Please note that confidentiality is subject to legal limitations (e.g., subpoena). All responses will be de-identified, but due to the small number of participating

registered nurses and research sites; the researcher cannot ensure complete confidentiality.

**Potential Risks and Discomfort**

A risk assessment on this research methodology suggests minimal potential risk for participants. However, should a participant feel uncomfortable during the interview the participant is able to stop the interview and withdraw their participation from the research. The researcher will encourage any participants who experience any emotional difficulty to seek assistance through their hospitals employee assistance program, Lifeline (phone: 131114) or their general practitioner.

**Participation is Voluntary**

Participation of both you and your health service in this research is voluntary. There is no obligation to participate. Anyone who agrees to participate in the research but later changes their mind is free to withdraw their consent from the project. Any information obtained during interview can be withdrawn prior to the final aggregation of data.

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If you have any questions, or you would like further information regarding the project titled *'Australian regional critical care nurses attempts to achieve social accountability through continuing professional development'*, please contact the Principal Researcher

**PH: Details removed for publication purposes**
**EMAIL:  Details removed for publication purposes**

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# Appendix C

| **PROJECT TITLE:** | Australian regional critical care nurses attempts to achieve social accountability through continuing professional development |
| --- | --- |
| **RESEARCHERS:** | Professor Kristine Martin McDonald<br><br>Ms Jo FINN |

**<u>Consent – Please complete the following information:</u>**

I, . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . of . . . . . . . . . . . . . . . . . . .

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hereby consent to participate as a subject in the above research study.

The research program in which I am being asked to participate has been explained fully to me, verbally and in writing, and any matters on which I have sought information have been answered to my satisfaction.

I understand that: all information I provide (including questionnaires) will be treated with

the strictest confidence and data will be stored separately from any listing that includes

my name and address.

- aggregated results will be used for research purposes and may be reported in scientific and academic journals
- I agree to any interview being audio-taped and I can choose to amend my responses within two weeks of interview.
- *I am free to withdraw my consent at any time during the study in which event my participation in the research study will immediately cease and any information obtained from it will not be used.*
- *once information has been aggregated it is unable to be identified, and from this point it is not possible to withdraw consent to participate*

**SIGNATURE**: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .     **DATE**: . . . . . . ....... . . .. . . .