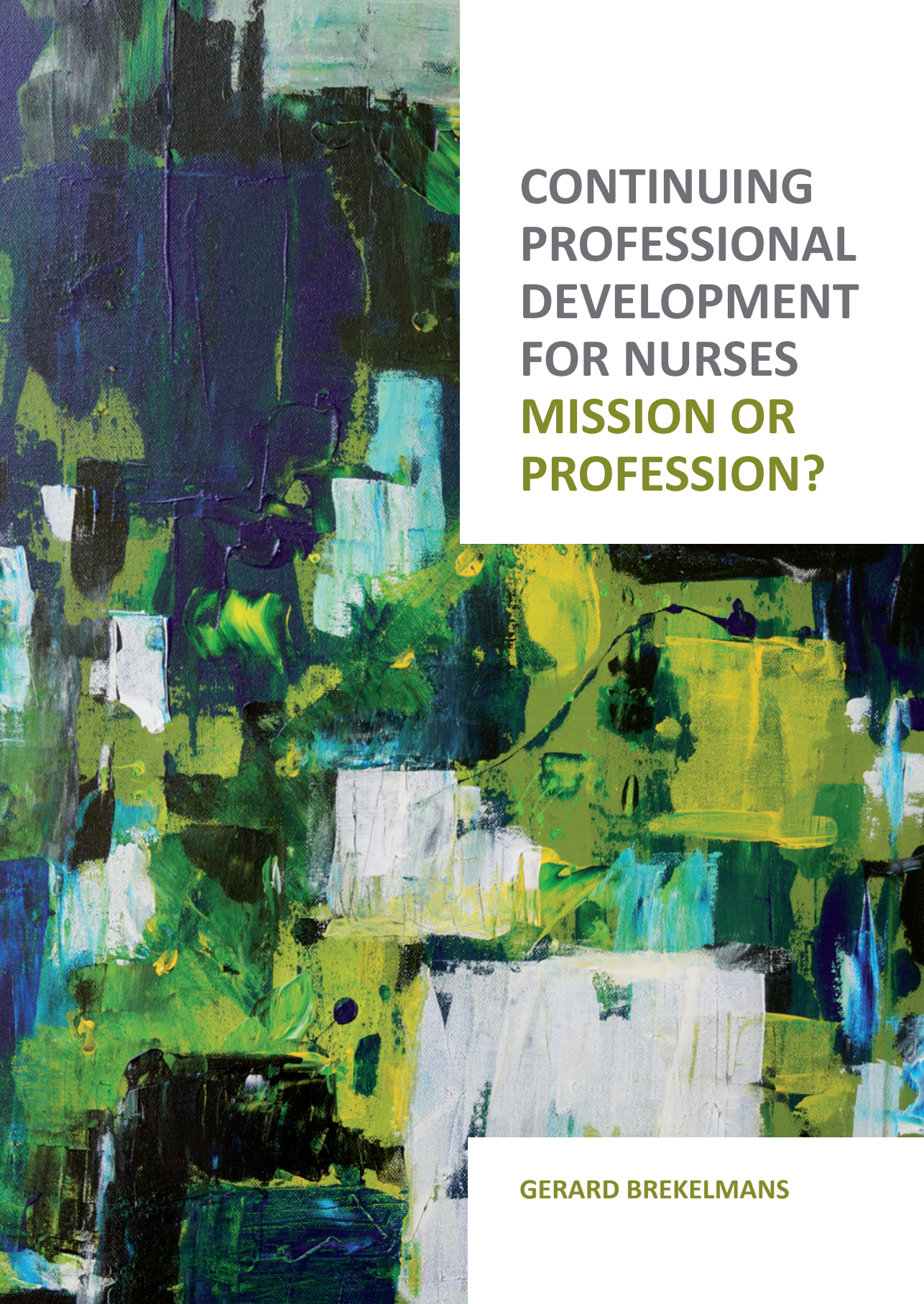

CONTINUING PROFESSIONAL DEVELOPMENT FOR NURSES MISSION OR PROFESSION?

GERARD BREKELMANS

Continuing Professional Development of Nurses

Mission or profession?

Gerard Brekelmans

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Continuing Professional Development of Nurses

Mission or profession?

Proefschrift

ter verkrijging van de graad van doctor aan Tilburg University op gezag van de rector magnificus, prof.dr. E.H.L. Aarts, in het openbaar te verdedigen ten overstaan van een door het college voor promoties aangewezen commissie in de aula van de Universiteit op woensdag 5 oktober 2016 om 16.00 uur

door

Gerardus Adrianus Brekelmans,
geboren op 7 februari 1955 te Goirle.

Promotor:

Prof. dr. R.F. Poell

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Prof. dr. H. Vermeulen
Prof. dr. D. Gijbels
Dr. M.J. Kaljouw

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In 2007 begon, naar aanleiding van het onderwijsinnovatieproject van de Erasmus MC Zorgacademie “Anders Leren”, de eerste overdenkingen om meer te doen met het onderwerp Continue Professionele Ontwikkeling. In het kader van de bovengenoemde onderwijsvernieuwing werden op een zevental ziekenhuizen op oncologische-, kinder- en operatieafdelingen werkplekanalyses uitgevoerd. De uitkomsten brachten interessante zaken naar boven die aanleiding gaven tot nader onderzoek. Met name de mate waarin zelfsturing ten aanzien van de eigen professionele ontwikkeling plaatsvindt. Het boek “Organiseren van leerwegen” van Ferd van der Krogt heeft hierbij de definitieve richting gegeven. De andere aanleiding lag meer in de richting van mijn persoonlijke ambitie. Wat wil ik zelf nog na Anders Leren. Een heroriëntatie dus. Onderzoek doen in combinatie met de dagelijkse leiding binnen mijn Unit Training en Ontwikkeling leek een prima optie. Na 1,5 jaar had ik eindelijk de onderzoeksopzet waarmee ik verder ben gegaan. Privé was alles uitgebreid besproken en het geheel werd enthousiast ontvangen. Nu ligt dan eindelijk het eindresultaat voor u.

Terugkijkend is het een persoonlijke leerweg geweest die indrukwekkend genoemd mag worden. Spannend, opgewonden, zenuwachtig, onzeker, twijfels, allemaal gevoelens die bij me opkwamen. En dat op je 61e!! Hoezo, een levenlang leren.

Het moge duidelijk zijn dat ik deze leerweg nooit volbracht zou hebben zonder de nodige steun en aanmoedigingen. Daarom wil ik hier even bij stil staan.

Ik had met Rob Poell en Kees van Wijk de juiste personen gevonden die zowel inhoudelijk als persoonlijk aansloten bij mijn begeleidingsbehoefte. De shock was groot toen Kees ons plotseling ontviel en er, ook in dit opzicht, een grote leegte ontstond. Het duurde dan ook even voordat ik alles weer op de rails had.

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Adri en Madelon; ik heb veel steun van jullie ondervonden. Jullie gaven me de ruimte die ik nodig had. Het vertrouwen dat jullie mij gaven is van grote waarde omdat resultaten niet direct zichtbaar waren en het geheel meerdere jaren in beslag nam. Het blijven geloven in een mooi resultaat en het creëren van de juiste randvoorwaarden zijn noodzakelijk om een dergelijk traject in te gaan. Ik waardeer dit enorm. Ik wil hierbij ook mijn collega's van de Zorgacademie bedanken. Carla, Mari Tere, Rick, Yvonne, Marijke, Sissy, Jos, Marga, Bas, jullie steun en de bereidheid om mij de ruimte te geven om dit onderzoek te doen was van grote waarde.

Inge, je was voor mij een perfect klankbord. Zeer nauwgezet en alle puntjes op de i. Daar waar ik nogal snel met grote stappen vooruit wilde gaan was jij meer beschouwend. Je feedback en "de stofkam" waarmee je door de stukken ging was een prima aanvulling voor mij. Het delen van de twijfels die we beide hadden zorgde ervoor dat we toch weer door gingen. Uiteindelijk hebben dan toch maar de eindstreep gehaald!

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Onderzoek doen betekend ook dat data op een juiste wijze geanalyseerd en geïnterpreteerd moeten worden. Dit bleek nog een hele klus en Ed, hierbij was jij van onschatbare waarde. Je hebt mij met veel geduld en kunde bijgestaan om uit al die gegevens datgene te halen dat cruciaal is voor mijn onderzoek. Zonder je hulp was me dit niet gelukt.

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Greet, we lopen nu 42 jaren samen onze eigen leerweg. Soms met vallen en opstaan maar altijd samen hand in hand. De laatste loodjes waren inderdaad de zwaarste maar ook daar zijn we goed doorheen gekomen. "Als liefde zoveel jaar kan duren dan moet

dat echt wel liefde zijn" zoals ons lied aangeeft. We zijn in 1973 samen op reis gegaan en hebben ons ontwikkeld tot waar we nu staan; hecht, onafscheidelijk en een rotsvast vertrouwen in de toekomst. Je bent mijn baken in soms woelige tijden en mijn liefde voor jou is dan ook grenzeloos.

Ik ben me ervan bewust dat ik niet iedereen genoemd hebt die mij bijgestaan hebben en steun, advies en vertrouwen hebben gegeven. Vrienden en collega's zonder jullie allemaal was het me niet gelukt. Dank daarvoor!!

Dit hoofdstuk wordt nu afgesloten maar heeft aanzet gegeven tot een vervolg. Ik zal zeker betrokken blijven bij de verdere ontwikkeling van ons wonderschone vak en een bijdrage blijven leveren om het verpleegkundig beroep de positie en waardering te geven die het verdient.

Oktober 2016

Contents

CHAPTER 1

Introduction

"You are not just a nurse. You are a spouse, a parent and a lot more. If you have some spare time left at the end of the day, you can do some study." (Gopee, 2002)

The above quotation is by an Accident & Emergency Nurse that was cited in a study by Gopee (2002. p.612). It indicates that activities undertaken for continuing professional development (CPD) are regarded as things that are pursued outside working hours and not integrated in the daily professional duties: if it is to be done reliably, one needs additional working time for it. But this cannot be separated from the daily practice because a lot is to be learned from one another. In the present set of studies, the following broad definition of CPD was used: "The lifelong process of active participation by nurses in learning activities that assist in developing and maintaining their continuing competence, enhancing their professional practice and support to achieve their career goals" (ANA, 2011). In America CPD is also referred to as continuing education. The aim of this thesis was to investigate the factors that affect nurses' CPD efforts.

Staff shortages and increased workload are arguments often used by individuals as an excuse not to invest in CPD (Gould, 2007; Jantzen, 2008). A constant threat in healthcare is a significant shortage of registered nurses. This shortage also threatens the nursing profession (Donelan, Buerhaus, DesRoches, Dittus & Dutwin, 2008). Studies in the last ten years warn that dissatisfaction among nurses is a crucial factor in their decision to leave the profession (Fochsen, Sjogren, Josephson & Lagerstrom, 2005; Sheward, Hunt, Hagen, MacLeod & Ball, 2005). Several issues that contribute to this have been identified: high pressure, struggling to deliver good care, staff shortages and lack of professional development (Fochsen et al, 2005). CPD is one of the strategies that may help to decrease the dissatisfaction among nurses because it contributes towards higher job satisfaction, organisational commitment and lower stress (Berings, 2006; Chien, Chou & Hung, 2008). Therefore, it was suggested that it is important that employers support nurses in their professional development (Hallin & Danielson, 2007).

Continuing Professional Development in Nursing: Boundaries and Definitions.

A variety of concepts may be thought to be within the scope of this dissertation: Lifelong Learning (LLL), Continuing Professional Development (CPD) and Continuing Professional Education (CPE). Much has been written on these concepts in both popular and professional contexts, where the acronyms of CPE and CPD have often been used interchangeably. Gopee (2005) affirmed that there was a clear distinction in the literature between the terms such as CPE, CPD and LLL in current use. Therefore, an overview of the different definitions in literature is provided and the final definition used for the ensuing set of empirical studies is described. Moreover, various factors that influence CPD activities pursued by nurses are introduced.

Definitions of Lifelong Learning, Continuing Professional Development and Continuing Professional Education.

Figure 1 shows that Lifelong Learning is an overarching concept, which includes CPD. CPE is a subset of CPD.

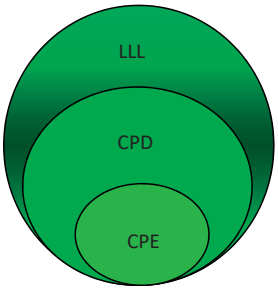

Figure 1. The inter-relationship between Lifelong Learning (LLL), Continuing Professional Development (CPD) and Continuing Professional Education (CPE).

Many professions such as those of teachers, accountants, medical doctors and the police force define CPD and/or CPE as a structured approach to learning to help ensure competence in practice, gaining knowledge, skills and practical experience (Flanagan, Baldwin & Clarke, 2000; van der Krogt, 2007). As previously mentioned, the concepts of CPD and CPE are often used interchangeably. This can be confusing and thought to imply that CPD primarily consists of training courses and education programmes. To clarify, the definitions of both are given. Each plays an important role as nurses gain knowledge and confidence in their abilities to care for patients (ANA, 2000). Several definitions have been used over the years for the three different concepts (see Tables 1a, 1b, 1c).

Lifelong Learning (LLL) is an important topic because of the rate of progress in the level of knowledge and rapid changes in healthcare. This means that some of what was once thought to be true may well change dramatically over the years in a career. The description of the professional profile of the nurse includes the phrase "Lifelong learning is a constant in the career of a nurse. He/she is transparent on his/her personal and professional development" (Schuurmans, 2012. p.25). As shown in Table 1, the terms CPD and CPE both contain elements of a continuous process involving the development of the nurse's professional skills in order to improve the quality of care. However, the term CPE is limited to training and education courses, whereas CPD also includes self-initiated learning activities. In that sense, CPE could be seen as a part of CPD. Although LLL also includes formal (organisation driven) and informal (self-initiated) learning activities, it concerns the personal as well as the professional life. Therefore, it encompasses a wider scope than CPD. Thus, CPD may be seen as a part of LLL. The relationship between these concepts is shown in Figure 1. The definitions have changed

Table 1a. *Definitions of Lifelong Learning (LLL) in chronological order.*

Lifelong Learning **Author**	**Year**	**Definition**
Department of Health United Kingdom *Continuing Professional Development, Quality in the New NHS*. Available from http://www.dh.gov.uk/en/Publicationsandstatistics/index.htm	1999	A process of continuing development for all individuals and teams, which meets the needs of patients and delivers the healthcare outcomes and healthcare priorities of the NHS, and which enables professionals to expand and fulfil their potential.
Learning for Life: White Paper, Department of Education and Science, UK.	2000	The ongoing, voluntary, and self-motivated pursuit of knowledge for either personal or professional reasons.
Organisation for Economic Cooperation and Development (OECD). Page. 1, AEGEE Education Working Group expert on LLL July 2007.	2002	All learning activity undertaken throughout life with the aim of improving knowledge, skills and competence within a personal, civic, social and/or employment-related perspective.
American Association of Colleges of Nursing (AACN) & The Association of American Medical Colleges.	2010	An understanding of evidence-based healthcare and critical appraisal, familiarity with informatics and literature search and retrieval strategies, practice-based learning and improvement methods, self-reflection and assessment, and other skill sets related to knowledge management.
Davis L*, Lifelong learning in nursing: a Delphi study*, *Nurse Education Today*, 34(3):441-5.	2014	A dynamic process, which encompasses both personal and professional life. This learning process is also both formal and informal.

Table 1b. *Definitions of Continuing Professional Development (CPD) in chronological order.*

Continuing Professional Development		
Author	**Year**	**Definition**
Madden CA, Mitchell VA. *Professions, Standards and Competence: a survey of continuing education for the professions*. Bristol: University of Bristol	1993	Maintaining and improving knowledge, expertise and competence of professionals throughout their careers according to a plan formulated with regard to the needs of the professional, the employer, the profession and society.
An Bord Altranais. *Continuing Professional Education for Nurses in Ireland: A Framework*, Dublin. P.11.	1997	A lifelong professional development process, which takes place after the completion of the pre-registration nurse education programme. It consists of planned learning experiences, which are designed to augment the knowledge, skills and attitudes of registered nurses for the enhancement of nursing practice, patient/client care, education, administration and research.
Lewis M. *Lifelong learning: why professionals must have the desire for and the capacity to continue learning throughout life*. Health Inf Manage; 28(2):62-66.	1998	CPD is a term used to encompass the variety of learning activities, which follow graduation and it builds on the experiences, knowledge, skills and abilities of individuals as adults and qualified practitioners.

Table 1b. *(continued)*

Continuing Professional Development		
Author	**Year**	**Definition**
Peck P. *Continuing medical education and continuing professional development: international comparisons*, *BMJ, Vol. 320:* 432-435.	2000	The term continuing professional development acknowledges not only the wide ranging competencies needed to practice high quality medicine, but also the multidisciplinary context of patient care.
Fikar CR, Keith L, Dobrochasov D. *Continuing professional development in the health professions: the role of the hospital librarian*. J Hosp Libr;2(3):11-28.	2002	An ongoing, career-long process of acquiring new knowledge, technical skills, learning skills, computer skills, managerial skills, interpersonal skills, and attitudes in order to enable competent practice in a specific field within the health professions.
Evans A, Ali S, Singleton C, Nolan P, Bahrami J. *The effectiveness of personal education plans in continuing professional development: an evaluation*. Med. Teach; 24(1):79-84.	2002	The process of lifelong learning for all individuals and teams, which enables professionals to expand and fulfil their potential and also meets the needs of patients.
Lawton S, Wimpenny P. Continuing professional development: a review. *Nursing Standard*. 17, 24, 41-44.	2003	The systematic maintenance, improvement and broadening of knowledge and the development of personal qualities necessary for the training of professional and technical tasks during the working life of the professional.
American Medical Association.	2007	CPD consists of any educational activity, which helps to maintain, develop or increase knowledge, problem-solving, technical skills or professional performance standards all with the goal that physicians provide better health care.
The American Nurses Association (ANA) (Nursing Professional Development: Scope and Standards of Practice) https://ananursece.healthstream.com/pages/about.aspx	2011	The lifelong process of active participation by nurses in learning activities that assist in developing and maintaining their continuing competence, enhancing their professional practice and support achievement of their career goals.

over the years, but the concepts have remained similar. LLL is described as a continuous process in which, activities that lead to both personal and professional development are pursued.

Regarding CPD, all the definitions are in line with each other because they refer to activities that raise professionals to a level of expertise that meets the requirements of good care and professional standards.

Definitions of CPE are consistent with those of CPD, but focus on compulsory learning activities rather than self-directed activities. The demands placed on the profession are often supported by mandatory learning activities. Only the definition by Bennett (2000) described optimal CPE as highly self-directed, but the later definition of CPE (Medical Dictionary for the Health Professions and Nursing, 2012) mentioned formal educational programmes. Eventually, they all should lead to the same goal namely competent professionals.

Table 1c. *Definitions of Continuing Professional Education (CPE) in chronological order.*

Continuing Professional Education		
Author	**Year**	**Definition**
The American Nurses Association (ANA).	1984	Planned educational activities intended to build upon the educational and experiential bases of the professional nurse for the enhancement of practice, education, administration, research or theory development to the end of improving the health of the public.
Bennett N. Continuing Medical Education: A New Vision of the Professional Development of Physicians. *Academic Medicine*: Volume 75 - Issue 12 - p 1167–1172. p 1169.	2000	Optimal CME is highly self-directed, with content, learning methods and learning resources selected specifically for the purpose of improving the knowledge, skills and attitudes that physicians require in their daily professional lives that lead to improved patient outcomes.
Davis N. Continuing medical education: AMEE Education, Guide No 35-Medical Teacher: 30: 652–666.	2008	Educational activities that serve to maintain, develop or increase the knowledge, skills and professional performance and relationships a physician uses to provide services for patients, the public or the profession.
Continuing education (n.d.) Medical Dictionary for the Health Professions and Nursing. Retrieved October 22, 2015 from http://medical-dictionary.thefreedictionary.com/continuing+education	2012	Formal educational programmes designed to promote the knowledge, skills, and professional attitudes of nurses. The programmes are usually short- term and specific; a certificate may be awarded for completion of a course and a number of continuing education units or contact hours may be conferred.

CPD definition adopted for this research.

The ANA definition is used for CPD, because it was refined by the representatives of the (American) nurses in 2000. Moreover, this definition was confirmed and readopted by the ANA in 2011 (see Table 1b).

> Definition: "The lifelong process of active participation by nurses in learning activities that assist in developing and maintaining their continuing competence, enhancing their professional practice and support achievement of their career goals." (ANA, 2011).

The ANA definition is mainly used to improve nursing competencies. The nurse's career goals are also included in the definition. This may embrace a more personal motive that is not necessarily linked to nursing. A nursing career can progress in several different directions such as that in the public- or the private sector, nursing education, healthcare policy making, or research. In light of this, a nursing career has wide horizons.

CPD Activities, Motives, Conditions and Importance.

From a professional perspective, one may expect that nurses invest in enhancing their professional development. It is after all their livelihood. The report of the General Association of Nurses and Caregivers (De Algemene Vereniging van Verpleegkundigen en Verzorgenden (AVVV)) and Nivel (2006) reported that nurses were generally (95 per cent) highly motivated to attend training sessions. In 90 per cent of all cases, the costs were entirely paid by the employer. Still, 50 per cent of the respondents felt that the employer should provide more money for education. Thus, in the opinion of these respondents more financial resources were needed to support their educational needs. However, the reason for more financial resources was not clear. This report provided only a limited picture, because it included only training courses, but CPD encompasses more than this (see definitions sub-section) (Nivel, 2006). Which activities are considered to be a priority in pursuing CPD? What motives are given by nurses for completing CPD? Are time and money the only factors, or are there others? These may include the opportunity for coaching, feedback, the presence of role models in the workplace or compulsory skills update etc. that play an important role. All these factors are explored in the following sections.

CPD: the Activities.

The American Nurses Association (ANA, 2011) referred in its definition of CPD to active participation by nurses in learning activities. It concerned activities that were pursued to improve their own professional practice or alternatively to support their career (ANA, 2011). The fact that the term "learning activities" was used meant that all kinds of learning activities could be used to achieve both objectives. However, the methods chosen to undertake CPD activities were often didactic in nature and less connected with the workplace and a more self-directed way of learning (Rodgers, 1994; Griscti & Jacono, 2006). Many CPD programmes consisted of training and education activities. These were also provided as part mandatory programmes in order to meet specific requirements, e.g. for the purpose of keeping a license and/or certification (ANA, 2011). The provision of formal training courses was extensive and nurses were generally (68.8 per cent) satisfied with it (Nivel, 2011). However, formal training often showed few results in the workplace (McGuire & Gubbins, 2010). The reason for this was that the transfer to the workplace may be difficult in terms of e.g. motivation of trainee, learning outcomes and supportive transfer climate (Blume, Ford, Baldwin & Huang, 2010).

In addition, the majority of the instruments used for supporting CPD, such as the portfolio, were focused on structured and planned programmes (Bullock et al, 2002; Chamblee, 2015; Gill & Ursic, 1994; Jordan, 1998; Jordan et al, 2000; Nielson & Miaskowski, 1987; Timms & Ford, 1995). Once again the emphasis was placed on formal learning activities with an emphasis on education rather than improving one's practice in the workplace.

Compulsory formal training programmes have a weakness: they do not necessarily take into account the fact that there are a lot of activities (working together, problem solving, critical thinking), which may also constitute valuable CPD (van der Krogt, 2007). Hence, these skills are not necessarily included in the programme. Learning may be on the basis of formal training courses or via informal learning activities that were more linked to the daily work and were less visible or quantifiable (Eraut, 2004). Eraut stated that workplace learning is a combination of thinking, trying things out and talking to other people. This may be driven by the requirements of the workplace. Eraut suggested that sometimes the need arises for additional knowledge or skills in order to improve the quality of the work, or to take on new tasks. Learning objectives will be achieved through self-directed, self-defined and relevant learning activities when they occur. To ensure effective CPD, nurses should play a greater role in directing their own learning (Griscti & Jacono, 2006). However, it often requires learning from experience and also observing other people at work.

The study by Berings *et al*, (2008) reported that learning was through various learning activities. She reported the following main categories of learning activities pursued by nurses in the Netherlands: learning by doing one's regular job, learning by applying something new in the job, learning by social interaction with colleagues, learning by testing out a new theory or under the supervision of a colleague, learning by reflection and learning through life experiences outside work. This list confirmed that nurses learned and thereby enhanced their professional development in many different ways.

In this section, the emphasis has been on the CPD activities themselves. In the next sub-sections, factors which may affect the actual CPD activities pursued are described.

CPD: the Motives.

With regard to their motives for pursuing CPD, nurses differentiate between CPD for their own career and personal development and CPD to keep their knowledge and skills up to date (Gould, Drey & Berridge, 2007). However, positive reasons to pursue CPD activities were tempered by the pressure on the individual nurse to maintain a good work/life balance (Gould, Drey & Berridge 2007). Some nurses participated only in those CPD programmes that were mandatory to continue practicing as a nurse (Grossman 1998, Lawton & Wimpenny, 2003). A number of studies also reported that nurses participated in CPD because of a desire to expand their own knowledge (Lindsay, 1990; Larcombe & Maggs, 1991; Turner, 1991; Thurston, 1992; O'Connor, 1992; Waddell, 1993; Friedman, 2004; Pool, 2012).

In short, from the perspective of the individual nurse, there are a number of motives for pursuing CPD. Friedman (2004) described a hypothetical set of reasons for undertaking CPD activities. These were written from a moral and an ethical perspective. He stated that CPD benefitted the public, patient, profession and/or employer. On the one

hand, another motive for investing in CPD could be the desire to pursue an interest in a particular subject (Friedman, 2004), or as a more personal accomplishment i.e. to be able to say "Yes, I can!" Friedman also listed career advancement, starting a new job or maintaining employment prospects. On the other hand, an employer may be required to support the specific CPD activities of an employee because of legislation (Friedman, 2004). An overview of the various motives that nurses may have for participating in CPD activities is presented in Table 2.

Table 2. *Motives of nurses for participating in CPD activities.*

Motives	Author
Career and personal development. To keep their knowledge and skills up to date.	Gould, Drey & Berridge, 2006.
To allow them to continue practicing.	Grossman, 1998; Lawton & Wimpenny, 2003.
The need to expand their knowledge.	Lindsay, 1990; Larcombe & Maggs, 1991; Turner, 1991; Thurston, 1992; O'Connor, 1992; Waddell, 1993; Friedman, 2013; Pool, 2012.
To benefit the general public, the patient, the profession and/or the employer. The desire and the curiosity to pursue an interest in a particular subject. Personal accomplishment. Career advancement, starting a new job or maintaining employment prospects. Compulsory requirement of the job and/or by the employer. Obliged by the ethical code of the workplace.	Friedman, 2004.

CPD: the Conditions.

Creating good conditions in the workplace stimulates nurses to pursue CPD activities such as learning to work together, on the job training etc.. Managers play a major role in encouraging or discouraging nurses to pursue CPD activities. Their management style plays an important role in allowing the individual to develop new skills and gain knowledge (Ellis & Nolan, 2005; Hughes, 2005). Nurses are willing to develop themselves, but they need a leader who is aware of the capabilities and the needs of their team (Acharya, 1994; Macdonald, 1994; Hogston, 1995). Moreover, nurses need a stimulating working environment including mentoring and support in order to pursue CPD activities (Danielson & Berntsson, 2007).

As shown in Table 3, work-related opportunities and barriers for professional development are described at three levels namely individual, workplace and organisational factors within the company (Hemmington, 2000).

Table 3. *Opportunities and barriers affecting CPD at the individual, workplace and organisational levels.*

	Individual	Workplace	Organisational
Opportunities	Career planning. (Gallagher, 2006).	Stimulating working environment. (Danielson & Berntsson, 2007).	Learning culture. (Nelson, 2006).
	To expand own knowledge for personal development. (Lindsay, 1990; Larcombe & Maggs, 1991; Turner, 1991; Thurston, 1992; O'Connor, 1992; Waddell, 1993).	Mentoring and support. (Hemmington, 2000).	Dynamics of change. (Hemmington, 2000).
	Supporting continuing clinical practice. (Grossman, 1998; Lawton & Wimpenny, 2003).	Leadership. (Acharya, 1994; Macdonald, 1994; Hogston, 1995).	Competitiveness. (Hemmington,, 2000).
	Awareness and understanding of the concept of CPD. (Gallagher, 2006).	Management style. (Ellis & Nolan, 2005; Hughes, 2005).	Strategy (Hemmington, 2000).
	Work/life balance (Gould, Drey & Berridge, 2007).		
Barriers	Work/life balance. (Gould, Drey & Berridge 2007).	Staff shortages. (Gould et al, 2007; Jantzen, 2008).	Lack of available places. (Macdonald, 1994; Robinson, 1994).
	Shifts (Gould et al, 2007; Jantzen, 2008).	Unjust selection of participants for CPD. (Nolan et al, 1995).	Lack of budget. (Larcombe & Maggs,1991; Hogston, 1995;Nolan et al, 1995; Minzo-Lewis, 2014).
	Heavy workloads. (Gould et al, 2007; Jantzen, 2008).	Poorly defined concepts of nursing. (Gould et al, 2007; Jantzen, 2008).	Commitment of key figures to CPD. (Hemmington, 2000).
	Little information on CPD. (Duckette, 1993; Nolan et al, 1995; Mackereth, 1989; Yuen,1991; Gould et al, 2007; Jantzen, 2008).	Shortage of encouraging managers. (Acharya, 1994; Macdonald, 1994; Hogston, 1995).	Internal infrastructure. (Hemmington, 2000).
			Low awareness or understanding of occupational health nursing by employees and no recognition of expertise. (Mizuno-Lewis, 2014).

■ *Individual level.*

At an individual level, nurses face barriers such as night and weekend shifts, staff shortages, heavy workloads, poorly defined concepts of nursing and poor information on the availability of CPD in advancing their professional development (Duckette,1993; Nolan, Owens, & Nolan, 1995; Mackereth,1989; Yuen, 1991; Gould *et al*, 2007; Jantzen, 2008). One factor that encourages the pursuit of CPD of the individual nurse is an awareness and an understanding of the benefits and value of CPD (Gallagher, 2006).

■ *Workplace level.*

The culture of the workplace influences both the organisational and the individual opportunities to implement CPD. There are positive elements such as career planning (Gallagher, 2006), a learning culture (Nelson, 2006), an awareness of the dynamics of change (Hemmington, 2000) and competitiveness (Hemmington, 2000). However, obstacles such as staff shortages (Mackereth, 1989), shortage of supportive managers (Acharya, 1994; Macdonald, 1994; Hogston, 1995; Mizuno-Lewis, 2014), lack of budget (Larcombe & Maggs, 1991; Hogston, 1995; Nolan et al, 1995; Mizuno-Lewis, 2014), lack of available places (Macdonald, 1994; Robinson, 1994) and an unjust selection of participants for CPD (Nolan et al, 1995) were also reported. An overwhelming majority of respondents also reported the need for support and advice on CPD (Hemmington, 2000). Nurses can only embrace the concept of CPD as professionals if this is fully recognised and incorporated into their professional careers (Gallagher, 2006). Hallin & Danielson (2007) reported that further research was needed to find which factors provided a balance between barriers and opportunities such as the nurse's potential, work/life balance, support and motivation, and career planning.

■ *Organisational level.*

At the organisation level, it is important that CPD correlates with the strategy of the organisation. The direction and the priorities chosen have a bearing on CPD options for the professionals. What competencies are needed in order to meet expectations? Which individuals are key figures to the organisation and are contractual obligations present? Finally, is there a good infrastructure in place for CPD. In other words, is the culture of the organisation forward- looking with regard to CPD and are the materials and the resources clearly and easily accessible? (Hemmington, 2000).

Mizuno-Lewis (2014) identified a low awareness or understanding of occupational health nursing by employees. The occupational health nurses stated that they were not recognised as experts in their field. This also affected the recognition of the importance of CPE and CPD by the employees. The study was done in the Japan so that it is possible that some cultural issues affected the outcome (Mizuno-Lewis, 2014). The nursing profession is regulated and protected by law (BIG register 1998) in the Netherlands, but

this is not the case everywhere around the globe. In the United Kingdom and Canada this is regulated by the Nursing and Midwifery Council (NMC 2005). In the USA it is regulated by the State, but nurses have to pass the NCLEX-RN (National Council Licensure Examination-Registered Nurse) or NCLEX-PN (National Council Licensure Examination-Practical Nurse) to get a licence (National Council of State Boards of Nursing, 1994).Nurses in Japan are not recognised by law or regulation. This is left to individual companies (Kono, 2008). These issues may affect the recognition of the nurse within the organisation.

The importance of CPD by nurses was reported by Broad (2002) as maintaining knowledge and development, legal requirement for employment, registration and for the protection of the public.

Regarding the importance attached to CPD as shown in Table 4, some nurses deem that the only value of CPD is to allow them to continue practicing (Grossman, 1998; Lawton & Wimpenny, 2003). A study conducted in the Netherlands reported that nurses think that "working together" is the most important CPD activity. Three aspects namely giving and receiving feedback and participating actively in team meetings appeared especially important to them (Speet & Francke, 2004). In addition, almost all nurses considered the aspect "reflecting on one's own practice" important. The least value was given to the use of nursing research ("evidence-based practice") and to "acting from a theoretical vision" (Speet & Francke, 2004).

Table 4. *Levels of Importance attached to CPD by nurses.*

	Importance	Author
Most	Maintain knowledge and development. Legal requirement. Protection of the public.	(Broad, 2002).
	Continue practicing.	(Grossman,1998). (Lawton & Wimpenny, 2003).
	Increase knowledge.	(Lindsay, 1990). (Larcombe & Maggs, 1991). (Thurston, 1992). (O'Connor,1992).
	Working together. Reflecting on one's own practice.	(Speet & Francke, 2004).
Least	Nursing research. Acting from a theoretical vision.	(Speet & Francke, 2004).

Summary

In this chapter, in addition to the definitions of LLL, CPD and CPE, the various factors that may influence the pursuit of CPD activities are outlined. A number of these activities are more related to workplace learning than to formal education and training. LLL, CPD

and CPE are linked to each other. Lifelong learning is an overarching concept, which includes CPD. CPE is a subset of CPD. Moreover, the relevance of CPD is described. The definition of CPD described by ANA is chosen for all investigations. It shows that CPD is not only central to improving the nursing profession as a whole, but also in pursuing an individual's career in nursing.

The participation of nurses in CPD may be viewed from different angles:

- Personal (career and the desire to develop themselves),
- Professional (to improve clinical practice) and
- Organisational (decrease staff turnover and reduce shortages, quality of care).

One relevant question is why do nurses pursue CPD activities? Is their motive primarily to improve patient care, or is it for a more personal reason such as career progression?

Another factor that may explain CPD participation is the importance that nurses assign to a particular CPD activity. A question that presents itself is: what happens if the employer attaches little importance to a nurse pursuing a CPD activity? Maybe the nurse's desire to do so will decrease?

A third factor affecting nurses' CPD participation is the pressure of the working conditions. Much has been written on the time and the money being the main factors that influence participation in CPD activities (Henderson & Winch, 2008; Hogston, 1995; Larcombe & Maggs, 1991; Manley, Titchen & Hardy, 2009; Merriam,Caffarella & Baumgartner, 2007; Nolan, 1995). However, there are multiple other factors (management, coaching) that affect participation in CPD activities (Ellis & Nolan, 2005; Hughes, 2005; Danielson & Berntsson, 2007).

The above three factors (motives, importance, working conditions) all seem to affect the actual pursuing of CPD activities. The best way to investigate which factors influence the actual pursuing of CPD activities is to ask the nurses.

A Study of CPD Activities Pursued by Nurses

In the set of studies presented in this dissertation, the extent to which motives, perceived importance of CPD and working conditions were related to nurses pursuing CPD activities were investigated. The individual factors were individually analysed in earlier studies (Berings, Poell, Simons, &Van Veldhoven, 2007; Broad, 2002; Hemmington, 2000; Friedman, 2004). However, the inter-relationships between these factors have not yet been investigated. Such investigations are important to the manner in which CPD activities can be best stimulated. Efforts are being made by employers to make the work environment more appealing so that nurses are retained. Professional bodies aim to stimulate the professionalism of nursing and education centres offer customised learning programmes. The opinions of nurses on CPD have neither been thoroughly investigated nor adequately heard. Their involvement has been limited to recording the pursued training activities only as inventory assets.

Various agencies are currently working together to support and stimulate CPD for nurses in the Netherlands. Employers and professional associations frequently collaborate on this issue and education centres facilitate this process with the appropriate learning programmes. Therefore, these stakeholders have been invited to participate in this study as well. In this way, the opinions and the views of these parties are obtained and compared with those of nurses. The results should provide an impression of the current state of affairs regarding CPD among nurses and other nursing stakeholders in the Netherlands.

Developments in the United States of America.

Internationally, developments in the nursing profession are emerging from which we can learn. For example, the concept of Magnet America has proved to have a positive impact on CPD and nursing (McClure, 2005; Hess, 2011).The label 'Magnet® Hospital' was given to hospitals that were able to successfully recruit and retain nurses during a national nursing shortage in the USA in the 1980s. These hospitals are known for their better work environments and more highly qualified nurses (Kelly, 2011). The programme is based on the 14 characteristics of 'Magnet' facilities. that were found to contribute effectively to the retention of nurses. These characteristics are known as the 'Forces of Magnetism' and are grouped under five 'Components' Professional development is mentioned under Component Two: Structural Empowerment as one of the forces of Magnetism and thus endorsed as an important pillar for the profession and the organisation (ANCC, 2014). In short, investment in the CPD of nurses as one of the pillars of the Magnet concept seems to be associated with a better quality of care and better outcomes for patients.

Therefore, the present set of studies includes an initial exploration of the differences and the similarities in CPD between the Netherlands and the USA in an attempt to learn from each other and take a step forward in the continuing professional development of nurses.

Focus and Aim of the Study

The main objective of this study was to clarify the relationships between various factors that affect nurses in their CPD. The studies described in this dissertation focussed on the nurses themselves. Their opinions and views were sought to clarify what would encourage them to pursue CPD activities. The three factors (motives, importance and conditions) were the independent variables. Their effect on those nurses who actually pursued CPD activities should provide an insight into which factors were most powerful in stimulating nurses to pursue CPD activities and into the interactions between these factors.

As previously mentioned, there are reported studies on the individual factors, but not on their inter-relationships (Berings, Poell, Simons & Van Veldhoven, 2007; Broad, 2002; Hemmington, 2000; Friedman, 2004).

Outline of this dissertation

A general introduction to and definition of CPD and its various concepts are described in Chapter 1 (the current chapter). An outline of the relevant literature on CPD in general and especially with reference to the medical and nursing professions is presented. CPD was distinguished from the broader concept of LLL and the narrower concept of CPE.

Chapter 2 is built on the assumption that in order to understand the present we have to take a good look to the past. The history of nursing and how the professional development of nurses has changed is described. How did the nursing profession get to where it is today? Nursing has existed as a profession for centuries. Taking care of the sick and the weak goes back into early history, but the nursing profession has not always carried prestige. The history of nursing is briefly described creating a picture of the evolution of professionalism of the nursing profession.

Chapter 3 deals with a Delphi study. The aim of this study was to identify the motivating and the impeding factors for registered nurses to pursue CPD activities. Thirty-eight experts were asked to complete two consecutive questionnaires and to participate in a face-to-face discussion meeting. Four main groups participated: nursing associations, nursing educationalists, nursing managers, and nursing employers. The opinions and the views of their different perspectives are described in this chapter. There was a clear consensus on the need for participation in CPD activities. Important roles for each stakeholder group were identified and a set of motivating factors emerged.

The development and the empirical validation of a questionnaire measuring continuing professional development among nurses is described in Chapter 4. The Questionnaire on the Continuing Professional Development of Nurses (Q-PDN) was used in this study to measure the motivation to pursue CPD, the perceived importance of CPD and the necessary working conditions that influence the extent to which nurses undertake CPD activities. The development and the initial psychometric testing of the Q-PDN instrument is also described.

A study among nurses working in healthcare facilities in the Netherlands, who were asked to take part in the Q-PDN survey is described in Chapter 5. The aim of the study was to establish the exact relationships between the three influencing factors of actual CPD participation (motives, importance and conditions). The results showed that the actual CPD participation was mainly affected by the importance that nurses attached to CPD, which in turn was influenced by their motivation to pursue CPD and by the extent to which relevant working conditions were met.

A study that examined the extent to which factors influencing participation in CPD activities differed between registered nurses from a Magnet University Hospital in the USA and a non-Magnet University Hospital in the Netherlands is described in Chapter 6. A mixed-methods design was used to examine the similarities and the differences in

CPD between the two hospitals. The results showed a clear difference regarding creating and maintaining policies by nurses at the ward level, much more pronounced in the Magnet® Hospital indicating amongst other things the cultural and structural differences within the nursing profession in the two nursing systems.

Chapter 7 deals with the general conclusions, discussion and recommendations of this dissertation, which set out to contribute to the existing knowledge on the continuing professional development of nurses. A discussion on the outcomes of the various studies is presented in this chapter and critical reflections are provided on the concept of CPD, the value of this dissertation for research and practice and the value of the Q-PDN instrument for research and practice. Finally, emerging research questions for the future are also discussed.

CHAPTER 2

The professional development of nurses from a historical perspective: Mission or Profession?

”The best way to predict the future is to create it.’’ (Abraham Lincoln, 1809-1865).

Abraham Lincoln’s famous aphorism also applies to the nursing profession. The image of nursing has changed enormously over the years. It is good to look back into history to understand the current situation. It used to be thought that being a nurse meant making beds, providing food and drink, taking someone to the toilet and wiping a fevered brow. Surely anyone could do this and it required no specific training or further professional development. Obviously perceptions have changed and nowadays the role is seen as being more complex and demanding.

The road to the present position of the nursing profession goes back a long way. To understand the current situation, it makes sense to take a closer look at the historical role of nursing and how it has developed. Therefore, a historical overview is given in this chapter of nursing and the professionalism of nurses. The final part of the chapter will specifically focus on the professionalism of nurses in the Netherlands.

Nursing in Ancient history.

Long before the 21st century, the first steps in healthcare were being taken although little is known on nursing at that time (van der Meij-de Leur, 1971). One of the first documented nursing acts was wound care. This was already being applied in Egypt in 2000 BC (van der Meij-de Leur, 1971). Recognition of nursing as a role was recorded in India in 500 BC. At that time nurses were already valued. In India they were often employed in so-called guesthouses where sick travellers were cared for. Nurses were expected to care for the bodily needs of the patients, for example, by providing massage and aiming to reduce pain. Their skills obviously reflected the knowledge of the time (Dane, 1976; Ellis, 2012).

At the time of the Romans in the first century AD there was the Latin verb “*profiteor*”, meaning to profess or declare (Reinders, 2006). At this point medical interventions were beginning (Dane, 1976; van der Krogt, 1981). To this day nurses still make a declaration (swear an oath) of good faith: “I swear / I promise that I will perform my profession as a nurse / carer in a responsible and reliable manner” (V & VN, 2009). This declaration instilled a sense of trust from the community. Nurses at that time were female without exception (Hughes, 1981). The professionalism of the nursing role has gradually produced the concept of nurses as specialists. Professionals are recognised by the community because of their specific expertise (Otten, 2008).

Nursing in the Middle Ages 500-1500 AD.

In the Middle Ages the nursing and the medical professions came out of a religious tradition. Augustinian and Benedictine monasteries were active in delivering healthcare (van der Meij-de Leur, 1971). The role of the nurse also expanded and men were included.

Care provided within the monastery was of great significance for nursing. The most important achievement for nursing from this time was that in order to deliver good care, four conditions were identified that are still valid today (Dane, 1976):

1. Sufficient dedicated staff.
2. Good organisation and manageable workload.
3. Good income (most monasteries were rich).
4. Education and training for new recruits.

Nursing in the early Modern time 1500-1700.

Under the influence of humanism the image of man changed from explaining things from the supernatural model of the Church to man as an individual (Dane, 1976). There was a shift towards more differentiated care on an individual basis because there was more attention paid to different patient categories. Hospitals (the word 'hospitality' is from the same root) were under the control of regents and for the daily management they appointed a so-called 'father' who oversaw the buildings, the staff and the sick. The regent appointed a 'mother' or 'Matron' who was charged with overseeing the female staff. Plague victims and the mentally ill were nursed in separate hospitals. Medical knowledge was able to spread more effectively because of the printing press. Well-known works on Anatomy (Vesalius, 1550) and Physiology (Harvey, 1625) were published (van der Meij-de Leur, 1971). Many religious orders of nurses were also disbanded because of the Church reforms – known as the dissolution of the monasteries. As a result the guesthouses disappeared or were taken over by the bourgeoisie. The question arose: who is responsible for caring for the sick? The Roman Catholics believed that the Church was responsible, whilst the Protestants felt that the (Christian) Government was responsible. Vincent de Paul (1581-1660) and his assistant Louise Legras de Marillac (1591-1660) managed to organise a thorough nursing training for women (1633) (van der Meij-de Leur, 1971). After a pre-selection on the basis of general development and certain personality characteristics (honesty, ability to work well together) there followed a two month training, and then five years and eight months of theory and practice. In other words, an initial training for nurses was introduced: a big step towards professionalism because one of the necessary features of professionalism is theoretical knowledge and a standard training programme (Dane, 1976).

Unfortunately, the situation in Europe deteriorated as a result of many wars and this led to an increase in the demand for care. Guesthouses were overcrowded and the quality of care deteriorated. Room servants and midwives carried out the nursing role, which focused on making beds, handing out food and assisting surgeons (van der Meij-de Leur, 1971).

The Age of Enlightenment.

The eighteenth century was a "dark time" for nursing. This was the time of Rationalism (van der Meij-de Leur, 1971). For wealthy people it was all well arranged. They were cared for at home (including operations), but the level of care in the guesthouses was very bad. Only the poorest and most desperate went to these houses and about 25 per cent of them died. Society was not concerned about helping the sick and needy and the image of nurses was weak. It was thought that well educated people could not be expected to work in a guesthouse. Moreover, there was also a general lack of personal hygiene. This resulted from the lack of clean water and the lack of knowledge. Consequently, nursing had a bad image; it was the last option for those seeking paid work (van der Meij-de Leur, 1971; van der Heyden, 1994).

Florence Nightingale.

A positive change took place in the nineteenth century. A very important woman from Great Britain, who brought recognition to nursing as a decent job, was of course Florence Nightingale (1820-1910); "the Lady with the Lamp". Her emphases were: that nursing is a profession and it must be learned like any other profession. Further on that it should be salaried as any other profession (Dane, 1976).

It was at St Thomas' Hospital in London that, in 1860, she established the first school for nurses (Graham, 2004). The standard work for nursing from that period was Notes on Nursing (Nightingale, 1859). Initially the book was written for housewives to nurse the sick at home. It describes six points (*'Sex res non naturales'*: literally meaning six unnatural things) that determine good health; light and air, food and drink, sleeping and waking, motion and rest, secretion and excretion, and moods. Nightingale collected data and analysed it. In this way she laid the foundation for nursing research and made an important contribution to the professionalism of nursing (Dane, 1976; Egenes, 2008; Ellis, 2012).

With the rise of hospitals, and the growing demand for nurses, the nursing profession expanded after 1900. The majority were still women who were respected because of their vocation. The proportion of men was extremely limited and society's appreciation of them as nurses was low. The caring role was seen to be reserved for women and certainly no job for a man. Following changes in medical practice and treatments, the demand for expert nurses increased. This led to a new healthcare provider: the trained and qualified nurse. Hospitals opened their own training schools and student nurses delivered free care for 2-3 years in exchange for lectures and clinical training (Egenes, 2008).

Mary Seacole.

Jamaican-born Mary Seacole (1805-1881), was voted top of the list of the 2004 '100 Great Black Britons' poll as the true 'heroine' of the Crimean War. She received the

Turkish Medjidie (A Turkish honorary order established in 1851 by Abdul-Mejid, often conferred on foreigners) and in 1869 was awarded the Légion d'Honneur (admission into this order requires extraordinary military bravery and service in times of war).

Nursing during the World Wars.

The first part of the twentieth century is characterised by two World Wars. This also had an impact on the nursing profession (van Bergen, 2010). During the First World War, care was focused on "combat-ready" soldiers (van Bergen, 2010). Given the horrific injuries coming out of the trenches, nursing was in all respects a very demanding job. The number of nurses and doctors increased tremendously, which in itself is not surprising: it is known that nine million people were killed and forty million wounded in World War I (1914-1918) (van Bergen, 2010). The knowledge and experience of nurses left much to be desired; there was barely time for any training or nurse education and the requirements for qualification were, by necessity, reduced (van Bergen, 2010). This was redressed after the First World War, but the Second World War soon followed. The weapons, tanks and aircraft were more modern and in cities that were regularly bombarded, hospitals were built underground. Nursing was modernised and professional nursing courses were started. The social status was higher and this was seen as a driver of emancipation, because for the first time married women were allowed to remain in the workforce (Egenes, 2008; van Bergen, 2010).

The New Era: 1950s to the present day.

Following the two World Wars, in the 1950s, the sense of vocation as the main motivation to enter the profession had reduced. There was a focus on nursing technique (de Jong, 2003). The emotional distance between the nurse and the patient increased and the first nursing posts on the ward appeared whereby the distance to the patients was also physically greater. A typical perception of a nurse at that time would be: hard-working, thorough, emotionless, competent, white, orderly and distant (de Jong, 2003). The attraction of men to the profession was higher as the attention on technique increased (de Jong, 2003). There was more attention to the psychosocial side of care in the 1970s. Social developments and social science were the drivers (de Jong, 2003). The theoretical framework and professionalism of nurses received increasing attention. A holistic human model was created and in the 1980s patient-centred care emerged.

Today, nursing is increasingly leaving the medical model behind, dealing instead with the behavioural sciences as a basis (Roodbol, 2005). Since 2000, the influence of science in nursing has increased significantly. The rise of the Nurse Practitioner and the influence of professional associations and Evidence-Based Practice are examples of this and important pillars for further professionalism of nurses (Roodbol, 2005; Egenes, 2008).

Evolving Understandings of Nursing Since the 19th Century.

In summary, it can be stated that the role of the nurse has developed enormously down the centuries. Under the influence of technological advances and nursing theories, numerous definitions of nursing have been described (Egenes, 2008). Over the years these definitions have evolved because nursing has grown into a profession (Egenes, 2008). A selection of definitions over the years is shown in Table 1.

Table 1. *Definitions of Nursing in chronological order.*

Nursing theorist	Definition
Nightingale, F. (1860/1957/1969). Notes on nursing: What it is and what it is not. In McEwen, M. and Wills, E. (Ed.). *Theoretical basis for nursing.* USA: Lippincott Williams & Wilkins.	The goal of nursing is to put the patient in the best condition for nature to act upon him, primarily by altering the environment.
Abdellah, F. G., Beland, I. L., Martin, A., & Matheney, R. V. (1960). Patient centred approaches to nursing. In George, J. (Ed.). *Nursing theories: the base for professional nursing practice.* Norwalk, Connecticut: Appleton & Lange	Nursing is a service to individuals, families and society based on an art and science that moulds the attitudes, intellectual competencies, and technical skills of the individual nurse into the desire and ability to help people cope with their healthcare needs.
Henderson, V. (1964). The nature of Nursing, *The American Journal of Nursing*, Vol. 64, No. 8, pp. 62-68.	Primarily complementing the patient by supplying what he needs in knowledge, will, or strength to perform his daily activities and also to carry out the treatment prescribed for him by the physician.
Orem, D. (1971). Nursing: Concepts of Practice. McGraw Hill, New York in McFarlane, J. A charter for caring, *Journal of Advanced Nursing*, 1976, Vol. I, 187-196.	The process of one person giving direct help to another person when that person is wholly or partly unable to help himself in the accomplishment of his own daily health-related care.
Rogers, M. E. (1989). *An Introduction to the Theoretical Basis of Nursing*. Philadelphia: F. A. Davis http://nursingcrib.com/news-blog/nursing-theory-theorists/	An art and science that is humanistic and humanitarian. It is directed toward the unitary human and is concerned with the nature and direction of human development. The goal of nurses is to participate in the process of change.
Leininger, M. M. (1991). Culture care diversity and universality: A theory of nursing. In George, J. (Ed.). *Nursing theories: the base for professional nursing practice.* Norwalk, Connecticut: Appleton & Lange.	A learned humanistic and scientific profession and discipline, which is focused on human care phenomena and activities in order to assist, support, facilitate, or enable individuals or groups to maintain or regain their well-being (or health) in culturally meaningful and beneficial ways, or to help people face handicaps or death.
ICN Internal Council of Nurses: *Definition of nursing* (2010).	Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles.
American Nurse Association: *Nursing: Scope and Standards of practice*, 2nd edn. Silver Spring: American Nurse Association; 2010.	Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations.

Each nation uses a more general statement about procedures that recognise that nursing practice is evolving (Egenes, 2008). However, there is some development. Nightingale (1860) focused on the patient alone while later authors saw nursing in a broader perspective, in which care is also focused on family, communities and populations (Abdellah, 1960; ANA, 2010; ICN, 2010). The profession will also develop a more social function. This is currently reflected in the competencies that are required in nurse training. These arise from the professional competencies listed by the Canadian Medical Education Directions for Specialists, CanMeds (nursing professional V & VN, 2012). The humanistic approach is on the increase (Leininger, 1991; Rogers, 1989), but also the scientific approach is taken (ICN, 2010; Leininger, 1991). In the later descriptions (ICN, 2010) there is an increasing focus on autonomy of nurses and emphasis on specific expertise and techniques. The latter are mentioned in detail in the aforementioned professional nursing profile (nursing professional V & VN, 2012). The last of the professional nurse profiles dates from 1999. A lot has changed socially in care and professional practice. Not only the patient's deficiencies are central, but also the adaptability of people and the capacity for self-management (Francke, 2012): how can nurses support patients as they manage their illness? In the nursing profile for 2020 (V&V, 2012), a challenge is given: to be prepared for the future. This will also have implications for the future definition of the profession. So as the profession grows, the definition of nursing will be constantly refined and developed.

Professionalism of Nursing in the Netherlands.

The nursing profession in the Netherlands has made major progress in recent decades. In order to identify CPD for nurses, we must also consider the professionalism process. Professionalism is a continuous and dynamic process aimed to intensify and improve the profession and to improve the quality of the work (Van Dam & Vlaar, 2007). More and more nurses have developed a vision of the nature and importance of their profession, duties and responsibilities (Speet & Francke, 2004). In the Netherlands, various professional associations like the Dutch Nurses Association (Verpleegkundigen & Verzorgenden Nederland (V&VN)) support nurses by providing information, conducting research, offering seminars and hosting events on the process of professionalism and how it can be accelerated and stimulated (Speet & Francke, 2004).

In defining professionalism, Hutschemaekers (2001) showed three clearly defined categories of the characteristics of professionals.

(1) They are constantly engaged in vocational activities: they develop their knowledge and learn new methods.
(2) At the same time, they are often concerned with the position of their own profession, and not infrequently they lay claims on the table about their particular expertise or they insist on a specific position within the organisation.

(3) The third component of professionalism is the 'autonomy' of the professional. On the one hand, autonomy is seen as the core of professionalism, which deepens and improves the nursing profession. On the other hand, there is an organisational and political reason: to differentiate itself from other professions, in which groups of professionals claim specific expertise on requirements and insist on legal protection.

In the literature, three approaches of professionalism are described (van Houten, 2009). The first is **the structural-functionalist** approach, which is particularly associated with Talcott Parsons. This approach states that society is becoming more complex with increasing demands and requirements. This requires professionals with specific expertise. Therefore, professionalism is a functional requirement for a modern society (Parsons, 1939; 1968). The principle of Evidence-Based Practice is characteristic of this approach. It is about doing things well and has a service-oriented approach where the professional is subordinate to the client. The second approach, proposed by Freidson (1970) is called **attribution**. Here the main features of professionalism are mentioned. He identified seven characteristics that must be satisfied: a theoretical and practical basis of the professional practice; a (scientific) training; the existence of a professional association; a code of ethics; legal protection and social recognition. Moreover, the group owns a precise vocabulary or "jargon", which is used in professional contexts and published in their own magazines or symposia. The difference compared with Parsons' approach is that the characteristics of professionalism are validated by the profession and not by society. In this way, the profession has a distinct character. The third approach is described by Ivan Illich (1977), in which **power** is a defining characteristic. This approach makes the clients (patients) dependent and gives nurses the authority to identify the problem and how it can be solved. Illich is critical of healthcare professionals. He claims that professionals monopolise knowledge and mystify their expertise for purposes of power and control (Hall, 2005).

In the nursing literature the power approach dominates (Roodbol, 2005). As a result of the power approach, professionalism among nurses is interpreted as efforts to improve the quality of care and to increase the nurses' autonomy, being able to make professional judgements and act as nurses based on scientific knowledge and methodology. It is an attempt to become more independent of the physician (Roodbol, 2005). Nurses in the Netherlands strived towards a professional status from the 1960s and the early 1970s onwards. Over time nursing has left the medical model and developed a social model stemming from the philosophy of the behavioural sciences (Roodbol, 2005). With the introduction of a Bachelor's degree for nurses (HBO-V) and a Master's degree in Nursing Science, the level of knowledge increased. Also with the introduction of evidence-based practice and the development of the nurse's own knowledge domain increased. This has

progressed the role of nurses in healthcare as a profession. In this way their own " level of knowledge" will be increased and actions will be based on scientific results.

Professionalism implies that one professional group differs clearly from other professional groups and seeks recognition for this (Hubert, 2001). Positioning (recognition of the profession in the workplace and in society), professional knowledge and expertise are central (Horenberg, 1999). This development of the nursing profession in the Netherlands is shown by the transition of (nursing) scientific results into practice and growing theories on the essence of nursing. The professional domain of nursing has been described by nurses themselves, recorded in a professional profile (Leistra, Lover, Geomini & Stephens, 1999) and a qualification framework for vocational education (Ministry of Education, Culture and Science and Health, Welfare and Sport, 1996) has been developed.

Conclusion

This chapter provides a brief overview of the history of nursing. Over time, nursing has undergone various developments. While caring for others is still crucial, there are also other motives that are important. The image of the profession has seen various trends, from uneducated carers to highly esteemed professionals (van der Meij-de Leur, 1971; Dane, 1976; Egenes, 2008; de Jong, 2003). The question of who is ultimately responsible for care is still relevant. Nurses are more representative of a profession, but they are still confronted with recurring questions around expertise, status and funding. The profession is swaying, like several other professions (e.g., education), on the waves of society. Our society today is highly influenced by rapid changes (digitisation, multicultural society, technology). These changes require a profession that can anticipate new developments and make a contribution from nurses' professional expertise. The nursing profile 2020 (V&VN, 2012) represents the first step, but nurses must also indicate how they intend to progress with their professional development. The legislation is clear and the representative bodies are also contributing. The studies presented in the following chapters examine what CPD nurses are prepared to undertake to be ready for the current and the ever increasing demands for care in the future.

CHAPTER 3

Motivating and impeding factors for continuing professional development: A Delphi study with experts in the field of nursing

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Motivating and impeding factors for continuing professional development:
A Delphi study with experts in the field of nursing
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Abstract

Purpose

To present an inventory of expert opinions on the factors that influence the participation of registered nurses in continuing professional development (CPD) activities.
Design: A Delphi study was conducted among 38 Dutch experts (nursing employers, managers, education institutions, and professional associations). Data collection comprised three rounds: experts completed two consecutive rounds of questionnaires and participated in a discussion meeting.

Findings

Main influencing factors were: a CPD registration system, the attractiveness of the nursing profession, nurses' identification with the nursing profession, opportunities for workplace learning, the line manager as role model, and attractive education programs.

Research limitations/implications

Being part of a larger study, for the present paper only nursing experts were asked what is their opinion about shaping CPD for nurses. Further research should bring in the views of nurses themselves and investigate how the wider environment influences CPD participation.

Practical implications

As all stakeholders were found to have their own roles in the CPD process, collaboration among employers, managers, education institutions, and professional associations will be crucial to create a conducive learning climate for nurses. HRD practitioners in healthcare can use the study findings to advise hospitals about implementing the right conditions to support CPD for nurses.

Originality/value

A qualitative study using the Delphi method to discover factors influencing CPD in nursing had not been conducted before. Unlike many studies looking essentially at formal education, the present paper takes into account workplace learning among nurses as well.

Keywords: Continuing professional development, Delphi study, nurses

In nursing literature the terms continuing professional development (CPD) and continuing professional education (CPE) are often used interchangeably (Perry, 1995). While CPE is more focused on didactic principles and formal educational contexts, CPD is more focused on self-directed learning, in which the nurse is the director of his or her own professional development (Grant and Stanton, 1998). CPE forms a significant element of CPD (Murphy *et al.*, 2006) because tailor-made education programs are important to develop the right skills as a professional. In the present study we use the term CPD unless referring to or citing from specific literature where a different term is used. The American Nurses Association (ANA) describes CPD as: 'a lifelong process of active participation by nurses in learning activities that assist in developing and maintaining their continuing competence, enhance their professional practice, and support achievement of their career goals' (ANA, 2000). The Royal College of Nursing in the UK describes CPD as "fundamental to the development of all health and social care practitioners, and (…) the mechanism through which high quality patient and client care is identified, maintained and developed" (Royal College of Nursing, 2007, p. 2). The difference between these two descriptions is that the first one also includes career goals, which is a more personal motive.

CPD plays an important role also in maintaining and improving the quality and efficiency of the healthcare system (Cooper, 2009). CPD is essential for nurses to enable them to provide safe and effective care; additionally, it improves job satisfaction and decreases burnout (Department of Health, 2003; Gould *et al.*, 2006, van Wijk, 2007).

Healthcare organizations need to demonstrate that their members are accountable, efficient, and effective. Employers want staff with appropriate skills and knowledge to deliver excellent care (O'Sullivan, 2004). It is therefore essential that employers create conditions for nurses that encourage them to take part in CPD activities (Hallin and Danielson, 2007). Speet and Francke (2004) indicate that more studies are necessary to identify what kind of individual professionalization support nurses need in addition to their initial education.

Nurses participate in CPD for many reasons. In an earlier Dutch study, Speet and Francke (2004) showed that nurses deem CPD important. Working together, reflection and evaluation of daily practice, and working within legal requirements were mentioned by nurses as the most important reasons for participating in CPD activities. The least interest was given to "acting on the basis of theoretical notions", "using (nursing) scientific research" and "making a contribution to professionalization of the nurse profession". In countries such as the United States and the United Kingdom, nurses must demonstrate that they meet the established requirements for renewing their registration (Edmunds, 2007; Gallagher, 2006). In other countries, such as Australia, nurses have a professional responsibility through codes of professional conduct to remain competent (Gallagher, 2006).

Under the influence of changes in healthcare in the Netherlands (technology and increasingly complex treatments) the nursing profession has changed over the last decades. The profession became recognized by law with the passing of the BIG Act (on professions in individual healthcare) in 1993. It has its own knowledge domain (Leistra *et al.*, 1999) and education is institutionalized (Structuring Qualification Commission, 1996). As in other countries, Dutch nurses must demonstrate that they remain competent since the passing of the BIG Act. Also the practice of nursing care has become more evidence based and less based on historical findings or trial and error. These all are features that a profession must have to distinguish themselves from other occupations (Freidson, 2001).

The need to keep "up to date" professionally to ensure high quality of care has become of critical importance. CPD is a necessity to deliver safe and effective health care (Gould *et al.*, 2006). As Speet and Francke (2004) pointed out, there is a difference between nurses that carry out their operations routinely and nurses that have a clear vision about the nature and the importance of their profession and about their own professional tasks and responsibilities. This last group uses current knowledge and insights that have been developed by the profession itself. They reflect on their roles, responsibilities, and motivation related to nursing and patient care.

In summary, the importance of CPD is widely supported (Flanagan *et al.*, 2000; Francke, 2004; van der Krogt, 2007). Whether or not nurses actually participate in CPD can be influenced by several factors, which will be outlined below.

Influencing Factors

According to Johnson *et al.* (2011), investment in learning and development for nurses has a positive impact on patient care, the individual nurse, and healthcare organizations. At the individual level, the key factors appear to be awareness and understanding of CPD, conflicting demands on time, the availability of funding, and access to CPD resources (Hemmington, 2000). However, the individual motivation of the nurse to engage in CPD is fundamental (Ellis and Nolan, 2005; Hughes, 2005). Individual motivation is among the most significant factors identified as contributing to participation in CPD (Furze and Pearcey, 1999; Nolan *et al.*, 1995). If the nurse is not motivated to change his or her behaviour, no amount of CPD (whether mandatory or voluntary) will be effective (Furze, 1999, Gallagher, 2006). Professional development should be a belief (Lannon, 2007), which each nurse must take personal responsibility for (Twadell and Johnson, 2007). Impeding factors include the amount of time needed to commute to study venues, child care issues, and problems accessing facilities after working hours. The most critical factor, according to the nurses themselves, is the amount of private time that needs to be invested in CPD activities (Gibson, 1998; Gould *et al.*, 2006). The demands of undertaking CPD conflict with domestic commitments, which is perceived as a barrier

to achieving a desirable work-life balance (Grossman, 1998; Lawton and Wimpenny, 2003).

At the level of the organization, the role of CPD is affected by its relationship to organizational strategy, the commitment of key decision makers, and the provision of an internal infrastructure for CPD. Without the support and encouragement of their employer, nurses will experience difficulties in their professional development. The overwhelming majority of nurses need support and advice for CPD (Hemmington, 2000, Murphy *et al.*, 2006). A non-inclusive style of nursing management and lack of support from managers have been identified as barriers (Nolan *et al.*, 1995). Another study showed that in a hierarchical organization with little support from colleagues, employees did not often practice any new ideas in their work (Daley, 2001).

Various other factors also affect both the individual's and the organization's commitment to CPD and ability to implement CPD, including professional development planning, learning culture, and the dynamics of change (Hemmington, 2000). Professional development can take many forms; however, fostering an organizational climate in which development is integrated into everyday working practices was felt to be just as valuable in one study (Gibson, 1997). Nurses require a stimulating work environment, in which coaching and support to engage in CPD are key components (Danielson and Berntsson, 2007). Teamwork and team spirit, the attitudes of the nurses themselves, possibilities to participate in training programs, and effective communication all stimulate CPD. High workload, lack of available literature at the workplace, and inefficient communication with the management are obstructing factors (Speet and Francke, 2004).

A number of parties are involved in shaping and delivering CPD activities for nurses. Employers and managers are involved by creating the right conditions (time, money, learning environment), professional associations by indicating which standards of the profession must be met, and institutions by offering appropriate educational programs. Furthermore, professional associations can support nurses and healthcare organizations by giving them information about the issue of how professional development can be stimulated (Speet and Francke, 2004). These parties therefore all have different roles regarding CPD for nurses.

As the literature review shows, many factors influencing CPD have been put forward in literature; however, what is not clear as yet is what are the most important factors influencing nurses' participation in CPD. The aim of this study is to identify and prioritize, according to nursing experts, the factors that influence the participation of nurses in CPD activities.

Method

Research Design

To identify and prioritize the factors influencing nurses' participation in CPD activities, a Delphi study (Brockhoff, 2002, McKenna, 1994) was carried out among a panel of 38 experts (Table 1). The following definition of an expert was used: "one who has skill, experience, or extensive knowledge in his calling or in any special branch of learning" (Webster's Online Dictionary). Data collection in this study consisted of three rounds. The first two rounds consisted of written questionnaires (Tables 2 and 3) and the third round comprised a face-to-face discussion among the panel.

Table 1. *Participants in the Delphi study (N=38)*

Area of Nursing	n
Professional Associations	9
- Dutch nurses	*1*
- Emergency Room nurses	*1*
- Intensive Care nurses	*2*
- Obstetric and Gynecology nurses	*1*
- Oncology nurses	*2*
- Nurses in Childcare	*2*
Educational Institutions	5
- Association of Education Centers in Healthcare	*4*
- Dutch Association of Educators	*1*
Management	23
- University hospital	*7*
- General hospital	*6*
- Regional hospital	*10*
Employers	1
- National Federation of University Hospitals	*1*

Sample

Participants were selected for their nursing backgrounds in combination with their current jobs. They all had extensive domain knowledge. Representatives of professional organizations (chairmen), employers (policy officers and managers), and nursing education (educators and head of the department) were approached (N=46). Ultimately, 38 individuals agreed to participate. Table 1 describes the sample. Consent to participate was given by the boards of their organizations.

Instruments

The data collection tools utilized for this study were largely based on previous research carried out by Gibson (1998). The three-round method promulgated by Gibson (1998) was also used in the present study with the exception of the third round, where a discussion meeting was used. The reason to hold this meeting rather than have yet another questionnaire (as Gibson did) is that discussion and debate were deemed to have a greater added value to the present study. In this way, common issues can be examined more thoroughly, depending of course on the number of actively participating experts (Brockhoff, 2002).

Table 2. *Questionnaire Used in Round 1*

1. "Life Long Learning"; what does this mean to you?
2. "Continuous Professional Development"; what does this mean to you?
3. What are the characteristics that a good professional nurse must have in relation to creating her/his professional development?
4. Which motivating factors for participation in CPD are present in your opinion?
5. Which conditions for participation in CPD should be present?
6. Which impeding factors play an important role in CPD participation?
7. In what way should CPD be shaped?
8. In what way can the nursing profession become more attractive?
9. An important aspect in shaping CPD is the environment in which it takes place. What conditions would the workplace of nurses have to meet?

Procedure and Analysis

In the first Delphi round, the members of the expert panel received a questionnaire containing nine open-ended questions (Table 2). Their answers from the first round were summarized in mind maps by the first author. For each participant background (nurse associations, nursing educators, managers, and employers) a separate mind map was created. In the second round, the participants received a follow-up questionnaire (Table 3)

Table 3. *Questionnaire Used in Round 2*

1. The responses from the first questionnaire on the need for Continuous Professional Development (CPD) for nurses were not entirely clear to us. Do you see the need for CPD and, if yes, what does it look like?
2. The concepts of Learning and Development were mentioned a lot in response to the first questionnaire; however, often seemingly referring to the same notion. What are your definitions of both concepts and what is, in your opinion, the difference between the two?
3. CPD for nurses; what is your role, speaking from your current job, in this process?
4. In answer to various questions, the concept of culture was mentioned a lot; in particular the notion of a learning climate. What do you understand by the concept of a learning climate?
5. The workplace was often mentioned as an important context for CPD to take place. What is your definition of workplace learning?
6. Leadership was often mentioned in response to questions about promoting, supporting and impeding factors for CPD. Which features of leadership are needed to enable CPD for nurses?
7. What is your view regarding compulsory training activities serving registration systems? Please motivate your answer.

containing seven questions based on the summary from the first round. Answers from the second round were summarized in mind maps as well.

As a next step, content analysis of the data gathered in the first two rounds was carried out by the first author. In the third round, a face-to-face discussion meeting was organized among the experts based on this content analysis. The aim of the discussion was to validate the findings from the first two rounds by reaching consensus about which main factors influence nurses' participation in CPD. Additionally, a number of suggestions were put forward about the shaping of CPD and about the specific roles that the various stakeholders should play in supporting CPD for nurses.

Results

The results demonstrated a clear consensus among the experts on the need for nurses to participate in CPD activities. The different stakeholders did seem to hold different viewpoints on the definition of CPD. However, there was common ground in a focus on the responsibility and desire to deliver high-quality patient care. Consensus was ultimately reached on the following definition of CPD:

> *CPD means systematically and deliberately developing one's professional repertoire aimed at improving one's performance as a professional and one's quality of care as a nurse, member of the team, and of the organization, to the highest possible level.*

Ultimately, CPD should affect the quality of care provided to clients by the nurses. In the opinion of the panel, the need for CPD is also located in the identity of the nursing profession. Inquisitive/analytical ability, initiative, flexibility, and critically reflective work behavior were the most important characteristics of the nurse profession mentioned by the experts. Furthermore, nurses have to be able to provide patient-centered care, work independently, and collaborate with other disciplines. As a member of a multidisciplinary team it is necessary to have a recognizable professional identity. In this way CPD is also important from a professional interest (development of the nursing profession).

Influencing Factors

The results from the questionnaires and face-to-face discussion meeting demonstrated a clear consensus by the experts on the need for nurses to participate in CPD activities. There were six main factors that were deemed to influence participation, which will be illustrated below.

1. CPD Registration System

Quote: "Find a balance in attractive and compulsory education" (Educator; School of Nursing, female 53 years)

Encouragement and support were mentioned by line managers and educational institutions as playing a pivotal role. Nurse associations advocated a more mandatory way to encourage CPD, that is, the implementation by the Dutch Nursing Association of a national CPD registration system with a minimum number of mandatory training credits each year. Currently, the Netherlands does not have such a system.

2. Attractiveness of the Nursing Profession

Quote:" There is a need for CPD because nursing is a profession and not a vocation. The ongoing changes within healthcare scream for development". (Employer; National Federation of University Hospitals, female 50 years)

CPD also has a more commercial / human resource interest for retaining staff. This is important in times of shortages and, during the discussion, the following question was raised; what would affect the attractiveness of the nurse profession? Decreasing workload and increasing finance and opportunities for learning and personal development were mentioned. The most important recommendation to the employers was to create a strategic policy for CPD with good conditions and facilities to support this. Creating conditions to integrate nursing science in daily practice was mentioned as well.

3. Identification with the Nursing Profession

Quote: "We can see the consequences of what we have neglected for a long time; it is too simple to now point to a lack of responsibility among the nurses' (Nurse Manager; General Hospital, female 52 years)

Mentality among nurses came up as an important factor. There was clear consensus advocating a change of mentality among nurses, from apathy to assuming responsibility for their own professional development. There was some support for the premise that most nurses do not undertake CPD activities by themselves. It was felt that the need for CPD is still not sufficiently recognized by nurses. Ageing was considered an important obstacle in CPD participation. The average age of nurses is increasing and as a result their motivation to invest in personal development is decreasing. The panel of experts also mentioned that nurses are by definition care takers and less focused on themselves and their own situation. This personal characteristic seems to be ingrained in the nursing profession. A recommendation by the panel was to encourage nurses to take more responsibility in taking part in CPD activities and clearly indicate what support they need, explore the opportunities at the workplace, and use different ways of learning to support CPD (e.g., reflection, 360° feedback, and peer assessment). Most of all, nurses should be proud to be a nurse and show what they do and how they do it (professional standards and registration).

4. Opportunities for Workplace Learning

Quote: "Every nurse learns informally continually, so explicit informal learning" (Educator; School of Nursing, male 45 years)

A lack of financial resources for participation in training programs, a heavy workload, lack of time for CPD activities, and staff shortages were mentioned as contextual barriers. Also often mentioned were cultural aspects and communication between the staff and other disciplines. The experts wholeheartedly agreed on the need to create the right conditions for workplace learning, for example, opportunities to engage in case discussions, reflection, action learning, dialogue and peer feedback. Instruments such as portfolios and personal development / activity plans can also encourage participation in CPD.

5. The Line Manager as Role Model

Quote: "The leader sees and recognizes the talents of individuals and looks together with the person for learning and development opportunities that add value for both individual nurses and the department, division, or organization" (Employer; National Federation of University Hospitals, female 53 years)

According to the panel, line managers need to acknowledge the tangible outcomes of professional development and reward them. Managers need to avoid, however, exercising control over the process of CPD. Nurse autonomy should be encouraged when it comes to professional development. The manager as a role model, engaged in his or her own developmental process, ensures that a good training policy and appropriate facilities are in place. Managers displaying leadership with a clear vision, creating appropriate structural and cultural conditions for CPD, would enhance the effectiveness of CPD. Lack of attention, lack of appreciation, and a perception of not being heard by their managers are cases in point. Conservative leadership and a lack of implementation of policies ("paper tigers") were mentioned in passing. The recommendation to the managers and nurse leaders was to give more autonomy to the nurse and to develop expertise on the ward but most of all show leadership and be a role model to their staff.

6. Attractive Education Programs

Quote: "People are willing to develop, as long as it is attractive" (President of the Nurse Association, female 53 years)

Experts agreed that education centers could encourage CPD by offering demand-oriented as well as supply-driven training courses. It was, however, deemed important to make (especially compulsory) education programs more attractive and accessible to nurses.

Workplace learning is the keyword so nursing educators should take advantage of the expertise on the wards, be a consultant regarding learning strategies, provide challenging and accessible additional learning programs, and use the available digital opportunities.

Conclusions and Implications

This study aimed to identify and prioritize factors for registered nurses to participate in CPD activities. A three-round Delphi study was conducted, involving 38 experts representing nursing associations, nursing education, nursing management, and nursing employers.

There was a clear consensus on the need for participation in CPD activities as it affects the quality of care provided by nurses to clients. Important roles were identified for education providers, staff, and other stakeholders (the organization and line managers). This result is consistent with the study by Danielson and Berntsson (2007). According to the experts, however, furthering awareness and a change of attitude towards CPD among nurses will be necessary. This supports the view expressed by Nolan *et al.* (1995), that one of the most significant factors identified is individual motivation. On the other hand, according to Hemmington (2000), an overwhelming majority of nurses need support and advice for them to increase their participation in CPD.

A CPD registration system, the attractiveness of the nursing profession, nurses' identification with the nursing profession, opportunities for workplace learning, the line manager as role model, and attractive education programs were mentioned as main motivating factors. The Institute of Medicine (2009) described a CPD registration system as "a coordinated continuing professional development system". Factors to increase the attractiveness of the profession included financial resources, workload, time and decreasing staff shortages. Factors related to the identification with the nursing profession included nurses' age and propensity to care for others rather than for themselves. These factors correspond to what has been described in previous literature (Gibson, 1998; Gould *et al.*, 2006).

Recommendations made to the managers and nurse leaders in the discussion round were to give more autonomy to the nurse and create a strategic policy for CPD. This must, however, be in line with the wider policy within the organization. McCabe and Garavan (2008) described "the fault line" between nurses and the organization by introducing general management concepts and practices. This "fault line" is caused by managers not using language that is commonly understood by nurses. In this way, organization development can lead to loss of commitment among nurses.

The suggestion that the HRD department in hospitals has an important role by devising HRD initiatives is clear but strongly depends on the position of HRD in the organization. It is evident that the HRD department does not always have the position it needs to fulfill this role. In the Netherlands, this position ranges from a close collaboration with the Human Resource Management function to a mere provider of training programs. A clear view about the results and effects of HRD activities is necessary at a time when economics and financial outcomes are becoming more and more important. A key chal-

lenge for HRD in the coming years will be to make this gap smaller and strengthen its position in healthcare.

A number of limitations of this study need to be mentioned. First, data collection was time consuming due to the use of three sequential rounds, which may have affected the response rate. In terms of methods used, however, the Delphi technique was found to be very useful to identify a wide range of issues that have an impact on nurses' CPD participation. This would have been difficult to achieve using a survey. Second, the opinion of a panel of experts was heard and not the opinion of nurses that work at the bedside. To avoid bias (socially desirable answers) nurses were not asked for their opinions in the present Delphi study. Further research should be done into their perceptions of the process and results of CPD, in order to get a full picture about the subject. The most important factors mentioned in this study are related to the nurses themselves; therefore their voices must be heard as well.

Further Research

The importance of CPD is clearly supported in literature and in the present study (Flanagan *et al.*, 2000; Speet and Francke, 2004; van der Krogt, 2007). What is as yet unknown, however, is how nurses themselves understand the process of CPD (Barriball *et al.*, 1992; Nolan *et al.*, 1995). This understanding is essential if nurses are to be responsible for their own CPD (Griscti and Jacono, 2005).

Several factors can influence the process of CPD in a positive or negative way, as the present study has shown. Further research among a generalizable sample of nurses will be needed to corroborate the findings, as indicated above. Another question that remains open as yet is in what way the wider environment influences CPD activities. The complexity and variability of the environment could have an effect on the available learning opportunities as well. What influence do these (often) informal learning moments have on CPD of nurses? The powerful influence of the learning environment has been described extensively in literature (Keeris, 2006; Heikkila and Makinen, 2001). This is reflected, for instance, in the way in which formal learning paths are currently constructed (competence oriented) and established within various regulatory systems. The environment can also, however, be characterized by factors such as production and personnel shortages. In what way are these factors barriers to creating a stimulating learning culture and does this lead to a greater recourse to individual responsibility, autonomy, and self-directed learning? Further research will need to shed more light on these questions.

Implications for HRD Practice

Nurses are responsible for identifying their own professional development needs. This topic is explored in the learning-network theory (Van der Krogt, 2007). The basis of the learning-network theory is that various actors shape networks, namely, work (care), the HRM process (personnel flow) and the HRD process (learning). These actors (nurses, managers, HR staff, etcetera) are the engines of the organization; they create these three processes and by doing this also shape their professional development. Nurses participate in these processes as well and gain experiences that can be relevant to their professional development. How nurses go about creating new experiences is crucial for their professional development. Nursing educators can help them give meaning to their efforts in this area.

In line with the learning-network theory, all stakeholders were found in the present study to have their own specific roles in supporting and facilitating CPD for nurses. Study by Jordan (2000) have demonstrated a clear link between CPD for health care professionals and clinical outcomes for patients. In conclusion, collaboration among the different stakeholders seems crucial to create a climate in which nurses are able to participate in CPD activities and learn autonomously. It will be up to HRD professionals to create opportunities to build bridges between the different actors and jointly seek solutions leading to improved professional development of nurses.

CHAPTER 4

The development and empirical validation of the Q-PDN: A questionnaire measuring continuing professional development of nurses

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The development and empirical validation of the Q-PDN:
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Abstract

Background

Although separate studies among nurses have been conducted into their continuing professional development (CPD) motives, importance attached to CPD, conditions deemed needed for CPD, and actual CPD activities undertaken, these variables have not yet been investigated at the same time, on the same sample.

Objectives

To report on the development and initial psychometric testing of the Q-PDN, a questionnaire measuring several aspects of CPD among nurses.

Method

Based on a survey administered to 1329 nurses in hospitals in the Netherlands, a multidimensional instrument for CPD was validated. The constructs 'CPD motives', 'CPD importance', 'CPD conditions', and 'CPD activities undertaken' were established through factor analyses.

Results

Reliability analyses showed satisfactory to good Cronbach's alpha scores on all factors, ranging from .70 to .89.

Conclusion

Using this instrument can stimulate and support CPD of nurses, which has been shown to contribute to increasing the quality of care. Human resource development (HRD) professionals, educators in healthcare, and managers can use this questionnaire to gain insight in the extent to which nurses undertake CPD activities, in the importance they attribute to CPD activities, in the conditions they deem necessary to participate in CPD, and in the motives that they have to engage in CPD.

Keywords: continuing professional development, nurses, instrument development, questionnaire, psychometric validation

Introduction

Many authors have stressed that continuing professional development (CPD) is important (Flanagan *et al.*, 2000; Speet and Francke, 2004; Van der Krogt, 2007) and that each nurse must take responsibility for professional development (Twadell and Johnson 2007). The American Nurses Association describes CPD of nurses as: 'a lifelong process of active participation by nurses in learning activities that assist in developing and maintaining their continuing competence, enhance their professional practice, and support achievement of their career goals' (American Nurses Association, 2000). It is still unclear, however, what nurses themselves understand by the concept of CPD. This understanding is essential if nurses are to be responsible for their own CPD (Griscti and Jacono, 2005).

Background

Professional organizations have to demonstrate that their members are accountable, efficient, and effective (Du Boulay, 2000). An institutional culture must be in place that encourages professional development (Nelson, 2006). Employers in healthcare need staff with the appropriate skills and knowledge to deliver excellent care (O'Sullivan, 2004). It is essential, therefore, that employers motivate their nurses for professional development and support their participation in CPD activities (Hallin and Danielson, 2007). Hemmington (2000) states that actual participation in CPD activities is influenced by at least three factors: motives of nurses, the importance they attach to CPD, and the conditions that they need to see in place in the work environment to participate in CPD activities (see Figure 1).

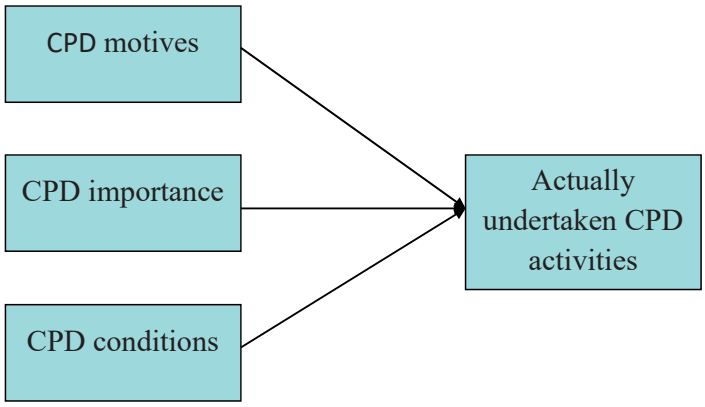


Figure 1. Factors influencing nurses' actually undertaken CPD activities.

Motives for nurses to engage in CPD activities may arise from a range of different needs, including requirements to which registered nurses must conform in order to keep their registration, a desire to improve the standards of practice, and gaining further qualifications to enhance promotion prospects (Quinn, 1998; Ryan, 2003). Similar motives emerged in studies of nurses' participation in formal learning activities for professional development (Gould *et al.*, 2007; Bahn, 2007). A number of elements that greatly affect the motives of nurses to participate in CPD activities are lack of time, available financial resources, and access to CPD (Hemmington, 2000). The individual motivation of the nurse, however, to engage in CPD is fundamental (Berings *et al.*, 2007; Ellis and Nolan, 2005; Hughes, 2005) and it is essential that nurses take personal responsibility for professional development (Twadell and Johnson, 2007). From an individual perspective, a number of conditions are well reported in literature as discouraging participation in CPD. Balancing work, continuing education, and home life can be very difficult; there can be an imbalance between professional and family life (Murphy, 2006). Time to attend courses and to complete assignments are important conditions to participate in CPD activities, as is employer support (Murphy, 2006). Regarding the importance attached to CPD and the actually undertaken CPD activities, some nurses participate in CPD programs only to allow them to continue practicing (Grossman, 1998; Lawton and Wimpenny, 2003). Other studies indicate that nurses participate in CPD from a felt need to expand their own knowledge (Lindsay, 1990; Larcombe and Maggs, 1991; Thurston, 1992; O'Connor, 1992). A study conducted in the Netherlands found that nurses deemed "working together" the most important CPD activity. Three aspects seemed especially important to them, namely, giving and receiving feedback, and participating actively in team meetings (Speet and Francke, 2004). In addition, almost all nurses deemed the aspect "reflecting on one's own practice" important. Significantly less important to nurses were "acting from a theoretical vision", "working evidence-based" and "making a contribution to the professionalization of nursing" (Speet and Francke, 2004). In practice, nurses spent most attention to "working together" and "reflection and evaluation on their daily practice." The least attention was paid to the use of nursing research ("evidence-based practice") and to "acting from a theoretical vision" (Speet and Francke, 2004).

Although separate studies among nurses have been conducted into their CPD motives, importance attached to CPD, conditions deemed necessary for CPD, and actual CPD activities undertaken, these variables have not yet been investigated together.

Aim

This paper reports on the development and initial psychometric testing of the Q-PDN, a questionnaire measuring the CPD motives, the CPD conditions deemed needed, the

importance that nurses attach to CPD activities, and the CPD activities that nurses actually undertake.

Method

To develop the questionnaire, at first items were generated for each construct (Motives, Importance, and Conditions; items for Activities were added at a later stage). To formulate items a literature search for scales measuring these constructs was conducted. Two existing instruments were found. The first one was a questionnaire to investigate professional development issues relevant to registered nurses and midwives, which examines their CPD activities, career choices, competency achievement, and maintenance, with relevance to service need and personal and professional development (National Council for the Professional Development of Nursing and Midwifery, 2004). Some items about CPD importance and motives underlying CPD activities were contained in this instrument. The second questionnaire was developed by the Dutch Institute for Health Care Research (Speet and Francke, 2004) and looks at the opinions of nurses about continuing professional development. Several single items from these scales seemed to fit with the constructs relevant to the present study and were adopted.

A Delphi study (Author, 2013) was conducted in order to get input to formulate more items measuring the constructs.

A questionnaire consisting of 82 items was the initial result, together with a demographic section. This draft version was discussed with five experts in the fields of nursing and human resource development to establish content validity. In the opinion of the experts not all questions were clear enough and the relation with CPD was insufficiently convincing. Based on this feedback the first draft of the instrument was modified into a second version comprising 92 items. This version of the questionnaire was pilot tested among a representative sample of 130 nurses working in one university hospital and three general hospitals in the Netherlands. An exploratory factor analysis was conducted on the pilot data. Based on the results, several items were deleted as they did not seem to fit the constructs. After the pilot test it was decided to add another set of items to measure the actual participation of nurses in CPD activities. These items run parallel to the construct Importance and measure to which extent nurses actually undertake CPD activities. Finally, the layout of the questionnaire was adjusted. This resulted in a questionnaire containing 80 items in total, measuring four constructs: ‘CPD motives’, ‘CPD importance’, ‘CPD conditions’, and ‘CPD activities undertaken’. For the present validation study, a survey using this questionnaire was conducted among nurses in the Netherlands to establish its construct validity and internal consistency (Polit and Beck, 2012).

Instrument

The questionnaire measures four constructs: CPD motives, importance attached to CPD, conditions deemed needed for CPD, and actual CPD activities undertaken. Each was represented by one scale in the questionnaire. The constructs 'importance attached' and 'activities undertaken' used identical items as they measured the extent to which nurses deemed CPD activities important and actually undertook them, respectively. Rating took place on a five-point Likert scale with ratings from 1 to 5; Table 1 explains their meanings.

Table 1. *Explanation of the meaning of the positions on the Likert scales for each construct.*

Construct	Likert scale 1-5
CPD Motives	Mainly disagree to mainly agree
CPD Importance	Not important at all to very important
CPD Conditions	Mainly disagree to mainly agree
CPD Activities Actually Undertaken	Never to very often

Sample, Setting and Procedure

A national convenience sample of 5500 registered nurses from Dutch general and university hospitals was used.

A national database was used in which registered nurses are included. Their addresses were used to send them the questionnaire. All nurses participated in the study voluntarily. After two weeks a reminder was sent. Participants were reassured that the results would be displayed anonymously and were not traceable to specific individuals. The completed questionnaires were collected by an independent external agency and processed in SPSS 17.0.

The entire process of administering was supervised by an independent external agency. They were contractually bound to strict confidentiality and privacy. Permission to conduct the study was requested and granted by the Board of the hospital. It took approximately 20 minutes to finish the questionnaire. Final submission deadline for the completed questionnaire was three weeks after the start of the process. Privacy was ensured as the data was only accessible to authorized persons.

As Table 2 shows, a total of 1329 nurses completed the questionnaire, constituting a response rate of 24%. Mean age was 41.9 years with an average of 19.7 years of work experience. 87% were female and 60% worked part-time.

Table 2. *Descriptives*

N = 1329	Mean (SD)	Min-max
Age	41,9 (10.8)	20-65
Work experience in years	19,7 (11.3)	0-45
	%	
Gender	Male: 13.4% Female: 86.6%	
Employment status	Fulltime: 40.3% Part-time: 59,7%	
Rotation shift	Regular: 41,7% Irregular: 58,3%	

Data Analysis

Data was entered in SPSS 17.0 by the independent external agency. To establish construct validity a principal component analysis using varimax rotation was performed. To test internal consistency Cronbach's alphas were calculated for each scale. Values for Cronbach's alpha above .7 were considered indicative of acceptable internal reliability (DeVellis, 2012). For inter-item correlations a value between .3 and .7 was considered acceptable (Polit and Beck, 2012).

Ethical Considerations

The study follows the Dutch privacy legislation and the Declaration of Helsinki. The questionnaires were anonymous and completing a questionnaire was on a voluntary basis. All data were treated confidentially and no patients were involved.

Results

The principal component analysis with varimax rotation was conducted on each of the three original constructs: motives, conditions, and importance as shown in Figures 2 and 3.

In terms of motives for nurses to participate in CPD, three factors emerged from the analysis:

A) α=.87; five items associated with personal and professional development;
B) α=.83; three items pertaining to requirements;
C) α=.76; four items related to career opportunities.

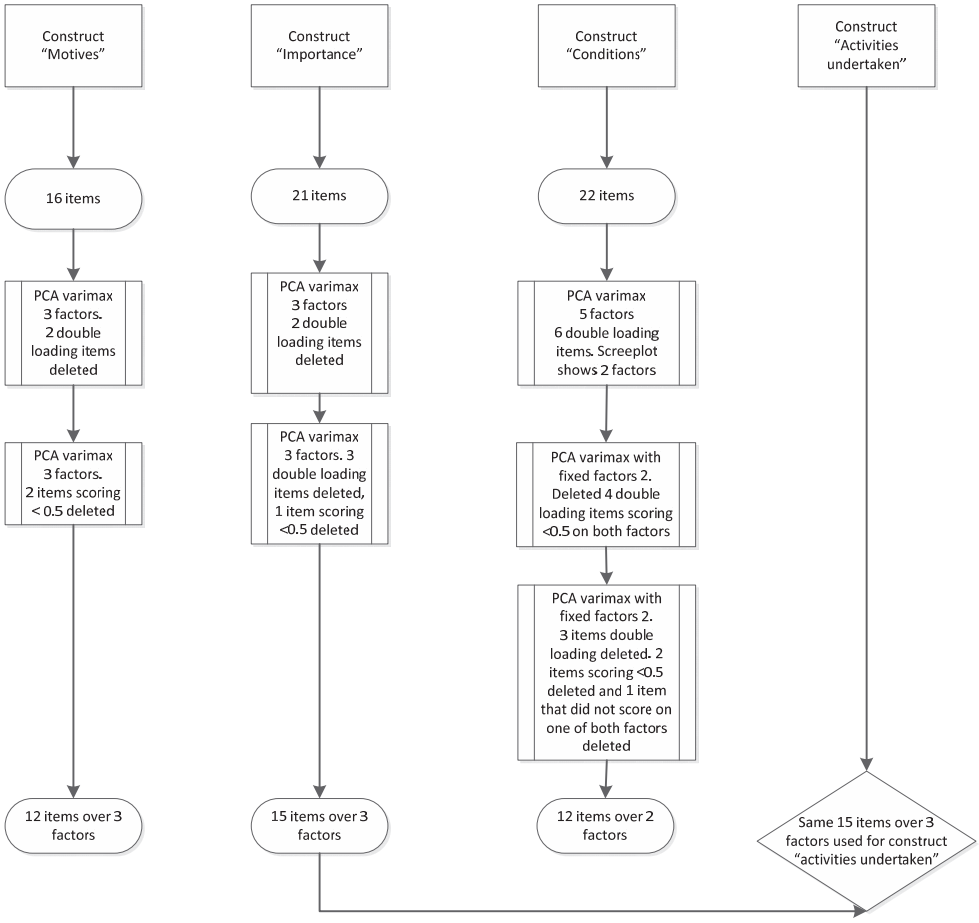
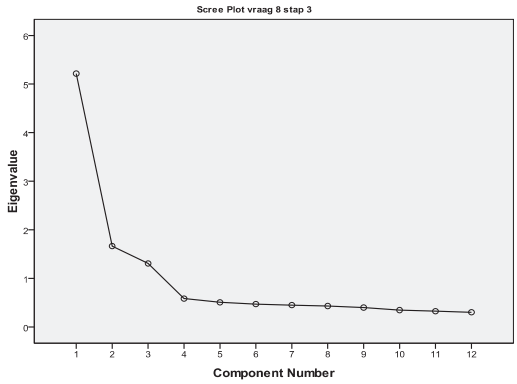


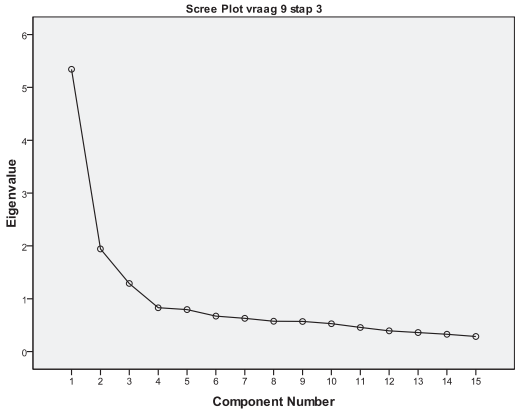
Figure 2. Flowchart of the principal component analysis for all scales.

Three factors also emerged for the importance that nurses attach to CPD activities:
A) α=.81; five CPD activities concerned with participation in research;
B) α=.79; five CPD activities related to the development of clinical practice;
C) α=.80; five CPD activities associated with participation in organization development.
Conditions that nurses need to see in place to participate in CPD activities were found to fall into two factors:
A) α=.88; nine items that have to do with intangible conditions;
B) α=.70; three items that refer to material conditions.
Upon checking, three factors emerged from the scale 'CPD activities actually undertaken', mirroring those that came out for the scale 'importance attached', with roughly equivalent Cronbach's alphas.

Construct 1: Motives



Construct 2: Importance



Construct 3: Conditions

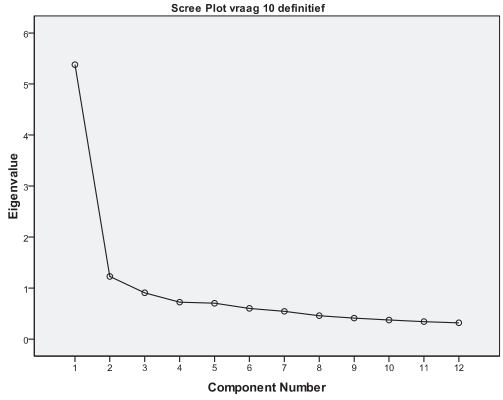


Figure 3. Scree plot of the constructs motives, importance and conditions.

Table 3. *Constructs, Factors and Items Contained in the Final Questionnaire.*

Constructs	Instruction provided	Factors	Mean (SD)	Item (factor loading)	Cronbach's α
Motives	The term Continuing Professional Development (CPD) refers to all activities which may contribute to your professional development. Below are a number of reasons and motivations for participating in CPD activities. Please indicate the extent to which you agree with each statement listed below. "I undertake CPD activities…."	Personal and professional development	4.54 (.57)	…because further professional development is important to me (.805) …to improve my current qualifications (.783) …to carry out my work better (.790) …to increase the quality of healthcare (.806) …to make a positive contribution to nursing practice (.707)	.874
		Requirements	3.87 (.78)	…to meet the requirements of the organization where I work (.757) …to prove to my employer that I am professionally competent (.716) …because this is considered highly important in my professional environment (.847)	.828
		Career opportunities	2.77 (.73)	…to increase promotion opportunities (.813) …to achieve a higher level of training (.728) …to support my career (.827) …to improve my leadership abilities (.748)	.762
Conditions	Below are several statements about the conditions under which your own Continuing Professional Development (CPD) can best be realized. Please indicate the degree to which you agree or disagree with the statements in the list. "I undertake CPD activities…"	Intangible conditions	3.53 (.71)	…if I receive career guidance (.576) …if I receive an annual appraisal (.662) …if my colleagues coach me (.683) …if taking part in CPD activities allows me to have a say in ward/ team policy (.768) …if I gain more independence (.709) …if the CPD activities have a clear career perspective (.677) …if my immediate supervisor coaches me (.752) …if other positions are offered within my organization (.626) …if I receive support from my supervisor (.649)	.879
		Material conditions	4.07 (.73)	…if the expenses are fully reimbursed by the employer (.795) …if suitable supplementary training courses are offered by my immediate supervisor (.647) …if my supervisor provides me with the necessary time (.810)	.698

Importance	Several CPD activities are listed below. Please indicate the degree to which you consider the items listed below to be important to your own professional development. "The following issues are important to my professional development… "	Participation in research	2.88 (.70)	…training courses (.575) …reviewing medical literature with regard to best practices (.764) …carrying out research (.760) …writing articles for professional journals (.819) …serving on the editorial board of a professional journal (.708)	.811
		Clinical practice development	4.18 (.48)	…following short courses (duration 2-8 hours) (.619) …informing my supervisor if I notice any developments at work that could have an adverse effect on professional practice (.627) …making sure that I keep up to date with professional developments (.756) …reflecting critically on practical situations (.817) …determining whether I performed well and whether I could perform better next time (.719)	.793
		Participation in organization development	3.58 (.66)	…participating in policy development (.653) …making sure that I keep up to date with policy developments (.654) …participating in recruitment and selection interviews with new members of staff (.726) …participating in reflection and/or intercollegial consultation meetings (.687) …participating in internal projects (.711)	.797
Activities undertaken (same items as importance)	Several CPD activities are listed below. Please indicate how often you actively perform each of these activities.	Participation in research	1.65 (.67)	I participate in training courses I review medical literature with regard to best practices I carry out research I write articles for professional journals I serve on the editorial board of a professional journal	.723
		Clinical practice development	3.71 (.59)	I follow short courses (duration 2-8 hours) I inform my supervisor if I notice any developments at work that could have an adverse effect on professional practice I make sure that I keep up to date with professional developments I reflect critically on practical situations I determine whether I performed well and whether I could perform better next time	.698
		Participation in organization development	2.85 (.88)	I participate in policy development I make sure that I keep up to date with policy developments I participate in recruitment and selection interviews with new members of staff I participate in reflection and/or intercollegial consultation meetings I participate in internal projects	.797

Reliability analysis showed estimated Cronbach's alpha scores on all factors ranging from .70 to .89. An overview of all 54 items measuring the constructs can be found in Table 3.

Discussion

Aim of the present study was to validate an instrument to measure nurses' CPD motives, the importance they attach to CPD, the conditions they deem necessary for CPD, and their CPD activities actually undertaken. Based on literature and a previously conducted Delphi study (Author, 2013), the analysis revealed four constructs comprising eleven factors totaling 54 items, with evidence of acceptable reliability and validity of the questionnaire.

The constructs 'activities actually undertaken' and 'importance attached' measure those CPD activities that are conducted in current daily hospital practice as well as their perceived importance. To support the participation in CPD, an institutional culture must be in place that encourages professional development. Culture is the sum of the beliefs and values that shape an organization (Nelson, 2006). Culture can place a strong emphasis on how work is conducted. An organizational culture that values professional development is essential for nurses to participate in CPD (Bally, 2007).

Another point of interest considering these two constructs is that nursing is a dynamic profession in an ever changing environment. CPD activities that nurses undertake in 2012 might not remain the same in future. The use of digital or e-learning as a CPD activity is not visible in the current questionnaire but might be necessary in a future version.

Studies over the last decade have warned about the dissatisfaction among nurses and their decision to leave the profession (Fochsen *et al.*, 2005; Sheward et al, 2005). The latter was due to a number of reasons: high pressure, the struggle to deliver good care, staff shortages, and lack of professional development. (Fochsen *et al.*, 2005). It is therefore essential that employers motivate nurses and support their professional development (Hallin and Danielson, 2007). Increasing job satisfaction by creating a culture of professional development in healthcare institutions is one way to combat the nursing shortage (Cooper, 2009). Hemmington indicates that an overwhelming majority of respondents pointed to the need for support and advice around CPD (Hemmington, 2000). Nurses can only embrace the concept of CPD as professionals if this is fully understood and incorporated within their professional careers (Gallagher, 2006). In view of the factors mentioned above, our recommendation for further research is to focus on the impact that workplace characteristics (both cultural and structural) have on CPD participation of nurses, as Hallin and Danielson (2007) had indicated before (cf. Poell *et al.*, 2007).

To find out what are the key factors influencing participation in CPD, it is important to hear the opinion of the nurses themselves. The questionnaire developed and validated in the present study provides insight into the opinions and beliefs of nurses about what their CPD motives are, what they deem important CPD activities, and what conditions they need to see in place in order to undertake actual CPD activities. The validation of the Q-PDN thus provides an important starting point to develop a constructive policy for continuing professional development of nurses within hospitals.

Conclusion

The aim of this paper was to report on the development and initial psychometric testing of the Q-PDN to measure CPD among nurses in hospitals. A four-phase investigation among samples of 130 (pilot test) and 1329 nurses (final test) yielded valid and reliable scales for four factors: nurses' CPD motives, the importance they attach to CPD activities, the conditions they need, and actual activities undertaken. The instrument can help stimulate and support the process of professionalization of nurses, thus contributing to increasing the quality of care. HRD professionals, educators in healthcare, and managers can use it to improve the current CPD situation at their wards.

CHAPTER 5

Similarities and Differences in Continuing Professional Development of Nurses in the Netherlands and in the USA

This chapter is currently under review as:
Similarities and Differences in Continuing Professional Development of Nurses in the Netherlands and in the USA
Brekelmans, G., Maassen, S., Poell, R., Weststrate, J. 2016

Objective

To compare factors influencing participation in continuing professional development (CPD) activities among registered nurses from a Magnet® hospital in the USA and from a non-Magnet hospital in the Netherlands.

Design

A mixed-methods study examined the similarities and differences in CPD at the two hospitals. The nursing governance structures, the education systems, and the legal frameworks were reviewed through document study. A survey was conducted regarding nurses' CPD activities and their influencing factors. Finally, the results from the Magnet® hospital were discussed in focus groups.

Settings

Data collection was among registered nurses at a Magnet® hospital in the USA and a non-Magnet hospital in the Netherlands.

Participants

The questionnaire was completed by 598 registered nurses (26 per cent response rate) in the Netherlands and 124 registered nurses (15 per cent response rate) in the USA. A total of 30 registered nurses participated in three focus groups in the USA.

Results

The American nurses showed a higher score on CPD activities relating to organization development; this may be a direct result of the Magnet concept. Another difference found was participation in research: US nurses scored higher on this CPD activity. In both hospitals the extent to which CPD activities were pursued was lower if they were perceived as less relevant for daily practice.

Conclusion

We conclude from the results of this study that there may be a relationship between the governance structure and the CPD activities at hospitals. Being able to influence the policy of the organization seems to affect the development of the individual nurse as well as the nursing profession as a whole.

Keywords: continuing professional development, governance structure, Magnet concept, nurses, the Netherlands, USA.

Introduction

The Dutch Situation

In the Netherlands, there is currently great interest in the American nursing culture and structure in Magnet® hospitals. In the 1980s the label 'Magnet® Hospital' was given to US hospitals that successfully recruited and retained nurses. Continuing professional development (CPD) is one of the fourteen forces of 'Magnetism' and is therefore an important pillar supporting the profession and the organization. To maximize benefit from CPD, it is important to examine nurses' participation in CPD activities, their motives for doing so, their views regarding the most important CPD activities, and the conditions that nurses need to see in place for participation in CPD.

In the current Dutch healthcare system, patients stay longer at home and spend less time in hospital following treatment because of advances in technical and medical treatment methods (Nivel, 2011). One of the effects is that the complexity of patient care in hospitals has increased and university hospitals increasingly focus on innovative and tertiary care (RVZ, 2011). This increased complexity requires highly trained nurses.

Continuing Professional Development

Taking part in CPD is essential for nurses to remain capable of providing safe and effective care (Cooper, 2009; Gould, Drey & Berridge, 2007). The American Nurses Association (ANA) uses the following definition of CPD; 'a life-long process of active participation by nurses in learning activities that assist in developing and maintaining their continuing competence, enhancing their professional practice, and supporting achievement of their career goals' (ANA, 2011).

It is necessary for nurses to have adequate and up-to-date knowledge to deliver the required quality of care. Aiken and colleagues reported that the level of education of nurses and mortality of hospitalized patients were negatively associated in the multicentered European RN4Cast study (Aiken, *et al.* 2013; Aiken, *et al.* 2014).

In the USA, the Institute of Medicine (IOM, 2009) recommended higher levels of education in the field of nursing. This recommendation was made to prepare nurses for the more complex care required by patients and the sophisticated new technologies available for providing the care. A specific goal was to increase the group of nurses in the USA with at least a bachelor's degree from 50 per cent in 2010 to 80 per cent by 2020. The IOM recommended a collaboration between various parties (school of nursing, healthcare organization, professional associations, etc.) involved in facilitating professional development, for nurses to gain competencies needed to provide care for diverse populations (IOM, 2009).

According to the 2014 Euro Health Consumer Index, standards of care are high in the Netherlands; the country even gained first place in Europe (Björnberg, 2014),

although nursing care was not explicitly mentioned. Nivel (2011) indicated that the professional profiles of nurses in the Netherlands were outdated and did not include new specializations and up-to-date new qualification requirements. In other words, the roles of the nursing profession are changing and therefore it would be apposite for the nursing profession in the Netherlands to build, where possible, on findings reported from abroad (Nivel, 2011).

Magnet Designation

Although some of the daily tasks of hospital nurses in Western society are largely the same as in previous decades, the staffing models are different, including the nursing governance structure in hospital organizations. Nursing governance is often referred to as a form of shared governance. Shared governance is defined by Porter-O'Grady (1991, p. 459) as a model in which 'nurses at every level of the organization play a role in decisions that affect nursing activity everywhere in the system'. Clavelle *et al.* (2013) reported in their recent study on Magnet organizations that there is a positive relationship between nursing shared governance and the nurse practice environment. When nurses are engaged in shared governance, they are active participants in improving their own nursing professional practice environment. It has also been shown that in hospitals with healthier work environments and more highly trained nursing staff, nurses showed evidence of better quality and safety of care, and patients were more satisfied (Aiken, 2012).

As mentioned at the outset, the label 'Magnet® Hospital' was given to hospitals that were able to successfully recruit and retain nurses during a national nursing shortage in the USA in the 1980s. These hospitals are known for their better work environments and more highly qualified nurses (Kelly, 2011). Kelly reported fourteen forces of 'Magnetism' that were found to contribute effectively to the retention of nurses. As indicated above, professional development is one of the fourteen forces of Magnetism and thus endorsed as an important pillar for the profession and the organization (ANCC, 2014). In short, investment in the CPD of nurses, as one of the pillars of the Magnet concept, seems to be associated with a better quality of care and better outcomes for patients.

Turning to the Dutch context, until the end of the twentieth century it was common that a hospital in the Netherlands had a nurse manager and nurse leader. The position of nurse leader has been subsumed in favor of the managers of today, through the development of hospitals into large healthcare organizations. Thus the direct influence of nurses at an administrative level has been lost (Ten Holter, 2011).

The lack of influence at the administrative level has been identified by the Dutch Nurses Association (V&VN) and research is being conducted to address this (de Brouwer, 2013). Hospitals are also examining other hospitals to see what could be learnt from and with each other (V&VN, 2010). There is a lot of interest in the Netherlands in the development of Magnet® hospitals. The transitions caused by the Magnet® program in

the USA have been effective over 30 years. This program is currently in the early stages of development in the Netherlands.

Aim and Research Questions

There is great interest in nursing practice in the Netherlands to obtain Magnet designation. It is as yet unclear whether such a concept, especially its CPD aspect, can be transferred from the United States to another country with its own structure and culture. To gain some initial insights into this issue, the aim of this study was to investigate the extent to which the factors influencing participation in CPD activities differ between registered nurses at a Magnet® university hospital in the USA and a (non-Magnet) university hospital in the Netherlands.

Since Magnet® hospitals in the USA have proved to be a good environment for nurses to work and to develop, it may be a concept that could be applied to improve hospital nursing practice in the Netherlands. Since the elaboration of the concept in the USA is more advanced than in the Netherlands, it will be helpful to examine both systems and compare these. The results may help nurses, managers, and educators to better create an environment that encourages registered nurses to pursue CPD activities, thereby helping the introduction of Magnet ideas in Dutch hospitals.

Method

Design

A three step method of data collection was utilized. An overview of the definitions of nursing and CPD, the nursing governance structures, the education systems, and the legal frameworks in both countries was compiled through document study. A survey at two hospitals was carried out using the Questionnaire Continuing Professional Development of Nurses (Q-PDN; Author, 2014) to examine CPD of registered nurses and its influencing factors. The results from both hospitals were compared with each other. Since the author was less familiar with the US system for offering CPD activities than with the Dutch system, the results of the survey obtained in the USA were presented to and discussed with focus groups in the US to increase reliability. These focus groups consisted of registered nurses, managers, and educators at the Magnet® hospital that was surveyed.

Sample and Setting

Data was collected from registered nurses at a university hospital in the USA and a university hospital in the Netherlands. Both hospitals are teaching hospitals and the complexity of care is similar. The hospital in the USA has been a Magnet® organization for 12 years. Questionnaires were distributed by email in June 2010 (the Netherlands) and November 2012 (USA). The completed questionnaires were collected by an independent external agency and analyzed using IBM SPSS 20.0 (SPSS, Chicago, IL, USA) software.

Focus groups were held in February 2013. These meetings were held on location at the Magnet® hospital in the USA. The results of the survey were presented first, after which they were discussed in detail with the participants.

Ethical Considerations

The study complied with the Dutch and US privacy legislations and the Declaration of Helsinki. Permission for data collection was given by both hospitals' Institutional Review Boards. The questionnaires were anonymous and completing a questionnaire was on a voluntary basis. All data were treated confidentially and no patients were involved.

Instrument

The Q-PDN (Brekelmans, 2015) was used to establish a picture of CPD participation, motives of nurses to do so, importance attached to CPD activities, and conditions deemed necessary for participation. The Q-PDN thus consists of four constructs: importance, motives, activities undertaken, and conditions required. These comprised eleven factors totaling 54 items, with evidence of acceptable reliability and validity of the questionnaire. The questions for each construct were rated on a five-point Likert scale. The development and validation of the instrument are described at length elsewhere (Brekelmans, 2014).

Participants

Registered nurses, 815 in the USA and 2,300 in the Netherlands, received the Q-PDN. In the Netherlands, 598 nurses (26 per cent) completed the questionnaire, whereas in the USA 124 nurses responded (15 per cent). The majority of the respondents worked as a bedside nurse (78 per cent in the Netherlands and 66 per cent in the USA). Most respondents were women in both groups. Working experience was similar at about 18 years on average. There was a difference in the employment status: 85.2 per cent of the USA respondents worked full time as opposed to 42.3 per cent of the Dutch respondents. The level of basic nursing education was not comparable because the education system in the USA differs from that in the Netherlands as shown in Table 1. The profile of the respondents is also shown in Table 1.

Table 1. *Profile of the Respondents*

University hospital (the Netherlands) (N=598)	Mean	Number	Frequency (per cent)	University hospital (USA) (N=124)	Mean	Number	Frequency (per cent)
Gender (N=598)				Gender (N=124)			
Woman		525	87.8	Woman		113	91.1
Man		73	12.2	Man		11	8.9
Age (N=598)	40.2 years			Age (N=120)	43.4 years		
20-34		208	34.8	20-34		41	34.1
35-49		236	39.5	35-49		32	26.7
50-65		154	25.8	50-65		47	39.2
Work experience (N=596)	18.3 years			Work experience (N=124)	18.4 years		
Basic training (N=594)		108	18.2	Basic training (N=112)		8	7.1
Level 5 (for description see table 2)		176	29.6	Associate degree		68	60.8
Level 4 (for description see table 2)		310	52.2	Bachelor of science in Nursing		25	22.3
In-service				Master degree in Nursing		10	8.9
				Doctoral degree in Nursing		1	0.9
				Other			
Employment status (N=598)				Employment status (N=122)			
Full time		253	42.3	Full time		104	85.2
Part time		345	57.7	Part time		18	14.8
Job category (N=598)				Job category (N=124)			
Nurse		466	77.9			82	66.1
Nurse specialist		56	9.4	Nurse		12	9.7
Management		64	10.7	Nurse specialist		20	16.1
Educator		12	2.0	Management		10	8.1
				Educator			

Note: The education system in the USA differs from that in the Netherlands. Associate nurses are registered nurses, but the education level is lower than the Bachelor of Science in Nursing (BSN).

Analysis

A contextual analysis was conducted through a document study, which described the definitions of nursing and CPD, the legal and nursing governance structures, and the education systems in both countries.

For analysis of the survey data, descriptive statistics were used to establish the importance nurses attached to specific CPD activities, the extent to which they took part in the activities, the conditions that must be present, and their motives for participation. A bivariate analysis of the survey outcomes was carried out using a non-parametric test

(Mann-Whitney U test). Where survey outcomes were normally distributed we referred to a Student's T test for the analysis. Cohen's D measure of effect size was used to compare the differences in outcomes between the two hospitals.

Discussions within the US focus groups were recorded and played back repeatedly to identify representative illustrations of the inputs provided by the participants.

Results

Contextual Analysis

An overview of the Dutch and US contexts is shown in Table 2. There are currently more than 5,600 hospitals in the USA, of which 406 have Magnet status. There are currently 362 hospitals in the Netherlands.

The contextual analysis revealed several differences between the USA and Dutch settings. There was a big difference between the two hospitals in the representation of

Table 2. *An Overview of the Dutch and USA contexts*

	The Netherlands	The USA
Definition of nursing	No definition available from Dutch Nurses Association. The Committee of the National Nursing Council for Health (RVZ) gives the following definition of nursing: "A professional nurse recognizes, analyzes, and provides advice and assistance with respect to actual or threatened impact of physical and /or mental illness processes, disabilities, developmental disorders, and their treatment of the individual's life. Nursing actions also means to influence people in such a way that human capabilities are being exploited in order to keep the instant and promotion of health." (RVZ, 2011).	ANA described nursing as follows: "Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations" (ANA, 2014).
Legal structure	The title of nurse is protected by law and therefore may only be used by nurses who have a level 4 or 5 diploma. They are registered in the BIG register (Ministry of Health, Welfare, and Sport, 1996). This register provides clarity and certainty regarding the care provider's qualifications and entitlement to practice.	Licensure is the process by which boards of nursing grant permission to an individual to engage in nursing practice after determining that the applicant has attained the competency necessary to perform a unique scope of practice. Components of nursing licensure: verification of graduation or eligibility for graduation from an approved pre-licensure RN or LVN/PN nursing education program; verification of successful completion of NCLEX-RN or NCLEX-PN examination. A criminal background will be checked for in some states.

Table 2. *(continued)*

	The Netherlands	The USA
Nursing governance structure	There are currently 362 hospitals in the Netherlands according to the Health Map of the Dutch Patient Consumer Federation (NPCF, 2015). Having a nurse in the Board is not a requirement at Dutch hospitals. Hospital governance is executed by a board of directors consisting of business administrators and physicians. The top of nursing managers are typically located at the level of middle management. However, having a nursing degree is not a requirement for this position. Nurses participate in the governance structure at the departmental level (Ten Holter, 2011).	Shared governance structures are mandatory for every hospital that is eligible for a Magnet accreditation. There is a Chief Nursing Officer in the top of the management (Hader, 2011). The shared governance model that was introduced in 2010 increased the influence of the nursing profession in the USA Magnet hospital (Hess, 2011). There are currently more than 5,600 hospitals in the USA (AHA, 2015) of which 406 have Magnet status (ANCC, 2015).
Education system	There are 2 levels of nurses: the level 4 nurse, through a 4-year diploma program that leads to registered nurse, offered at community colleges; and the level 5 nurse, through a 4-year diploma program that leads to registered bachelor of nursing. After this education it is possible to train as a specialized nurse (Oncology, Intensive care, Pediatric care, etc.). At this moment the system is being evaluated and the first ideas on a new profile called "Nurse 2020" are being discussed. In the current practice both levels 4 and 5 nurses perform the same tasks at hospitals. In addition to basic education, there is a training for nurse specialist and a national university course, which leads to a Master of Science in Nursing.	To become a registered nurse there are three routes (Rosseter, 2014): - a 3-year diploma program typically administered at hospitals; - a 2-year associate degree usually offered at community colleges; - and the 4-year baccalaureate degree offered at senior colleges and universities. Nurses in all the three programs have to pass the NCLEX-RN© licensing examination. After entering the RN workforce, many nurses attain additional qualifications to advance in their careers, which prepares them for advanced practice, teaching, or research roles.
Continuing professional development	"The process by which individual nurses, based on knowledge and insights that have been developed within the nursing profession, develop their own vision and importance of the development of the nursing profession, as well as their professional duties and responsibilities" (van der Arend, 2001).	"A life-long process of active participation by nurses in learning activities that assist in developing and maintaining their continuing competence, enhancing their professional practice, and supporting achievement of their career goals" (ANA, 2011).

the nursing profession at the administration level. In the USA, a degree is not sufficient to allow nurses to work in clinical practice. All candidates must pass an examination of the State Board of Nursing, the National Council Licensure Examination Program (NCLEX). The representation of a chief nurse at the top of the organization was a condition required to be eligible for Magnet accreditation. The required structure (shared governance) was not present at the Dutch hospital.

Both education systems led to the qualification and the title of registered nurse. However, the approaches were different and the legal structures differed. To protect the patient against improper actions the Dutch nurses were registered in the so-called BIG (Professions in Healthcare) Register and thus protected by law.

Survey Outcomes

Analyzing the survey outcomes revealed that the data appeared not to be normally distributed. Therefore a bivariate analysis was carried out using the Mann-Whitney U test.

The results of the survey reflected the opinions of the nurses at the two hospitals. The comparison of the data from both hospitals in Table 3 showed a significant difference for almost all CPD activities, with effect sizes ranging from small to moderate. Only the aspect "mandatory requirements" was not significantly different between both hospitals. The USA hospital nurses showed significantly higher scores than those from the Netherlands, with only a few exceptions.

"CPD activities pursued" showed a significant difference in all three aspects; research development, clinical practice development, and organization development. The difference in terms of research development was noteworthy because it showed the largest difference between both hospitals.

Table 3. *Description and Comparison of USA/Dutch Samples.*

	USA Magnet hospital (N= 124) Mean (SD)	**NL university hospital (N= 598) Mean (SD)**	**Effect size (Cohen's D)**	**P value**
CPD activities actually pursued by nurses				
- research development	2.5 (.69)	1.8 (.63)	.47 (1.06)	.000**
- clinical practice development	3.8 (.65)	3.7 (.61)	.08 (.16)	.001**
- organization development	3.1 (.97)	2.7 (.81)	.22 (.45)	.000**
Importance nurses attached to CPD activities	3.4 (.77)	2.9 (.71)	.32 (.68)	.000**
- research development	4.2 (.52)	4.2 (.49)	.00 (.00)	.802
- clinical practice development	3.8 (.77)	3.5 (.63)	.21 (.43)	.000**
- organization development				
Motives of nurses to undertake CPD activities				
- personal and professional development	4.5 (.72)	4.6 (.57)	-.07 (-.15)	.287
- career opportunities	4.1 (.78)	3.5 (.92)	.33 (.70)	.000**
- mandatory requirements	4.1 (.83)	3.9 (.79)	.06 (.12)	.004**
Conditions required to pursue CPD activities				
- intangible	3.4 (.87)	3.6 (.71)	-.12 (-.25)	.000**
- material	3.7 (.93)	4.2 (.69)	-.29 (-.61)	.000**

Note: ** Significant at .05 level

Almost the same picture emerged for "Importance attached to CPD activities". The US data showed a significant difference on two of the three aspects; research development and organization development. Effect sizes were moderate. The scores on clinical practice development were the same in the two hospitals.

Regarding "Motives of nurses to undertake CPD activities", US nurses showed significantly higher scores only in the area of career opportunities. Dutch nurses rated the motive of 'personal and professional development' a little higher. Effect sizes were small to moderate.

In terms of "Conditions required", both aspects (intangible and material conditions) showed significant differences, with small effect sizes. Dutch nurses required more conditions to be in place for their CPD participation, compared to their American counterparts.

Focus Groups

The results of the US survey were discussed within focus groups at the participating Magnet® hospital. These were recognized and confirmed by the participants. The attendees stressed that the Magnet designation is more than just a concept. As one participant pointed out:

"Magnet is not putting the papers together but you have to practice it every day at that level" (nurse manager).

Transparency and communication on how decisions were made were deemed crucial. As one of the participants commented:

"Nursing is the backbone of the hospital. Transparency and communication are keywords for the commitment of nurses to the hospital" (nurse manager).

Finally, it was stated that overseeing agreed rules was monitored by the nursing profession to provide insight into what CPD activities were actually undertaken. This is illustrated by the following quote from a focus group participant:

"It is very strictly enforced to take mandatory programs each year. Not taking this program can lead to disciplinary sanction or even to dismissal" (educator).

In conclusion, the results of these focus group interviews confirmed the findings of the US survey and the contextual analysis.

Discussion

The aim of this study was to compare the factors influencing registered nurse participation in CPD activities between a Magnet® university hospital in the USA and a non-Magnet university hospital in the Netherlands. A three-step method of data collection was used for the investigation; a document study of the context, a survey among 598

nurses in the Netherlands and 124 nurses in the USA, and discussions with several focus groups. Many differences were found, some of which are likely related to the presence (US) or absence (the Netherlands) of a Magnet designation. Their main implications will be discussed below.

Organization Development

The comparison between the Dutch and American nurses showed higher scores by the American nurses on CPD activities pursued that are related to organization development. This may be a direct result of the Magnet® concept. Magnet® hospitals have a significantly better working environment and also a high number of nurses with bachelor's degrees and specialty certification; these factors explain much of the Magnet® hospital effect on patient outcomes (mortality, patient satisfaction) (McHugh, Kelly, Smith, Wu, Vanak, Aiken, 2013). The Magnet concept could have a positive effect on the commitment and professionalization of nurses. Discussions with the focus groups seemed to confirm this explanation. However, it is also clear that the Magnet concept is no panacea for every barrier, such as shortage of staff for example. Nonetheless, there are advantages of the Magnet concept regarding the position of the nurse, especially in shaping and monitoring the individual's professional practice.

The autonomy of the nursing profession within Magnet® hospitals is such that the policies, the requirements, the standards, and the values are developed by the nurses themselves and adopted by the organization. Weggeman (2008) described a number of characteristics of a professional in his aptly titled book "Managing professionals? Don't do it!" Beside autonomy he mentioned specialized knowledge, needs of identification, enthusiasm, strong professional ethics, and professional standards as characteristics of professionals. Freedom and autonomy were particularly mentioned as reasons for choosing a particular occupation. The need for freedom and autonomy were reasons why it was often difficult for a professional to have a lasting commitment to the organization and willingness to cooperate. Autonomy was described by Weggeman in terms of self-determination, or "the opportunity to make one's own decisions independent of others."(p. 260) As the structure changes into a more self-regulated system for nurses, the culture changes with it. Such changes inspired by the Magnet concept lead to a more stimulating work environment and encourage nurses to pursue CPD activities (Church, Baker, & Barry, 2008; Hess, 2004).

Self-regulation of the nursing profession is a crucial issue. The main difference between the two types of hospitals was the structure (present in the US) in which nurses created self-governance to influence the policy and the culture at their hospital. History has shown that shared governance is a journey which can be long and steep (Hess, 2004). Hospitals in the Netherlands are currently at the beginning of this journey.

Research Development

Another difference between the two hospitals is levels of research, for which the US data showed higher scores. The central position of evidence-based care and research for the nursing profession in the Netherlands is shown in the Professional Practice Model (Maassen, 2015; see Figure 1) and in the Magnet Recognition Program® Model (ANCC, 2008) for the nursing profession in the USA (see Figure 2). Although both these models are important, the Magnet Recognition Program® model seems to be more relevant for daily practice. The nursing profession must be able to translate scientific findings into daily practice. Applying scientific results in daily practice seems to be organized in a

Figure 1. Professional Practice Model of a Dutch Hospital.

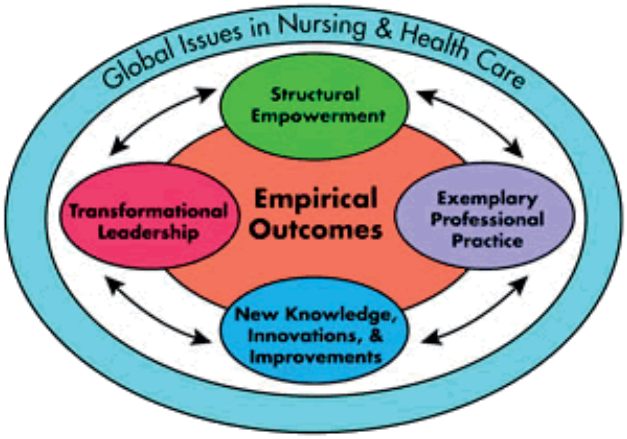


Figure 2. The American Nurses Credentialing Center (ANCC) model for the Magnet Recognition Program®.

more structured manner in Magnet® hospitals in the USA than that in Dutch hospitals. This was probably because it was part of the accreditation requirements to receive the Magnet label (Hess, 2011).

Culture

A difference between the two countries that is not directly traceable from this study, although it was alluded to in the contextual analysis, but which certainly should be addressed is the differences in national cultures. "Culture" is how we describe those unwritten rules about how to be a good member of the group (Hofstede, 2001). The American culture is known as 'masculine', where hierarchical relationships are more obvious than in the Dutch culture, which can be termed as more 'feminine' (Hofstede, 2001). Femininity is shorthand for the fact that caring for others is appreciated; care for one another comes before competition in the Netherlands. Quality of life and equality are more important than work ethics (Hofstede, 2001). A more assertive and proactive attitude on behalf of the status of a profession, instead of "just following", will make transparent what the professionals stand for and what they have to offer. Trust in the nursing profession by patients and other healthcare disciplines will increase, as nurses demonstrate that they are competent to maintain a high level of expertise and remain in control. Possibly masculine culture characteristics fit better here than feminine culture characteristics.

Conditions Required for CPD Participation

Both in the Magnet® hospital and in the non-Magnet hospital, the extent to which CPD activities were pursued was lower if they seemed to be less relevant for daily practice. That CPD activities related to daily practice in the profession showed the highest scores in both hospitals is not surprising in itself. Undertaking CPD activities depends on several factors and specific conditions. Dutch nurses indicated that they needed to see more conditions in place for them to participate in CPD activities, compared to their US counterparts. Literature supports the link between conditions and CPD activities actually undertaken (Larcombe & Maggs, 1991, Nolan, Owens & Nolan 1995, Minzo -Lewis 2014). The data seems to support this as US nurses participated more in CPD activities than their Dutch colleagues (see Table 3).

Limitations

There are possibly a number of ways in which the Dutch and the American nursing professions differ, which are not reflected by the results of this study since only two hospitals participated. However, both are representative of a larger group of hospitals.

because the US hospital meets the Magnet criteria, and thus may be compared in this respect with the other 405 Magnet® hospitals in the USA. The Dutch hospital also fulfills the criteria of the Dutch Institute for Accreditation in Care (NIAZ) and is therefore similar to a larger group of (teaching) hospitals.

Discussions with focus groups to increase reliability and validate the results of the survey took place in the USA only. This should not have affected the outcomes of the comparison as the authors of the present study know the Dutch nursing profession and its CPD efforts very well. Follow-up discussions may nevertheless help to understand more about the differences in CPD activities pursued by registered nurses both in the USA and the Netherlands. In order to get a better and more nuanced picture, it would be preferable to undertake such studies also at non-Magnet hospitals in the USA and non-Magnet general hospitals in the Netherlands. The present study should be viewed as offering a first impression of the state of affairs regarding CPD activities pursued by registered nurses at two types of hospitals in two different countries.

Conclusion

Overall, there are major differences between the two countries regarding the organizational structures that nurses work in and the mandatory CPD requirements set by the nursing profession. This was apparent in all three steps of the analysis. However, there is also a concern in both countries for which the Magnet concept seems to provide no answer at the moment, namely a projected shortage of nurses in future. This is remarkable because it was for this reason that the Magnet accreditation was introduced in the 1980s.

Tentatively, we conclude from the results of this study that there may be a relationship between the governance structure and the CPD activities at hospitals. Being able to influence the policy of the organization seems to affect the development of the individual nurse as well as the nursing profession as a whole. The results put forward by the Magnet concept in the US can be attractive in the Dutch context. In examining which elements of the concept are relevant and may be implemented, differences in national cultures might turn out to be a determining factor.

As mentioned, although a large group of nurses was heard, only a first impression of their opinions was established. The Magnet concept has proved its value, particularly with regard to CPD, so that the Dutch nursing profession can learn from the experiences of their American colleagues. Exchange programs among hospitals may be able to offer targeted handles. Projects can be started and measurements done to see what is and is not working.

CHAPTER 6

Factors influencing nurse participation in continuing professional development activities: Survey results from the Netherlands

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Factors influencing nurse participation in continuing professional development activities: Survey results from the Netherlands.
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Background

Professionals are individually responsible for planning and carrying out continuing professional development (CPD) activities, ensuring their relevance to current practice and career development. The key factors that encourage nurses to undertake CPD activities are not yet clear. Several studies have investigated motives of nurses to participate in CPD programmes ("Motives"), the importance they attach to CPD ("Importance"), the conditions they consider necessary for participation ("Conditions"), and their actual participation in CPD activities ("Pursued"). The relationships among these variables, however, have neither been investigated nor reported to date.

Objectives

The aim of this study is to investigate the nature of the relationships among those factors that influence nurse participation in CPD in the Netherlands.

Design

An exploratory cross-sectional study was carried out using quantitative data collected with the previously validated Questionnaire Professional Development of Nurses (Q-PDN)

Settings and Participants

A convenience sample of 5,500 registered nurses working at one Dutch university hospital and several general hospitals was addressed.

Methods

A descriptive study using a survey was undertaken. The questionnaire was completed and returned by 1,226 nurses. Correlation analyses were conducted to determine which factors were related to nurses undertaking CPD activities. Structural equation modelling was deployed to determine the relationships among the variables.

Results

"Conditions" was found to be moderately related to "Motives", which itself was strongly related to "Importance", which itself was very strongly related to "CPD activities pursued". If nurses considered a CPD activity important they were highly likely to pursue it; however, the importance attached to specific CPD activities was influenced by the presence of particular motives, which depended in part on the way CPD conditions were perceived.

Conclusions

The key factor influencing CPD participation of nurses is how important they deem particular CPD activities; the latter is a function of their CPD motives and of their perceptions that the right conditions for participation are in place. Implications are discussed.
Keywords: continuing professional development, CPD, nurses, survey, the Netherlands, motives for participation in CPD.

Background

Professionalisation of Nursing in the Netherlands

The nursing profession in the Netherlands has undergone major changes in recent decades. An internationally supported body of knowledge has been developed in terms of nursing theory and research, the results of which have been implemented into daily nursing practice. However, this does not ensure that professionalisation automatically leads to an increased level of professional development for individual nurses. Speet and Francke (2004, p. 7) defined the individual professional development of nurses as follows:

"The process in which individual (student) nurses, based on knowledge and insights that have been developed within the nursing profession, develop their own vision of the nature and importance of the nursing profession, as well as of their professional duties and responsibilities. Ultimately, this process should result in (student) nurses practicing their profession in a reflective, confident, effective and collegial manner."

In 1998, the Dutch Individual Healthcare Professions Act ("BIG Act") came into force (Ministry of Health, Welfare and Sport, 1996). This law regulates the rights and the duties of certain healthcare providers including nurses. Professionals who are registered in the BIG register have the right to pursue their profession and are also protected by law. The registration lasts 5 years before revalidation is due. For re-registration to occur it is essential to be employed as a nurse. To be eligible for re-registration, the nurse must satisfy the experience requirement of having worked at least 2,080 hours as a nurse. The use of a portfolio is increasingly encouraged to demonstrate that the nurse has undertaken professional development activities over the five years. Rapid developments within the profession create a challenging context for the professional development of individual nurses. Speet and Francke (2004) reported that more than 80 per cent of nurses rated it as highly important to keep up to date with developments within their profession.

A personal budget and government subsidies are provided at all hospitals in the Netherlands to support CPD. Various associations also support nurses and healthcare organisations in general by providing them information on how the process of professional development may be stimulated and improved (Speet and Francke, 2004). The

Dutch Association of Nurses (V&VN) has taken the initiative to implement a quality register. This Quality Register for Nurses and Caregivers (www.kwaliteitsregistervenv.nl) keeps track of what nurses do to maintain their expertise. The registration system was designed by the profession itself based on a professional standard that was developed in consultation with patient organisations, education centres, employers, and healthcare insurers.

Speet and Francke (2004) reported that in terms of CPD activities, nurses in the Netherlands on average paid most attention to "working together" and "reflection and evaluation". Nurses also spent a lot of time reflecting on their actions considering whether they had interacted correctly and effectively with a client, and whether there was any potential for further improvement. Nurses paid least attention to the use of scientific results in daily practice ("evidence-based care") (Speet and Francke, 2004).

As Hemmington (2000) stated, actual participation in CPD activities was influenced by three factors: the motives of nurses, the importance they attached to CPD, and the conditions that they required in the work environment to participate in CPD activities. The relationships among these variables have not yet been investigated. Our expectation is that actual participation in CPD is influenced by nurses' motives, the importance attached to the specific CPD topic, and the conditions considered necessary, as shown in Figure 1.

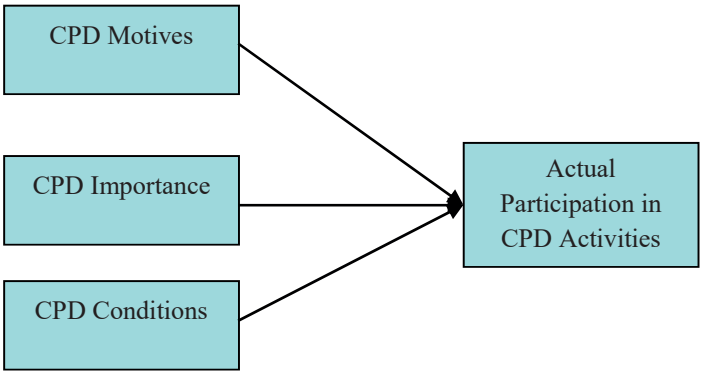


Fig. 1. Factors Influencing Nurses' Actual Participation in CPD Activities, proposed theoretical model.

CPD Activities Pursued by Nurses

The CPD activities that nurses pursue vary considerably (Speet and Francke, 2004). Much has been written on how nurses learn (Eraut, 2004). Learning may be on the basis of formal training courses or via informal activities that are more connected to daily work and are less visible (Eraut, 2004). An earlier study (de Laat *et al.*, 2001) established that only a small proportion (10 per cent) of professional development activities consisted of

formal learning that was conscious, actively controlled, and off-the-job. However, the vast majority (90 per cent) consisted of planned and unplanned activities around work and the workplace (de Laat *et al.*, 2001).

Most respondents in the study reported by Eraut (2004), based on research projects focused on the workplace learning of professionals, technicians, and managers, experienced working and learning as two separate activities, whereas Eraut suggested that most learning is in the workplace and not outside it. Workplace learning is reported as one of the most powerful ways to learn (formally and informally) and the workplace is a powerful learning environment (Kessels, 1996; van Lakerveld, 2005). However, these workplace learning activities are often not visible and hence more difficult to be influenced by others.

Berings *et al.* (2008) reported the following main categories of learning activities pursued by nurses in the Netherlands: learning by doing one's regular job, learning by applying something new to the job, learning by social interaction with colleagues, learning by theory or supervision, learning by reflection, and learning through life outside work. The above list confirms that nurses learn in many different ways to enhance their professional development.

Veer *et al.* (2012) showed that more than three quarters of all nurses participated in continuing professional education (CPE), which was more than professionals in other sectors. However, the term CPE is limited to training and education courses, whereas CPD also includes other contexts of learning (as already mentioned).

Motives for CPD Participation

Van der Krogt (2007) distinguished between three types of 'orientations' that employees consider to be important as outcomes of CPD (i.e. three motives): improving one's current work (organisational orientation); securing one's career opportunities and employability (professional orientation); and advancing one's personal development (individual orientation). The motivation for nurses to pursue CPD activities may arise from a range of different needs, including the mandatory requirements to which registered nurses must conform in order to keep their registration, a desire to improve the standards of practice, and gaining further qualifications to enhance promotion prospects (Quinn, 1998; Ryan, 2003). Murphy (2006) reported that the top three motives were related to increasing the knowledge and the level of skills, increasing career satisfaction, and gaining promotion. Similar motives emerged in studies of nurses' participation in formal learning activities for professional development (Gould *et al.*, 2006; Bahn, 2006). Van Grinsven and Westerik (2009) investigated the motives of nurses in the Netherlands for participation in training programmes and found that 'keeping up to date' was viewed as the most important motive (reported by 93 per cent of respondents). Speet and Francke (2004) reported that nurses in the Netherlands considered the following motives among the most

important for participation in CPD activities: collaborating, reflecting and evaluating, and compulsory requirements for (continued) registration. Among the least important motives were: working on the basis of theoretical nursing concepts, using the results of (nursing) research, and contributing to the professionalisation of nursing as a profession.

Conditions Considered Necessary for CPD Participation

As Hemmington (2000) concluded, factors that significantly affected the participation of nurses in CPD activities were: lack of time, available financial resources, and access to CPD. Funding for re-training was mostly provided by the employer. However, often the employee had to pay (part of) the costs (Larcombe and Maggs, 1991; Nolan *et al.*, 1995; Minzo-Lewis, 2014).

The financial resources of hospitals are decreasing and so are the opportunities to invest in training programmes. The Dutch National Work in Healthcare 2011 survey (Veer *et al.*, 2012) showed that a majority of nurses preferred a job that provided development opportunities. Furthermore, more than half of the surveyed nurses would participate in training only if the employer reimbursed the costs. They were willing to spend some of their own time to participate. A number of conditions have been reported in literature as discouraging participation in CPD. Balancing work, continuing education, and home life may be very difficult; there may be a disequilibrium between professional and family life (Murphy, 2006). Time to attend courses and to complete assignments are important conditions for participation in CPD activities, as is employer support (Murphy, 2006).

Importance Attached to CPD

Broad (2002) identified the importance of CPD by answering the ''three whys'': (1) Why embrace CPD? – to maintain knowledge and development; (2) Why maintain knowledge and development? – it is a legal requirement for employment and registration; and (3) Why is it a legal requirement? – for the protection of the public. Regarding the importance attached to CPD, some nurses deem the only value of CPD is to allow them to continue practicing (Grossman, 1998; Lawton and Wimpenny, 2003). Other studies indicated that nurses regard CPD as important from a felt need to expand their own knowledge (Lindsay, 1990; Larcombe and Maggs, 1991; Thurston, 1992; O'Connor, 1992). A study conducted in the Netherlands found that nurses think that "working together" is the most important CPD activity; three aspects appeared especially important to them, namely: giving and receiving feedback, and participating actively in team meetings (Speet and Francke, 2004). In addition, almost all nurses deemed the aspect "reflecting on one's own practice" important. The least attention was paid to the use of nursing research ("evidence-based practice") and to "acting from a theoretical vision" (Speet and Francke, 2004).

Method

Aim

The aim of the study was to investigate the relationships among factors that influence nurse participation in CPD in the Netherlands.

Design

An exploratory cross-sectional study was carried out using quantitative data collected with the previously validated Questionnaire Professional Development of Nurses (Q-PDN) (Author, 2014).

Participants

A convenience sample of 5,500 registered nurses working at Dutch hospitals was addressed for the study. One university hospital and individual nurses from several general hospitals were invited to participate. Addresses were obtained from a national database and from the participating university hospital. All nurses participated in the study voluntarily. Permission to conduct the study was granted by the Board of the participating university hospital.

Instruments

The survey questionnaire consisted of two parts. The first part was a demographic section. In this part the following demographics were addressed: gender, age, level of basic nursing education and specialist nursing education programme, type of workplace, and role. The second part was the Q-PDN previously developed and validated by Author (2014). The Q-PDN consists of items measuring four constructs: actual participation in CPD activities, the importance that nurses attach to CPD activities, the motives that nurses have for participation in CPD, and the conditions that must be present for nurses to participate in CPD. Items for the first two constructs ("Pursued" and "Importance") are the same; however, the sentences leading up to the items differ, one emphasising actual participation and the other perceived importance. The structure of the questionnaire is shown in Tables 1 and 2. It took participants approximately 20 minutes to complete the questionnaire.

Data collection took place between October 2009 and August 2010 using a hard copy questionnaire for registered nurses at general hospitals (distributed by post) and a digital version at the university hospital where the study originated (a link distributed by email). Participants were reassured that the results would be reported anonymously and were not traceable to specific individuals. A reminder was sent to recipients of the digital version after two weeks. Recipients of the hard-copy version were not sent a reminder (as indicated in Figure 2) because the agreement made with the national database from

Table 1. *Constructs and Factors Included in the Final Questionnaire.*

Constructs	Factors (n of items)	Mean (SD)	Cronbach's α
Motives	Career and performance improvement (5 items)	4.54 (.57)	.874
	Mandatory requirements (4 items)	3.87 (.78)	.828
Conditions	Material and Intangible conditions (4 items)	3.53 (.71)	.879
Importance	Participation in research (3 items)	2.88 (.70)	.811
	Clinical practice development (3 items)	4.18 (.48)	.793
	Participation in organisational development (3 items)	3.58 (.66)	.797
Activities pursued (same items as Importance)	Participation in research (3 items)	1.65 (.67)	.723
	Professional/personal development (2 items)	3.71 (.59)	.698
	Participation in organisational development (3 items)	2.85 (.88)	.797

Table 2. *Meanings of the Positions on the Likert Scales for Each Construct.*

Construct	Likert Scale 1-5
CPD Motives	Mainly disagree to mainly agree
CPD Importance	Not important at all to very important
CPD Conditions	Mainly disagree to mainly agree
CPD Activities Actually Undertaken	Never to very often

which the postal addresses had been obtained precluded this. The completed questionnaires were collected by an independent external agency and processed with Statistical Package for the Social Sciences 20.0 (SPSS).

The agency was contractually bound to strict confidentiality and privacy. The final submission deadline for the completed questionnaire was three weeks after the first invitation to participate had been issued.

Ethical Considerations

The study followed Dutch privacy legislation and the Declaration of Helsinki. The questionnaires were anonymous and completing a questionnaire was on a voluntary basis. Privacy was ensured as the data was only accessible to a limited number of authorised persons. All data were treated confidentially and no patients were involved.

Data Analysis

Following the previous validation study (Author, 2014) confirmatory factor analysis and further analyses aimed at testing the Goodness of Fit between the model (Figure 1) and the data were performed using AMOS 21.0, a Structural Equation Modelling (SEM)

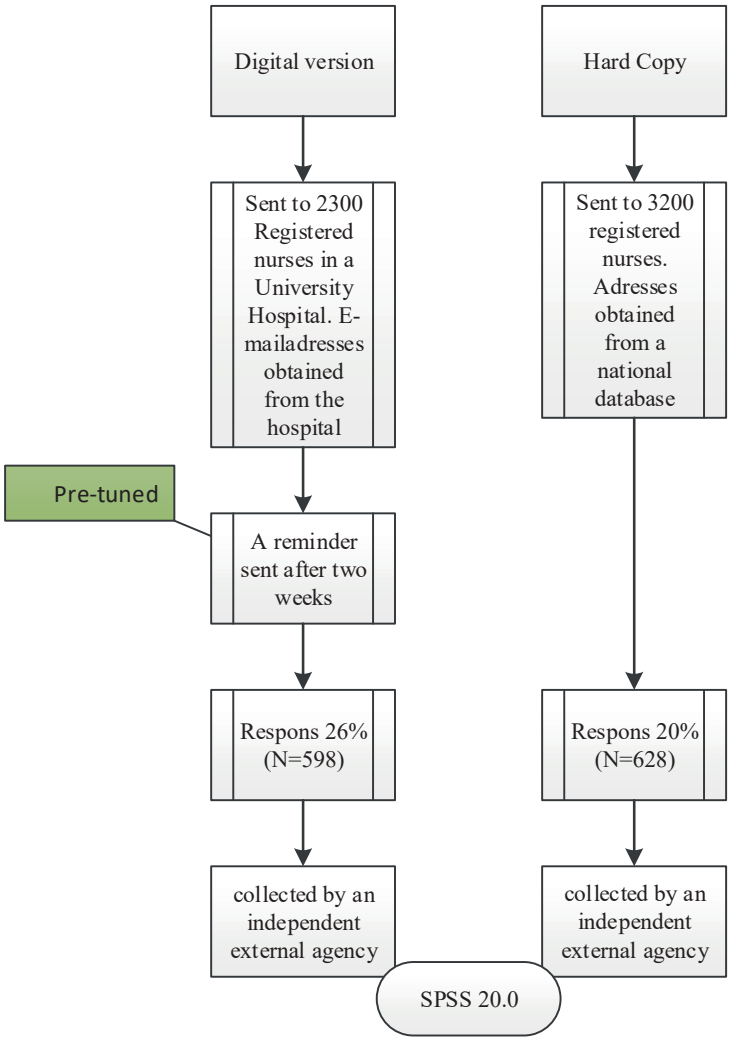


Figure 2. Flowchart of the Digital and the Hard-Copy Versions of the Survey.

programme (Arbuckle, 2006). The factors that affected the CPD activities undertaken by nurses were examined. Furthermore, Cohen's D was calculated to check whether there were any differences between the digital and hard-copy versions of the survey responses.

Results

Sample Characteristics

In total 1,226 registered nurses from one Dutch University hospital and several general hospitals participated in the current study. The overall response rate was 23 per cent. Data from 104 participants had been excluded as they did not complete the questionnaire fully. Most of the participants were women (86.6 per cent). The average age of the participants was 42 years with an average of 19.9 years' work experience. The characteristics of the participants are shown in Table 3.

Table 3. *Sample Description for the Survey (N=1,226)*

	Mean	n	%
Gender (N=1,226)			
Female		1,062	86.6
Male		164	13.4
Age (N=1,224)	42.0 years		
20-34		348	28.4
35-49		509	41.6
50-65		367	30.0
Work experience (N=1,226)	19.9 years		
Employment status (N=1,208)			
Full time		488	40.4
Part time		720	59.6
Job category (N=1,182)			
Nurse		765	64.7
Nurse specialist		195	16.5
Management		166	14.0
Education		56	4.7

Descriptive Results of the Survey

The means, standard deviations, and correlations among all variables under study are presented in Table 4.

The highest score for CPD motives was career and performance improvement (M = 4.46; SD = .51). The most important CPD activity considered was clinical practice (M = 4.46; SD = .53).

Personal and professional development was the most frequently pursued CPD activity (M = 2.95; SD = 1.02).

Furthermore, in terms of the CPD conditions that nurses required, scores regarding conditions showed the next results (M = 3.30; SD = .72). CPD activities related to participation in research were considered less important (M = 3.07; SD = .66). Actual participation in research had a little higher score (M = 2.57; SD = .82) than the score of

Table 4. *Means, Standard Deviations and Correlations between CPD Motives, Importance Attached to CPD, Conditions Considered Necessary for CPD and CPD Activities Actually Pursued (N=1,226)*

Variable	M	sd	1	2	3	4	5	6	7	8	9
1.Motive; Career and performance improvement	4.46	0.51									
2.Motive; Requirements	3.13	0.68	.541**								
3.Importance; Research	3.07	0.66	.335**	.497**							
4.Importance; Clinical practice	4.46	0.53	.423**	.286**	.457**						
5.Importance; Organisational development	3.41	0.58	.360**	.572**	.683**	.533**					
6.Material and Intangible conditions	3.30	0.72	.217**	.382**	.218**	.186**	.263**				
7.CPD pursued; Research	2.57	0.82	.237**	.365**	.852**	.368**	.561**	.031			
8.CPD pursued; Pers. And prof. development	2.95	1.02	.177**	.333**	.355**	.242**	.724**	.105**	.544**		
9.CPD pursued; Clinical practice and Organisational development	2.52	0.92	.211**	.266**	.390**	.283**	.380**	-.059*	.543**	.415**	

**p<.0.05, two-tailed.

participation in clinical practice and organisational development (M = 2.52; SD = .82) but lower than participation in personal/professional development (M = 2.95; SD = 1.02).

The motive of career and performance improvement had a moderate correlation with importance of clinical practice (.42). Moreover, participation in research as a CPD activity and the importance of research showed the strongest correlation (.85). In terms of conditions that nurses needed to see in place to participate in CPD, the strongest correlation was between conditions and the motive to meet requirements (.38).

Fit between the Model and the Data

To determine consistency among all variables, we calculated the fit between the model (Figure 1) and the data, the traditional Chi-square value, the goodness-of-fit index (GFI), the sample Root Mean Square Error Approximation (RMSEA), and comparative fit index (CFI). A GFI value of between .00 and 1.00 (Bentler, 1990) and a RMSEA value equal to or lower than .08 indicate a reasonable fit between the model and the data (Browne and Cudeck, 1993). As shown in Table 5 the RMSEA of .056 was acceptable. Also, the CFI was below the listed value of 1.00 mentioned by Bentler (1990). We did a curve estimation for all relationships in our model and determined that they were (mostly more) than

Table 5. *Fit Indices for the Measurement Model*

	observed	*traditional*	*suggested*	*remark*
CMIN/DF	*4,865*	*< 3 / <5*	*< 3*	*N = 1226*
SRMR	*0,0589*	*< 0,08*	*< 0,08*	*good fit*
IFI	*0,907*	*> 0,900*	*> 0,950*	*good fit*
RMR	*0,058*	*< 0,06*	*< 0,06*	*good fit*
GFI	*0,904*	*> 0,900*	*> 0,950*	*good fit*
AGFI	*0,884*	*> 0,800*	*> 0,800*	*good fit*
CFI	*0,917*	*> 0,900*	*> 0,950*	*good fit*
RMSEA	*0,056*	*< 0,050*	*< 0,050*	*sufficiënt fit*
LO 90	*0,054*	*< 0,050*	*< 0,050*	*sufficiënt fit*
HI 90	*0,059*	*< 0,050*	*< 0,050*	*sufficiënt fit*
PCLOSE	*0,000*	*> 0,050*	*> 0,050*	*N = 1226*

sufficiently linear. We did a linear regression to test for multicollinearity and no issues were found. Common factor analysis using a CLF in AMOS confirmed that there was no common method bias (0,073) in the measurements of the variables in the data set.

The relationships among the constructs Motives, Importance, Conditions, and Actual participation in CPD activities are shown in Figure 3. Actual participation in CPD activities was very strongly (.94) related to the CPD activities that nurses considered important, which itself was strongly (.70) related to the CPD motives of nurses. Conditions that should be present and CPD motives were moderately (.42) related.

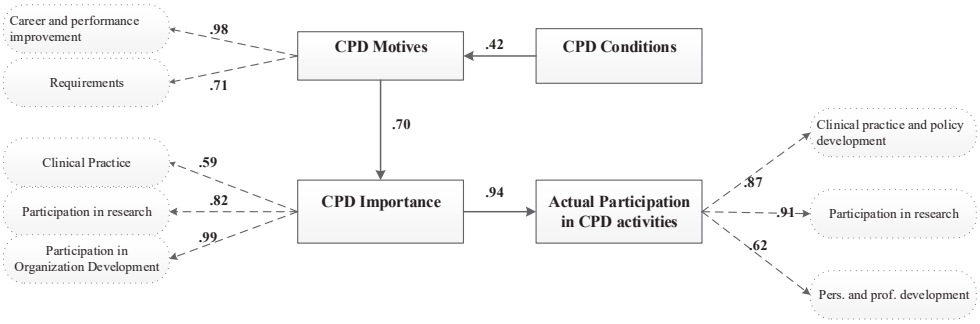


Figure 3. *Emerging model*; relationships among CPD Motives, CPD Importance, CPD Conditions and Actual Participation in CPD Activities.

Discussion

The aim of this study was to investigate the relationships among factors that influence nurse participation in continuing professional development (CPD) in the Netherlands. Structural Equation Modelling analysis demonstrated that "Conditions" and "Motives" were moderately related and "Importance" was very strongly related to "CPD activities pursued". If nurses considered a CPD activity important they were highly likely to pursue it; however, the importance attached to specific CPD activities was influenced by the presence of particular motives, which depended in part on the way CPD conditions were perceived.

The three factors within the construct "Importance" were Research development, Clinical practice and policy development, and Professional and personal development. The scores on Professional and personal development were the lowest, meaning this was deemed the least important area.

Regarding the equally low score on Actual participation in research, it was not clear whether nurses considered this CPD activity unimportant or that this was more an effort associated with another job category such as the nurse specialist. Participation in research by nurses in daily practice is not very common in the Netherlands. With the introduction of Nurse Practitioners in 1997, research started to receive more attention as a CPD activity.

Participation in organisation development was seen as an important CPD activity; however, there might be a difference between having influence on developments at the level of the workplace (team and patient care) and at the level of the organisation (hospital policy). In the Netherlands, it is not evident that nurses participate at all levels (ward and hospital) in the organisation.

The way nurses act and develop their profession is determined by the constraints (resources) and requirements of the organisation. Professional development and organisational development are closely linked. In 1983, Thomas described nursing as 'the glue that holds together the complex system of care within hospitals'. Attention must be given to mastering the professional and the organisational skills associated with the role of an employee. This has not changed over the years. Tharenou *et al.* (2007) reported in their study that professional development and organisational performance were positively correlated. In this study, we noted that nurse participation in organisational development was considered to be important. This may indicate that nurses want to have more influence on the (nursing) policy similar to that in the Magnet® hospitals in the USA (Scott, 1999). These hospitals are known for their better work environments and more highly educated nurses compared to non-Magnet hospitals (Lesley, 2011). A higher level of professional development is one of the fourteen features of Magnet® hospitals (ANCC, 2011). For that reason it may be useful to take a better look at this concept to investigate

factors that stimulate nurses in the USA to pursue CPD activities and which may be useful in the Dutch context.

Although nurses' motives for participating in CPD activities in the present study were generally in line with previous research both in the Netherlands and internationally (Quinn, 1998; Speet and Francke, 2004; Van Grinsven and Westerik, 2009) the current study showed that the main influencing factor was the importance that nurses attached to specific CPD activities, which was in turn affected by their CPD motives and by the conditions they needed to see in place.

Limitations and Implications

Both a hard-copy version and a digital version of the same questionnaire were used in the survey. The use of two different questionnaires could have had a disruptive influence on the outcome. A comparison of the main scores of the hard-copy and the digital survey is shown in Table 6. Statistical significance would not be a helpful indicator of any 'real' differences because of the large sample size. Therefore, effect sizes were computed using Cohen's d. The effect size is defined as the difference between the mean scores of the hard-copy and the digital group divided by the pooled standard deviation of the change scores. An effect size of .2 reflects a small effect, .5 medium, and .8 a large effect. (Coe, 2000). Results were .21 or smaller, therefore both groups were largely comparable.

The influence of the environment (organisation, workplace) on CPD was not included in the present study. As described in literature, the workplace is an important place to

Table 6. *A Comparison of the Digital and the Hard-Copy Versions of the Survey*

	Digital Mean (SD)	Hard-Copy Mean (SD)	Sig. p	Effect Size (Cohen's d)
Activities pursued				
Research development	2.54(.83)	2.61(.82)	.132	-.04 (-.08)
Clinical practice and Organisational development	2.40(.93)	2.63(.89)	.000	-.13 (-.25)
Professional development	2.73(.95)	3.16(1.04)	.000	-.21 (-.43)
Motives				
Career and performance improvement	4.47(.52)	4.42(.50)	.144	.05 (.10)
Mandatory requirements	3.14(.69)	3.12(.67)	.719	.03 (.01)
Importance				
Research development	3.08(.67)	3.01(.65)	.549	.05 (.10)
Clinical practice development	4.47(.54)	4.44(.52)	.357	.03 (.06)
Organisational development	3.35(.56)	3.48(.60)	.000	-0.11 (-.22)
Conditions				
Material and Intangible	3.32(.72)	3.28(.72)	.323	.03 .06)

learn (Kessels, 1996; Van Lakerveld, 2005; Eraut, 2004). Further research may focus on the influence of workplace characteristics (e.g., the complexity and variability of work; Keeris, 2006) on CPD.

It is the CPD activities of nurses working in hospitals only that have been included in this study. As mentioned before, the influence of the workplace i.e. context can influence participation in CPD activities. It may be useful to study other contexts such as Community Care and nursing homes. These environments differ from hospitals with regard to patients and technical skills. Follow-up studies may provide a better and more complete picture of factors that have an influence on participation in CPD activities.

The group of nurses investigated was only in the Netherlands; however, the opinions of nurses internationally who were not participants in this study remain unknown. Therefore, this study reports only preliminary results of the factors influencing participation in CPD activities. To gain further insight into the views of a larger group of nurses, further research is essential for distinguishing the views of nurses in other contexts and countries.

CHAPTER 7

Conclusions and Discussion

Conclusions and Discussion

The main objective of this study was to clarify the relationships between various factors that affect nurses in their Continuing Professional Development (CPD). An instrument was developed to measure these factors and analyses were conducted to investigate their relationships. The findings should provide an impetus to interventions that support and promote CPD opportunities for nurses.

Summary of Conclusions.

Research question
Which factors influence nurses to pursue Continuing Professional Development (CPD) activities and what are the relationships between these factors?
Sub-questions:
1. Which CPD activities are actually pursued by nurses?
2. Which motives do nurses have to pursue CPD activities?
3. Which CPD activities are considered important by nurses?
4. Which conditions must be present for nurses to pursue CPD activities?

First, the conclusions in relation to the research questions and reflections on the concept and research method are described. Insight is given into decisions that were taken during the research process and the implications they had for the study. Finally, the scientific and practical relevance of the study are described and a research agenda for the future is set.

Definition of CPD.
Different previously developed definitions are described in Chapter 1 in order to be able to present a clear definition of CPD for this study. In all definitions CPD is described as a continuous process, which develops or updates knowledge and skills (competencies) or keeps the nurse competent. The preferred definition for the present study is that by the American Nurses Association (ANA 2011), which also refers to career aspirations. This gives nurses not only a substantial professional purpose, but also a more personal goal.

The meaning and the definition of CPD have been and continue to be reformulated over the years. This has happened under the influence of social and professional developments. An overview of the history of the nursing profession is presented in Chapter 2 to provide an insight into these developments. Can it still be stated that the primary aim of the nursing profession is to provide 'care for others', although this is referred to as 'quality of care' now? The entry requirements for the nursing profession increase under the influence of medical technical advances. Thus, certain CPD topics are mandatory requirements that regulations and standards stipulate. Official professional registers are

maintained, which include mandatory training requirements and records. The nursing profession is thus adopting more characteristics that define it as a profession.

Instrument.
The development and validation of the Questionnaire Professional Development of Nurses (Q-PDN) is described in Chapter 4. This instrument measures different factors, which are present in CPD. The constructs 'Motives', 'Importance', 'Conditions' and 'CPD Activities pursued' were formulated. Factor analysis showed that underlying factors were present in these constructs. The Q-PDN can be presented to nurses in order to obtain their opinions and views on CPD.

Studies on CPD for nurses.
Three studies were conducted on CPD for nurses. Each with a different aspect on the topic. First, various stakeholders are involved in CPD for nurses. The Delphi study described in Chapter 3 included the following stakeholders: professional associations, employers, managers and educational institutions. There was consensus that the need for CPD is indicated by the fact that it must have effect on the quality of care. Each stakeholder has a specific role in facilitating CPD. Awareness and change in attitudes with regard to CPD among nurses remains necessary according to the participants. There has been inadequate attention paid to CPD. Motivating and stimulating factors were mentioned as a registration system, making the profession attractive, opportunities for workplace learning and attractive educational programmes. A manager who acts as a role model was also seen as stimulating. Impeding factors such as workload, financial resources, staff shortages and time, which also influenced the attractiveness of the profession were also mentioned. During the face to face meeting nurse leaders were recommended on how to give nurses more autonomy and the strategic policy for CPD. However, this must be in line with the general policy within the organization.

Second a Survey was conducted in the Netherlands. The answers to the main research question are described Chapter 6. To answer the research question we looked at the motives that were present, the extent to which nurses needed certain conditions and the factors that nurses considered important to stimulate CPD participation. These factors are dealt with in the next paragraphs.

Motives for CPD Participation.
The study identified three main reasons that emerged for nurses to pursue CPD activities to support their personal or professional development, to support their career and to meet mandatory requirements of the employer and professional association, law and regulation (e.g. registration).

■ *Personal / Professional Development.*

Nurses pursued activities to support their personal or professional development as described in the literature (Gould, Drey & Berridge, 2007; Lindsay, 1990; Larcombe & Maggs, 1991; O'Connor, 1992; Turner, 1991; Thurston, 1992; Waddell, 1993). As previously mentioned, in the Twentieth Century nursing became a profession. Professionals are required to keep their professional development up –to- date to meet the expectations of patients and society.

■ *Career.*

The second reason that nurses pursued CPD activities was to enhance their careers (Friedman, 2013, Gould; Drey & Berridge, 2007). The possibilities for a next step in a nurse's career have increased by horizontal and vertical differentiation (Nivel, 2004). Horizontally, the many specialisations such as Intensive Care, Oncology, Paediatrics and Rheumatology offer increased possibilities, whereas with the advent of the nurse specialist the nursing profession has vertical capabilities at the scientific level (Nivel, 2004). Van der Krogt (2007) described the importance of CPD for a more strategic focus on career opportunities. A more systematic focus on CPD activities that support nurses' careers is enabling nurses to be in charge of their careers.

■ *Meeting Mandatory Requirements.*

The third reason for nurses enrolling in CPD activities is "meeting mandatory requirements". This may be described at different levels. Meeting the needs of the patient is foremost. The increasingly assertive patients and their advocates (be they relatives or lobby groups) expect increasing customised care. Together with the rapid expansion of modern treatments and medical procedures, nurses must keep their knowledge and skills up- to- date in order to provide high quality care. The employer's mandatory requirements play a role. Employers are obliged to observe the rules set by accrediting organisations to comply with current legislation. It is highly important to meet these requirements in order to provide safe, transparent care. In addition to the working and training conditions for nurses specified in the Act on Professions in Individual Health Care (the BIG Act), the requirements of the quality registers of the various professional bodies must also be met (BIG register, 1996; V&VN, 2007). These developments have become increasingly demanding, prescriptive and normative in recent years. Formally accredited CPD enable nurses to show that they have satisfied these requirements (Friedman, 2013; Grossman, Lawton & Wimpenny 2003).

Importance of CPD Activities

The second construct comprises those CPD activities that nurses consider important. Three elements are participation in research, clinical practice and participation in organisational development.

■ *Participation in Research.*

The first element distinguished was the extent to which nurses' participate in research. One of the characteristics of a profession is that the level of knowledge is built (Nieswiadomy, 2009). In other words, all activity is evidence- based. A major boost was given by the introduction of nurse specialists. However, translating, implementing and applying these results into daily practice still requires attention. The fact that this element showed to be the least important to nurses could mean that nurses do not immediately see a role for themselves in implementing research results in the daily practice (Speet & Francke, 2004). Another explanation may be that this role is more appropriate for other, more highly trained nurses such as nurse specialists. Perhaps, their role is to translate and implement the scientific results into the everyday practice. It may be that the nurses find the best way to prioritise the implementation of findings from the scientific literature. In this way, the nursing profession itself determines what is important and what is not and thereby provide an incentive to actually implement these results into clinical practice (Leistra, Lover, Geomini & Stephens, 1999). An agreed infrastructure at hospital level for identifying and analysing issues, scientific results and the implementation of these results would be supportive here. As described, the Magnet Concept is an example from the USA that has proved itself in this respect (Hess, 2011).

■ *Clinical Practice.*

This study showed that nurses pursue CPD activities primarily for the purpose of clinical practice. This is in itself not surprising, since this purpose is at the core of the nurse profession. The literature supports this finding (Grossman, 1998; Lawton & Wimpenny, 2003).

■ *Participation in Organisational Development.*

Participation in organisational development emerged as an important CPD activity. This may be translated into having an influence on policy given the items from the Q-PDN ('Participation and keeping up- to- date with policy developments'). A distinction can be made in the policy at the ward and at the organisational level. Nurses attach great importance to be involved in policy formation. The literature supports this by endorsing the shared governance structure where nurse influence is present at all levels within the organisation (Clavelle, Porter-O'Grady & Drenkard, 2013).

■ *Conditions Required.*

Two types of necessary conditions emerged from the analysis: material and intangible conditions. Each of these focused on different kinds of support. Material constraints such as time and money were frequently cited in literature as being barriers to CPD (Larcombe & Maggs, 1991; Hogston, 1995; Nolan et al, 1995). Various efforts are currently made to alleviate such barriers by means of a personal budget (Collective Agreement for University Medical Centres, 2007) and the quality impulse for professionalism of hospital staff (Quality Impulse, 2014). Material conditions can be met by the personal budget and the quality impulse materials. The results showed the significance of the attitude and support of the manager and the nurse's colleagues with regard to the intangible conditions. The results showed that these conditions also need to be favourable to support CPD of nurses. Coaching, inter-collegial consultation and collaborative learning are conditions that are desirable in nursing departments for pursuing CPD activities. This was described under the heading of mentoring and support (Hemmington, 2000). The need for a positive and supportive leadership and management style was also supported in the reported literature (Acharya, 1994; Macdonald, 1994; Hogston, 1995; Ellis & Nolan, 2005; Hughes, 2005). In short, the workplace needs to satisfy a large number of preconditions to enable nurses to pursue CPD activities.

■ *CPD Activities Pursued.*

The CPD activities that nurses pursued varied constantly (Speet & Francke, 2004). Erraut (2004) reported that workplace learning was most essential and that the workplace was a powerful learning environment (Kessels, 1996; Laker & Field, 2005). Bering et al (2008) distinguished three categories of learning activities by nurses in the Netherlands. These were learn by regular work, to add something new to the workplace, social interaction with peers, learning through theory of supervision, learning through activities outside of work and learn through reflection. However, study by Veer et al (2012) showed that three quarters of the nurses participated in CPE by attending training courses. However, CPD is more than just taking courses. The question is why these seminars are followed. Is it because it is compulsory, or is it because they think this is important or is it that since nurses consider some activities more important that they are more willing to pursue these? To find the answer, the construct "undertaken CPD activities" was used in the same format for the construct Importance; Participation in Research, Clinical Practice and Organisation Development. Validation Study showed that the reliability was good. Conclusion was that the CPD activities that were considered important were not always actually pursued. Reasons for this may be found in the way conditions were present (conditions at the workplace) or affected policy. The comparative study between the Dutch and the American hospital showed that there may be a relationship between the governance structure and the CPD activities at hospitals. Being able to influence the

policy of the organization seemed to affect the development of the individual nurse as well as the nursing profession as a whole.

The third study was a Comparative Study in the USA and the Netherlands. A first exploration comparing the Dutch and the American contexts is described in Chapter 5. A comparison was made between a University hospital in the Netherlands and a Magnet® University Hospital in the USA. The label 'Magnet® Hospital' was given to hospitals that were able to successfully recruit and retain nurses during a national nursing shortage in the USA in the 1980s. These hospitals are known for their better work environments and more highly qualified nurses (Kelly, 2011).The data showed significant differences between the Dutch and the USA groups in almost every aspect. The American nurses showed a higher score on CPD activities relating to organization development. This may be a direct result of the Magnet concept. Another difference found was participation in research: US nurses scored higher on this CPD activity. The extent to which CPD activities were pursued was lower if they were perceived as less relevant for the daily practice at both the hospitals.

Structural Equation Modeling; 'Rethinking the best model'.

Finally, the research examined whether 'Motives', 'Importance', and 'Conditions' affected the actual CPD activities pursued. Initially, it was assumed that all three factors have a direct relationship with CPD activities pursued (Figure 1). The analysis (Structural Equation Modeling -- SEM) showed that Actual participation in CPD activities was very strongly (.94) related to the CPD activities that nurses considered important, which itself was strongly (.70) related to the CPD motives of nurses. Conditions that should be present and CPD motives were moderately (.42) related.

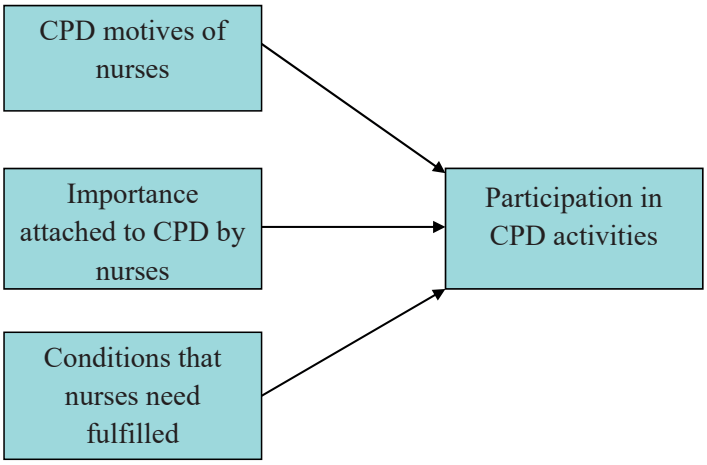


Figure 1. Relationships between CPD Motives, CPD Importance, CPD Conditions and Actual Participation in CPD Activities.

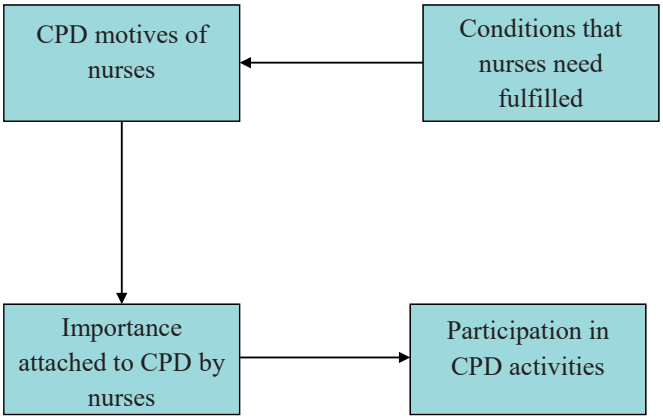


Figure 2. *Emerging model*; relationships between CPD Motives, CPD Importance, CPD Conditions and Actual Participation in CPD Activities.

The next step was to examine the relationships between 'Conditions', 'Motives', and 'Importance'. The assumption examined was that to consider a CPD activity important may be affected by the extent to which the conditions and motives were present (Figure 2).

Although the SEM results were inconclusive as to which of the two models in Figures 1 and 2 had the best fit, model 2 was chosen because its interpretation was much easier and better understandable. Hence, 'Conditions' affect 'Motives' and 'Motives' affect how important specific CPD activities are considered, which in turn affects nurses' actual participation in CPD. Relationships between these four constructs was not reported in literature earlier. A key outcome of this study was that a valid and reliable picture of the factors that should be addressed in order to raise nurses' CPD participation are those is presented in Figure 2.

The data resulting from the survey of Dutch nurses showed that 'importance attached to a CPD activity' had the strongest correlation with the 'CPD activities actually undertaken'. 'Conditions' showed a moderate correlation with 'Motives' and 'Motives' showed a strong correlation with 'Importance'. The construct 'Importance' consisted of the following factors: Research development, Clinical practice development and Organisational development. The finding that 'development of clinical practice' was the most important, was in itself not so surprising because this is at the heart of the nursing profession. 'Participating in organisational development' was an interesting finding as it indicated that nurses wanted to actively contribute ideas and influence in the way the organisation developed. A desire to propose improvements which did not have an outlet could lead to frustration and disillusionment. Therefore, a part of the present study looked at hospitals in the U.S.A. where the role of nurses is embedded in such a way that influence can be exercised.

Reflection on the Methodology.

This section contains a reflection on the research methods that were used in this study. The design and the instruments of the study are discussed first followed by the data analysis. Finally, the extent to which the results may be applied to other healthcare professions is addressed.

Research Approach.

This study began by asking experts in the field of nursing to join a panel for their opinions on the professionalism of nurses in the Netherlands. They were also committed to the nursing profession besides being experts in their field. They were asked to participate in a Delphi Study. The following groups were represented in this first phase of the study.

1. Representatives of Professional Associations.

They represented and defended the interests of the nursing profession. Their focus is to improve and strengthen the position of nursing professionals. There are an estimated 300,000 nurses and carers working in the Netherlands. In 2012, 68,000 were carers, nurses and nurse specialists who were members of the Dutch Nurses Association (V & VN). A large number of professional associations (127) are united on this platform. Representatives from various fields were asked to serve on the panel and thus, the voices of nurses were (indirectly) heard as a result.

2. Employer Representatives.

Representing the eight cooperating University Hospitals in the Netherlands as an advocate and as an employer of more than 65,000 employees (Dutch Federation of University Hospitals -- NFU) and general hospitals (Dutch Association of Hospitals -- NVZ). They represent the interests of their members on care-related, economic and social levels. Their representation was small in number thereby limiting the views from the employers.

3. Representatives of Educational Institutions.

The Association of Educational Institutions (VBG) is a network in which a number of educational institutions work together. Representatives from Human Resources Development departments of various hospitals also participated. Thus, input was obtained from an educational perspective.

4. Management Representatives.

Managers involved in daily practice from different hospitals and wards were invited to participate. They were asked about their expectations of nurses regarding professional expertise and about their opinions on CPD needs for nurses.

Thus, a group was set up that looked at the subject of nursing CPD from a number of different angles. Answers to a survey consisting of a two-part questionnaire were obtained, which set the scene for a face to face meeting. This method was described by Brockhoff (2002), McKenna (1994) and also used by Gibson (1998). A possible criti-

cism of this approach was that individual nurses did not participate and their opinions were not heard. However, the study intended that the results of this first phase would provide an input and a starting point for the next phase, in which individual nurses would participate. Moreover, the professional associations representing the nurses participated thus, their opinions were heard.

For the second phase, a questionnaire was developed that was used to seek the opinions of individual nurses. The model studied relationships between four factors, which are described in Chapter 4 (what motives are present, what activities are considered important, what conditions must be present, and what CPD activities are actually pursued). A reflection on the validation of the questionnaire (Q-PDN) is described later in this Chapter. However, it should be considered to what extent socially acceptable or desirable answers were given. On the one hand, sometimes in these settings peer group pressure, subjectivity and perception comes more to the forefront than the actual underlying reasons (Tourangenau, 2008). On the other hand, the anonymity was guaranteed so that the results could not be traced to individuals. Discussions with additional focus groups were also conducted to test whether the results of the survey were consistent with the views and the opinions of the focus group. The latter is in accordance with the results of the Delphi study. As a whole, the study was consistent and it heard the voices of many nurses, nurse leaders, managers and educators. This large and diverse group produced a picture of their current opinions and views, which were then compared with those in the existing literature.

Analysis.

The aim of the present study was to investigate nurses' CPD motives, the importance they attached to CPD, the conditions they considered necessary for CPD and the CPD activities actually pursued. This was based on existing research literature and a previously conducted Delphi study. The analysis was conducted on the four constructs listed above, each comprising eleven factors with a total of 54 items. This analysis produced evidence of acceptable reliability and validated the design of the questionnaire.

We were able to verify whether or not the factors that were identified supported the theoretical conceptual model of CPD (Figure 1, page 105) (Polit & Beck, 2012) by Exploratory Factor Analysis (EFA) of the data. This turned out to be the case. By using Confirmatory Factor Analysis (CFA), correlations and (co-)variances, this analysis reviewed the assumed causal relationships in the theoretical conceptual model of CPD and found them to be sufficiently present. Finally, it was examined by Structural Equation Modeling (SEM) whether competing alternative models could be constructed with a better fit and/or more explained variance (Arbuckle, 2006).

The Q-PDN was a validated instrument that was applied to hospital settings. To date, the instrument was only used for a survey of nurses in hospitals. The instrument

measured the views and opinions of nurses. In future, it can be used by professional nursing organisations, Human Resources Departments, training officers and managers to improve the current CPD arrangements on their wards in their hospitals.

Generalisation.
The study was conducted among nurses in general- and university hospitals. The voices of professional organizations, employers, managers and educational were also heard. Thus, CPD was viewed from different angles. Therefore, the results provided a good picture of CPD among nurses in hospitals and were representative for a larger group of nurses in the Netherlands.

Use of the Q-PDN in other contexts such as home care and nursing homes has not occurred yet. The Q-PDN can be used for this purpose, because the constructs (motives, importance, conditions and actually pursued) are generic constructs, which can be used in the various fields within healthcare. The results may show interesting similarities and differences between the various fields within healthcare.

Internationally, the Q-PDN was only used in one hospital. The hospital also had a special status given the three Magnet accreditations received by the organization. This meant that the results gave a limited picture of the American [North/South] context. Therefore, it should be seen as a first exploration. The context and the views concerning CPD of the individual nurses from the corresponding Magnet® hospital were studied and compared. These were initial findings. It confirmed a picture previously outlined by Dutch nurses after they returned from a study tour in America (Buijck *et al.*, 2008). Comments from the above study showed that such an exchange was inspiring. The question was whether the Magnet concept could also apply within the Dutch context. In the Netherlands, the Magnet concept is synonymous with excellent care (V & VN 2009). Features of this concept include control of professional practice and autonomy. In 2009, V&VN launched a pilot project that was completed in 2010. The project was continued with the aim of "a proper positioning of nurses and carers who can exercise their profession well, in a way that it is and remains attractive" (Brewer, 2010). The Q-PDN may give insight into what is considered important by nurses and deploy interventions, which may be used in the context of their CPD.

Further application of the Q-PDN in other (non) Magnet® hospitals may provide a more nuanced picture.

Reflection on Relevance.
This section further elaborates on the scientific and practical relevance of this study.

Scientific Relevance.

The aim of this study was to contribute to the existing knowledge on the Professional Development of nurses. This was done by seeking the opinions and the views of experts and nurses from the Netherlands and the U.S.A. Both qualitative and quantitative methods were used in this study. By using the Delphi method, views and opinions were inventoried and discussed. The outcomes of the Delphi Study were used for the next phase. For this a questionnaire was developed and validated. The scales used had an adequate internal consistency and a clear factor structure. The reliability was good as confirmed by Cronbach's Alpha, a coefficient of reliability (or consistency) (DeVellis, 2012). In the literature much attention was paid to single factors that affected CPD, namely Motives (Gould, Drey & Berridge, 2007; Grossman, 1998; Lawton & Wimpenny, 2003; Pool, 2012; Friedman, 2014), Importance (Broad 2002; Lawton & Wimpenny, 2003) and Conditions (Hemmington, 2000; Jantzen, 2008). However, if and how these factors were correlated was not investigated. Conditions proved to be an important factor. However, when nurses considered a particular CPD activity important they were also likely to pursue it, especially if it was able to increase their influence on hospital policy. This was not reported previously in literature.

Each construct built on previous studies, but they all described CPD from a certain point of view (motivation, importance, conditions). From these findings we knew which factors had the closest relationship with pursued CPD activities. Relationships were also present between the factors. Since the relationships between the different constructs were not described previously in literature, this study was of added value.

Practical Relevance.

■ *Nurses.*

It is not surprising that CPD activities are strongly related to daily practice. The results showed that nurses in hospitals chose to pursue CPD activities that were closely linked to their daily practice. Moreover, when nurses considered something important they pursued CPD in that area of work. This gave a useful starting point for identifying what nurses considered important. From the results it appeared that having influence on policy was an important factor. This meant that there was a positive impact on actively participating in specific CPD activities when nurses had influence and control over the way policy was developed and implemented. The shared governance structure proved its worth and was also implemented in the Netherlands. However, it takes a lot of effort from both the employing organisations and the nursing profession. It is a decision that, if properly applied and secured, may bring considerable advantage to the position of the nursing profession in hospitals. However, this requires commitment and participation. An improvement in patient care provides the greatest incentive to pursue the profes-

sion. Developing their own professional identity introduces an incentive for nurses to progress. This should be reflected in a specific and recognisable nursing policy within the hospitals that runs parallel to the medical policy. In this way, the multidisciplinary nature of care is powerfully brought into the limelight. However, the nurses will have to unite and operate as a collective that endures for a long time. There will be strategic and political storms to survive. This requires a lot of nurse professionals where the workload is already high and the work-life balance is not always in good proportion. Therefore, the continuity of the development process will have to be guaranteed.

■ *Employers.*

From the perspective of nurses, the most important CPD activities are those that are related to their clinical practice. Professional/personal development showed the highest score as a motivation factor. Employers can focus on the workplace to make this an interesting and stimulating place for professional and personal development. As the findings in the U.S.A. showed, (Table 3, Page 76) an attractive workplace acted like a magnet and had a positive impact on both the quality of work and on retaining staff (Taylor, 2015). In the current economic climate where financial possibilities appear limited, it is important to look at other opportunities that will encourage CPD. The present study showed that both material and immaterial conditions must be present to enable nurses to pursue CPD activities. Conditions such as coaching, leadership and collaborative learning were found to be highly influential from the nurses' perspective. By paying attention to these conditions, a favourable learning and working culture in the nursing department can be created and supported by good quality CPD.

■ *Education Centres.*

There is a role for education centres in facilitating the learning, training and development of nurses. Initially, a freshly qualified professional needs to be brought to the level of a competent professional at the start of their career. This may then be developed further to the level of expert. Patricia Banner described this process in her book "From Novice to Expert" (1982). Despite the fact that this book is 33 years old, it is still relevant today (Gobet, 2007; Kim, 2015). Education centres have a role in supporting this process. Although this is done in a more modern way, for example by using digital resources, the core of their role still remains the same. The results of this study may help education centres to gain additional insight into what is more important to nurses and what nurses need to support their personal and professional development. Education centres provide training, of which internship is an important component. Information gained from measurements using the Q-PDN may prepare professionals in their new job or internship in the future.

■ *Educators.*
Most wards have nurses who have a specific focus on training and education. The question is whether they merely coordinate training or whether they actually support learning on the ward. This study may support educators by using instruments such as the Q-PDN on the wards to gain additional insight into the views and the opinions of the nurses on the ward. The effect of interventions deployed at the department level may be measured and implemented.

■ *Human Resource Development.*
Human Resource Development (HRD) is often a part of Human Resource Management (HRM). The position of HRD within the hospitals is located in the HR department and sometimes in the Learning and Development department. The HRD professionals can conduct research, which favourably influences factors that support participation in CPD in cooperation with the wards or hospitals. By applying these factors the HRD professional becomes more visible in the workplace as a consultant and as a facilitator thereby creating a positive learning environment. Thus, HRD builds a bridge between HR policy and the ensuing projects that support this policy.

■ *Professional Association.*
Currently the largest professional nursing organisation in the Netherlands has 68,000 members. There are 178,000 registered nurses and 109,000 carers in the Netherlands (CBS Labour position medically qualified 2010; van de Velden, 2013). Therefore, the membership stands at around 25 per cent. This number needs to be higher in order to represent and defend the interests of the nursing profession. This is important because a higher influence from the profession may be exercised over developments that affect nurses and their patients. This will follow national trends towards 2020-2030. The voices of nurses must be heard at this level.

For the individual nurse, the quality register V & V offers the possibility to create a transparent overview of his or her own CPD activities. The system is not yet fully used. The system possibly evokes a concept that is more focused on mandatory activities. The Institute of Medicine (2009) described a CPD registration system as “a coordinated continuing professional development system”. Tone makes the music and a name can adjust the image to something that does more justice to the objective namely insight into the professional development. Through education and information on the registration, more attention may be directed to CPD than on the operation of the system itself.

Agenda for Future Research.
As mentioned, thus far the Q-PDN has only been used in the context of a hospital. Use and validation in other environments such as home care, nursing homes and psychiatric

institutions would make the instrument more versatile. Moreover, the instrument has the potential to be used internationally to enable a comparison between different countries. The Q-PDN instrument may be used anywhere where healthcare professionals are employed and should as such not have to be restricted to nurses, although the name of the instrument may give this impression.

Nurses' commitment to the organisation and job satisfaction were not included in this study. Another factor excluded from the study is the effect of the working environment. The Work Environment Scale Index (Lake, 2002) e.g. could be added.

The challenge for the future is in encouraging nurses to pursue CPD activities. In subsequent research into interventions (such as coaching, protected time, conditions in the workplace) the interventions deployed and the consequent effects need to be examined. Furthermore, these effects will indicate the next steps that can be undertaken to support the professional development of nurses. This creates a cyclical process, repeatedly reporting the effects of the interventions (for example, an impact assessment of scenario training, community of practice, visualising and sharing best practices and evidence-based care). This is important as it would measure and provide an insight into other participants: patients, colleagues, other healthcare disciplines and the employer, but primarily to support the personal and professional development of nurses. Therefore, intermediate measurements are of interest to see whether the correct interventions have been deployed. The Q-PDN may be used for these measurements.

It is important to learn from each other internationally as described in Chapter 5. However, the findings described in Chapter 5 are limited to only one hospital in the U.S.A. Nevertheless, several countries are engaged in studying CPD of nurses (Courtenay, 2009; Gould, 2007; Hughes, 2005). There is best practice in clinical work, but there are also issues to address that are recognisable to everyone:

- How can we make the profession more attractive?
- How can we respond to the continuing changes and developments in the demand for care?
- How can we continue to provide the required quality of care?
- How can we gain influence and control for nurses over their own professional standards?

As described previously, the positions and the roles of nurses in the organisation are important in order for them to be able to contribute their own expertise on policy development. Learning from colleagues who have already gained the experience of having influence on policy may be highly valuable. The Q-PDN may also be used to measure nurses' CPD in hospitals in other countries, to compare the results with Dutch hospitals and to publish them. In this manner we can learn together, with one another and from one another. After all, quality nursing is a global issue.

Future Research Questions.
Which interventions are most effective in stimulating worthwhile CPD for nurses?

It is difficult to pre-determine, which interventions within the organisation or the department will have the desired effect. Local conditions such as corporate culture and the learning environment are important influencing factors. Therefore, the effects may differ from one organisation to the other. More clarity will be obtained when the interventions and measurements (before and after) have been done. To focus effort within the existing potential and resources, it is useful to determine which intervention leads to the highest stimulus for CPD.

What impact does the shared governance structure have on CPD for nurses?

Building a (new) structure requires support from all the stakeholders (boards of directors, medical staff, Union) and unswerving commitment because construction takes years. This can be seen in the example of hospitals from the U.S.A. It must be a deliberate choice of a hospital for this development to proceed. Early results must show that this development is the right way forward. This study showed that the impact on policy is an important factor. Further research must show whether this is achieved through the shared governance structure and whether it results in an increase in CPD.

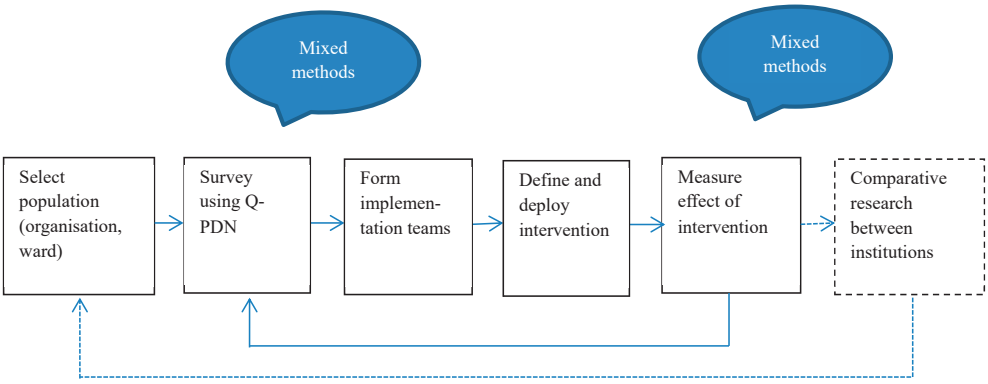
What is the influence of the work environment on CPD for nurses and which motivation and impeding factors can be identified?

Much has been written on the work environment as a learning environment. Working and learning are closely linked. However, the working environment in hospitals varies according to the specialisation (e.g. Intensive Care, Paediatrics, Oncology). This influence was not examined in the present study. For example, the Work Environment Index (Lake, 2002) may be helpful in examining the influence on CPD and what local factors are present that stimulate or impede participation in CPD activities.

■ *One Possible Future Research Design for a Hospital.*
This researcher would suggest that only one institution or department be selected for the next stage of research. After approval by the Executive Board and Ethics Committee, a survey using the Q-PDN would be the starting point. After analysing the data, results would be presented and local implementation teams formed. The implementation teams would propose specific interventions and predict the benefits to be gained. After an agreed period, the questionnaires would be sent out again to measure the effects of the intervention. New interventions would then be introduced, based on the findings of the survey and the survey then reseeded for another cycle in the process. The whole project would have a cyclical character in which the continuity of the process is crucial and decisive.

As for comparisons between departments and between institutions (national and international), these will probably produce revealing and contrasting results. Hospitals

can learn together and from one another and the findings may be published. Each context has its own successes, from which lessons can be learned and successful interventions identified. A cyclical process may be followed again. The model below shows the process schematically.



Samenvatting (Dutch)

In een ziekenhuisorganisatie zijn de professionele kwaliteiten van medewerkers van doorslaggevende betekenis voor de kwaliteit van het primaire proces. Het op peil houden van deze kwaliteit is van groot belang voor de patiënt en organisatie. Momenteel lopen binnen ziekenhuizen tal van projecten die inzichtelijk moeten maken in welke vorm dit proces het meest doelmatig en doeltreffend kan verlopen. Hierbij manifesteert zich een spanningsveld met aan de ene kant professionalisering gericht op de dienstverlening, loopbaan en persoonlijke/professionele ontwikkeling (Kwakman, 2001) en aan de andere kant de invloed die de organisatie hierop heeft (contextuele invloed) (van der Krogt, 2007).

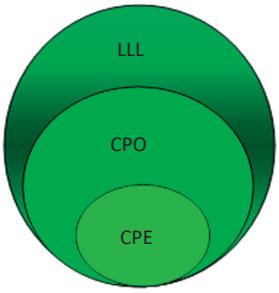
Enerzijds is dus de bedrijfsmatige kant te onderscheiden die zich richt op het optimaliseren van de dienstverlening en anderzijds doen werknemers pogingen om hun vak, hun functioneren en loopbaankansen verder te ontwikkelen. Met andere woorden: zij zijn bezig met het vormgeven van hun Continue Professionele Ontwikkeling (CPO).

De concepten CPO en CPE (Continue Professionele Educatie) worden vaak door elkaar gebruikt. CPO kan gaan om alle relevante leeractiviteiten, hetzij op formele en gestructureerde wijze of informeel en zelf-gericht. Binnen deze studie wordt de definitie van the American Nurse Association (ANA) overgenomen: “een levenslang proces van actieve deelname door verpleegkundigen aan leeractiviteiten die helpen bij het ontwikkelen en onderhouden van hun bekwaamheid, verbetering van hun beroepspraktijk, en ondersteuning bij het bereiken van hun loopbaandoelen” (ANA, 2010). Deze definitie wordt gekozen voor alle deelonderzoeken. Hij toont aan dat CPO niet alleen belangrijk is voor het verbeteren van de verpleegkundige beroepsuitoefening, maar ook bij het nastreven van doelen ten aanzien van de individuele loopbaan.

Doel van dit onderzoek is om de relatie tussen de verschillende factoren die invloed hebben op CPO van verpleegkundigen te verduidelijken. De in dit proefschrift beschreven studies zijn alle gericht op de individuele verpleegkundigen zelf. Hun meningen en opvattingen werden gevraagd om helder te krijgen wat hen zou stimuleren om CPO-activiteiten te ondernemen. Drie factoren (motieven, belang en condities) waren hierbij de onafhankelijke variabelen. Het effect van deze variabelen op het daadwerkelijk ondernemen van CPO-activiteiten verschaft inzicht in de vragen welke factoren verpleegkundigen het sterkst stimuleren en wat de interactie is tussen deze factoren. Andere studies beschrijven wel de individuele factoren, maar niet hun interacties (Berings, Poell, Simons & Van Veldhoven, 2007; Broad, 2002; Hemmington, 2000; Friedman, 2004).

In aanvulling op de beschreven definities van een Leven Lang Leren (LLL), Continue Professionele Ontwikkeling (CPO) en Continue Professionele Educatie (CPE), worden de verschillende factoren die op de uitoefening van CPO-activiteiten van invloed kunnen zijn geschetst. Een aantal van deze activiteiten is meer gerelateerd aan werkplekleren dan aan formele onderwijs- en opleidingstrajecten. LLL, CPO en CPE zijn onderling met

elkaar verbonden. LLL is een overkoepelend concept dat CPO bevat. CPE is een subset van CPO. Onderstaande figuur geeft dit schematisch weer (zie Figuur 1).



Figuur 1. De relatie tussen een Levenlang Leren (LLL), Continue Professionele Ontwikkeling (CPO) en Continue Professionele Educatie (CPE).

Het daadwerkelijk ondernemen van CPO-activiteiten kan vanuit verschillende invalshoeken bekeken worden:

- Persoonlijk (loopbaan en de wens om zichzelf te ontwikkelen)
- Professioneel (de klinische praktijk verbeteren) en
- Organisatorisch (daling personeelsverloop en vermindering van tekorten, de kwaliteit van de zorg).

Een relevante vraag is daarom welke overwegingen verpleegkundigen hebben om CPO-activiteiten te ondernemen. Is hun motief in de eerste plaats om de patiëntenzorg te verbeteren of is het om een meer persoonlijke reden, zoals loopbaanontwikkeling? Een andere factor die CPO-deelname kan verklaren is het belang dat verpleegkundigen toekennen aan een bepaalde CPO-activiteit. Een derde factor die van invloed is op CPO-deelname zijn de condities waaronder deze plaatsvindt. Er is veel geschreven over tijd en geld als belangrijkste factoren die de participatie in CPO-activiteiten beïnvloeden (Henderson & Winch, 2008; Hogston, 1995; Larcombe & Maggs, 1991; Manley, Titchen & Hardy, 2009; Merriam, Caffarella & Baumgartner, 2007, Nolan, 1995). Echter, er zijn meerdere andere factoren (bv. management, coaching) die deelname aan CPO-activiteiten beïnvloeden (Ellis & Nolan, 2005; Hughes, 2005; Danielson & Berntsson, 2007). De drie bovengenoemde factoren (motieven, belang, condities) lijken allemaal het ondernemen van CPO-activiteiten te beïnvloeden. De beste manier om te onderzoeken welke factoren daadwerkelijk invloed hebben is om het de verpleegkundigen zelf te vragen.

In de reeks studies binnen dit proefschrift werd onderzocht in welke mate de motieven, het belang van CPO en de condities waren gerelateerd aan het daadwerkelijk ondernemen van CPO-activiteiten. Zoals eerder gemeld zijn de individuele factoren in vroegere studies reeds geanalyseerd (Berings, Poell, Simons, & Van Veldhoven, 2007; Broad, 2002; Hemmington, 2000; Friedman, 2004). Echter, de onderlinge relaties tussen deze factoren zijn nog niet onderzocht. Dergelijke onderzoeken zijn belangrijk voor de

wijze waarop CPO-activiteiten het beste kunnen worden gestimuleerd. Werkgevers doen inspanningen om de werkomgeving aantrekkelijker te maken, zodat verpleegkundigen behouden blijven voor de organisatie. Professionele organisaties zetten zich in om de professionaliteit van de verpleegkundigen te vergroten en onderwijscentra bieden op maat gemaakte leerprogramma's. Verschillende actoren zijn op dit moment samen aan het werk om CPO voor verpleegkundigen te ondersteunen en te stimuleren. Werkgevers en beroepsverenigingen werken regelmatig samen aan deze kwestie en onderwijscentra ondersteunen dit proces met leerprogramma's. Daarom zijn deze stakeholders uitgenodigd om deel te nemen aan de eerste deelstudie. Er was in deze Delphi-studie een duidelijke consensus over de noodzaak van deelname aan CPO-activiteiten. Belangrijke rollen voor elke groep belanghebbenden werden geïdentificeerd en een set van motiverende factoren kwam naar voren.

De mening van de verpleegkundigen werd in kaart gebracht d.m.v. een survey. De hiervoor gebruikte vragenlijst "Questionnaire – Professional Development of Nurses" (Q-PDN) werd uitgezet om de motivatie, het belang en de benodigde condities te meten, die invloed kunnen hebben op de mate waarin verpleegkundigen CPO activiteiten ondernemen. Factoranalyse liet vervolgens een aantal onderliggende factoren zien, die hierna worden toegelicht.

Motieven voor CPO-participatie.

De studie identificeert drie belangrijke motieven voor verpleegkundigen om CPO-activiteiten te ondernemen:

1. Persoonlijke / Professionele ontwikkeling.

Eerste motief is om de persoonlijke en professionele ontwikkeling op peil te houden c.q. te verhogen. Dit motief werd al eerder in de literatuur beschreven (Gould, Drey & Berridge, 2007; Lindsay, 1990; Larcombe & Maggs, 1991; O'Connor, 1992; Turner, 1991; Thurston, 1992; Waddell, 1993). Belangrijk kenmerk van professionals is dan ook de verplichting om hun professionele ontwikkeling up-to-date te houden en aan de verwachtingen van patiënten en samenleving tegemoet te komen.

2. Loopbaan.

Tweede motief is gericht op de loopbaan. Friedman (2013) en Gould, Drey en Berridge (2007) beschreven dit motief eerder al. De mogelijkheden voor een volgende loopbaanstap van een verpleegkundige zijn toegenomen door horizontale en verticale differentiatie (Nivel, 2004). Horizontale carrièremogelijkheden bieden meer mogelijkheden door de vele specialisaties zoals bijv. Intensive Care, Oncologie, Pediatrie en Palliatieve zorg, terwijl met de introductie van de verpleegkundig specialist het beroep van verpleegkundige verticale mogelijkheden biedt op het wetenschappelijk niveau (Nivel, 2004).

Van der Krogt (2007) beschreef het belang van CPO vanuit een meer strategische focus op carrièremogelijkheden: een meer planmatige aanpak voor CPO-activiteiten die de loopbaan van verpleegkundigen ondersteunen en hun in staat stellen om meer regie over de eigen loopbaan te hebben.

3. Voldoen aan eisen.

Derde motief is "het voldoen aan eisen". Dit kan worden beschreven vanuit verschillende invalshoeken. Op de eerste plaats vanuit de behoeften van de patiënt. De steeds assertievere patiënten en hun pleitbezorgers (familieleden of belangenbehartigers) verwachten steeds meer zorg op maat. Gevoegd bij de snelle ontwikkeling van moderne behandelingen en medische procedures, moeten verpleegkundigen hun kennis en vaardigheden up-to-date houden met het oog op een hoge kwaliteit van zorg. Dwingende eisen van de werkgever spelen hierbij een belangrijke rol. Werkgevers zijn verplicht om vastgestelde regels in acht nemen om te voldoen aan de huidige wetgeving. Het is van groot belang om aan deze eisen te voldoen voor een veilige en transparante zorg.

In aanvulling op de werk- en opleidingseisen, omschreven in de Wet op de beroepen in de individuele gezondheidszorg (de Wet-BIG), moet er ook aan de eisen van de kwaliteitsregisters van de verschillende beroepsorganisaties worden voldaan (BIG-register, 1996; V & VN, 2007). Deze registers zijn in de afgelopen jaren steeds veeleisender, voorschrijvender en normatiever geworden. Geaccrediteerde CPO-activiteiten stellen de verpleegkundigen in staat aan te tonen dat zij voldoen aan deze eisen (Friedman, 2013; Grossman, Lawton & Wimpenny 2003).

Welke CPO-activiteiten worden belangrijk gevonden?

Ook het belang van CPO liet drie factoren zien.

1. Klinische praktijk.

Deze studie toonde aan dat verpleegkundigen in de eerste plaats CPO-activiteiten belangrijk vinden gericht op de klinische praktijk. Dit is op zich niet verrassend, aangezien dit doel het hart van het verpleegkundige beroep is. De literatuur ondersteunt deze bevinding (Grossman, 1998; Lawton & Wimpenny, 2003).

2. Deelname aan onderzoek.

De tweede factor was de mate waarin verpleegkundigen het belangrijk vonden aan onderzoekprogramma's deel te nemen. Een van de kenmerken van een beroep is dat het een Body of Knowledge opbouwt (Nieswiadomy, 2009), met andere woorden, evidence-based handelt. Een belangrijke impuls is gegeven door de introductie van de verpleegkundig specialisten. Echter, het vertalen, implementeren en toepassen van onderzoeksresultaten in de dagelijkse praktijk vraagt nog steeds de nodige aandacht. Het feit dat deze factor het minst belangrijk werd bevonden zou kunnen betekenen

dat verpleegkundigen geen directe rol voor zichzelf zien bij de implementatie van de onderzoeksresultaten in de dagelijkse praktijk (Speet & Francke, 2004). Een andere verklaring kan zijn dat deze rol meer geschikt geacht wordt voor andere, hoger opgeleide verpleegkundigen, zoals verpleegkundig specialisten. Hun mogelijke rol is het vertalen en implementeren van wetenschappelijke resultaten in de dagelijkse praktijk. Door prioritering van uitvoering van bevindingen uit de wetenschappelijke literatuur kan de verpleegkundige beroepsgroep zelf bepalen wat belangrijk is en wat niet. Mogelijk dat dit stimulerend werkt om deze resultaten in de klinische praktijk te implementeren (Leistra, Lover, Geomini & Stephens, 1999). Een overeengekomen infrastructuur op ziekenhuisniveau voor het identificeren en analyseren van problemen, wetenschappelijke resultaten en de implementatie van deze resultaten zou hierbij ondersteunend kunnen zijn. Het Magnet-concept is een voorbeeld uit de Verenigde Staten dat in dit opzicht (Hess, 2011) positieve effecten laat zien.

3. Deelname aan Organisatieontwikkeling.

Deelname aan organisatieontwikkeling komt naar voren als een belangrijke CPO-activiteit. Dit kan worden vertaald in het hebben van invloed op het beleid, gezien de items uit de Q-PDN ("Participatie in en het up-to-date houden van het voorgestelde beleid"). Een onderscheid kan worden gemaakt in het beleid op afdelings- en organisatieniveau. Verpleegkundigen hechten er veel belang aan om te worden betrokken bij de vorming van dit beleid. De literatuur ondersteunt dit door het onderschrijven van de shared-governancestructuur, waarin de verpleegkundige invloed aanwezig is op alle niveaus binnen de organisatie (Clavelle, Porter-O'Grady & Drenkard, 2013).

Benodigde condities

Twee factoren kwamen naar voren: materiële en immateriële condities. Materiële beperkingen zoals tijd en geld werden vaak aangehaald in de literatuur als barrières voor CPO (Larcombe & Maggs, 1991; Hogston, 1995; Nolan et al, 1995). Verschillende pogingen zijn op dit moment gedaan om deze belemmeringen op te heffen. Bijvoorbeeld door middel van een persoonsgebonden budget (CAO Universitair Medische Centra, 2007) en de kwaliteitsimpuls voor de professionaliteit van het ziekenhuispersoneel (Kwaliteitsimpuls, 2014).

Immateriële condities hebben betrekking op de houding en steun van de leidinggevende en collega's. Coaching, intercollegiaal overleg en samenwerkend leren zijn voorwaarden die op verpleegafdelingen wenselijk zijn voor het stimuleren van CPO. Dit wordt ook beschreven door Hemmington (2000), die ingaat op het belang van collegiale ondersteuning en begeleiding. De behoefte aan een positieve en ondersteunende leiderschaps- en managementstijl wordt ook onderschreven in de literatuur (Acharya, 1994;

Macdonald, 1994; Hogston, 1995; Ellis & Nolan, 2005; Hughes, 2005). Kortom, de werkplek kan een belangrijke plaats innemen bij het ondernemen van CPO-activiteiten; echter, er moet dan wel aan de eerder beschreven condities voldaan worden.

Ondernomen CPO-activiteiten

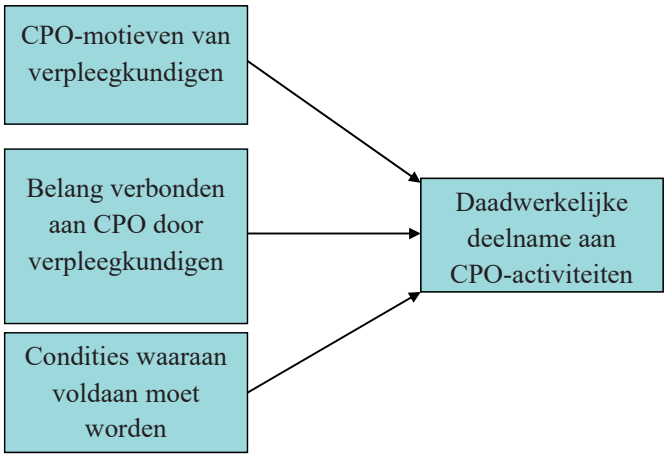
De CPO-activiteiten die verpleegkundigen ondernemen variëren voortdurend (Speet & Francke, 2004). Eraut (2004) meldde dat werkplekleren essentieel is en dat de werkplek een krachtige leeromgeving is (Kessels, 1996; Laker & Field, 2005). Berings *et al.* (2008) onderscheidden een aantal categorieën van leeractiviteiten bij verpleegkundigen in Nederland. Dit betrof leren door het reguliere werk te doen, door iets nieuws toe te voegen aan het werk, door sociale interactie met collega's, door theorie, door activiteiten buiten het werk, en door reflectie. Echter, onderzoek van Veer *et al.* (2012) laat zien dat driekwart van de verpleegkundigen deelgenomen heeft aan CPO door het volgen van cursussen. CPO is meer dan alleen het volgen van cursussen. De vraag is waarom deze cursussen worden gevolgd. Is het omdat het verplicht is, of is het omdat het belangrijk gevonden wordt? Bij "ondernomen CPO-activiteiten" kwamen dezelfde factoren naar voren als bij "belang"; Deelname aan de Klinische praktijk, Deelname aan Onderzoek, en Organisatieontwikkeling. Conclusie was dat de CPO-activiteiten die belangrijk werden geacht niet altijd worden ondernomen. Redenen hiervoor zijn te vinden in de condities (werkplek) en/of het beleid.

Uit een vergelijkende studie die vervolgens is uitgevoerd tussen een Nederlands en een Amerikaans ziekenhuis is gebleken dat er een mogelijk verband bestaat tussen de organisatiestructuur (shared governance) en de CPO-activiteiten in ziekenhuizen. Er werd een vergelijking gemaakt tussen een academisch ziekenhuis in Nederland en een Magnet®-ziekenhuis in de Verenigde Staten. Het label 'Magnet® Hospital' werd toegekend aan ziekenhuizen die in staat zijn om succesvol verpleegkundigen te werven en te behouden. Deze ziekenhuizen staan bekend om hun betere werkomgevingen en hoger opgeleide verpleegkundigen (Kelly, 2011). Het hebben van invloed binnen de organisatie lijkt de ontwikkeling van de individuele verpleegkundige en van de verpleegkundige beroepsgroep als geheel te beïnvloeden.

De data toonden significante verschillen tussen de Nederlandse en Amerikaanse groepen op bijna alle factoren. De Amerikaanse verpleegkundigen toonden een hogere score op CPO-activiteiten ten aanzien van organisatieontwikkeling. Dit kan een direct gevolg zijn van het Magnet®-concept. Een ander verschil was de deelname aan onderzoek: Amerikaanse verpleegkundigen scoorden hoger op deze CPO-activiteit. Als laatste lieten beide ziekenhuizen zien dat de mate waarin CPO wordt ondernomen minder is als deze minder relevant voor de praktijk wordt bevonden.

Relatie tussen de factoren: het best passende model

Het doel van het onderzoek was om de relatie tussen de drie beïnvloedende constructen en de werkelijke CPO-participatie vast te stellen. De resultaten toonden aan dat de feitelijke deelname aan CPO-activiteiten voornamelijk beïnvloed wordt door het belang dat verpleegkundigen hechten aan CPO, welk op zijn beurt beïnvloed wordt door hun motivatie om CPO te ondernemen en door de mate waarin aan relevante condities wordt voldaan. Aanvankelijk werd aangenomen dat alle drie de factoren een directe relatie met CPO-activiteiten hebben (figuur 2). De volgende stap was om de relatie tussen "Condities", "Motieven" en "Belang" te onderzoeken. De aanname was dat het belang van een CPO-activiteit kan worden beïnvloed door de mate waarin de omstandigheden en motieven aanwezig waren (zie Figuur 2).

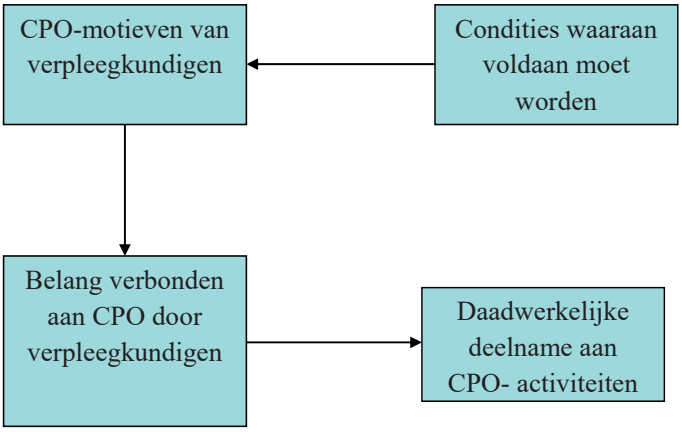


Figuur 2. Aanvankelijk veronderstelde relaties tussen CPO-motieven, CPO-belang, CPO-condities en Daadwerkelijk ondernomen CPO-activiteiten.

Na toepassing van Structural Equation Modeling (SEM) werd deze aanname nogmaals en diepgaander onderzocht. De factoren bleken nog steeds van invloed te zijn, alleen de relaties tussen de verschillende factoren bleken anders te liggen. Figuur 3 toont het uiteindelijke model dat op basis van de analyses vastgesteld werd.

"Condities" beïnvloeden "motieven", en "motieven" beïnvloeden hoe belangrijk een specifieke CPO-activiteit wordt gevonden, wat op zijn beurt van invloed is op de daadwerkelijke deelname aan CPO-activiteiten. Relaties tussen deze vier constructen werden niet eerder gemeld in de literatuur. Een belangrijk resultaat van dit onderzoek is dat een valide en betrouwbaar beeld is verkregen van de factoren om CPO-deelname van verpleegkundigen te stimuleren (weergegeven in Figuur 3).

Verpleegkundigen geven dus aan actief te willen bijdragen en invloed willen hebben op de manier waarop de organisatie zich ontwikkelt. Daarom is een deel van deze studie



Figuur 3. *Uiteindelijk vastgestelde* relaties tussen CPO-motieven, CPO-belang, CPO-condities en Daadwerkelijk ondernomen CPO-activiteiten.

besteed aan een onderzoek in de USA, waar de rol van verpleegkundigen is ingebed op een zodanige wijze dat invloed kan worden uitgeoefend. Kantekening hierbij is dat een dergelijk proces lange tijd in beslag neemt. In de VS is men reeds in de jaren ‘60 begonnen met het bouwen van de governance-structuur. Vasthoudendheid en een lange adem zijn daarom noodzakelijk. Andere kanttekening is het cultuurverschil. De Amerikaanse cultuur verschilt met die van Nederland. Waar de Amerikaanse cultuur meer masculien is en ingesteld is op competitie en hiërarchie is de Nederlandse cultuur meer feminien en ingesteld op dialoog en consensus (Hofstede, 2001). Echter met de ervaringen opgedaan in de VS kunnen ziekenhuizen in Nederland wel hun profijt doen om te komen tot een structuur waarbinnen de verpleegkundige beroepsgroep meer invloed kan uitoefenen op het beleid en het beroep de plek krijgt die het verdient.

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About the Author

Gerard Brekelmans werd op 7 februari 1955 in Goirle geboren. Na de middelbare school begon hij als ziekenverzorger in het Verpleeghuis St. Elisabeth in Goirle. Daarna startte hij zijn opleiding tot A-verpleegkundige in het St. Elisabeth ziekenhuis in Tilburg. Na het afronden van de Intensive Care opleiding werkte hij 14 jaar op de Intensive Care in het genoemde ziekenhuis in Tilburg. Zijn interesse voor het onderwijs groeide met de jaren en hij verzorgde lessen bij verschillende opleidingsinstituten. Om de benodigde deskundigheid verder uit te breiden rondde hij de 1ste en 2de graads lerarenopleiding af. In 1993 maakte hij de definitieve overstap naar het onderwijs. Eerst 2 jaar in Bennekom om daarna in 1995 de overstap te maken als coördinator specialistische vervolgopleidingen Intensive Care naar het Erasmus MC in Rotterdam. Daarnaast was hij tevens voorzitter van de Nederlandse Vereniging voor Intensive Care verpleegkundigen. Hierdoor kwam hij in aanraking met tal van landelijke ontwikkelingen en stond o.a. aan de wieg van de Landelijke Regeling Verpleegkundige Vervolopleidingen (momenteel het College Ziekenhuis Opleidingen) en Algemene Vergadering Verpleging en Verzorging (AVVV). Hij was mede intiator van een uitwisselingsprogramma tussen de Intensive Care's van het Erasmus MC en Strong Memorial Hospital Rochester NY. Verder was hij medeoprichter van Cadran waardoor hij in aanraking kwam met leren in een breder perspectief. Professionele Ontwikkeling als aandachtsgebied werd geboren en hij volgde de leergang FCE in België om daarna zijn leerweg te vervolgen bij de opleiding Master of Science Human Resource Development aan de Universiteit van Twente. Dit combineerde hij met de coördinatie van de unit training en Ontwikkeling binnen de Zorgacademie van het Erasmus MC. Momenteel werkt hij binnen de unit Eduplaza; Opleiding, Advies & Innovatie en houdt zich vooral bezig met Kennis en Wetenschap. Hij verzorgt hiervoor colleges Evidence Based Practice, begeleidt studenten bij hun literatuurstudie en doet onderzoek naar professionele ontwikkeling van verpleegkundigen en de invloed van de omgeving daarop.

Gerard is getrouwd en heeft drie dochters en drie kleinkinderen.

Oral presentations;

April 1999: Education system in the Netherlands; exchange program Strong Memorial Hospital Rochester USA
Oct. 2000: Training of special skills in Intensive Care education; European Congress European Society of Intensive Care Medicine Rome.
Oct. 2001: European approach for training Intensive Care nurses; 8th World Congress of Intensive and Critical Care Medicine Sydney Australia.
June 2009: The nurse as director of het own professional learning path; Academy of Human Resource Development, Newcastle UK
Dec. 2009: Strategic planning of professional development, Nursing event
Feb. 2010: Why do nurses participate in continuing professional development? A Delphi study into motivating and impeding factors, Academy of Human Resource Development, Washington USA
July 2010: Using a Delphi technique to identify motivating and impeding factors for nurses to participate in continuing professional development. International Council of Nurses, Orlando USA
Feb. 2011: Euthanasia; a close view to nurse practice in the Netherlands. Strong Memorial Hospital, Rochester USA
Feb. 2011: Continuing Professional Development; Motives and activities of Nurses in the Netherlands. Academy of Human Resource Development, Chicago USA
July 2011: Motivating and impeding factors for nurses to participate in continuing professional development, International Nursing Research Congress, Cancun Mexico
Feb. 2012: The development and empirical validation of a questionnaire measuring continuous professional development activities of nurses. Academy of Human Resource Development, Denver USA
Feb. 2013: Factors influencing the extent to which nurses in the Netherlands conduct continuing professional development activities; Academy of Human Resource Development, Washington USA
Feb. 2014: Continuous Professional Development: A Comparative study between Dutch and American nurses; Academy of Human Resource Development, Houston USA
June 2014: Continuous Professional Development: A Comparative study between Dutch and American nurses; Stti European Conference, Gothenburg

Poster presentation;

April 2009: Continuous Professional Development for Nurses; business meeting Shell Rijswijk the Netherlands

June 2009: The nurse as director of her own professional learning path; using the Delphi technique to identify the perception of experts towards Continuous Professional Development; Academy of Human Resource development (AHRD), Newcastle England.

Publications;

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