Inge A. Pool

continuing professional development across the nursing career

A lifespan perspective on CPD motives and learning activities

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Continuing professional development across the nursing career

A lifespan perspective on CPD motives and learning activities

Continue professionele ontwikkeling gedurende de verpleegkundige loopbaan.
Een levensloopperspectief op CPO motieven en leeractiviteiten
(met een samenvatting in het Nederlands)

Proefschrift

ter verkrijging van de graad van doctor aan de Universiteit Utrecht op gezag van de rector magnificus, prof. dr. G.J. van der Zwaan, ingevolge het besluit van het college voor promoties in het openbaar te verdedigen op dinsdag 17 november 2015 des middags te 2.30 uur

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Promotoren:

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chapter 1

General introduction

Introduction

> To what extent I was engaged in professional development as a nurse in the past few months? I think a little bit. When I look back, it happened mainly in the years before my postgraduate intensive care training. Between my in-service nursing education and the postgraduate intensive care training, which I finished in 1992, I completed a course in tropical healthcare, a course in oncology and a management education programme of two years.
>
> We have a training day with our team twice a year. We are informed about everything that we need to know, such as diseases or new technologies. It is a kind of a refresher course, just like the symposia you visit, and the clinical teaching sessions. But these are not as specific as an educational programme, from which you learn a lot. For an educational programme you have to do homework, which can take 10 to 20 hours a week. That is something that I have not done anymore after my intensive care training.
>
> Did I miss that lately? No. It is not that I'm done with learning, but your needs change. When you are younger, you want many things. You think, "I like this and that". And when you get the opportunity, you do it. But when you are 45, 50, or even older, as I am, your needs stabilise at a certain moment. I am at a point, a destination would sound too stark, but when I look to the future; I do not want anything other than to keep working agreeably. I hope this ward stays a nice place to work at, and I try to contribute my bit. My development is located in small things'. *(Wendy, 54)*

Within the context of rapidly changing patient care, there is a growing consensus that pre-registration nursing education is just the start of learning that continues throughout a nursing career (Davis et al., 2014; Gallagher, 2007; Gopee, 2001; Webster-Wright, 2009). Continuing professional development (CPD) has been identified as crucial to maintain safe and good healthcare (Page, 2004) and is recognised as an implicit responsibility of nurses, reinforced by the increasing explicit requirements of professional regulatory nursing bodies and employers (Cutcliffe and Forster, 2010; Friedman and Phillips, 2004; Webster-Wright, 2009).

This increased emphasis on CPD coincides with an ageing workforce. Nursing workforces are ageing worldwide (Harris et al., 2010; Letvak, 2002; Spinks and Moore, 2007; Stewart-Amidei, 2006; Wray et al., 2009). In the Netherlands, where the studies for this thesis were conducted, the proportion of hospital workers aged 50 and above is growing rapidly, rising from 19% in 2003 to 27% in 2009, and it is expected to grow further to 36–39% in 2018 (Van der Windt et al., 2009). Recent changes in the retirement age from 65 to 67 will boost these changing demographics. Furthermore, the Dutch nursing workforce is ageing at a rate greater than that of the general population; in 2008, the

proportion of registered nurses over 50 years of age was higher than for the total Dutch population (Hellenthal, 2011).

A nursing career can last for more than 40 years. In these years, CPD needs can change, as Wendy's quote illustrates. A challenge for human resource development (HRD) professionals and hospital managers is to develop CPD approaches geared towards the needs of nurses of different ages (Andrews et al., 2005; Lammintakanen and Kivinen, 2012). To do this, one needs to have a clear understanding of the professional development of nurses, and of the influence of age. Knowledge about CPD is still growing. Recently, new relevant research has been published on nurses' professional development, focussing on learning on the ward (Bjørk et al., 2013; Drach-Zahavy et al., 2014; Govranos and Newton, 2014), nurses' learning paths (Poell and Van der Krogt, 2014b), and factors influencing engagement in CPD (Brekelmans et al., 2013). However, few studies have focused on CPD of nurses 45 years and older (Laughlin, 2012) and age differences in CPD (Lammintakanen and Kivinen, 2012). Accordingly, we lack knowledge on whether and how the individual professional development strategies employed by nurses change with ageing. This thesis aims to fill this knowledge gap by combining insights from the literature on CPD and lifespan theories.

In this introductory chapter, we will address the following issues. First, the concept of CPD is introduced and definitions are provided. Then we will describe nurses' CPD strategies, followed by a lifespan perspective on CPD. Next, the context of the studies, the aim of the thesis, and the research topics are defined. Finally, an outline of the thesis is given.

Definition of continuing professional development

There is no single definition of CPD that is widely accepted (Friedman and Phillips, 2004). In this thesis, we have chosen to use the term CPD to refer to '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, n.d.), which takes place after initial nursing education. This definition encompasses different functions of CPD. Through professional development, nurses update their knowledge and skills to meet the needs of patients and the health service and enhance their career and personal development (Gould et al., 2007; Peck et al., 2000).

CPD is often used interchangeably with continuing professional education (CPE) and lifelong learning (LLL) (Gallagher, 2007; Gopee, 2001), but we differentiate CPD from these related concepts. CPE commonly refers to formal educational programs (Gallagher, 2007) that can lead to recognised accredited qualifications or take the form of an accredited course (Munro, 2008). However, there are more ways to achieve professional

development. Munro (2008) postulates that nurses can also learn through non-certificated in-house training courses, learning groups in the clinical setting, and through work-based learning. Indeed, most learning required for work occurs through enactment in practice (Billett, 2014a, 2014b). The day-to-day nursing practices provide a rich resource for learning (Jantzen, 2008) through challenges of the work itself and consultation of and collaboration with colleagues (Berings et al., 2008; Eraut, 2007). Thus, CPE can be understood as part of CPD, but does not define it. CPD can also be differentiated from LLL, as these concepts differ in breadth (Garofano and Salas, 2005). The concept of CPD restricts its focus to the development of an employee during employment (Garofano and Salas, 2005), while LLL is not only considered essential for the development of employment, but also of citizenship and social cohesion (Commission of the European Communities, 2000). LLL covers the entire lifespan, and can take place lifewide (Alheit and Dausien, 2002). It is, therefore, a broader concept than is CPD.

Defining continuing professional development is complicated by the fact that it is, on the one hand, viewed as a professional's commitment to continuous learning, and on the other hand, it is approached from a re-registration perspective (Lawton and Wimpenny, 2003). From an individual professional's perspective, all situations where professionals have learned in ways that shape their practice can be defined as professional development, whether this was in formal education programmes, through interaction with colleagues, or from experiences outside work (Munro, 2008; Webster-Wright, 2009). However, a re-registration perspective on CPD more often focuses on the input of learning (the process) rather than on the outcome for practice (Lawton and Wimpenny, 2003). Influenced by an increasing sense of accountability demanded by society today, the assumption is that CPD requires monitoring (Lawton and Wimpenny, 2003). From this perspective, formal learning activities – activities that are widely recognised and legitimate for professional practice (Friedman and Phillips, 2004) – are often emphasised over informal learning activities that are less easy to count and register. The complexity is that undertaking a formal education course in nursing does not necessarily equal learning. It is possible that more meaningful learning occurs in, for instance, interaction with colleagues (Lawton and Wimpenny, 2003). Furthermore, even when meaningful learning occurs, this does not necessarily result in performance; transfer of training is affected by several factors, including climate, job utility, and rewards (Holton III et al., 2000).

Nurses' continuing professional development strategies

CPD can be studied from the perspective of various stakeholders, including the individual professional, employers, and professional bodies. All these actors have an interest in nurses' professional development, but there can be a rift in their interests and needs (Griscti and Jacono, 2006; Lawton and Wimpenny, 2003; Nolan et al., 2000; Poell and Van der Krogt, 2014a). Tensions can arise when, for instance, an employer focuses on

short–term skill development for improvement of the primary work processes, while an individual prefers to focus on personal development or career development (Lawton and Wimpenny, 2003; Poell and Van der Krogt, 2014a). Alternatively, nurses may feel pressed to comply with professional and managerial demands rather than pursue their own needs (Griscti and Jacono, 2006).

In this thesis, we study nurses' professional development from the perspective of nurses. We see nurses as 'active meaning makers who do much to shape the direction and intensity of the learning processes' (Billett, 2010, p.402). In this context, Billett (2001, 2006) differentiates between workplace affordances and individual engagement. Work–place affordances are the invitational qualities of the workplace, and refer to 'the access to activities and interactions that are required to secure the knowledge required for performance' (Harteis and Billett, 2008, p.211). Nurses' workplaces vary in the degree to which they afford opportunities for learning. They differ in the learning activities organ–ised at the ward, in learning culture, job autonomy, variety of tasks, feedback, and support (Drach–Zahavy et al., 2014; Govranos and Newton, 2014; Hart and Rotem, 1995). Further, hierarchical structure and cultural practices influence nurses' accessibility to knowledge and experiences (Skår, 2010). The opportunities for learning afforded by the workplace are a crucial factor in workers' professional development (Billett, 2001).

However, while acknowledging this key contribution of workplace affordances, it is also necessary to take into account workers' individual engagement (Billett, 2001; Harteis and Billett, 2008). People elect to engage with what is afforded to them (Billett, 2001, 2006; Harteis and Billett, 2008). Their professional development is largely influenced by their values, norms, attitudes, and competencies (Davis et al., 2014; Poell and Van der Krogt, 2011). People direct their professional development towards the continuity of their goals and interests (Billett, 2006). Even when participating in mandatory learning activities, one can exercise agency by engaging superficially or wholeheartedly in learning (Billett, 2001, 2006). In this sense, nurses can be seen as acting strategically in their professional development (Poell and Van der Krogt, 2014a). Although not always deliberately, they align their CPD activities with their CPD motives.

Lifespan perspective on CPD

People change during their lifespan. Changes occur in biological, psychological, and social functioning (Kooij et al., 2010; Sterns and Miklos, 1995). In contrast to the wide–spread belief that people's initial development is followed by a general decline with age, these changes are not solely negative (Kanfer and Ackerman, 2004; Nauta et al., 2010). Lifespan theories propose that from birth until death, both growth and decline occur (Baltes et al., 1999; Kanfer and Ackerman, 2004). In the first part of life, growth is more manifest and the decline is not yet visible, while in the second part of life, it is reversed:

growth is latent and decline is manifest (Nauta et al., 2010). In line with this, Kanfer and Ackerman (2004) distinguish four patterns of development: loss, growth, reorganisation, and exchange. In the context of CPD, losses occur in, for instance, fluid intellectual abilities, such as attention, and processing of novel information (Kanfer and Ackerman, 2004). Growth occurs in crystallised intelligence, such as general knowledge, verbal comprehension, and vocabulary (Kanfer and Ackerman, 2004). Reorganisation refers to some type of discontinuity around midlife (Kanfer and Ackerman, 2004) caused by a change in the perception of time (Carstensen et al., 1999). After this life turn, wherein people recognise that one's remaining time is not unlimited, people shift their social motives (Kanfer and Ackerman, 2004) and become more selective in the learning in which they invest effort (Illeris, 2011). The last pattern of adult development refers to an exchange in the primacy of motives across the lifespan caused by changes in personality traits and self-concept. For instance, openness to new experiences declines with age, while conscientiousness increases. Protecting the self-concept also becomes more important, leading to the avoidance of certain kinds of career development activities (Kanfer and Ackerman, 2004).

To understand the influence of ageing on nurses' CPD strategies, we use a lifespan perspective. A lifespan can be considered as a sequence of positions a person holds through time, whereby significant changes, such as marriage, getting children, and getting promoted, mark the transition from one position or social identity to the other (Nauta et al., 2010). A lifespan perspective recognises the influence of people's past experiences and expectations for the future on their attitudes and behaviour (Schalk et al., 2010). Additionally, it acknowledges the effects of inner changes (e.g. biological, psychological) and of external forces on individuals and groups (e.g. sociological changes for specific cohorts) (Kanfer and Ackerman, 2004). It recognises that people's opinions and behaviours are framed by the context of their family life and other social networks (Schalk et al., 2010). Inspired by work on motivation of older workers (Kooij, 2010), we use two lifespan theories as well as career development theory.

First, Socioemotional Selectivity theory posits that time is fundamental to people's motivation (Carstensen et al., 1999). When moving through life, people's perception of time changes from open-ended to limited. This temporal shift influences people's selection of certain types of goals. When time is perceived as unlimited, people are more likely to prioritise future-oriented goals aimed at knowledge acquisition and expanding horizons. However, when time boundaries are perceived, people are likely to select present-oriented emotional goals. In a work setting, younger workers may be more oriented to participate in training and development of new skills, while older workers may have higher motivation for activities such as building relationships with colleagues than they do for learning new skills, as they perceive their time limited to use these skills (Beier, 2008).

Second, Selective Optimisation with Compensation (SOC) theory (Baltes et al., 1999) describes how successful development across a lifespan requires the maximisation of gains (desirable goals or outcomes) and minimisation of losses (undesirable goals or outcomes). People can allocate their resources to different types of development goals: growth, maintenance, and the regulation of loss. The theory states that resources for growth will decrease with age, whereas investments in maintenance and regulation of loss increase with age. This is supported by Ebner et al. (2006), who found that younger adults had goals with a primary growth orientation, while older adults showed a stronger orientation toward maintenance and loss prevention. To develop successfully, people have to select feasible goals, optimise resources to reach these outcomes, and compensate for losses that might affect the outcome. In the context of CPD, this means that older people might restrict their work by selecting domains in which they excel, invest in training to optimise their performance, and compensate for losses by getting help from external sources such as memory aids and reference materials (Beier, 2008).

Finally, the career development model of Super and Hall (1978) proposes that people progress through different life stages. Workers progress through four stages. First, there is a trial stage characterised by identifying interests, capabilities, and fit between self and work. This is followed by the establishment stage, characterised by increasing commitment to career, career advancement, and growth. At midcareer, there can be a period of either growth, decline, or maintenance. In the late career, the disengagement stage (Kooij, 2010) is characterised by a withdrawal from the work organisation and planning for retirement (Super and Hall, 1978). A career stage model helps with understanding how nurses' needs vary at different points in their careers (Chang et al., 2006; Kooij, 2010). At the start of a vocational career, they might need support identifying their interests and developing their capabilities, while a concentration of experience after doing the same task for 10 or more years might impede workers to learn or change jobs (Nauta et al., 2010).

Context of the study

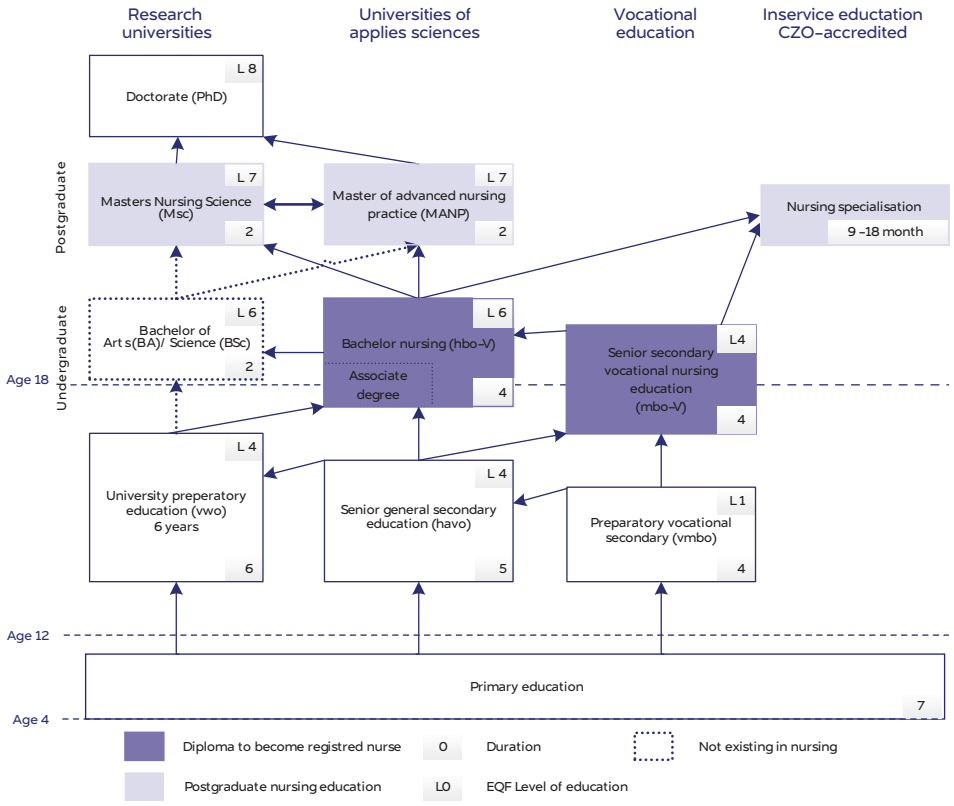
Pre-registration education

At present, in the Netherlands, there are two education programmes of four years to become a registered nurse: the senior secondary vocational education (mbo-V) and the bachelor nursing education (hbo-V) (Figure 1.1). In terms of the European Qualifications Framework (EQF) (European Commission, n.d.), the first is at EQF-level 4, and the second at EQF-level 6. The secondary vocational education is at a lower academic level than is the bachelor nursing education (Robinson and Griffiths, 2007). Confusingly, these pre-registration education programmes both lead to the same profession and the official title of Nurse.

Most middle-aged and older nurses have followed a third educational route that does not exist anymore (not depicted in Figure 1.1). Until 1997, most nurses were trained in-service in a hospital (A-nurse), a psychiatric hospital (B-nurse), or an institution for mentally handicapped individuals (Z-nurse).

In the near future, the nursing profession will be subject to changes. To keep in line with developments in healthcare, and to be prepared for the future, a new classification of professions and a corresponding educational structure for the healthcare sector will be developed. An Advisory Committee on Healthcare Professions will advise the Minister of Health, Welfare and Sport on these. Advice on the educational structure is expected in 2016 (National Health Care Institute, n.d.). This might result in a change of the Dutch nursing education, and probably lead to a change of the current system, which includes two different education programmes leading to the same profession.

Figure 1.1. The Dutch (postgraduate) nursing education system (based on Nuffic, 2015a, 2015b).



Post-registration education

After pre-registration nursing education, nurses can obtain qualifications at the post-registration level in a variety of nursing specialisations. Postgraduate training is mandatory to be eligible to work in certain specialised wards, such as paediatrics, intensive care, and emergency care. These programmes for nursing specialisation have a length of 9 to 18 months. In these months, traineeship and education are combined. They are primarily provided by hospital education centres and some universities of applied sciences (hbo), and are nationally accredited by the National Institute for Accreditation of Care Education Programmes (CZO). Specialised postgraduate training programmes also exist for other wards such as neurology, but these are not nationally obligatory. Nurses with a bachelor's degree in nursing can also enrol in a professional master's programme at a university of applied sciences (hbo) to become a nurse practitioner and in a scientific master's programme in nursing science at a research university (Figure 1.1).

Regulation

The provision of healthcare services by individual practitioners is regulated by the Individual Healthcare Professions Act, generally known by its Dutch acronym, 'BIG'. Nurses must be BIG-registered to be eligible to work as a nurse[1] and, since 2009, they must re-register every five years. To renew their registration, they have to provide proof of a minimum of 2080 hours of practice over five years.

In contrast to some other countries such as the United Kingdom (Cutcliffe and Forster, 2010), there is no mandated requirement for CPD. Nurses can voluntarily register CPD activities in the National Quality Register (Dutch Nursing Association [V&VN], n.d.). Nevertheless, engagement in CPD is becoming less optional. Employers increasingly require nurses to be involved in CPD, given the need for accountability demanded by society. To become awarded with an accreditation by institutions such as the Joint Commission International or the Netherlands Institute for Accreditation in Healthcare, hospitals are progressively requested to demonstrate that their workforce is competent.

Therefore, some hospitals require nurses to keep track of their CPD activities in a portfolio, some use a learning management system for this purpose, and others demand nurses to register their activities in the National Quality Register. The Netherlands has engaged in a growing debate on mandatory CPD. In December 2014, the Dutch Minister of Health, Welfare and Sport sent a letter to the House of Representatives expressing the intention to extend the legal requirements for re-registration with mandatory CPD with a final test and peer evaluations.

1. Nurse practitioners have to register in a specialists' register, which has stricter requirements that fall under another section of the BIG-law than nurses. We will not expand on these, as the studies in this thesis focus on nurses and not on nurse practitioners.

Aim of the thesis

The purpose of this thesis is to contribute to a better understanding of the dynamics of CPD across the nursing career. It presents a series of studies aiming to clarify how and why nurses engage in CPD, and to what extent their CPD strategies are influenced by age-related changes. The following topics and research questions will be addressed:

Topic 1 **The concept of CPD**
a) What are nurses' and managers' perceptions of the concept of CPD?

Topic 2 **The operationalisation of ageing in the context of CPD**
a) How can age in the context of CPD be conceptualised and operationalised?

Topic 3 **Nurses' CPD strategies**
a) What motives do nurses have to engage in CPD activities?
b) Which CPD activities do nurses use?

Topic 4 **The influence of age on nurses' CPD strategies**
a) What is the influence of age on CPD motives?
b) What is the influence of age on CPD activities?
c) Which age-related factors contribute to differences in CPD strategies?

Thesis outline

Five studies were conducted, which are described in Chapters 2 to 6. This thesis can be read as a book with successive chapters. However, as the thesis is also a collection of related (published) papers, some repetition and overlap across chapters is inevitable.

Chapter 2 describes our first study. In this exploratory study, we aim to develop a better understanding of nurses' and managers' perceptions of the concept of CPD, and to obtain insight into the perceived differences in CPD of younger and older nurses. For a better understanding of these issues, we held focus group discussions with nurses and nurse managers.

Chapter 3 (study 2) describes the results of a literature review examining whether and how CPD differs across age groups. We applied a framework with five perspectives on age to distinguish factors contributing to these age differences. As research on age differences in CPD is scarce in nursing, we also included studies of workers in general.

Chapter 4 (study 3) addresses CPD strategies across a nursing career. In biographical interviews, nurses were asked about their CPD motives and activities in the past, present,

and future across their nursing careers. The focus is on similarities and differences in CPD strategies used by younger, middle-aged, and older nurses, and on exploring the relationship between life, work, and learning.

In Chapter 5 (study 4) we explore how CPD motives and activities are related. It describes a literature review on nurses' motives to engage in CPD activities, and their CPD activities. The review results were used to develop a framework to examine more thoroughly relationships between CPD motives and CPD activities that we had noticed in the data of our third study.

In Chapter 6 (study 5) we describe a survey study. This study forms an integration of insights of the earlier studies and examines these understandings in a larger group of nurses. Nurses' engagement in professional development across the career is investigated by examining the influence of age, tenure, and home situation on nurses' CPD motives and learning activities.

Chapter 7 summarises and discusses the findings of the thesis. Limitations of the studies are addressed as well as theoretical and practical implications. In addition, suggestions for future research are discussed.

chapter 2

Nurses' and managers' perceptions of continuing professional development for older and younger nurses

A focus group study

This chapter is based on:
Pool, I., Poell, R., Ten Cate, O., 2013.
Nurses' and managers' perceptions of continuing professional development for older and younger nurses:
A focus group study.

International journal of nursing studies 50 (1), 34–43.

Abstract

Background

Continuing professional development of nurses is increasingly necessary to keep abreast of rapid changes in nursing care. Concurrently, the nursing workforce is growing older. Therefore, future strategies for continuing professional development should be directed at both younger and older nurses. Although there is some evidence that various personal, organisational and social factors result in lower participation of older workers in development activities, age-related differences in continuing professional development among nurses remain under-explored.

Objective

This study explored nurses' and their managers' perceptions of the differences in continuing professional development between younger and older nurses.

Design

A qualitative study using focus groups. The interviews were analysed using a thematic analysis strategy.

Settings and participants

This study took place in a large academic hospital in the Netherlands. Twenty-two nurses in three age groups (20–34 years, 35–49 years and 50–65 years) and 10 nurse managers participated in four focus groups.

Results

Six themes regarding differences in continuing professional development for younger and older nurses emerged from the data: (1) level of focus, (2) creating possibilities to leave the bedside, (3) ambitious young nurses, (4) same resources, different requirements, (5) ceiling in courses for older nurses, and (6) social status and self esteem. Overall, participants seemed to conceptualise continuing professional development along three dimensions: purpose, level of formality of learning activities, and scope of development.

Conclusions

The findings suggest that participants perceive differences in continuing professional development between younger and older nurses. Its purpose and the contributing learning activities are considered to change during the lifespan. When developing strategies for continuing professional development, the requirements and needs of different age groups need to be taken into account. Whether the scope of professional development is confined to 'keeping up to date' or used more broad, including 'expansion of skills and knowledge' seems to relate more to nurses' attitudes towards work than to their age.

Introduction

Continuing professional development (CPD) of nurses is increasingly necessary to keep abreast of rapid changes in patient care due to advancements in knowledge and technology (Atack, 2003; Berings, 2006; Gopee, 2001). Concurrently, the nursing workforce is growing older. In Dutch hospitals, the percentage of workers over 50 years of age has grown from approximately 19% in 2003 to 27% in 2009 and is expected to grow further to 36–39% in 2018. The average age, 41 in 2008, is likely to increase in coming years (Van der Windt et al., 2009). This demographic trend is seen in other western countries, such as the United Kingdom (Harris et al., 2010; Wray et al., 2009), Canada (Spinks and Moore, 2007) and the United States (Letvak, 2002; Stewart-Amidei, 2006).

These two issues underscore the importance of understanding and managing CPD of older nurses. Employers, nurses associations and national health agencies, used to a workforce traditionally dominated by younger nurses (Palumbo et al., 2009), are challenged to develop CPD approaches geared towards the needs of all age groups (Andrews et al., 2005; Lammintakanen and Kivinen, 2012). As different age groups have different work-related concerns due to differences in experience, level of seniority, and skill set (Buchan, 1999; De Lange et al., 2010; Wray et al., 2009), it is likely that they also have different CPD needs.

Continuing professional development

There is no doubt about the importance of CPD in nursing. CPD benefits patient care, the organisation and the individual (Nolan et al., 2000; Wood, 1998). It reportedly contributes to higher job satisfaction, organisational commitment, and lower stress (Berings, 2006; Chien et al., 2008). Lack of CPD appears to influence nurses' decisions to leave their profession (Hallin and Danielson, 2008) and to retire early (Andrews et al., 2005; Armstrong-Stassen and Schlosser, 2008). Therefore, employers, nurses' associations and national health agencies are developing strategies to promote CPD. In several countries, such as Canada and the United Kingdom, CPD is required for renewal of registration as a nurse (Cutcliffe and Forster, 2010; Nursing and Midwifery Council, 2010). This is different in the Netherlands, where nurses can voluntarily register their CPD activities in a National Quality Register developed by the Dutch Nurses Association (Dutch Nursing Association [V&VN], n.d.).

Despite the importance of CPD, there seems to be little consensus on its definition. Several related concepts, such as continuing professional education (CPE) and lifelong learning are used interchangeably, but sometimes with different meanings (Gallagher, 2007; Gopee, 2001). There is confusion on the definition of CPD, its purpose, the related learning activities and its beneficiaries (Friedman and Phillips, 2004). The American Nurses Association (ANA) has defined nursing professional development as '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, n.d.). This is a useful definition because it encompasses different purposes of CPD. It fits with nurses' perceptions of CPD as important for enhancing service provision, maintaining safety for patients and themselves, and increasing career and personal opportunities (Gould et al., 2007).

Nurses develop their expertise through a broad range of learning activities varying from formalised courses to interactions with colleagues and other daily work experiences (Berings, 2006; Eraut, 2007; Estabrooks et al., 2005). Opinions vary on the learning activities that can be qualified as CPD (Friedman and Phillips, 2004). Some confine CPD to formal learning or CPE, referring to intentionally planned learning in an educational setting. Others use a broader definition of CPD, and include informal learning activities, defined as learning in a workplace environment. Both the Dutch Quality Register and the UK PREP (CPD) standards hold this broader perspective, providing nurses the opportunity to record formal and informal learning activities (Nursing and Midwifery Council, 2010; Dutch Nursing Association [V&VN], n.d.).

Age-related differences in CPD

In nursing, little research has been done on the relationship between participation in CPD activities and age, and existing data seem to be contradicting. Dorsett (in Letvak, 2002) found that age was a predictor of updating behaviour: older nurses (defined as age 40 and older) were more likely to keep up to date. This was confirmed by Lammintakanen and Kivinen (2012) who showed that of three age groups the youngest nurses participated least in CPD. In contrast, Wray et al. (2009) found that nurses over 50 years undertook fewer development activities than nurses under 50. These contradicting findings might be explained by differences in research design. Lammintakanen and Kivinen (2012) investigated participation in 23 different CPD activities, both formal and informal learning activities, while Wray et al. (2009) appeared to investigate formal learning activities. Research in other professions shows that in general, older workers tend to be less likely to participate in CPD, especially when considering formal CPD activities and workers in late career (older than 50/55 years) (Maurer et al., 2003; Taylor and Urwin, 2001).

Age differences in CPD participation rates can be caused by several factors. First, ageing can result in a higher level of knowledge and expertise. This might reduce the need for older workers to participate in learning activities (De Lange et al., 2010; Wray et al., 2009) and might influence their preferences for certain CPD activities. Daley (1999) showed that more experienced nurses preferred work-based activities such as dialogue with colleagues, while novice nurses reported to learn more from formal training. This was supported by Lammintakanen and Kivinen (2012), who found similar variation in CPD activities among nurses from different ages.

Second, lower participation in CPD by older workers might also be a result of a lack of training opportunities, limited employer support for older workers (De Lange et al., 2010; Lankhuijzen, 2002; Taylor and Urwin, 2001) and less encouragement from co-workers and others (Maurer et al., 2003; Van Roekel-Kolkhuis Tanke, 2008). This lower social support can be caused by existing stereotypes of older workers (Gray and McGregor, 2003; Maurer, 2001). One stereotype is that older workers are often perceived as less able to learn than their younger colleagues (Gray and McGregor, 2003; Maurer, 2001). Two meta-analyses seem to confirm this. Ng and Feldman (2008) found older workers' performance in training to be slightly lower than that of younger workers. Kubeck et al. (1996) concluded from their meta-analysis that older adults showed less mastery of training material, completed the final task more slowly, and took longer to complete the programme. However, these findings should be interpreted with caution as the outcome differences could also reflect pre-training differences, and laboratory samples showed larger age differences than field samples (Kubeck et al., 1996). In addition, a large proportion of the studies in this meta-analysis focused on technology training (Ng and Feldman, 2008). These findings therefore seem to have limited implications for informal learning activities. Schulz and Stamov Roßnagel (2010) found that success in self-regulated workplace learning activities is not contingent on age. They argued that these learning activities offer workers opportunities to compensate for cognitive effects of ageing. Another stereotype is that training of older workers is a poor investment because they will retire shortly. This view is difficult to sustain as new skills often become obsolete after a few years (Gray and McGregor, 2003). Therefore, updating skills of an older worker who still has ten or more years of employment has the same benefit as doing so for a younger worker (Sterns and Doverspike, 1989). The issue of 'return on investment' becomes more complex when considering that younger workers leave organisations more often than older workers (Gray and McGregor, 2003).

To summarise, there is some evidence that age influences participation in formal learning activities and, to a lesser extent, in informal learning activities. This seems to be due to a complex set of interrelating factors, including internal attributes in nurses as well as factors outside the individual worker. However, the exact relationship between age and CPD remains poorly understood. Therefore more research on this theme is needed (Lammintakanen and Kivinen, 2012; Schalk et al., 2010).

Aim of the study

The aim of the present study was to explore nurses' and their managers' perceptions of the differences in CPD between younger and older nurses. Understanding of the relationship between age and CPD will help to better adjust CPD approaches to the needs of different age groups.

Methods

We employed a qualitative, exploratory study design using focus group discussions in a Dutch university medical centre.

Participants and groups

Four focus groups with different groups of participants (nurses in three age groups, and one group of managers) were arranged, to enable the exploration of different views (Bloor et al., 2001). As it was expected that nurses' perceptions of CPD are influenced by their age and career stage, three successive age groups were created. In accordance with previous research (Schulz and Stamov Roßnagel, 2010; Van der Heijden, 2006), the following groups were distinguished: group I (20–34 years), group II nurses (35–49 years) and group III (50–65 years). The fourth focus group consisted of nurse managers. This group was added as their management styles and views of CPD may be different and are thought to affect employees' perceptions (Hughes, 2005; Keeling et al., 1998).

Nurses who worked as a registered nurse in direct patient care and belonged to one of the specified age groups met inclusion criteria for the study. Nurse team leaders were used as intermediaries in the recruitment process. Nurse managers had to have worked as a mid-level manager (at the level between nurse team leaders and department managers) for at least 1 year to be eligible for the study. Nurse managers are responsible for the organisation of the ward, for development of local policies in line with hospitals policies and the objectives of the department manager, and they supervise and guide nurse team leaders. Nurse managers were recruited through personal invitation e-mails. Based on their willingness and availability, a suitable meeting date was chosen. Correspondence with potential participants included information on the aim and design of the study, participant inclusion criteria, the audio recording, and the researcher's telephone number and e-mail address. All participants received a confirmation e-mail specifying a meeting date, time, and place.

Data collection

In December 2009, data were collected using a semi-structured interview guide, which had been pilot tested among a group of seven experts and nurses resembling the intended study group. The discussions started with an exploration of general perceptions of CPD. Participants were encouraged to think of a nurse who 'develops continually' and a nurse who does not, and to describe the differences. Dialogue was encouraged using follow-up questions about why the first nurse develops continually while the other does not, and whether the ward staff reacts differently to developing and non-developing nurses. The second part of the discussion revolved around perceived differences between CPD for younger and older nurses. This was initiated by the question, 'Do you see differences in the way younger and older nurses develop continually?', with follow-up questions, such as 'Do the same CPD standards apply to younger and

older nurses?' As we were interested in participants' perceptions of CPD for younger and older nurses we did not define CPD, nor did we precisely define young and old.

The focus groups were held in a conference room in the hospital. The duration of each focus group was 2 h. They were audio recorded, and transcribed verbatim, using established methods for focus group transcription (Bloor et al., 2001). The discussions were facilitated by a moderator and field notes were made by the first author.

Ethical considerations

Consistent with national practice in the Netherlands, no ethical approval was required for this study because no patients were involved. The Academy of Human Resource Development standards on ethics and integrity (Russ-Eft et al., 1999) were followed. Participants were informed, both in writing and verbally, about the study's objectives and methods before providing written consent. Participants were asked to treat all information confidentially. Transcripts maintained participants' anonymity and individuals were not identifiable. The audiotapes were only accessible to the first author and the transcriptionist, and the transcripts only to the authors and a second coder.

Data analysis

Data analysis followed three steps in accordance with methods described by Miles and Huberman (1994). Analysis began after the first focus group. The transcript from this group was read several times to ensure understanding of its content and to assign codes to text segments. Then, texts from the other focus group sessions were reviewed and coded in a consecutive fashion. Codes were developed based on constant comparison and contrasting of data across focus groups. The second step of analysis involved identifying themes and trends, while the third step consisted of developing and testing propositions for constructing an explanatory framework (Miles and Huberman, 1994). To aid in the coding and retrieving of data, Maxqda (2007) software was used.

Validity and reliability

To enhance reliability, the first text was coded independently by the first author and a second coder (see Acknowledgements) (Miles and Huberman, 1994). Codes were compared, differences in opinion were discussed, and, if necessary, codes were changed. Code checking with the second coder was also performed for approximately one-fifth of the second text. The third and fourth texts were coded by the first author only. For the text that was coded by two coders, the same codes were applied by both most of the time and there were only a few differences in interpretation that required discussion and were subsequently resolved. To increase the study's credibility member validation was performed (Bryman, 2008). Participants were invited to react to the accuracy and completeness of the preliminary findings by e-mail (Chioncel et al., 2003). This validation process did not lead to any changes.

Findings

In total, 22 nurses and 10 managers from various wards in a Dutch university medical centre participated. Table 2.1 shows that age and tenure are highly interrelated: ageing coincided with years of working experience as a nurse. The findings were grouped in two categories: perceptions of CPD in general and of differences in CPD between younger and older nurses.

Table 2.1. Participants in focus groups.

	Nurses			Managers
	Group I 20–34 years	Group II 35–49 years	Group III 50–65 years	
Gender	1 male 6 female	3 male 5 female	1 male 6 female	2 male 8 female
Mean age (SD)	29.1 (4.6)	42.1 (6)*	54.6 (2.6)	47.9 (5.6)
Mean years of experience (SD)	7.6 (3.6)	16.4 (4.7)*	27.4 (7.6)	15 (7.2)
Total number	7	8	7	10

** Of one person this information is not known.*

Perceptions of CPD associated with three dimensions

Participants in all groups perceived nurses who develop continually as up to date, equipped to gain in-depth knowledge, enrolling in courses, having an intrinsic desire to develop, and open to feedback. They were seen as innovative, critically reflective, and were perceived to be key contributors to the development of the hospital ward. Participants frequently mentioned that CPD-inclined nurses tend to share their knowledge freely and invite others into their development process.

Participants identified nurses who do not develop continually as people who complete only their designated work and do not engage in extra tasks. However, these perceptions became ambiguous when the 'non-developing' distinction was linked to performance. Only a few participants related non-development to poor job performance. Most associated this with nurses who actually function well in direct patient care, even though they do not participate in special assignment teams, enrol in courses, or go to symposia. The general perception was that these nurses stay up to date to the degree necessary to keep abreast of changes in healthcare. Participants were however divided whether staying up to date should 'count' as CPD.

These ambiguous perceptions of nurses 'who do not develop continually' are likely linked to participants' divergent views on different dimensions of CPD. Three dimen-

sions emerged from the focus groups: purpose, level of formality of CPD activities and scope of development.

Purpose

Participants in all groups acknowledged that nurses could develop in order to move away from direct patient care and undertake extended nursing roles, such as teaching or becoming a team leader. However, it was stressed that nurses could also improve their direct patient care capabilities through CPD. Participants described a dichotomy: pursuing career-related learning was associated with development 'away from the patient', while becoming a better nurse was connected to development 'around the patient'. One manager articulated this as follows:

> Really, I recognise two groups. There is a group that develops in care, I mean the caring for patients. And there is a group that develops in the direction of manager or something similar.' *(Manager)*

Level of formality of CPD activities

Most participants thought of CPD as a broad range of learning activities. They perceived that nurses develop professionally through continuing education, clinical teaching sessions, reading professional journals, learning from students and other colleagues, or learning from experience. A few participants related CPD primarily to formal learning activities, such as taking a course or studying for a master's degree in nursing. These participants changed their views during the session influenced by reactions from the other participants in the focus groups.

In general, the importance of informal learning activities was emphasised. Nurses who take many courses were not necessarily perceived as 'good nurses'. After a course, one should take time to practice what has been learned. The importance of learning by experience was emphasised, as one nurse explained:

> It is also important that what you have learned is not immediately followed by another course. Things you have learned, you have to apply in practice. That is sometimes forgotten.' *(Nurse, 50–65 years)*

Scope of development

Participants agreed that nurses have to keep up to date to avoid becoming incompetent, but differed in their views as to whether this qualifies as CPD. Participants seemed to associate keeping up to date with 'reactive learning' whereby learning occurs merely as a reaction to changes on the ward. A nurse was positive that this qualifies as CPD as she said:

> The basic level of nursing is what you have to keep up with. You should already call this development. Surpassing this basic level is not the only sign of development.' *(Nurse, 35–49 years)*

Another nurse doubted that this 'narrow scope of development' could be seen as CPD, when she said:

> The question is this: Do we call keeping up to date "development"?' *(Nurse, 21–34 years)*

Participants contrasted this narrow scope with a 'broad scope of development', involving the acquisition of new knowledge and skills. They associated this kind of development with highly proactive nurses, motivated not just by changes on the ward, but also by an intrinsic desire to grow and to improve healthcare. A nurse, however, raised the question if this proactivity is necessary:

> What is development? What for? If a basic nurse is OK and you have to keep up to date, that is something different than always knowing the last developments such as best practices.' *(Nurse, 35–49 years)*

The question about the desired scope of CPD was also linked to nurses' perceptions of their profession. One manager felt strongly about this:

> That difference in perception is a barrier in our profession. Some nurses say, "Just attending patients on the ward should be enough: not using the electronic patient record, nor participating in the multidisciplinary consultation meetings. I wash the patient, I talk to the patient, I clean it here and at half past ten he lies fresh and clean in his bed. This is my thing". As long as a part of our professional group says this, we fall short; it is about total care.' *(Manager)*

Differences in CPD for younger and older nurses

Six themes emerged from the discussions on differences in CPD for younger and older nurses. Table 2.2 shows which themes emerged in which focus groups.

Level of focus

Two focus groups (managers and group III) acknowledged that younger nurses may not yet have a well-defined purpose of development. The world remains open to them and they are searching for what they ultimately want to do. They tend to pursue various developmental activities, especially compared to older nurses, who tend to focus their development more narrowly.

> Young nurses are searching more and have many possibilities to switch — "maybe I will do this or maybe I will do that" — so the range is much bigger from which they can choose. [. . .] Older nurses are more focused. At the moment they want something, their ideas show a definite shape and they go for it.' *(Manager)*

Table 2.2. Themes in CPD for younger and older nurses emerging from the focus group data.

Themes	Group I 20–34 years	Group II 35–49 years	Group III 50–65 years	Managers
Level of focus			x	x
Creating possibilities to leave the bedside	x	x		
Ambitious young nurses		x	x	x
Same resources, different requirements	x	x	x	x
A 'ceiling' in courses for older nurses			x	
Social status and self esteem		x	x	x

Creating possibilities to leave the bedside

The nurses in the two other focus groups (groups I and II) did not mention differences in focus between younger and older nurses. However, the discussions in these groups revealed that several of them pursue developmental activities to become a better nurse, but also to create possibilities to leave direct patient care in the future.

> While I am working in my team, I just want to be a good nurse there. But, when I look at myself and my personal development I think I do not want to stay at the bedside, so I am going to take up a new study.' *(Nurse, 21–34 years)*

Ambitious young nurses

Participants in three focus groups (group II, group III and managers) perceived some young nurses as being especially ambitious. This ambition occasionally led to incomprehension and even annoyance. The eagerness of some young nurses for further career opportunities gave them the impression that these young colleagues did not find their work appealing. One nurse stated:

> Those people that apply for a nurse job and say "I will do this for two years and then I like to move on". Then I think, it will take you two or three years to fully learn this work by doing it. I don't appreciate it when people think they can do my job easily [. . .] for just two years and then move on.' *(Nurse, 35–49 years)*

Same resources, different requirements

In all focus groups, participants expressed that CPD for younger and older nurses was judged by the same standards and both get the same CPD resources and opportunities.

> All have the same opportunities. If you do not want to, in some respects it will also be OK. But when I, at 55+, like to do a specific course and there is also a 30-year old nurse who wants to enrol for it, I do not believe that will make a difference. No I do not think so.' *(Nurse, 50–65 years)*

However, it was acknowledged that the requirements are sometimes less strict for older nurses. Occasionally, older nurses take on less complex patients.

> At our ward continuing development is more for the younger people. They seize the opportunities. The older nurses take care of different patient categories than the younger people. That is accepted. You can see that clearly.' *(Nurse, 21–34 years)*

Older nurses' decisions to not attend symposia were also more readily accepted.

> I am accommodating towards older nurses. They follow all the ward-based training courses. They keep up to date regarding nursing care. But when an older nurse says to me, "I'd rather not go to a symposium or conference", I say, "That is fine with me". With younger nurses I will not easily do that.' *(Manager)*

Finally, some older nurses may need more time especially when computer skills are involved, as one manager explained:

> With older nurses you accept that it takes them twice as long.' *(Manager)*

A 'ceiling' in courses for older nurses

Focus group III raised the issue of a 'ceiling' in training courses. It was suggested that when nurses have many years of experience and reached a high level of expertise, formal education might provide less added value. In these cases, development takes place through informal learning activities such as daily experiences. One nurse made the following observation:

> I do not think that development means you have to do one course after the other. Naturally, at a certain moment you have reached a ceiling and it is not necessary anymore. But I think you are developing every day. Day-by-day you hear new things or you check things with your colleagues. [...] And sometimes it should be more than that, for instance, now with the [introduction of the] electronic patient record. Yes, that takes more energy.' *(Nurse, 50–65 years)*

Undergoing unit-based training was widely seen as essential for keeping up to date. However, training sessions that were considered repetitive and did not bring something new were questioned. One nurse stated:

> I have had it with those training courses on giving feedback. Those courses on feedback and teamwork, I have joined them often. If you have been working for a long time, this comes along with a certain regularity.' *(Nurse, 50–65 years)*

Social status and self-esteem

In all groups, except for group I, issues of social status related to CPD emerged. Participants sensed a social pressure to develop continually, but they also felt that some CPD activities and purposes were more rewarding than others. They suggested that social standards favoured formal learning activities over others. In addition, they described that development 'away from the patient' often resulted in higher salary and status than growth in direct patient care competence. According to one participant:

> The proficient nurse has the same salary as the nurse who recently started. But you want status and you want recognition. That recognition should also be translated in your salary.' *(Nurse, 35–49 years)*

Participants noticed two negative effects of these social standards. First, the emphasis on career advancement could result in nurses leaving direct patient care:

> All people want to climb higher, but who stays with the patient? That is the problem.' *(Nurse, 50–65 years)*

Second, these social standards could negatively affect the self-esteem of nurses who have worked in nursing for a long time:

> When I tell them that I have worked in nursing for 25 years, they say: "What, are you still there?" People from outside think that you stagnate, while I think, "I do not stand still."' *(Nurse, 50–65 years)*

> So I never take courses, at least not those which result in a diploma. This always feels a bit like "failing", as if I do not develop.' *(Nurse, 50–65 years)*

In contrast with these perceived social standards, participants valued nurses who stayed in direct patient care and developed through informal learning activities. Both nurses and managers stressed the importance of a diverse team composition, in which nurses who remain in a fixed position for a long time are necessary:

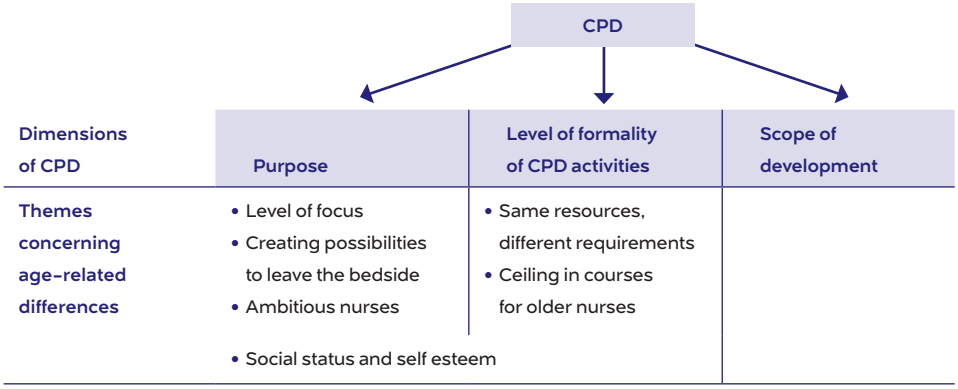
> If you have a team with nurses who all want to develop professionally, that does not work either as they all leave at some point. They grow too fast and want to move on'. *(Manager)*

Discussion

This study used a qualitative design that centres on nurses' and managers' perceptions of differences in CPD between younger and older nurses. Its findings confirm and extend existing data on this topic. Like others (Friedman and Phillips, 2004), we found that participants have different perceptions of CPD. Their perceptions were found to diverge on three dimensions of CPD. In addition, six themes regarding differences in CPD between younger and older nurses were found. When combining these three dimensions and six themes (see Figure 2.1) age-related differences appear in two dimensions: the purpose of CPD and the level of formality of learning activities. The study did not uncover age-related differences in the scope of CPD.

The first dimension of CPD is 'purpose of CPD'. Consistent with others (Drey et al., 2009; Friedman and Phillips, 2004; Gould et al., 2007) we found that CPD can aim for retention of core skills, improvement of career opportunities and extension of nursing roles. New in this study is the distinction between professional development 'around the patient' and 'away from the patient'.

Figure 2.1. Relationship between 3 CPD dimensions and 6 themes concerning age-related differences.



The themes 'level of focus', 'creating possibilities to leave the bedside' and 'ambitious nurses' suggest that the purpose of CPD can be different for younger and older nurses. Older nurses were perceived as bringing more focus to their development, compared to younger nurses whose career paths remained more open. Younger nurses seemed

focused on becoming a better nurse, but also pursued opportunities to leave direct patient care after some years. The nurses in focus group III appeared to focus mainly on development in direct patient care, on CPD 'around the patient'. These findings are consistent with the Selective Optimisation with Compensation theory (Baltes et al., 1999), which underscores age-related differences in goal orientation. Younger adults have a primary goal focus on 'growth', while older adults focus more on 'maintenance and loss prevention' (Ebner et al., 2006). Age-related changes in purpose of CPD can also be expected based on the Socioemotional Selectivity theory (Carstensen et al., 1999), which posits that selection of goals is influenced by a changing time perspective. People select goals in accordance with their perceptions of the future as being open-ended or limited. When growing older, people become more present-oriented and less concerned with the distant future (Carstensen et al., 1999).

The second dimension of CPD is 'level of formality of CPD activities'. This finding supports previous work (Berings, 2006; Eraut, 2007; Estabrooks et al., 2005) on nurses' learning activities. Participants acknowledged that both formal and informal learning activities are part of CPD. It was stressed that courses should be followed by informal learning activities in the workplace, to extend and reinforce what was learned in courses by applying it to work situations (Eraut, 2001).

The themes 'same resources, different requirements' and 'a ceiling in courses for older nurses' suggest age-related differences in this dimension. The findings of the study suggest that managers and colleagues sometimes express lower expectations of older workers by allowing them to participate in fewer CPD activities and to take on less complex work than their younger colleagues. This, however, reduces their opportunities for continuing development (Van Roekel-Kolkhuis Tanke, 2008). Surprisingly, CPD resources seemed to be the same for all nurses. Nevertheless, the findings suggest that some older nurses may use fewer of these resources as they perceive a 'ceiling' in relevant courses. Experienced workers might feel that they have learned enough, causing a barrier for participating in formal CPD activities. This is in agreement with Gould et al.'s (2007) findings, which showed that a few very senior and highly specialised nurses perceived a lack of courses that meet their needs.

The theme 'social status and self-esteem' can be linked to both the dimension 'purpose' and 'level of formality of CPD activities'. Some positions on these dimensions (namely, CPD away from the patient and formal learning activities) were perceived as garnering more social recognition and appreciation than others, thereby negatively influencing nurses' self-esteem and their intentions to remain within direct patient care. This seems consistent with earlier research indicating that nurses perceived longer courses with an academic emphasis to be promoted at the expense of training courses on clinical skills and experienced-based learning (Gould et al., 2007).

The third dimension of CPD is 'scope of development'. Nurses with a narrow scope of development seem to learn as a reaction to changes at the ward. Their learning is merely confined to keeping up to date. Nurses with a broad scope of development seem to be more proactive and intrinsically motivated to develop and improve their work. This dimension shares traits with the cognitive styles of adaptation vs. innovation (Kirton, 1976). Nurses signified as 'adaptors' focus on performing tasks better, learn within existing frames of reference, and are engaged in lower levels of learning. 'Innovators' consider how tasks can be done differently, are more prepared to challenge existing paradigms, and are engaged in learning at a higher level. This dimension also resonates with the distinction between adaptive and developmental learning made by Ellström (2001).

The study did not reveal age-related differences in this dimension, but the scope of development seems to be linked closely to nurses' work attitude. Innovative nurses who share knowledge with others were distinguished from nurses who do their work but are not willing 'to go the extra mile'. It is interesting to note that the learning of the former group is unmistakably perceived as CPD, whereas the keeping up to date of the latter is not always counted as CPD. This implies that CPD is perceived as related to extra-role behaviour, which Organ (1988) and others (Chien et al., 2008) referred to as 'organisational citizenship behaviour' (OCB). Nurses engaging in this behaviour, which is neither mandatory nor directly compensated for by a formal reward system, can be much more readily identified as continually developing nurses than nurses who do not engage in such behaviour.

Strengths and limitations

In interpreting the results, the study limitations should be considered. The qualitative design and the convenience sampling methods limit the generalisablity of the findings. Another limitation is the use of focus groups with nurses of similar age. This increases the risk of attributing stereotypes and the results should therefore be interpreted with caution. Observed differences in CPD between younger and older nurses might reflect stereotype perceptions rather than age differences. However, by asking the focus groups to reflect not just on CPD of other age groups but also on their own CPD, it was possible to analyse which perceptions were shared and which were attributed to another age group only. Despite the risk of attributing stereotypes, the focus group discussions revealed findings that would probably not have been found with more heterogeneously composed groups (Bloor et al., 2001).

In addition, we are not able to determine from this data if differences in CPD are related to chronological age or to other age-related factors. This study showed that chronological age and years of working as a nurse often coincided. Several scholars emphasise that age in itself is not a useful indicator of behavioural change (Kooij et al., 2008; Settersten and Mayer, 1997). During their lives people change in biological, psychological, and social functioning (Sterns and Miklos, 1995). Age differences in CPD can therefore be

influenced by several age-related factors, such as years of experience, career stage, life stage and cognitive changes (Kooij et al., 2008; Schalk et al., 2010; Sterns and Miklos, 1995). Since we did not define 'younger' and 'older' specifically, the discussions were not confined to chronological age. Participants seemed to associate 'younger and older' with different age-related factors, such as caring for young children or having many years of experience. Although the results show that CPD can be different for younger and older nurses, further research should be done to investigate which of these age-related changes influence CPD over time.

Implications of findings

The study shows that the concept of CPD can be understood along three dimensions. These dimensions might support nurses associations, employers and health agencies in defining CPD. To prevent miscommunication it seems essential to define CPD by describing its purposes, the contributing learning activities and the required scope.

The data suggest that the purpose of CPD and the learning activities might change during a lifetime. To keep nurses committed, CPD has to take their needs and aspirations into account (Nolan et al., 2000). This implies that a 'one size fits all' approach to CPD will not work. While some younger nurses, for instance, might need support getting a realistic picture of the nursing job and focusing their development, some older workers might need assistance in finding learning activities that suit their level of experience.

The results indicate age-related differences in CPD. This supports earlier research. However, more research is needed to investigate if these data indeed reflect age differences or are merely based on stereotypical perceptions. There is also a need to establish nurses' CPD needs in different phases of life. In addition, more information on the perceived 'ceiling' in courses would help to take appropriate steps in enhancing older nurses' participation in formal learning activities. Are courses that meet their needs not available, or does a higher level of experience lead to a feeling that formal education is no longer needed and to a preference for informal learning activities?

The findings suggest that nurses are generally perceived to develop in some capacity, as most nurses make an effort to remain up to date. More insight is needed on how they do this and whether their strategies change during the lifespan. Overall, the question can be raised what has greater impact on nurses' continuing professional development during the lifespan: age, years of experience or attitude towards work?


chapter 3

Perspectives on age and continuing professional development for nurses

A literature review

This chapter is based on:
Pool, I.A., Poell, R.F., Ten Cate, T.J., 2013.
Perspectives on Age and Continuing Professional Development for Nurses:
A Literature Review.

Vocations and Learning 6 (3), 297–321.

Abstract

The need for nurses to participate in continuing professional development (CPD) is growing to keep abreast of rapid changes in nursing care. Concurrently, the nursing workforce is growing older. Ageing leads to changes in biological, psychological, and social functioning. Little is known about the effects of age-related changes on nurses' CPD. A literature review was conducted to examine whether and how CPD differs across age groups. A framework with five perspectives on age was used in an attempt to distinguish factors contributing to these age differences. Given the limited research on this topic with respect to nurses, we also included studies of workers in general. The literature search revealed 27 relevant studies. In general, older workers appeared less likely to participate in CPD, when considering formal learning activities and late-career workers (older than 50/55 years). We found no clear age patterns for motivation to participate in CPD, for learning outcomes, and for participation in informal and non-formal learning activities. The study showed that more nuanced results are found when studies distinguish at least three age groups. By using different perspectives of age, a comprehensive overview of age-related factors in CPD was generated and gaps in current research were identified. Recommendations for further research are discussed, such as the need for research on whether the types of learning activities that nurses undertake change with ageing.

Introduction

Continuing professional development (CPD) in nursing is increasingly necessary for nurses to keep abreast of rapid changes in patient care due to advancements in knowledge and technology (Atack, 2003; Berings, 2006; Gopee, 2001). In addition, there is a growing sense that CPD contributes to higher job satisfaction, organisational commitment, and lower stress (Berings, 2006; Chien et al., 2008). Lack of CPD influences nurses' decisions to leave their profession (Hallin and Danielson, 2008) and to retire early (Andrews et al., 2005; Armstrong-Stassen and Schlosser, 2008).

At present, the nursing workforce is ageing, and fewer young people are entering the nursing profession. In Dutch hospitals, the percentage of workers over 50 years of age has grown from approximately 19 % in 2003 to 27 % in 2009, and it is expected to grow further to 36–39 % in 2018 (Van der Windt et al., 2009). To prevent a looming nursing shortage, there is a need to retain older nurses and sustain their employability beyond existing retirement ages. This trend is seen in other Western countries (Spinks and Moore, 2007; Wray et al., 2009).

Consequently, employers, nurses' associations, and national health agencies, accustomed to a workforce traditionally dominated by younger nurses (Palumbo et al., 2009), face the challenge of having to develop CPD approaches geared towards the needs of all age groups (Andrews et al., 2005; Lammintakanen and Kivinen, 2012). This underscores the importance of understanding CPD in different age groups and, in particular, in older nurses. However, few studies have examined older nurses' CPD, and even fewer have studied differences with other age groups. In an attempt to fill this gap a research project on nurses' CPD from a lifespan perspective was started (Pool et al., 2013b). Part of this project is a literature review, which is presented in this paper. It examines the ways in which older nurses' CPD differs from other age groups' CPD, and which age-related factors contribute to these differences. Because we expected the number of studies in the nursing field to be low, this review also includes relevant literature on workers in general. Before addressing the research questions, the concepts of CPD and age are discussed.

Continuing professional development

The American Nurses Association (ANA) has defined nursing professional development as '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, n.d.). This is a useful definition because it encompasses different purposes of CPD. It fits with nurses' perceptions of CPD as important for enhancing service provision, maintaining safety for patients and themselves, and increasing career and personal opportunities (Gould et al., 2007).

Opinions vary on the learning activities that can be qualified as CPD (Friedman and Phillips, 2004). Some confine CPD to planned learning in an educational setting. However, the growing concern about maintaining workers' competence has led to increased attention to ongoing development at the workplace and to development through work experiences (Harteis and Billett, 2008). Other researchers, therefore, use a broader definition of CPD that includes learning activities in a workplace environment. This accords with research showing that nurses develop their expertise through a broad range of learning activities varying from formalised courses to interactions with colleagues and other daily work experiences (Berings, 2006; Eraut, 2007; Estabrooks et al., 2005). Discussion on the learning activities that can be considered CPD is hindered by the lack of a widely accepted typology of learning activities. Often, formal learning is distinguished from informal learning, with the former referring to intentionally planned learning in an educational setting and the latter to learning in a workplace environment. Nevertheless, this distinction does not take into account the fact that learning at the workplace can also be highly structured and designed to ensure the continuity of an organisation (Billett, 2006). Tynjäla (2008) identifies three modes of workplace learning: incidental and informal learning as a side effect of working, intentional but non-formal learning activities, and formal on- and off-the-job training. In this paper, we will review the literature by using a broad perspective on CPD.

The concept of age

There has been much debate on what is considered an 'older worker'. Age seems a simple concept, but a closer look reveals that age can be conceptualised in many ways (Schalk et al., 2010). During their lifetimes, people develop in biological, psychological, and social functioning (Sterns and Miklos, 1995). These three types of ageing call for different approaches to conceptualise and operationalise age (Schalk et al., 2010; Sterns and Doverspike, 1989). In a study on the (re)training of older adults, Sterns and Doverspike (1989) identified five approaches that recently have been used as a framework in two studies to examine issues of ageing and work (De Lange et al., 2006; Kooij et al., 2008). In order to ensure a broad conceptualisation, we have used these perspectives on age as a framework to review the literature on age differences in nurses' CPD.

Chronological age

This refers to one's calendar age. The distinction between younger and older workers is frequently based on chronological age (Sterns and Miklos, 1995). Although age in itself is not a useful indicator of behavioural change (Kooij et al., 2008; Settersten and Mayer, 1997), chronological age is convenient and broadly used. The 'older nurse' is often conceptualised as nurses in their 40s, 50s, and 60s (Buchan, 1999; Fitzgerald, 2007). The demarcation between younger and older workers is not fixed, but depends on legal, governmental and organisational practices (Kooij et al., 2008; Palumbo et al., 2009). For instance, statutory regulations on retirement age and special provisions such as additional holidays, use chronological age to define the 'older worker' (Schalk et al.,

2010). According to the Lisbon Strategy of the European Union, those between 55 and 64 years of age are the priority group of older workers, while researchers often tend to take the age of 45 as the cut-off point between younger and older workers (Tikkanen and Nyhan, 2006).

Many people experience their calendar age as a determining factor (Tikkanen and Nyhan, 2006). Some people cannot keep working when they reach a certain chronological age, others feel discriminated against as they are considered too old when applying for a job, and recent retirement reforms force people to work for a longer period than they initially anticipated (Tikkanen and Nyhan, 2006).

Functional age

This construct recognises that ageing individuals go through various biological and psychological changes (Sterns and Doverspike, 1989), which may be reflected in health status, physical capacity, and cognitive performance (Kooij et al., 2008; Sterns and Miklos, 1995). When studying age differences in CPD cognitive functioning seems to be especially relevant. Older workers are often viewed as less able to learn than are their younger colleagues (Gray and McGregor, 2003). This view appears to be supported by the results of a meta-analytic review of the relationship between age and job-related training (Kubeck et al., 1996), which revealed that older adults show less mastery of training material, complete a final task more slowly, and take longer to complete a programme. However, these findings should be interpreted with some caution. Outcome differences could also reflect pre-training differences instead of indicating that older adults learn less (Kubeck et al., 1996). Furthermore, laboratory studies showed larger age differences than did field studies, probably implying that in real-world tasks, the effects of practice and experience may counter age-related declines. Finally, learning at the workplace may allow older workers to compensate for less mastery of training material (Kubeck et al., 1996).

Age differences in learning depend on the content to be learned and the cognitive abilities necessary. Kanfer and Ackerman (2004) argue that a decline in cognitive abilities is found when considering fluid intelligence (working memory, abstract reasoning, attention, and processing novel information). In contrast, crystallised intellectual abilities, representing aspects of educational and experiential knowledge, show increasing levels of performance into middle age and beyond. Therefore, it might be relevant to make a distinction between learning in a radically different field and learning new skills within the expert domain of the experienced worker (Lahn, 2003). In addition, Beier and Ackerman (2005) provided a more optimistic view on the relationship between learning and ageing than that often assumed. Their research showed that prior knowledge was an important predictor of knowledge acquisition for learning.

Psychosocial age

Psychosocial definitions of older workers include those based on social and self-perceptions of the older worker (Kooij et al., 2008; Sterns and Doverspike, 1989). Social perception refers to expectations and norms of appropriate behaviour and characteristics for people at different ages (Schalk et al., 2010). A significant amount of research focuses on the perceived attributes (or stereotypes) of older workers. Several reviews show that although research results are equivocal, older workers are perceived as harder to train, less motivated to learn, inflexible, and less able to keep up with technological changes (Gray and McGregor, 2003; Kooij et al., 2008; Sterns and Doverspike, 1989). Perceived positive traits of older workers are that they have a strong work ethic, are conscientious, knowledgeable, and have greater commitment (Kanfer and Ackerman, 2004; Kooij et al., 2008; Sterns and Doverspike, 1989).

Negative stereotypes of older workers lead to a paradox (Billett et al., 2011). Employers are increasingly in need of the service of older workers, but negative views about their performance and adaptability can lead to discriminatory managerial decisions (Billett et al., 2011; Kooij et al., 2008), such as providing fewer opportunities for training and development (Gray and McGregor, 2003). Paradoxically, social support is important for older workers' participation in CPD (Liu et al., 2011). Stereotypical views can also influence older workers' motivation for CPD. An experimental study showed that older workers confronted with negative stereotypic information were less motivated to learn and develop than workers confronted with positive stereotypic information (Gaillard and Desmette, 2010).

Self-perception of age refers to how old a person feels, with which age cohort one identifies, and how old the person desires to be (Kooij et al., 2008; Settersten and Mayer, 1997). In this view, ageing refers to a shift in time orientation. Socioemotional Selectivity theory (Carstensen et al., 1999) claims that when people move through life, their perception of time changes from time as open-ended to time as limited. Older people become increasingly aware that their time is running out. This influences the selection of social goals. When ageing, people become mostly present-oriented and less concerned with the distant future.

Self-perception of age also influences preferences for activities that support one's self-concept (Kooij et al., 2008). Ageing individuals try to protect their self-concept, avoiding development activities that make use of fluid intelligence and preferring activities that build upon their expertise ((Kanfer and Ackerman, 2004). Along these lines, Morgenthaler (2009) suggests that returning to school might be intimidating for nurses because people do not like to be novices again after attaining recognition as a professional in their field.

Finally, one's self-perception of age is also likely to affect self-efficacy (Kooij et al., 2008), thereby affecting older workers' participation in CPD (Maurer, 2001). Maurer (2001)

argues that various processes (including a decline in social support and an exposure to age stereotypes) might negatively affect older workers' self-confidence for learning and development.

Organisational age

Older workers have often spent a substantial amount of time in a job and even more time in an organisation (Sterns and Doverspike, 1989). This perspective recognises this confounding of age and job or company tenure (Schalk et al., 2010; Sterns and Doverspike, 1989). Organisational age may refer to tenure and career stage.

A longer work history can have two opposite effects. Work experience can lead to an increased level of expertise (Benner, 1984), which might influence workers' preference for certain CPD activities. Daley (1999) found that novice nurses benefited from formal training, while more experienced nurses preferred work-based opportunities like dialogue with colleagues. In contrast, longer tenure might lead to deterioration of knowledge and skills. Obsolescence can be expected to increase with age (Kooij et al., 2008), leading to a higher need for CPD.

In their careers, workers progress through different stages in which CPD needs may vary. Super (1984) proposed a sequence of career stages starting with trial (characterised by identifying interests, capabilities, and fit between self and work), then establishment (increasing commitment to career, career advancement, and growth), maintenance (maintaining self-concept, holding onto accomplishments earlier achieved), and finally decline (developing new self-image independent of career success). It should be noted that career paths have ceased to show a linear pattern. People enter and exit different life arenas at different times (Lahn, 2003). At the beginning of a career, workers might need support in identifying their interests and developing their capabilities. In late career, after doing the same task for ten or twenty years, a concentration of experience might be a problem, making it difficult for workers to learn or to change jobs (Nauta et al., 2010).

Lifespan age

This perspective adds that behavioural change can occur at any point in the life cycle (Kooij et al., 2008; Sterns and Doverspike, 1989). Many variables may impact the ageing process, such as unique career and life changes and individual health and stress-inducing events. A possible indicator of lifespan age is the individual's personal situation and situation at home (De Lange et al., 2006). Exploring possible barriers for nurses to pursue additional education, Morgenthaler (2009) argues that one's situation at home can be a significant barrier. Going to school might not be an option for nurses who have the responsibility for older parents while also caring for their own families. The financial situation at home might be another barrier. The lifespan approach stresses that more individual differences exist as people grow older (Sterns and Doverspike, 1989).

Comparing the five perspectives

An underlying continuum of these perspectives is that age can be a characteristic of the individual (e.g. calendar age), the environment (e.g. social age in the psychosocial perspective), or the person–environment interaction (e.g. tenure in the organisational perspective) (Schalk et al., 2010). A critique on these conceptualisations of age might be that they are discussed mainly on a theoretical level and that, to our knowledge, no studies have validated the conceptualisations and their independent qualities. The overlap between some conceptualisations complicates the description of possible indicators. Kooij et al. (2008), for instance, used 'skills obsolescence' as a possible indicator of organisational age, whereas others (Sterns and Doverspike, 1989; Sterns and Miklos, 1995) discussed skills obsolescence under the psychosocial perspective. Similarly, career stage is an indicator of organisational age (Kooij et al., 2008) or of the lifespan perspective (Sterns and Doverspike, 1989; Sterns and Miklos, 1995).

Despite these shortcomings, we think this framework enhances the discussion and the research on issues of age and CPD. It illustrates the multidimensional process of ageing and shows that these issues can be studied from different perspectives. It gives reason to believe that CPD of older nurses differs from that of younger workers. However, the exact relationship between age and CPD remains poorly understood. The main research questions of this study are therefore, 'Is CPD for older and younger nurses different and if so, in what respect?' and 'Which age-related factors contribute to these differences?' An understanding of the relationship between age and CPD will help to better adjust CPD approaches to the needs of different age groups.

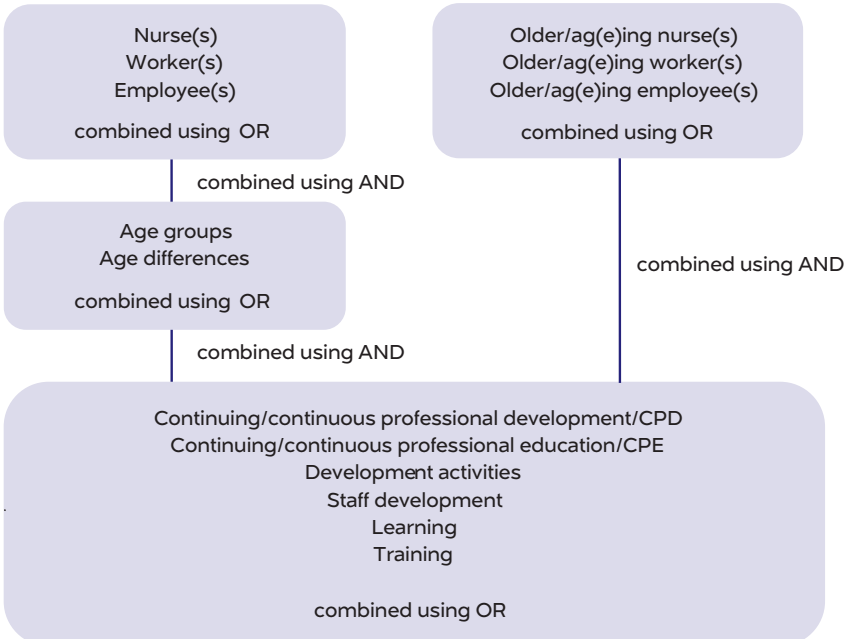
Methods

A literature review was conducted in four phases. First, inclusion and exclusion criteria were formulated. To be eligible for inclusion, publications must have reported (1) on age differences in CPD, (2) on an empirical study or meta-analysis in a peer-reviewed journal, and (3) in the English language. Publications were excluded when (1) reporting on one age group without examining age differences, (2) having an experimental design with workers participating in non-work-relevant learning, and (3) reporting on differences between generations. When publications reported on the same study, the most informative publication was selected. We did not limit our search to a specific time frame.

Second, a search strategy was developed. Key publications were analysed to identify relevant search terms. We used a broad definition of CPD referring to various learning activities, and, therefore, listed search terms such as learning, training, and staff development. As we expected that relevant studies in the nursing field would be scarce, we also searched for studies on workers in general. In addition, we observed two viewpoints in the research on age differences. Some of the researchers were interested in

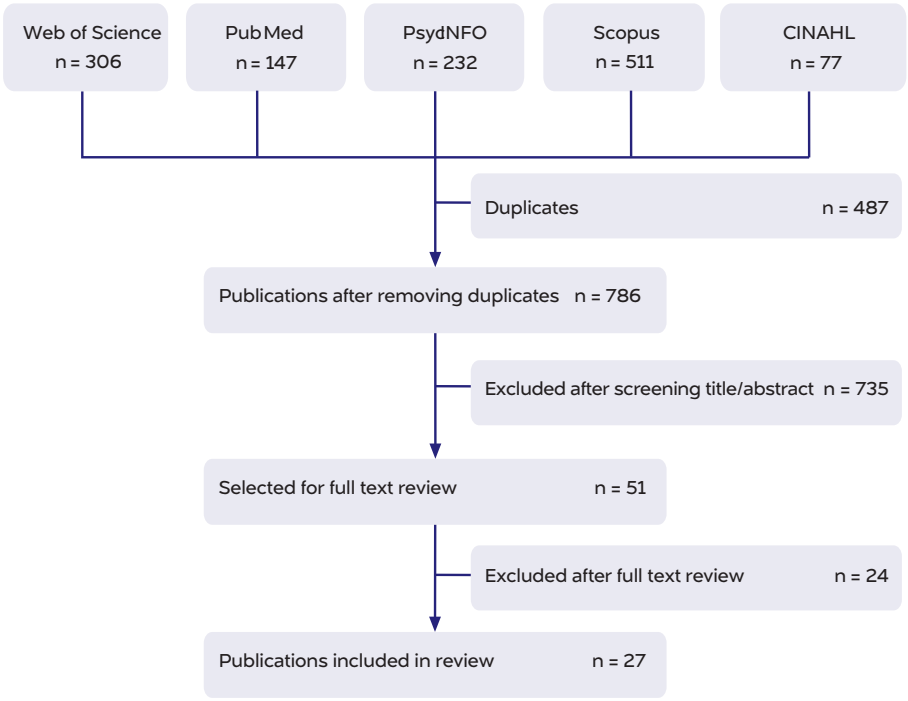
age differences in CPD, while others were mainly interested in older workers' CPD and examined whether this CPD differs from that for younger workers. In order to identify studies from both viewpoints, we used a double search strategy on the combination 'nurses–age differences–CPD' and the combination 'older nurses–CPD'. Various search terms and their combinations were listed and pilot tested. After careful consideration of the consequences of removing potential search terms, we identified the most informative search terms (see Figure 3.1).

Figure 3.1. Search terms.



Third, literature was searched in five databases: PubMed, Web of Science, Scopus, PsycINFO, and CINAHL in December 2011. We focused on the title, abstract, and keywords. All abstracts were screened for relevancy. If the abstract did not give sufficient information, the full text was scanned. The search resulted in 786 unique publications, which were screened for relevancy. Finally, 27 articles met the inclusion criteria (Figure 3.2 shows the flow chart of the review). A relatively large amount of literature that was excluded from the review did not focus on CPD. These publications used the search word 'training' or 'learning' in the abstract, for instance when recommending more training for nurses or other workers, without studying the learning or training of these workers. A smaller amount was excluded because it was on people above the retirement age, or because it examined one age group without making comparisons with other age groups.

Figure 3.2. Search results.



Fourth, the literature was reviewed using a self-devised review form. For each study, background information (e.g. research design, sample, country) and a short summary of the relevant findings were described. Then, several questions were answered concerning the examined age differences in CPD and the perspective used on age. Many studies used several indicators (e.g. tenure, marital status, calendar age), but a perspective on age was marked only when the study reported and analysed the results of these indicators.

Table 3.1 presents information on the studies reviewed. As expected, only a small number of studies (n=3) examined CPD for nurses in hospitals and other healthcare settings. The table shows that the other studies examined workers in various other professions and occupational branches. Although we did not use a limited time frame, relevant publications were only found in the years 1996–2012. Earlier studies did not meet the inclusion criteria. All studies were from industrialised countries, mostly from Australia (n=6), the United Kingdom (n=5), and the United States (n=6). Most studies (n=21) had a cross sectional design, some were longitudinal (n=2), (quasi) experimental (n=2), phenomenographical (n=2), and meta-analytic (n=1). Some cross-sectional studies used data from large general-purpose surveys such as the Labour Force Survey (UK) and others used specifically designed surveys.

Results

We examined the literature to identify whether and in what respect CPD differs across age groups. The results revealed four themes relevant to age differences in CPD: motivation for CPD (n=12), participation in CPD activities (n=12), learning outcomes (n=5), and learning competence (n=3). In addition, we identified factors contributing to these age differences using the framework with five perspectives on age. Table 3.1 shows that all studies used a chronological perspective on age (n=27), and only a few used a functional (n=4) or lifespan (n=3) perspective. The psychosocial (n=17) and organisational perspective (n=14) were used most often. The findings for each of these themes and perspectives on age are described below. The findings on the learning-competence theme were related to cognitive abilities and will therefore be described as part of functional age.

Age differences in motivation

Twelve studies examined whether younger and older workers differ in their motivation for CPD. The results showed some age differences in motivation, but without a clear direction. Some studies found that older workers were less willing to invest in learning and training (Van Vianen et al., 2011) and to improve their working skills and qualification (Pillay et al., 2006) compared to younger workers. These results should be interpreted with some caution. The effect sizes in Pillay's study were low, and motivation in Van Vianen's study was examined in a particular situation. Workers' motivation was defined as the attitude towards a request from the organisation to participate in learning and training activities. Another study (De Lange et al., 2010) revealed no motivational differences between younger and older workers. This longitudinal study showed that middle-aged workers (31–44 years) reported significantly higher motivation to learn than both younger (≤31 years) and older workers (≥45 years).

According to lifespan theories, people can strive for different goals during their lives, influenced by a reciprocal interaction between the individual and the environment. Based on these ideas, Tones and Pillay (2008) developed a learning and development survey to investigate workers' selection of learning and development goals. This survey was tested with different demographic variables in three studies (Tones and Pillay, 2008; Tones et al., 2010; Tones et al., 2011). A study among local government workers found that older workers were less engaged in learning and development goals than were younger workers (Tones and Pillay, 2008). Unexpectedly, a study among nurses revealed that goals associated with decreased career involvement were linked with younger workers (Tones et al., 2010). The researchers suggested that a large proportion of the nurses work part time and were probably balancing career and family life.

Table 3.1. Reviewed studies. *(p 54 ➲ 55)*

Authors	Design	Data collection method	Sample
Nurses			
Lammintakanen and Kivinen (2012)	Cross sectional	Survey	N = 653 (9 without age information)
Tones et al. (2010)	Cross sectional	Survey	N = 110
Wray et al. (2009)	Cross sectional	Postal survey	N = 510
Other professionals			
Berg and Chyung (2008)	Cross sectional	Online survey	N = 125
Cully et al. (2000)	Cross sectional	Data from 3 surveys between 1989–1993 *Australian Bureau of Statistics of training and education* and other sources	Not reported
De Lange et al. (2010)	3 wave , 3 years longitudinal	Survey	N = 1742 (T1) N = 1473 (T3)
Delgoulet and Marquié (2002)	Quasi-experimental	Survey, video-observation, written knowledge tests	N = 43
Felstead (2010)	Cross sectional	Data from 5 surveys between 1986–2006: *Social change and economic life initiative*, *Employment in Britain*, *Skills surveys*	N = 22,000
Greller (2006)	Cross sectional	Survey	N = 450
Guthrie and Schwoerer (1996)	Cross sectional	Survey	N = 380
Kyndt et al. (2011)	Cross sectional	Survey	N = 628
Maurer et al. (2003)	3 wave, 13 month longitudinal	Survey	N = 1395 (T1) N = 800 (T3)
Maurer and Weiss (2010)	Cross sectional	Survey	N = 906

Country and profession	Age groups	Category[1]	Perspectives on age				
			calender	functional	psycho-social	organi-sational	lifespan
Finland (6 hospital districts) Nurses	<39, 40–50, ≥ 51	B	x		x		
Australia Private hospital employees	<45, 45–55	A	x		x		
United Kingdom Nurses and midwives	< 50, and ≥ 50	B	x				
5 list serv of profes-sionals working in field of learning and performance improvement	Mean age 42.36 (SD 10.02)	B	x				
Australia Diverse sectors & jobs	Different age groups	B	x			x	
Netherlands Diverse sectors & jobs	≤30, 31–44, ≥45	A	x		x	x	
France Maintenance operators railway	25–49 ≤ 38 and ≥39	C	x		x		
United Kingdom Diverse sectors & jobs	20–34, 35–49, 50–60 (one survey 61–65)	A,B,C	x		x	x	
United States of America College-educated men	23–31, 32–39, 40–49, 50–70 Mean age 45	B	x			x	
United Sates of America, Managerial & supervisory employees of a public employer	≤35, 36–49, ≥ 50. Mean age 43,7	A, D	x	x	x	x	
Belgium Public health sector, diverse jobs	< 45, ≥45	A	x		x	x	x
United Sates of America Diverse sectors & jobs	Mean age 43.87 (SD 10.75)	A, B	x	x	x	x	x
United Sates of America Telecommunications company, managerial jobs	Mean age 43.21 (SD 7.95)	D	x	x		x	

Table 3.1. Continued *(p 56 ➲ 57)*

Authors	Design	Data collection method	Sample
Newton (2006)	Cross sectional	Data from *Labour force survey (Spring 2004)* & *National adult learning survey 2002*, and qualitative interviews	Not reported
Ng and Feldman (2008)	Meta-analysis		380 empirical studies, 438 samples
Paloniemi (2006)	Phenomeno-graphical	Group and individual interviews	16 interviews N = 43
Pillay et al. (2003)	Phenomeno-graphical	Interviews	N = 55
Pillay et al. (2006)	Cross sectional	Survey	N = 397
Schmidt (2009)	Cross sectional	Survey	N = 301
Simpson et al. (2002)	Cross sectional	Data from *National household education survey*	N = 19,722
Stamov Roßnagel et al. (2009)	Cross sectional Experimental	Online survey E-learning with knowledge test	N = 479 N = 60
Taylor and Urwin (2001)	Cross sectional	Data from *Labour force survey (Spring 1997)*	N = 55,085
Thangavelu et al. (2011)	Cross sectional	Data from *Singapore Labour Force survey 2004*	98% of 2400
Tones and Pillay (2008)	Cross sectional	Survey	N = 112
Tones et al. (2011)	Cross sectional	Survey	N = 137

Country and profession	Age groups	Category[1]	Perspectives on age				
			calender	functional	psycho-social	organi-sational	lifespan
United Kingdom	Grouped in 5 years	B	x		x		
	<30, 31–35, 36–40, >40	C	x				
Finland Employees from SME's	Mean age 41	A	x			x	
Australia Diverse jobs in medical service & transport industry	< 40 (N = 16), > 40 (N = 39)	A	x				
Australia Diverse jobs of local government councils	≤ 40, > 40	A	x		x		
United Sates of America & Canada Call centre services, diverse jobs	57% between 20–35 years	C	x			x	
United Sates of America Diverse sectors & jobs	16–39 40–65 40–49 50–65	B	x		x		
Germany Mail order company, diverse jobs	Study 1: 18–35, 36–50, 51–65 Study 2: 18–35 (N = 30), 51–65 years (N = 30)	C, D	x	x	x		
United Kingdom Diverse sectors & jobs	16–24 25–39 40–49 50–59/64	B	x		x	x	
Singapore Diverse sectors and jobs	Not reported	B	x		x	x	x
Australia Government employees, different jobs (blue and white collar)	51% ≤45	A	x		x		
Australia Local government employees (professional/managerial jobs)	58% < 45	A	x		x		

Table 3.1. Continued *(p 58 ➲ 59)*

Authors	Design	Data collection method	Sample
Urwin (2006)	Cross sectional	Data from *Labour force survey (Spring 2004)*	Not reported
Van Vianen et al. (2011)	Cross sectional	Survey	Employees: N = 208, supervisors N = 30

[1] *Studies fell in four categories: (A) motivation for CPD, (B) participation in CPD, (C) learning outcomes and*

Age differences in participation

Twelve studies examined whether participation in CPD activities is influenced by age. The results of the studies seemed to be contradictory. Greller (2006) found that career motivation, rather than age, was a factor in the hours spent in professional development. Late career workers did not spend less time on professional development than the other age groups. Two other studies showed that older workers participated even more in CPD activities than younger workers did, especially in informal learning activities (Berg and Chyung, 2008; Lammintakanen and Kivinen, 2012). However, most studies found that participation in CPD decreased with age. A survey of employment experiences of older nurses in the United Kingdom showed that 73 % of the sample aged 50 and over had not accessed any CPD activities in the last 2 years compared with 27 % of those under 50, with women experiencing greater barriers than men (Wray et al., 2009). Also in other professions, the incidence of training declined with age (Felstead, 2010; Thangavelu et al., 2011; Urwin, 2006).

Studies distinguishing between middle-aged and older workers, or mid- and late-career ones, showed more nuanced results. Participation rates of 45–54 year-olds in CPD activities were not substantially lower than that of younger cohorts, while participation rates of workers above 54 years were much lower (Cully et al., 2000). Others reported similar results for workers above 50 years (Simpson et al., 2002; Taylor and Urwin, 2001).

Younger and older workers also differed in the type of CPD activity they undertook. Older workers were more likely to undertake short training courses of less than 1 week's duration (Urwin, 2006) or activities that develop focused occupational skills (Simpson et al., 2002). Older nurses participated more in information meetings and had more appraisals, but they participated slightly less in in-service training programmes and mentoring than did younger nurses (Lammintakanen and Kivinen, 2012).

Country and profession	Age groups	Category[1]	Perspectives on age				
			calender	functional	psycho-social	organi-sational	lifespan
United Kingdom Diverse sectors & jobs	16–24 25–39 40–49 50–59/64	B	x			x	
Netherlands Diverse jobs in public city council	Workers' mean age:44.4 (SD 10.42) Supervisors' mean age: 49.1 (SD 6.47) < 45, ≥ 45	A	x		x	x	

(D) learning competence

Age differences in learning outcomes

Five studies examined age differences in learning outcomes at two different levels: satisfaction and performance. Schmidt (2009) examined learning outcomes at the level of job training satisfaction, which refers to workers' feelings about the job training they received as a whole (not a single course or training programme). They found no significant correlation between age and job training satisfaction. Job tenure, or experience on the job, did relate to satisfaction. Workers in the first year of employment were more satisfied than workers with a longer tenure were.

In a meta-analysis of the relationship of age to ten dimensions of job performance, Ng and Feldman (2008) examined learning outcomes at the level of training performance. They found that the training performance of older workers was slightly lower than that of younger workers, but noted that only studies with post-training scores on performance were included and that a large proportion of the studies were on technology training (Ng and Feldman, 2008). In another study, workers who received training rated its impact on performance as high, but these ratings fell a little with age. For older workers, training was less likely to result in a pay increase or more enjoyment of their work (Felstead, 2010).

Chronological age

All studies used calendar age to divide the sample of participants in age groups organised. Some studies divided the sample in two groups: older and younger workers, using a demarcation somewhere between 38 and 50 years. Others made a distinction in three (using a middle-aged group) or more groups. Not all studies used the term 'older worker' or 'mature-aged worker', but used calendar age as a demarcation between workers in the first and second half of their career (Kyndt et al., 2011) or late career (Greller, 2006). Although all studies used calendar age as a variable, only one used chronological age as a perspective to explain the relationship between calendar age and participation in

CPD. Urwin (2006) argued that it was not age per se, but the time until retirement that explains the differential treatment of older workers. Raising the retirement age might influence employer support for older workers. Chronological age and participation in CPD seem therefore linked through the legal regulations of retirement (Urwin, 2006).

Functional age

From this perspective, differences between younger and older workers are defined by their cognitive abilities. Four studies examined indicators of functional age. CPD requires that workers possess learning competencies, which involve a cognitive dimension (the ability to learn new things); a meta-cognitive dimension (the ability to recognise strengths and weaknesses and to use strategies for planning, self-regulation, and evaluation of the learning); and a motivational dimension (a learning orientation and inner work standards) (Maurer and Weiss, 2010; Stamov Roßnagel et al., 2009). Two studies reported that older workers felt less cognitively able and had lower perceptions of themselves as possessing learning qualities (Guthrie and Schwoerer, 1996; Maurer et al., 2003). Nevertheless, this did not handicap them in overall involvement, according to the results of a longitudinal study of 800 workers (Maurer et al., 2003). Examining learning competencies in informal workplace learning, Stamov Roßnagel et al. (2009) found an age effect in an experimental study that was not found in their questionnaire study. They suggested that age effects on learning competencies might depend on the degree of self-regulation the learning activity provides. Self-regulated learning is likely to provide workers with opportunities to compensate for age-related cognitive decline (Stamov Roßnagel et al., 2009). In the experimental study, learning was relatively inflexible, resulting in lower performance for older workers. In the questionnaire study, participants referred to a variety of learning activities, including self-regulated learning, resulting in similar results for younger and older workers.

Psychosocial age

Seventeen studies used a psychosocial perspective, mainly examining social perception and, less often, self-perception of age. Stereotypical assumptions about older workers might lead to less social support for older workers by employers, resulting in age differences in CPD participation rates. Several researchers supported this idea when they concluded that the lower incidence of vocational education and training among older workers could be mainly attributed to employer decision-making (Newton, 2006; Taylor and Urwin, 2001). Tones and Pillay (2008) found that older workers reported fewer opportunities for learning and development at the workplace, with a stronger effect for blue-collar than for white-collar workers.

Labour economic models also suggest that older workers are less likely than are younger workers to receive employers' support when making human capital investments (Simpson et al., 2002). High costs related to productivity loss during training and the expected short payback period lead to these lower investments. However, testing

this hypothesis, Simpson et al. (2002) found no significant differences – older and younger workers received the same support. It should be noted that the results were for workers who participated in some developmental activity (Simpson et al., 2002). Also in line with these results, other researchers did not find significantly lower levels of supervisory support for older workers than for other age groups (De Lange et al., 2010; Guthrie and Schwoerer, 1996).

In contrast, three studies even reported lower levels of employer support for younger workers. Younger workers reported more reluctance of employers to offer training (Felstead, 2010), more experiences of injustice in terms of CPD (Lammintakanen and Kivinen, 2012), and they perceived less organisational support (Pillay et al., 2006) than older workers did.

In addition to social support, the psychosocial approach refers to self-perception of age. Only one study (Maurer et al., 2003) used two alternative age measures: subjective age (how old an individual perceives him- or herself) and perceived relative age (the perceived age of an individual compared with others in the workplace in terms of how they look, feel, and act). In this longitudinal study, subjective age did not add anything unique beyond chronological age. Perceived relative age, however, was negatively related to work support. Maurer et al. (2003) suggested that being older in a young group might lead to less support and encouragement, and they called for attention in the workplace to employees' relative age and not just chronological age.

Delgoulet and Marquié (2002) studied whether increased age was associated with higher learning anxiety. Some training activities might lead to greater anxiety for older workers when they perceive a gap between their capabilities and the requirements of the learning activity, depending on what is at stake for them (Delgoulet and Marquié, 2002). Studying a vocational training course, they found that the older the trainee, the higher the training-related anxiety. This anxiety, however, had no significant effect on the performance of older trainees as measured by two tests.

Organisational age

Fourteen studies examined two indicators of organisational age: career stage and tenure. Tenure and chronological age appear to be highly interrelated. Both Maurer et al. (2003) and Van Vianen et al. (2011) reported that age effects were no longer significant when tenure was controlled for. More years of experience appeared to be related to motivation for and participation in CPD. Accumulating skills and experience negatively influenced the perceived need for CPD (Cully et al., 2000; Felstead, 2010; Guthrie and Schwoerer, 1996). Compared to those aged less than 50 years, older workers perceived a training deficit to be of less consequence in terms of requirements of the job and the enhancement of the prospects of promotion (Felstead, 2010). Kyndt et al. (2011) showed that for experienced workers, the feeling they had learned enough caused a barrier

for participating in CPD, whereas less experienced workers were more stimulated by professional and personal development: they wanted to learn and progress in their jobs, and they were curious. On the other hand, work experience was also reported to be helpful in focusing on relevant information, understanding theoretical knowledge, and maintaining and increasing one's learning motivation (Paloniemi, 2006). More experienced workers might increasingly recognise the need to learn and develop new skills and knowledge (Maurer and Weiss, 2010). Career stage also seemed to be influential. De Lange et al. (2010) suggested that older workers might have a reduced time perspective, have reached the highest position in the organisation, and do not have options for job transfer, resulting in lower learning-related behaviour.

Lifespan age

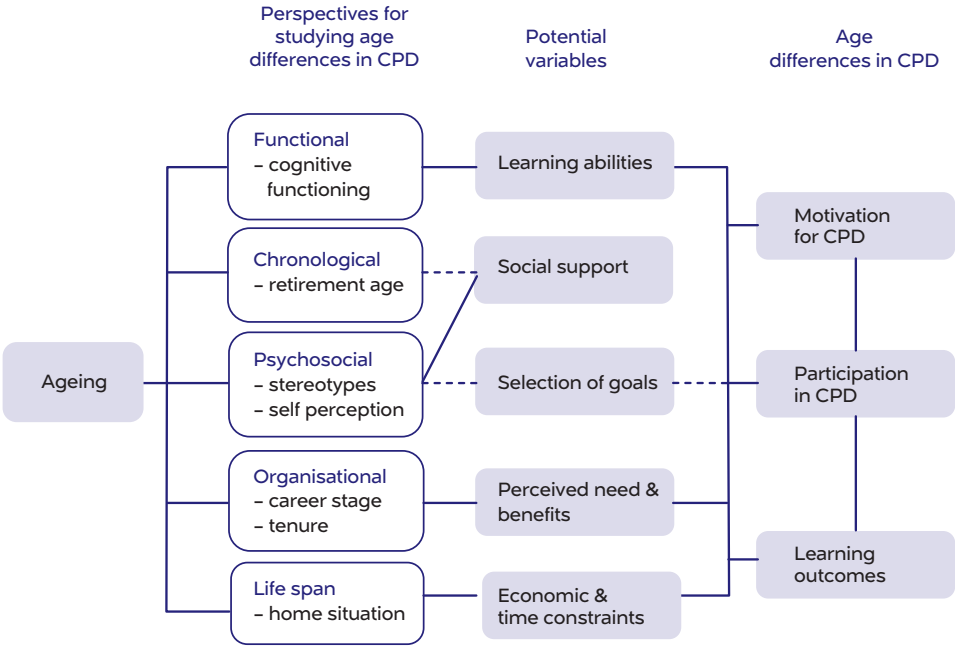
Several studies included indicators of lifespan as a variable, such as care-giving duties due to having children or other care-needing persons at home (De Lange et al., 2010) and marital status (Maurer et al. 2003). Only three studies reported findings on the relation- ship between family situation and CPD. One study showed that married women with children were less likely to participate in training programmes, but these results were not significant (Thangavelu et al., 2011). In a study on stimulating and prohibiting reasons for participation in learning activities, Kyndt et al. (2011) found that younger workers (<45 years) are discouraged by the required investments (e.g. distance, costs, time) of learning activities. They suggested that younger workers are more likely to have younger children, reducing their amount of spare time (Kyndt et al., 2011).

Conclusions and discussion

This study reviewed the literature to examine age differences in nurses' CPD. The literature review included 27 empirical studies, demonstrating that research in this field is still limited among nurses as well as among workers in general. In Figure 3.3, we summarise the results of this literature review. The study aimed at examining in what respect CPD differs across age groups. Figure 3.3 shows that studies reported on age differences in motivation for CPD, participation in CPD, and CPD learning outcomes. In general, workers in late career (older than 50/55 years) seemed less likely to participate in formal CPD activities. For workers in mid career and for non-formal and informal learning activities, age patterns seemed less clear. Also, no clear age patterns were found for motivation and learning outcomes.

The study showed that at least three age groups and different types of CPD activities should be distinguished when examining age differences in CPD. Studies examining more formal CPD (Felstead, 2010; Thangavelu et al., 2011) found a negative relationship between age and participation in CPD, whereas others examining primarily non-formal and informal learning activities (Berg and Chyung, 2008; Lammintakanen and Kivinen,

Figure 3.3. Five perspectives show potential variables causing age differences in CPD.



2012) found a positive correlation with age. These differences probably reflect differences in the ways in which younger and older workers learn (Luger and Mulder, 2010). These findings are consistent with other research, which showed that novice nurses prefer other learning activities than expert nurses do (Daley, 1999) and that the purpose of CPD can be different for younger and older nurses (Pool et al., 2013b). When examining age differences in CPD, different learning activities and purposes should be taken into account. Distinguishing at least three age groups makes it possible to examine whether nurses participate in different CPD activities, with different purposes, when they make transitions from early to mid career, and from mid career to late career.

Another aim of the study was to disclose factors contributing to age differences in CPD. It used a framework with five perspectives on age (Kooij et al., 2008; Sterns and Doverspike, 1989) in an attempt to identify these factors. The framework was useful as it showed that age differences in CPD are studied from different perspectives. Some studies examined the direct relationship between chronological age and participation in CPD (Wray et al., 2009) or learning outcomes (Ng and Feldman, 2008). Most studies searched for explanations by using one or more of the five perspectives on age. Explanations were searched from psychosocial and organisational perspectives, whereas functional, chronological and lifespan perspectives were used less. Figure 3.3 illustrates the age-related factors that were studied using these five perspectives.

(1) Functional perspective. Research on learning abilities in CPD is still limited. The results showed that older workers sometimes perceived themselves as less able to learn than younger workers, but this seemed to depend on the type of learning activities. It might be assumed that age effects on learning abilities depend on the type and content of the learning activity.

(2) Chronological perspective. Calendar age is often used to divide participants in age groups. However, research using a chronological perspective to explain age differences identified is scarce. Chronological age, when operationalised as 'time till retirement', is likely to have a negative impact on social support for CPD. However, this assumption was not clearly supported in the empirical studies. Therefore, we illustrated this in Figure 3.3 with a dotted line.

(3) Psychosocial perspective. Negative stereotypes can influence managerial support, thereby limiting possibilities for CPD. The results showed no clear age pattern. Some studies found less social support for older workers, some found less of the same for younger workers, and others found no age differences. These contradictory results may be explained by cultural differences between countries. Social perceptions of older workers are culturally influenced, and CPD opportunities for older workers in Northern European countries might be better than those in other industrialised countries (Billett et al., 2011), resulting in contradicting study results. It also might be that the middle-aged workers get more social support than do younger workers who just started and older workers who are near retirement. In addition to social support, self-perception might change with ageing, thereby influencing workers' motivation for CPD. It seems reasonable to assume that a change in time orientation and the attempt to protect one's self-concept influence workers' selection of goals (Carstensen et al., 1999; Kooij et al., 2008). However, this assumption was not clearly addressed and supported in the empirical studies, and is illustrated in Figure 3.3 with a dotted line.

(4) Organisational perspective. Tenure and career phase have an ambiguous effect on the perceived need for and benefits of CPD. More years of experience leads to a lower perceived need for CPD, but can also be helpful in recognising what still needs to be learned. Results did not specify whether the perceived need for all types of learning activities diminished. In nursing, this probably accounts more for formal than informal learning activities, as older nurses still want to learn but prefer practice-based learning (Daley, 1999) and perceive a ceiling in relevant courses (Gould et al., 2007; Pool et al., 2013b). Preferences for formal modes of learning might decrease in late career when job transfer becomes less of an option for nurses.

(5) Lifespan perspective. The results suggest that nurses' situations at home can influence their participation in CPD, particularly with respect to nurses with young children. Nurses perceive economic and time constraints as a barrier to participation

in CPD (Gould et al., 2007). Results, however, did not specify whether the home situation affects participation in all types of learning activities. It might be assumed that learning activities that take place in one's own time are more affected than learning activities that take place during work time.

Strengths and limitations

Four limitations should be considered. First, the number of empirical studies was limited and study populations were diverse. This diversity limits the opportunity to apply the findings to the nursing workforce. Several situational factors affect the relationship between age and CPD, such as type of job, educational level and gender (Pillay et al., 2006; Tones and Pillay, 2008). For instance, the relevance of a study on college-educated men (Greller, 2006) might be limited for the nursing workforce, with a predominance of women atypical of the general population (Hill, 2011). Besides, findings might be difficult to apply to all nurses, as learning in nursing can differ substantially due to workplace characteristics (Skår, 2010) and occupational roles.

Second, the studies gathered data on CPD in different ways. Some examined CPD by asking open questions, giving participants the opportunity to refer to all the learning activities they had undertaken. Others examined specific learning activities, which had been listed in their questionnaires. These differences in data collection and the focus on different types of learning activities complicate a comparison of the findings.

Third, the framework used has its shortcomings. The overlap between some of the perspectives complicated the analysis and description of the results. In particular, the chronological perspective, when operationalised as calendar age, did not seem an independent perspective, as all studies used calendar age to divide participants in age groups. However, when chronological age was operationalised as 'time till retirement', it gave a different perspective on age differences in CPD. The latter operationalisation resembles the career stage from the organizational perspective.

Finally, as we were interested in age differences, we examined group-level differences between workers at one age and workers at another age. We did not study the ageing process, that is, intra-individual changes occurring over time. Therefore, it is not possible to disentangle cohort effects from age differences. The age differences in CPD found presently may not exist in the future. The gap between younger and older workers is shown to have become smaller over the years (Cully et al., 2000; Felstead, 2010). Increasing attention to lifelong learning skills in education, growing attention to CPD by workers and employers, and the shifting of the retirement age might have influenced the study results in the period between 1996 and 2012, and it might reduce this gap even more in the future.

Despite these limitations, the strength of this study is that it is the first review of age differences in nurses' CPD. By using different perspectives of age, a comprehensive

overview of age-related issues in CPD is given, and gaps in current research are identified. This gives input for a research agenda for future studies on age differences in CPD.

Suggestions for further research

Further research on CPD in the nursing field is needed. We found only a limited number of relevant studies on age differences in nurses' CPD. Although it will be difficult not to recognise the relevance of studies on other workers, more research in the nursing field is needed to better adapt CPD approaches to the needs of different age groups.

Furthermore, additional attention should be given to whether the type of learning activities workers undertake changes as they grow older and gain more experience. Our results suggest that older workers (older than 50/55 years) in general participate less in formal CPD activities than their younger colleagues. Several studies on older workers, however, found that older workers continue to learn but have particular approaches to and participation in learning (Fenwick, 2012; Fuller and Unwin, 2005). Research should examine if and how these approaches differ from those of younger workers. In addition, research using a longitudinal design seems necessary. This will give more insight into intra-individual differences: does the motivation for, participation in, and learning outcomes of CPD change as nurses grow older? The present studies only suggest that there are differences, but these could be attributed to cohort effects as well as the ageing process.

More research is also needed on learning outcomes. Only five studies focused on this issues; the specific topics examined varied from workers' satisfaction with CPD to performance in CPD. Research on age differences in learning performance seems to be limited to experimental or laboratory designs where workers do not learn real-work tasks. Assessing learning outcomes in the professional context of workers might give a more accurate view on whether older nurses learn as much as younger nurses in CPD activities. Along these lines, additional attention should be given to the effects of cognitive ageing on CPD.

Finally, additional studies are needed on the effects of the home situation on workers' participation in CPD. Only three studies used indicators from a lifespan perspective. Particularly for nurses, of which the majority are women and might have care duties at home, the home situation might influence participation in CPD.

When studying age differences in CPD, at least three age groups should be used. Younger workers, middle-aged workers, and older workers should be distinguished (Ng and Feldman, 2008; Simpson et al., 2002). In accordance with other authors (De Lange et al., 2010; Sterns and Doverspike, 1989), we find lifespan theoretical perspectives particularly useful to guide further research on age differences in CPD. These theories recognise both inner changes (e.g. biological and psychological) as well as the effects

of external forces on individuals and groups (e.g. sociological changes for cohorts) (Kanfer and Ackerman, 2004). They emphasise individual differences in ageing. A relevant theory seems to be the Socioemotional Selectivity theory (Carstensen et al., 1999), which posits that the changing perception of time influences the selection of social goals. Also relevant is the Selective Optimisation with Compensation (SOC) theory (Baltes et al., 1999), which underlines differences in the way people allocate resources to various goals of development across the lifespan. According to these theories, workers may have different motives in different phases of their lives. Knowing these motives might help the concerned authorities to better support workers in their learning and development during different phases of their lives and careers.


chapter 4

Strategies for continuing professional development among younger, middle-aged, and older nurses

A biographical approach

This chapter is based on:
Pool, I.A., Poell, R.F., Berings, M.G.M.C., Ten Cate, O., 2015.
Strategies for continuing professional development among younger, middle-aged, and older nurses: A biographical approach.

International journal of nursing studies 52 (5), 939-950.

Abstract

Background

A nursing career can last for more than 40 years, during which continuing professional development is essential. Nurses participate in a variety of learning activities that correspond with their developmental motives. Lifespan psychology shows that work-related motives change with age, leading to the expectation that motives for continuing professional development also change. Nevertheless, little is known about nurses' continuing professional development strategies in different age groups.

Objectives

To explore continuing professional development strategies among younger, middle-aged, and older nurses.

Methods

A qualitative study using semi-structured interviews, from a biographical perspective. Data were analysed using a vertical process aimed at creating individual learning biographies, and a horizontal process directed at discovering differences and similarities between age groups.

Participants

Twenty-one nurses in three age groups from general and academic hospitals in the Netherlands.

Results

In all age groups, daily work was an important trigger for professional development on the ward. Performing extra or new tasks appeared to be an additional trigger for undertaking learning activities external to the ward. Learning experiences in nurses' private lives also contributed to their continuing professional development. Besides these similarities, the data revealed differences in career stages and private lives, which appeared to be related to differences in continuing professional development strategy; 'gaining experience and building a career' held particularly true among younger nurses, 'work-life balance' and 'keeping work interesting and varied' to middle-aged nurses, and 'consistency at work' to older nurses.

Conclusions

Professional development strategies can aim at performing daily patient care, extra tasks and other roles. Age differences in these strategies appear to relate to tenure, perspectives on the future, and situations at home. These insights could help hospitals to orientate continuing professional development approaches toward the needs of all age groups. This should be particularly relevant in the face of present demographic changes in the nursing workforce.

Introduction

People learn continuously throughout their lives (Billett, 2010). From birth until death, humans encounter new experiences and acquire new skills and knowledge (Alheit and Dausien, 2002). This learning can be trivial or meaningful, but people cannot *not* learn and are therefore inherently lifelong learners (Alheit and Dausien, 2002; Grotendorst and Van Wijngaarden, 2005). In society, the importance of lifelong learning is stressed increasingly (Commission of the European Communities, 2000, 2010; OECD, 2012). Lifetime employment with one employer is no longer guaranteed (D'Amato and Herzfeldt, 2008), and people need to develop continuously to remain informed and maintain their value on the labour market. Moreover, changing demographics increase the need for organisations to retain older workers and sustain their employability beyond existing retirement ages (Billett et al., 2011). As a result, continuing professional development (CPD) has become essential for the individual worker, organisations, and society in general (Alheit and Dausien, 2002; Billett, 2010).

This also holds for healthcare. Nurses work in rapidly changing environments due to the pace of technological change and advancements in knowledge (Gopee, 2001). Continuous learning plays a vital role in improving patient care and job satisfaction (Skår, 2010). Therefore, managers and educators create various CPD approaches, such as organising training programmes and introducing personal development plans. The research community has responded accordingly. We now know much more about nurses' learning activities (Berings, 2006; Eraut, 2007; Estabrooks et al., 2005), stimulating factors and barriers for engagement in professional development (Brekelmans et al., 2013; Gould et al., 2007), and perceptions of CPD (Gopee, 2001; Hughes, 2005).

Remarkably little is known about differences in nurses' continuing professional development between age groups (Pool et al., 2013a). With an aging workforce, this knowledge becomes more relevant. Currently, the healthcare field employs four distinct generations of nurses with different values, work-related motives, and competencies (Lammintakanen and Kivinen, 2012). Employers, used to a workforce dominated by younger nurses (Palumbo et al., 2009), face the challenge of developing CPD approaches geared towards the needs of all groups (Andrews et al., 2005; Lammintakanen and Kivinen, 2012). In this study, we aim to explore nurses' professional development strategies in different age groups.

Continuing professional development strategies

Nurses engage in professional development when they have reasons to do so (Govranos and Newton, 2014). As active meaning makers who do a great deal to shape the direction and intensity of their learning processes, they participate and learn in ways directed towards the continuity of their interests and goals (Billett, 2006, 2010). Nurses' ideas and beliefs regarding CPD can differ from those of other stakeholders in healthcare,

such as employers and professional bodies (Griscti and Jacono, 2006; Nolan et al., 2000). Therefore, individuals determine how to engage with what is afforded to them (Billett, 2006). This may be particularly relevant in countries without national professional development requirements. In the Netherlands, nurses have to demonstrate a minimum practice requirement to renew registration. There is no mandated requirement on continuing professional development. Nurses can register their learning activities in a National Quality Register voluntarily (V&VN). In other countries, such as the United Kingdom, both minimum practice and professional development are required to maintain registration (Cutcliffe and Forster, 2010). Also in these countries individuals can exercise agency. Workers may engage superficially or wholeheartedly in learning, depending on their appreciation of the importance of a particular practice (Billett, 2006). Poell and Van der Krogt (2014b) showed that nurses act strategically in their professional development; they create individual learning paths, which comprise a set of learning-relevant activities around a theme that they find relevant.

The American Nurses Association (ANA) has defined professional development as '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, n.d.). Accordingly, we define a nurse's professional development strategy as a combination of CPD activities that correspond to explicit or implicit motives for CPD (cf. Berings et al., 2007). Using the word 'strategy' does not imply that continuing professional development is always actively planned and intentional, but acknowledges that nurses implicitly or explicitly direct their learning towards their interests and goals. CPD activities refer to nurses' learning methods and are numerous (Berings et al., 2007; Eraut, 2007; Estabrooks et al., 2005), varying from formal continuing education to spontaneous learning during work experiences with patients or social interaction with colleagues. CPD motives refer to reasons to engage in professional development activities, such as knowledge acquisition, core skill retention, career advancement, and extension of nursing roles (Gould et al., 2007; Nolan et al., 2000; Pool et al., 2013b).

Age and continuing professional development

The previous sub-section demonstrated that nurses direct their professional development towards their interests and goals, which are likely to change with ageing. Buchan (1999) suggested that nurses' requirements and attitudes to nursing work differ according to age. This is supported by insights from the field of lifespan psychology, which indicate that work-related motives are influenced by age (Baltes et al., 1999; Carstensen et al., 1999; Kanfer and Ackerman, 2004). Socioemotional Selectivity theory posits that ageing leads to a shift in time orientation, which influences goal selection (Carstensen et al., 1999). Initially, people view time as open ended, and knowledge-related goals assume primacy; however, with age, time is perceived to be limited and emotional goals take precedence. According to Selection, Optimisation with Compensa-

tion (SOC) theory people allocate resources to various developmental goals throughout their lives (Baltes et al., 1999). Younger adults' goals are primarily growth orientated, whereas those of older adults involve maintenance and loss prevention (Ebner et al., 2006). Accordingly, we assume that, rather than through the influence of chronological age itself, ageing affects nurses' professional development strategies by serving as a proxy for several age-related processes (Kanfer and Ackerman, 2004), such as lifetime career and private life changes (Kooij et al., 2008; Sterns and Doverspike, 1989).

Nurses' careers involve various stages, which Donner and Wheeler (2001) described as follows: (1) the entry stage, which involves newly graduated nurses selecting their first workplaces; (2) the commitment stage, during which nurses develop preferences at work (e.g. preferred nursing specialties or working practices); (3) the consolidation stage, during which nurses adapt to their chosen career paths and the connections between their personal and professional lives, and (4) a withdrawal stage, during which they prepare for retirement. Others (Chang et al., 2006; McNeese-Smith, 2000) distinguish slightly different career stages.

Career stage models show that workers' needs vary with different points in their careers (Chang et al., 2006). Professional development needs are also expected to vary with career stages (Gould et al., 2007), but research on this topic is limited. Daley (1999) found that novice nurses benefited from formal training, while more experienced nurses preferred work-based opportunities, such as conversations with colleagues. Nurses over 50 years of age generally appear to be less likely to participate in formal CPD activities, such as courses, relative to younger workers (Pool et al., 2013a; Wray et al., 2009). They wish to learn, but use different learning activities (Lammintakanen and Kivinen, 2012).

Nurses' private lives also change with ageing. People may move, marry, have children, become ill, or experience the death of a relative. Their personal lives may influence their participation in continuing professional development, particularly when they have young children (Pool et al., 2013a). Economic and time constraints can also be barriers to engaging in professional development (Gould et al., 2007; Morgenthaler, 2009).

Aim of the study

Our study explores nurses' continuing professional development strategies in three age groups by examining the following research questions:

a) Which continuing professional development strategies do nurses in each age group use?
b) How are continuing professional development strategies related to career stage and private life?

A biographical approach

We used a biographical approach. Biographical research studies life histories to gain insight into an individual's experiences, perspectives, and action strategies with respect to social and societal contexts (Stroobants, 2001). A learning biography is a particular type of biography that represents the individual's learning history (Grotendorst and Van Wijngaarden, 2005). We deemed a biographical approach appropriate for this study. First, this approach treats humans as agents who actively give meaning to their lives and learning (Billett, 2010; Stroobants, 2005). The biographical approach takes the complex interwoven relationship between social structure and individual subjectivity into account (Alheit, 1994; Hallqvist et al., 2012; Stroobants, 2005); it also acknowledges that nurses establish their own routes through the professional development opportunities available to them, based on their interests and goals.

Second, a biographical approach to continuing professional development includes not only formal and organised learning activities, but also everyday learning (Hallqvist et al., 2012) which takes place while working. Learning biographies are detailed, rich descriptions of personal learning experiences, which do not differentiate between modes of learning (Grotendorst and Van Wijngaarden, 2005). It recognises that nurses develop through a rich variety of CPD activities.

Third, biographies form connections between different life domains and stages. This enables exploration of developments in nurses' professional lives, focusing on the relationships between their lives, careers, and learning (cf. Smilde, 2009). It acknowledges that these domains are interrelated, and that nurses' experiences and expectations influence their professional development strategies.

Methods

Design

We employed a qualitative study design with a biographical approach, using interviews.

Participants

Participants were nurses, selected according to purposive and maximum variation sampling principles (Coyne, 1997; Miles and Huberman, 1994). We strove for variation, selecting nurses from different hospitals, different specialties, with or without extra roles, and with or without children. A literature review (Pool et al., 2013a) showed that at least three age groups should be used to study age differences in continuing professional development. Accordingly, and similar to previous research, (Pool et al., 2013b; Schulz and Stamov Roßnagel, 2010; Van der Heijden, 2006) we used the following age groups: younger (20–34 years), middle-aged (35–49 years), and older nurses (50–65 years).

Participants were required to work in direct patient care and have at least two years' experience as a registered nurse. Nurses were recruited using intermediaries from the first author's network, such as nurse team leaders and educators. We guarded the diversity by instructing the intermediaries on the type of nurse to recruit (gender, age, speciality, with or without extra roles).

We selected 21 nurses, the majority of whom were female (n = 17; see Table 4.1); 20 had participated in postgraduate training in a nursing specialty or another nursing role. The participants worked on various general hospital wards (n = 9) and university hospitals (n = 12). Age and tenure were highly related; the younger nurses, aside from Miranda, had worked on their current ward for a maximum of 4 years. The middle-aged and older nurses had worked on their current wards for 9–15 and 14–34 years, respectively. Karen seemed to be an exception, with tenure of 3 years. However, she had 30 years experience on wards in the same paediatric department.

Data collection

Data were collected between February and August 2013, using semi-structured interviews. Prior to the interview, the nurses were asked to provide brief biographies along a time line (c.f. Grotendorst and Van Wijngaarden, 2005), including (1) important life events, such as marriage, illness, and their own and their children's birth dates, (2) their career, and (3) their education. The interviews started with an open question, 'You have written your biography. Can you elaborate on this'? The interviewer did not interrupt the subsequent narration but encouraged the participant with paralinguistic and verbal expressions of attentiveness (Apitzsch and Siouti, 2007) and took notes. If the participant interrupted her/his story, the interviewer would request clarification or further exploration of the topics and themes mentioned (Apitzsch and Siouti, 2007). This part of the interview concentrated on the nurse's life story, particularly regarding career and learning biography information. The second part of the interview focused on learning episodes or moments of importance to the participant. We asked three questions: (a) what were the important learning moments in your career, (b) which learning moments or episodes have been crucial to do your current job properly, and (c) what are the milestones in your development as a nurse? In the last part of the interview, the participants described professional development strategies they had used in preceding months, recounting learning activities they had engaged in and their motives for doing so. Finally, participants described their ideas regarding work and professional development for the next five years. This ensured that nurses' professional development was narrated from past, present, and future perspectives. Participants were asked if they had missed or wished to add anything, and the interview was closed. The interviews lasted approximately 90 min.

Table 4.1. Characteristics of participants.

Pseudonym	Gender	Age	Nursing education[1]	Postgraduate training	Hospital[2]	Ward	Tenure[3]	Children
Younger nurses								
Rachel	F	24	B	Oncology	G	Hemato-oncology	3	–
Harry	M	24	B	Geriatrics	G	Chirurgical	0,25	–
Mathilde	F	26	V, B	Intensive care (in training)	A	Intensive care	0,08	–
Marianne	F	27	B	Paediatrics	G	Paediatrics	4	–
Andrea	F	29	B	Emergency room, master social sciences	A	Emergency room	3	–
Esther	F	29	B	Oncology	A	Oncology	2	–
Miranda	F	34	V, B	Paediatrics, intensive care neonatology, nurse educator	A	Neonatal ICU	10	–
Middle-aged nurses								
Emma	F	37	B	Oncology	A	Chirurgical-oncology	9	yes
Silvia	F	45	H	Dermatology	A	Dermatology	13	yes
Danielle	F	45	H, B	Paediatrics	A	Paediatrics	9	–
David	M	46	H	–	A	Neuro-chirurgical	13	yes
Carrie	F	46	V	Oncology (in training)	G	Cardio-lung	15	yes
Christina	F	48	H	Intensive care, emergency room, preceptor	G	Emergency room	12	–
Tess	F	48	H	Management, obstetrics & gynae-cology	G	Obstetrics	10	yes
Older nurses								
Wendy	F	54	H	Management, oncology, intensive care	G	Intensive care	18	–
Anne	F	54	H	Paediatrics, intensive care neonatology	G	Neonatal ICU	30	yes
Janet	F	54	H	Management	A	Pulmonary care	32	yes
Simon	M	57	H	Cardiac Care, management, geriatrics	A	Geriatrics	20	–
Karen	F	57	H	Paediatrics	A	Generic paediatrics	3	yes
Edith	F	59	M, H	Management, oncology, geriatrics	G	Geriatrics	14	–
Robert	M	61	H, P	Management, hospital fire brigade	A	Psychiatry	34	–

[1] *In the Netherlands, two nursing education programmes exist: vocational (V) and bachelor (B). Till 1997 in-service nursing education existed in a hospital (H), a psychiatric hospital (P) or institution for mentally handicapped (M).*

[2] *G = general hospital setting, A = academic hospital setting.*

[3] *Tenure on present ward in years.*

Ethical considerations

Consistent with national practice in the Netherlands, no ethical approval was required for this study (CCMO, 2015). The Academy of Human Resource Development standards on ethics and integrity (Russ-Eft et al., 1999) were followed. Participants were informed of the study purpose and approach in the invitation e-mail and orally at the start of the interview, and informed consent was sought. They were informed they could exit the interview and refuse to answer a question, whenever they wanted. We asked their accord on audio recording of the interview. We explained that we would anonymise transcripts as much as possible by replacing names by pseudonyms and removing dates. The audiotapes were only accessible to the first author and the transcriptionist. The other authors had only access to the transcripts that were coded together. The three participants of the condensed biographies in this paper agreed by email with its publication, realising that anonymity could not be guaranteed because one's biography is unique.

Data analysis

Interviews were audio recorded and transcribed verbatim. The interviews were analysed using vertical (within-case) and horizontal (cross-case) processes (Hunter, 2010; Stroobants, 2001). By coding transcripts (horizontal analysis) the essence of individual stories and situated nature of the text are gradually lost (Chase, 2005; Hunter, 2010; McCormack, 2004; Stroobants, 2001). Therefore, we began with a vertical analysis. Rather than locating distinct themes across interviews, we listened to the 'voices' within each narrative first (Chase, 2005). Each interview was summarised in four to six pages to create an individual learning biography using the participant's own words (Hunter, 2010; Smilde, 2009). We used a flexible framework to guarantee that the research questions held a place in each learning biography, but also ensured that the nurses' individuality would emerge (Smilde, 2009). These learning biographies were sent to the participants for validation, which resulted in some minor changes at sentence and linguistic levels.

Horizontal analysis was aimed at discovering themes across the interviews via coding of the transcripts (Miles and Huberman, 1994). Maxqda software (2007) was used to aid in data coding and retrieval. The first eight interviews were coded using a short provisional start list of codes (Miles and Huberman, 1994) based on the theoretical background, research questions and insights from the vertical analysis. These 'etic' codes were extended and sometimes replaced with 'emic' codes, inductive codes that emerged from the data (Miles and Huberman, 1994). The first author did the coding.

The others read a sample of coded interviews to check the coding. All authors discussed the assigned codes multiple times, until consensus was reached, and classified them into five categories: career stage, private life, professional development motives, professional development activities, and learning triggers. These categories and codes were subsequently used for coding of the remaining 13 transcripts, while allowing for the inclusion of potential new codes. After coding was completed, themes and trends

were identified and propositions for an explanatory framework were tested against the data (Miles and Huberman, 1994).

Results

Three individual accounts: Results of the vertical analysis

We approach the research questions by beginning with summaries of three learning biographies. These were chosen to provide an example of the interwoven relationships between life, work, and professional development and represent examples of CPD strategies in three age groups. We then summarise the findings across individuals and age groups.

Marianne (27) has worked on a paediatric ward for four years

As a student on the postgraduate training programme for paediatric nurses, I did not witness many complex situations. That's why I took a European Paediatric Life Support course quite soon after graduation. I want to be prepared, and able to say: I can have the pager today. For the same reason I joined the working group Resuscitation. In this role, I teach my colleagues and keep the resuscitation policy up to date. On the ward, I show more willingness to do extra things than the average colleague. For instance, I recently replaced the preceptor, who was pregnant, and underwent training to do this.

On this ward, you can become an expert nurse in a short time. In my first year, I had gained some experience, and four years later, I'm even more experienced. Now I know more about how to react in exceptional cases, and I can answer students' questions. I keep up to date through e- learning modules, symposia, and clinical teaching sessions. As a newly qualified paediatric nurse, you engage in a lot of learning activities unconsciously. I register these in the National Quality Register [the voluntarily register for nurses' CPD activities]. When I apply for a job, I have a nice overview of what I have done.

We learn every day, mostly from the unexpected. We recently had a new born here. We expected her to do well, but she didn't. We talked about it during service rounds: you put the pieces of the puzzle together and oversee the total picture. Some nurses know a lot, because they are receptive to new or complex children, while others choose familiar situations at the onset of a shift.

I have to work for another 40 years, so I don't want to climb the ladder too fast. Preceptorship is nice for later, when I'm done with patient care. For now, my private life plays a role. I'm going to be married and would like to have children. With children, I want to work two or three days a week. Do I have things I want to develop? I cannot say; 'this or that is what I would like to develop'. Much is happening on this ward, and I can keep improving parts of nursing care, but these are small things'.

Emma (37) has worked at a chirurgical–oncology ward for nine years

At 24, I went to nursing school, after I had quit other studies. After graduation, I started on this ward. When they introduced senior positions, I tried to distinguish myself, and six months later I was offered this position. This soon became too much, because I was also enrolled in postgraduate training in oncology and had a miscarriage. After a year, I stepped down from the senior position. My private life and work are intertwined. When life goes well at home, it goes well at work and with me. I have two little children, whom I want to see grow up. That's why I took parental leave and work 2.5 days a week now. It is not hard to keep up to date, but you stay in the background.

One learns something new every week. These are small things. I try to fit what doctors say into the total picture of the patient. Also, you continually learn from colleagues and develop through interactions with patients. We have to undertake e–learning yearly. Everyone dreaded this, but it turned out to be fun. We learned during quiet shifts and discussed what we did not know. It made me reflect on my daily practice. I learn new things from doctors without having to read the articles. Sometimes, I read nursing journals, but they are not very interesting. I know what I'm supposed to know and can answer students' questions, but I don't renew my knowledge or come up with new things. I'm not being challenged to do so.

When my youngest goes to school, I want to work more days every week, possibly change jobs, and enrol in an education programme. What do I want to develop? At the moment, I learn from e–learning and doctors, but in future I wish to learn more structured leading to a certificate. I like to learn in a school situation, where you learn new things and meet other people. In future, I wouldn't mind attending education outside working hours, but I don't have the money to cover enrolment fees'.

Simon (57) has worked on a geriatric ward for 20 years

I completed my nursing education in a military hospital. After graduation, I took post–graduate training in cardiac care and worked in that field for three years. I still felt like studying, so I engaged in management training. Twenty years ago, I applied for a job on this geriatric ward and took postgraduate training in geriatrics. After two years of being a nurse and learning a lot about geriatrics, I became a team leader. In 12 years, the position changed gradually, and I moved away from the bedside. I started missing patient care, and in my private life, several relatives died, my wife had cancer, and I was hospitalised for some time. This made me decide to step back from being a team leader, and I requested a position as senior nurse. As senior nurse, I have patient mobility as a focus area. I teach this, coach colleagues, and pay attention to patient transfers. I have a terrific profession, but I constantly check whether I still enjoy it.

My education is important and I learn a lot in daily practice. Geriatrics is complex; diseases present themselves in many different ways. Over time, you learn through

experience and reading. You learn to see relationships and reason clinically by observing patients, conferring in doctors' rounds, and engaging in clinical teaching sessions. I attended several training courses, for example, a technical skills course. I'll shortly be going to a symposium on mobility. I occasionally go to symposia to present, and at other times, to listen. I learn from journal articles on geriatrics, but my wife's journal on critical care can also be interesting. I learn from students; they serve as a mirror. For instance, a student noticed that I didn't wear gloves while dissolving antibiotics; nowadays, I do.

I have come to a point where I just want to work happily in the coming years and use all of my effort. I want to do some projects and give lessons. What do I want to develop? These are small things. I don't aim to undertake any long educational programmes. It refers to learning new things, keeping up to date, gaining competence in the electronic health record system, and making PowerPoint presentations for my lessons'.

Results of the horizontal analysis: Similarities in CPD strategies

As these and the other 18 learning biographies showed, there are a number of similarities in continuing professional development strategies across the three age groups.

Daily work is an important trigger for learning on the ward

The learning biographies revealed that nursing work had changed significantly over the years. During the past three decades, nursing care has become more complex and intensive, with a reduction in inpatient care. Anne remarked, 'Everybody thinks that 30 years on the same ward is tedious, but the ward is never boring. There is always something happening: new equipment, new insights, and the age limit for treatment [of neonates] changed from 28 to 24 weeks. That makes a huge difference'. Nurses experienced several organisational changes, and patient categories altered periodically on the wards. These developments, combined with technological changes and new insights, were important learning triggers.

The learning biographies showed that nurses felt that they learned almost every day. This professional development was largely embedded in everyday work and took place through various learning activities, driven by different motives. First, encountering problems in patient care and changes at work prompted self-directed learning. Understanding patient cases or unexpected situations motivated learning in all groups. Several nurses mentioned 'putting the pieces of a puzzle together' when attempting to understand a patient's situation, by exchanging information with physicians and colleagues. Unfamiliarity with a treatment or disease prompted nurses to consult sources such as the Internet. When they felt insecure regarding new equipment or a nursing skill, they asked a colleague for help. Tess: 'Some love to take care of dirty wounds, while others are good with technology. When I have to take care of wounds, I prefer to consult an expert colleague, so that I can learn a lot'.

Second, nurses indicated that they learned via organised ward-based learning activities, such as clinical teaching sessions, annual (re)training days, and e-learning. Employers often obliged nurses to participate in these activities. Nurses seldom questioned these requirements, because of the practical applicability and often short duration of the learning activities. David commented, 'Skills training courses (. . .) I have followed a lot of them (. . .) it is appropriate to learn how to administer an infusion again (. . .) it keeps you up to date. This training usually takes 45 min, and you arrive earlier or stay longer. This does not reduce time for patient care'.

Third, continuing professional development partly appeared to occur spontaneously while executing daily tasks, without explicit intention to learn. Nurses learned from patients, colleagues, and their own experiences. Simon learned from the student's reminder to wear gloves, and Janet explained that, when a patient asked her to sit down because she gave the impression that she was in a hurry, she learned about the impression she made on patients. Although this learning appeared to occur unintentionally, several nurses stressed that one has to be receptive in order to learn from such situations.

Performing extra or new tasks are an additional learning trigger

Besides these external changes, nurses also made their work interesting and varied by adding extra tasks to daily patient care. This served as an additional prompt for professional development, which is not restricted to the ward. Additional tasks or responsibility for a focus area seemed to trigger external course and symposium enrolment. For example, Marianne attended training for her role as preceptor, and Simon attended symposia to maintain his knowledge on patient mobility.

The learning biographies showed differences between nurses who explicitly strove for variety in their work by adding extra tasks, and those who did so to a lesser extent. This difference did not appear to be age related.

Learning from experiences in private life

Several nurses mentioned the importance of learning from their private lives. They learned from raising children, and sickness and death in their personal circles. In particular, middle-aged and older nurses stressed that life experiences supported them in understanding patients and their families. Edith said, 'A strong example is the death of my parents. I have always provided palliative care with my heart and soul. I did this well, but you cannot imagine what it means for people until you experience it yourself. Since then, I have addressed people differently, with more patience and empathy'.

Results of the horizontal analysis: Differences in CPD strategies between age groups

The learning biographies revealed differences in career stage and private life between the three age groups, which appeared to be related to differences in professional development strategy. The following themes appeared to be more important in one age group than in the other age groups.

Gaining experience and building a career (younger nurses)

Younger nurses' professional development was characterised by intensive learning periods. Most nurses were building experience as nurses and in nursing specialties. Professional development was deemed important in preparing for unfamiliar situations and expanding knowledge. Most nurses were participating in or had recently completed specialised postgraduate training. Besides learning on the ward, they attended short external training programmes and symposia. The nurses were aware that they were gaining expertise, as Marianne's biography illustrated.

Additionally, career development and task enrichment appeared to be a focus. All nurses, aside from those following postgraduate training, performed tasks that served as learning triggers, in addition to direct patient care. For some, building curriculum vitae was a motive. They displayed a desire to distinguish themselves from others, with a view to future job applications. Harry, like Marianne, registered his learning activities in a portfolio and said, 'An employer will form a better impression of me than from a curriculum vitae alone. Many nurses say, "I do my job, and I will be told the rest by others". They are not actively expanding their knowledge. I want to show that I am actively involved in it'.

The future seemed open to these nurses. If work ceased to be a challenge, they showed a desire to move on. Five participants considered undertaking postgraduate training in a different nursing specialty or obtaining a master's degree in nursing in the future. Marianne and another nurse indicated that work would probably play a different role in their lives. They expected to start a family and preferred working part-time if they had young children. Their professional development motives would then focus on improving their current jobs.

Balancing life at home and work (middle-aged nurses)

The expectation of these two nurses seemed to be confirmed by the interviews involving middle-aged nurses. As Emma's sketch illustrates, balancing work and home life was clearly more of an issue for middle-aged nurses. Four nurses had children, and two had also cared for seriously ill family members for some time. Like Emma, Silvia depicted how private life, work, and continuing professional development required balancing: 'When all goes well at home, I can develop. But when you don't have child care, a child gets ill, or something else happens (. . .) your beautiful picture collapses'.

Life at home was the reason why several nurses worked part-time. Two nurses decided to work less than two-and-a-half days per week when their children were young. Working fewer hours seemed to influence professional development. Emma felt that keeping up to date was not problematic, but she did not want to enrol in continuing professional development outside working hours. Silvia remarked that keeping up to date required more effort, particularly for nurses who mainly worked late shifts. Carrie, who kept working full-time with small children, remarked about nurses working less than 50% of the hours in full working week, 'You miss many of the alterations on the ward. Sometimes, when you are away for one-and-a-half weeks, many things happen. You read about it by e-mail, but it differs from continually participating in it'. Anne (an older nurse) supported this. Becoming accustomed to a new respirator was more difficult for her, as she only worked two days per week.

Keeping work interesting and varied (middle-aged nurses)

Another theme mentioned specifically by nurses in the middle-aged group was that of keeping their work interesting. They had worked on the wards for several years and enjoyed their work but needed challenges. Christina remarked that, after working in an emergency room for 12 years, she had been exposed to most situations. The initial excitement had faded. She created new challenges by combining nursing with being a preceptor, which provided a new impetus for professional development. Others enriched their work by adding tasks such as committee participation. Danielle sought challenges by enrolling in postgraduate education, 'I can keep simmering this way, but that is not very pleasant. That's why I have recently decided to obtain a master's degree in nursing. (. . .) It is nice to be challenged again'.

Consistency at work (older nurses)

Simon's statement illustrates a theme in the older group of nurses. The older nurses had previously confronted similar issues as those currently faced by younger and middle-aged nurses; they had built their careers, completed postgraduate training, changed their jobs, and some had added additional tasks to patient care; however, they had reached a point, as Simon noticed, at which they wanted to keep working as they did. Some questioned whether they would physically endure the job until retirement. Janet saw an escape in preceptorship if nursing care were to become too difficult physically. The two oldest nurses were faced with changing retirement policies, which would probably force them to work for longer than expected.

Consistency at work did not imply indifference to further development. Rather, future learning pertained to what they called 'small things'. Some nurses had an explicit learning goal, e.g. Simon wished to increase his PowerPoint skills, and Anne wished to learn additional technical nursing skills. Others indicated that they lacked clear goals. Edith said, 'It is not that I have a goal or something I want to learn, but if an interesting course on dementia crosses my path, I would say yes'. Wendy clearly demonstrated

changing motives for engagement in continuing professional development, 'It is not that I am done with learning, but your needs change. When you are younger, you want many things (. . .) but when you are 45, 50, or even older, as I am, it stabilises at a certain moment. I am at a point (. . .) when I look to the future; I do not want anything other than to keep working agreeably. (. . .) My development is located in small things'.

Conclusions and discussion

This study aimed to explore the professional development strategies of younger, middle-aged, and older nurses by creating individual learning biographies. To our knowledge, it is the first study to use a biographical approach to examining nurses' continuing professional development. This approach bridges insights from literature on continuing professional development and lifespan psychology. By placing nurses' professional development in the context of career stage and private life, and focussing on various CPD motives and activities, we obtained a better understanding of nurses' professional development strategies in different age groups.

The study revealed that continuing professional development strategies can aim at performing daily patient care, extra tasks, or other roles and jobs. We found similarities and differences in these strategies across age groups. Table 4.2 summarises how these strategies, and their underlying CPD motives and activities, are related to career stage and private life. Perhaps the most novel finding was that differences appeared to be related to tenure, perspectives on the future, and situations at home.

Like others (Berings, 2006; Eraut, 2007; Jantzen, 2008), we found that performing daily patient care provided important triggers for learning on the ward, through self-directed learning, participation in organised learning activities, and spontaneous learning. Keeping abreast of changes, understanding patient cases, and gaining competence appeared to be crucial motives for professional development. Besides, undertaking extra tasks served as an additional learning trigger.

A novel finding was that professional development strategies directed at daily work and extra tasks appeared to be important at all career stages, but professional development intensity differed. For younger nurses, continuing professional development appeared to be more intensive relative to other age groups; however, intensity increased when nurses performed new tasks or roles. Takase (2013) showed that competence development is characterised by rapid growth during the first 10 years of clinical experience, particularly the first few years, followed by more stable periods. With longer tenure and growing experience, the need for intensive learning seems to disappear. This is possibly caused by more frequent engagement in new tasks at a younger age.

Table 4.2. Relationships between CPD strategies and career stages and private life.

	CPD motives (examples)	CPD activities (examples)	Relationships with career stages and/or private life
CPD strategies directed at performing daily patient care	• Understanding of unfamiliar patient cases • Keeping up to date • Gaining competence • Meeting expectations	• Self-directed learning (e.g. consulting the Internet and colleagues) • Organised learning activities on and outside the ward (e.g. courses, symposia) • 'Spontaneous' learning (e.g. feedback from colleagues, and learning from experiences in private life)	• Seem important at all career stages. • The intensity appears to be related to tenure. • Appears to be negatively associated with CPD opportunities when working few hours a week.
CPD strategies directed at performing extra tasks	• Keeping up to date • Gaining competence • Improvement of knowledge	• Self-directed learning • Organised learning activities • 'Spontaneous' learning	• Seem important at all career stages. • Appear to be related to work motives and attitudes (the wish to have a challenging and varied job).
CPD strategies directed at performing other roles/jobs	• Career development	• Postgraduate training	• The importance of career development seems to decrease with age.

We found that regardless of age, continuing professional development strategies directed at daily work, and particularly at extra tasks, appeared to be related to work-related motives and attitudes. Some nurses seemed satisfied with a job that is stable over a long period of time, and confined professional development primarily to ward activities, while others preferred a diverse or challenging job and considered the benefits of leaving the ward for learning activities. This supports earlier findings indicating that the scope of nurses' professional development was linked to their perceptions of their profession and work attitudes (Pool et al., 2013b).

In addition, the findings suggest that changes in private life, such as having small children, may influence nurses' continuing professional development. Most of the nurses with children worked part-time, which is in accordance with national statistics showing that female nurses over 30 years work more often part-time with an average part-time factor between 0.6 and 0.7. Nurses with older children work more hours a week, but not as much as nurses between 20 and 30 years (Hellenthal, 2011). For nurses working a few days per week, particularly those working predominantly late shifts, it appeared more difficult to keep up to date. This corroborates earlier findings that part-time nurses and

night staff have fewer CPD opportunities (Barriball et al., 1992; Furze and Pearcey, 1999). However, working part-time did not necessarily lead to less CPD engagement. This seemed to depend on how much a nurse valued work and professional development.

We also found differences across age groups in professional development strategies directed at performing other roles and jobs. The learning biographies confirmed that the groups' perceptions of time differed (Carstensen et al., 1999). Younger nurses perceived the future as open, and considered various career development possibilities, while older nurses were inclined to remain in the same job for as long as they were physically able. The importance of career development and postgraduate training appeared to decrease with age. The findings show an age-related decline in preferences for growth (Kooij et al., 2011), while CPD motives, such as increasing knowledge or keeping up to date continued to be important.

Limitations

This study had some important limitations. First, it is likely that nurses using certain continuing professional development strategies were absent from the middle-aged and older groups, because they left direct patient care earlier and were inherently excluded from participation in the study. This may have biased the learning biography comparison. We could not prevent this, as we were interested in professional development in nurses working in direct patient care.

A second methodological concern was that of sampling. We requested intermediaries to approach different types of nurses, but were dependent on their choices. This might have biased the results. The respondent group was quite diverse, but nurses who did not care about continuing professional development or nursing research may not have responded.

Third, the cross-sectional design makes it impossible to disentangle age and generational differences. Generational cohorts mature simultaneously, which may lead to similar values, opinions, and preferences. The learning biographies illustrated that the times during which the groups were educated differed in terms of values and competencies regarding lifelong learning. This may also have influenced their professional development strategies. In contrast, the study's strength was that by constructing biographies, middle-aged and older nurses also described professional development strategies they had used when they were younger. In doing this, we were able to triangulate data regarding early-career CPD strategies.

Implications of findings

Our study has implications for future research. Our findings suggest that the concept of continuing professional development should be reconsidered. Friedman and Phillips (2004) revealed that opinions vary regarding which learning activities qualify as CPD. Our study showed that nurses develop through more activities than those usually

defined as continuing education. This broader understanding provides a more nuanced view of nurses' professional development strategies, particularly those of older nurses. Stereotypical views state that older workers are less motivated to learn relative to their younger colleagues (Gray and McGregor, 2003). It could be that generally, age negatively influences participation in formal education programmes, but our results support earlier studies indicating that older workers continue to learn through other CPD activities (Fenwick, 2012; Fuller and Unwin, 2005). Hence, future research should report in a more detailed fashion regarding relationships between age and different types of CPD activity, and distinguish between self-directed learning, organised ward-based and external CPD activities.

Another suggestion for further research is to examine relationships between CPD motives and activities. This will extend our understanding regarding reasons for workers' preferences for certain CPD activities. Studies on learning styles (Berings, 2006) provide useful insights into these preferences; however, our study suggests that nurses' CPD motives also affect the types of activity undertaken.

Our study has two practical implications. First, as daily practice is a rich resource for learning in all age groups, its learning potential should be recognised and used systematically (Jantzen, 2008; Lammintakanen and Kivinen, 2012). Nurse managers play a crucial role in creating a supportive learning environment. They can encourage learning by monitoring nurses, by providing feedback (Drach-Zahavy et al., 2014), sufficient job autonomy, and social support (Berings et al., 2010). They can enable the organisation of ward-based learning activities and facilitate self-directed learning by providing information resources such as protocols and literature.

Second, managers should be aware that nurses of different ages may have different CPD needs. For instance, younger nurses may require support to gain experience, while middle-aged nurses may need the provision of challenging tasks, and older nurses may require support in finding learning activities that suit their level of experience. Some more experienced nurses, who limit their work to what they already know, may need encouragement to perform new tasks and accept challenging patient cases. Managers should ensure that part-time nurses have sufficient CPD opportunities to keep up to date.

To conclude, while the number of studies examining nurses' continuing professional development has grown, few have explored nurses' professional development strategy differences according to age. Our study contributes to developing knowledge in this area. Hopefully, this study will lead to a better understanding of nurses as lifelong learners.

chapter 5

Motives and activities for continuing professional development

An exploration of their relationships by integrating literature and interview data

This chapter is based on:
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Motives and activities for continuing professional development:
An exploration of their relationships by integrating literature and interview data.

Submitted for review and publication

Abstract

Background

To effectively enhance professional development, it is important to understand the motivational factors behind nurses' engagements in particular types of learning activities. Nurses have various motives for professional development and utilise different learning activities. Not much is known about how these relate.

Objectives

To explore the relationship between nurses' motives and activities for continuing professional development.

Design

This study combines a literature review with biographical interviews.

Methods

The literature on nurses' motives and activities for continuing professional development was reviewed using three databases; the framework that was thus formulated was used to re-analyse the data of an earlier study, in which 21 nurses working in Dutch hospitals were interviewed about their learning biographies. The interview transcripts were analysed for motives, learning activities and their relationships.

Results

Nine motives and four categories of learning activities for continuing professional development were delineated. Increasing competence was the primary motive that stimulated nurses to engage in self-directed learning during work, and in formal learning activities. To comply with requirements, they engaged in mandatory courses. To deepen knowledge, they registered for conferences. To develop their careers, they enrolled in postgraduate training. The other five motives were not mentioned as frequently.

Conclusions

Specific motives were found to be related to engagement in particular learning activities. Nurses could use these findings to increase their awareness of why and how they develop professionally, and managers and human resource development professionals could develop approaches that would better suit nurses' needs.

Introduction

Continuing professional development (CPD) in nurses is crucial to maintain a competent, motivated workforce, and to provide safe patient care. In many parts of the world, professional nursing regulatory bodies mandate that nurses comply with CPD requirements to maintain their professional registrations (Cutcliffe and Forster, 2010). Furthermore, nurse managers organise CPD interventions to ensure a competent nursing workforce. However, nurses' interests and ideas about CPD could differ from those of professional bodies and managers (Griscti and Jacono, 2006; Nolan et al., 2000). This may result in a mismatch between the individual's personal aspirations and the demands of others (Munro, 2008).

There is a growing notion that employees act strategically in their professional development (Poell and Van der Krogt, 2014a). 'Acting strategically' does not imply that employees always plan their CPD deliberately; however, it needs to be recognised that employees learn by using methods that suit their interests and goals, and choose how to engage in what is afforded them (Billett, 2006, 2010). Gradually, they learn to strategise by choosing those CPD activities that best suit their motives (Poell and Van der Krogt, 2011). This notion is confirmed by Poell and Van der Krogt (2014b), who found that nurses created individual learning paths; nurses engaged in learning activities around a theme they deemed relevant.

Research on nurses' CPD strategies is limited. Studies have shown that nurses have varied CPD motives including career advancement and core skill retention (Brekelmans et al., 2015; Griscti and Jacono, 2006; Nolan et al., 2000; Tassone and Heck, 1997), and develop through a broad range of CPD activities (Berings, 2006; Eraut, 2007; Estabrooks et al., 2005). Some studies mention a relationship between CPD motives and CPD activities. Bahn (2007a) for instance, describes how nurses use mandatory sessions to keep up to date, engage in informal learning activities to enhance knowledge, and enrol in continuing education because they feel that they are lagging behind new entrants. Others investigated nurses' motives for specific learning activities, such as a post-registration degree course (Dowswell et al., 1998) or a Master's programme (Watkins, 2011). However, to our knowledge, no study has explicitly examined the relationship between various CPD motives and different CPD activities.

The aim of this study was to explore this relationship; we investigated which types of CPD activities a nurse would engage in and why. This was achieved in two steps. The first step included classifying CPD motives and CPD activities through a literature review. The second step included exploring the relationships between CPD motive and CPD activities in an empirical investigation of nurses learning biographies. This paper thus attempts to synthesise and combine studies on motives and learning activities. This knowledge would help organisations to gear CPD approaches to suit nurses' needs better.

Literature review

Aim

We reviewed the literature on CPD motives and CPD activities to develop a framework for analysing the qualitative data of the subsequent study. The literature review focussed on the following questions:

a) What motives do nurses have to engage in CPD activities?
b) Which CPD activities do nurses undertake?

Design

As there were no recent classifications of nurses' CPD motives, a review was undertaken combining data from quantitative and qualitative empirical studies. However, as several classifications of nurses' CPD activities were available, we did not search for additional literature on CPD activities; instead, we reviewed three recent classifications.

Search methods and outcome

The literature search on nurses' CPD motives was performed in July 2014 using three databases: CINAHL, PubMed, and Web of Science. Search terms used were nurs* AND motives (OR motivation OR motivational orientations OR reasons) AND continuing professional development (OR CPD OR continuing education OR CE OR continuing nursing education OR CNE). We focused on the titles and abstracts. The search returned 278 publications, which were screened for relevance. Publications from English-language journals reporting on empirical studies on motives for CPD were included. Studies on students, midwives, and staff development specialists were excluded. We identified 22 relevant studies. The majority of the studies (n = 17) had quantitative designs and used questionnaires. Four were qualitative, using focus groups or individual interviews, and one had a mixed approach. We decided not to exclude studies based on quality, because quality appraisal of studies with different research designs (quantitative and qualitative) is complex and no gold standards exist (Whittemore and Knafl, 2005).

Data abstraction and synthesis

We listed all the motives mentioned in the selected 22 studies and then grouped them into categories of similar motives. Those mentioned by fewer than three authors were removed.

Table 5.1. CPD motives derived from the literature.

Motives	Description
To increase competence in present job	To keep up to date, improve knowledge and competence to optimise proficiency in current work.
To deepen knowledge	To seek knowledge for its own sake, to satisfy an inquiring mind and to deepen knowledge.
To enhance career development	To increase possibilities to move sideways into a new area of work, through extended nursing roles or another nursing specialty, or to other jobs within or outside nursing.
To comply with requirements	To meet expectations, comply with policy or formal requirements of an authority, such as the employer and the professional body.
To supplement gaps in prior education	To supplement narrow or unsatisfactory previous education.
To increase self-esteem	To boost self-esteem and increase self-confidence during practice.
To get relief from routine	To prevent becoming 'stale' and bored, and get a break from the routine of work or home.
To build a professional network	To meet and interact with other professionals in order to share knowledge and build professional networks.
To improve healthcare	To enable service development and improve healthcare at the ward.

Results

Motives for CPD

We derived nine categories of nurses' motives to engage in CPD activities. An overview of each category and its description is given in Table 5.1, and the supporting studies in Table 5.2.

This classification of these nine motives is largely based on two scales (see Table 5.3): the Education Participation Scale (EPS) (Boshier, 1971, 1977) and the Participation Reasons Scale (PRS) (Groteluesch en et al. in DeSilets, 1995). Boshier had studied motives for participation in adult education and identified six motivational orientations. Boshier's EPS and modified versions were used in five studies. The PRS was used in two studies. Groteluesch en (in DeSilets, 1995) expanded on Boshier's work by developing an instrument that focused exclusively on motives for participating in professional continuing education activities. The five motivational orientations that were identified overlapped

Table 5.2. CPD motives and the supporting studies.

CPD motive	O'Connor (1979)	O'Connor (1982)	Urbano et al. (1988)	DeSilets (1995)	Staring (1995)	Dealy and Bass (1995)	Cividin and Ottoson (1997)	Dowswell et al. (1998)	Dowswell et al. (2000)	Smith and Topping (2001)	Ryan (2003)	Robinson and Tingle (2003)	Murphy et al. (2006)	Peña Flores and Castillo (2006)	Bahn (2007a)	Bahn (2007b)	Joyce and Cowman (2007)	Liang and Wu (2010)	Watkins (2011)	Nalle et al. (2010)	Haywood et al. (2013	Ni et al. (2014)
To increase competence in present job	x	x	x	x		x		x		x	x	x	x	x	x	x	x	x			x	x
To deepen knowledge	x	x	x	x	x	x	x	x				x		x			x	x	x	x		
To enhance career development	x	x	x	x	x	x		x	x		x	x	x	x	x	x	x	x	x	x	x	x
To comply with requirements	x	x	x		x	x	x	x	x		x	x					x	x		x	x	x
To supplement gaps in prior education	x	x						x	x		x					x			x			
To increase self-esteem								x			x		x				x				x	x
To get relief from routine	x	x	x					x	x		x							x			x	
To build a professional network	x	x	x	x	x	x	x			x			x	x				x				
To improve healthcare	x*	x*	x*	x	x*					x		x		x		x			x		x	

** In these studies, this category of motives was broader and had names such as 'social welfare'.*

partly with those of Boshier (Table 5.3), but were reoriented into a professional context. For instance, Boshier's category of social welfare (sample item: 'To become more effective as a citizen of this city') was changed to professional service (sample item: 'Improve my individual service to the public as a nurse'). All studies before 1996 made use of one of these two scales. In those after 1996, most researchers had developed their own measurement tools listing several CPD motives or had held interviews. The motives in these studies largely concurred with those of the two scales. Based on the studies after 1996, we added two categories, 'to increase self-esteem' and 'to supplement gaps in prior education', and renamed some categories – for example, 'social contact' was changed to 'to build a professional network'.

Table 5.3. Two scales used in 8 of 22 studies.

	Education Participation Scale (Boshier, 1971, 1977)	Participation Reasons Scale (Grotelueschen et al. in DeSilets, 1995)
Used in	O'Connor (1979, 1982): modified Urbano et al. (1988) Staring (1995) Liang and Wu (2010): modified Dealy and Bass (1995) used several items of O'Connor's modified EPS	DeSilets (1995) Peña Flores and Alonso Castillo (2006)
Categories of motives	Escape/stimulation	
	Professional advancement	Personal benefits and job security
	Social welfare	Professional service
	External expectations	
	Cognitive interest	
	Social contact	Collegial learning and interaction
		Professional improvement and development
		Professional commitment and reflection

The motives had varied natures. Motives such as 'to increase competence' and 'to deepen knowledge' were directed primarily towards the present job, while 'to enhance career development' focussed on future tasks. These motives had a professional nature, while others, such as 'to increase self-esteem' or 'to get relief from routine' were more personal. Generally, professional motives seemed to have primacy over personal motives. O'Connor (1979, 1982), in her two studies of 843 and 1,152 nurses, concluded that the desire to improve professional knowledge had the strongest influence on participation in continuing education programmes. This was confirmed by Dealy (1995); recent studies also corroborate that the need to expand professional knowledge is a major reason to engage in CPD (Murphy et al., 2006; Ni et al., 2014; Ryan, 2003).

The natures of motives also differed based on levels of self-determination. Distinction is often made between intrinsic and extrinsic motivation. Intrinsic motivation relates to genuine interest in the activity itself, while extrinsic motivation refers to engaging in an activity because of external factors. Extrinsic motivation is considered non-autonomous; however, self-determination theory (Ryan and Deci, 2000) posits that extrinsic motivation can vary in its level of self-determination. The least autonomous extrinsically motivated behaviours serve to satisfy an external reward or demand, whereas in the most autonomous form, external regulation is fully integrated into the self. In this integrated regulation, extrinsically regulated motivation is fully developed in congruence with one's own values (Ryan and Deci, 2000); the person feels a strong need to show this behaviour.

Some motives, such as 'to deepen knowledge', had a strong intrinsic nature, whereas others, such as 'to comply with requirements', had a strong extrinsic nature.

In several countries, participation in CPD is legislatively required to maintain registration. This was not the case in the Netherlands, where the current study took place. Nevertheless, in the Netherlands, employers are increasingly mandating that nurses be involved in CPD, given the need for accountability. An implicit assumption underlying this obligatory stance is that nurses lack intrinsic motivation and need external pressure (Urbano et al., 1988). Several studies showed that need to comply with external expectations influenced nurses' participation in CPD to some extent; however, an intrinsic interest to improve and expand professional knowledge had the strongest influence (Cividin and Ottoson, 1997; Dealy and Bass, 1995; Ni et al., 2014; O'Connor, 1979, 1982; Ryan, 2003; Staring, 1995).

CPD activities

Research on how nurses learn and develop after graduation is growing. Studies have identified different learning activities used by nurses, ranging from formalised continuing education in a classroom to learning from colleagues during regular work (Berings et al., 2008; Eraut, 2007; Estabrooks et al., 2005). Various dimensions have been used to describe different types of learning activities (Van der Klink and Streumer, 2004). An often-used dimension is formal and informal CPD, with the former referring to intentionally planned learning in an educational setting and the latter to learning in the workplace. Billett (2006) challenged the description of workplace learning as 'informal'. He argued that workplace learning could also be highly structured and designed to ensure the continuity of the organisation. Both on- and off-the-job formal organised training and learning activities take place, where the learning route is largely pre-planned and similar for everyone (Berg and Chyung, 2008).

Another descriptive dimension of CPD activities is the intention to learn. At one end, there is implicit or incidental learning. This takes place without any active intent and the learner may even be unaware that he/she is learning (Doornbos et al., 2004; Eraut, 2000). This spontaneous learning frequently occurs while executing daily tasks (Berg and Chyung, 2008). The opposite of implicit learning is deliberate learning, wherein activities are performed with the goal of learning in mind (Doornbos et al., 2004). Deliberate learning is easier to observe and describe, compared to implicit learning, which is a by-product of work (Berg and Chyung, 2008).

A third dimension is the control of the learning situation, i.e. the agents that influence the content of learning (Van der Klink and Streumer, 2004). Control is exerted by the learner him/herself, the hospital management or teaching staff. Often, there is joint control of learning (Van der Klink and Streumer, 2004). The level of control by the learner is influenced by his/her self-directing abilities. Self-directed learning has been defined in

various ways; however, common elements are that the learner identifies his learning needs and objectives, decides how and where to learn, and evaluates the learning outcomes (O'Shea, 2003).

Capturing nurses' learning activities in a classificatory system is a challenging process, because nurses are working, thinking, making decisions and learning simultaneously (Berings et al., 2008). Nevertheless, several typologies of nurses' learning activities do exist. We found three of these useful. The first is Eraut's typology (Eraut, 2007) of early career learning, based on research among nurses, engineers, and accountants. He classified learning processes according to their principal object: working or learning. In work processes, learning is a by-product. Examples include learning by working with clients, tackling challenging tasks, and consultation. Eraut found that learning in work processes formed a large proportion of learning. Clearly recognised learning processes took place at or near the workplace (e.g. conferences, supervision, and courses). Within these primary work and learning processes, several short (learning) activities occur, such as reflecting, questioning, providing, and obtaining feedback (Eraut, 2007).

Berings et al. (2008) created a more detailed classification, based on research on nurses and validated among supervisors and educators. They delineated six categories of learning activities: learning (1) by doing one's regular job, (2) by applying something new in the job, (3) by theory or supervision, (4) through life outside work, (5) by social interaction with colleagues, and (6) by reflection. The first four were described as first-order learning activities, which were often preceded or succeeded by the last two (second-order learning activities).

Estabrooks et al. (2005) had a different focus – they targeted nurses' sources of practice knowledge. Based on two ethnographic studies, they categorised these sources into four broad groups: social interactions, experiential knowledge, documents, and a priori knowledge. The category 'social interaction', which dominated their findings, was divided into informal and formal interactions. Informal interactions included exchange of information with other nurses, professionals, and patients. Formal interactions were organised events usually aimed at enhancing nurses' skills, which could be discipline-, institution-, or unit-based (Estabrooks et al., 2005). Some categories of this taxonomy correspond with those of Berings et al. (2008). For instance, 'informal interactions' has some overlap with Berings et al.'s 'social interactions with colleagues', and 'formal interactions' and 'documentary sources' are combined in Berings et al.'s 'theory and supervision'.

Based on the three dimensions and the three classifications, we distinguished four categories of CPD activities. An overview of these learning activities and their descriptions is given in Table 5.4. We decided not to include the short (Eraut, 2007) or second-order (Berings et al., 2008) learning activities, such as reflection, in a separate category, as they could occur as part of all other learning activities.

Table 5.4. CPD activities derived from the literature.

CPD activity	Description
Learning from experience	Knowledge and skills gathered through experiences on the job. Learning happens as a by-product of working.
Learning from social interaction with colleagues	Informal learning activities with and from peers, students, and other healthcare professionals through exchange of knowledge, consultation, feedback, and observation.
Learning from organised learning activities	Formal learning activities at the ward, hospital, or outside the workplace setting. This includes conferences, postgraduate training, clinical teaching sessions, (online) courses, etc.
Learning from consulting media	Self-directed learning through media including the Internet, books, journals, protocols, etc.

Qualitative study

Aim

We aimed to explore the relationship between CPD motives and CPD activities by empirically examining the question: How do CPD motives relate to CPD activities?

Design

The study design was qualitative and exploratory. We re-analysed interview data from an earlier study. For a detailed description of the sampling strategy and data collection, see Pool et al. (2015). We had examined nurses' CPD in different career stages using a biographical approach. Nurses narrated their past, present, and future CPD details. The focus of the study was on similarities and differences in CPD strategies across three age groups, and on exploring the relationship between life, work, and learning. We had noticed substantial relationships between CPD motives and CPD activities, which needed further investigation that was beyond the scope of the earlier study. Hence, in the present study, we re-analysed this data using the categories created following the literature review described above.

Participants

Nurses were recruited from three age groups: 24–34 years, 35–49 years, and 50–65 years old. To be included, nurses had to be working in direct patient care, and not solely as a manager or educator. Nurses were selected from different specialties, and with or without extra roles (such as taskforce membership or coordinating tasks). We assumed that the variation in these background characteristics would provide a variety of CPD strategies. Twenty-one nurses (seven in each age group) working in general and academic hospitals were interviewed (see Table 5.5). The majority were female (n = 17), average age was 43 years, and average tenure at the current ward was 12 years.

Table 5.5. Characteristics of participants.

Characteristic	Number
Gender	Male: n = 4, Female: n = 17
Mean age (SD)	43.05 (12.62)
Mean years of working experience at present ward (SD)	12.22 (10.09)
Type of hospital	General: n = 9, Academic: n = 12

Data collection

Data were collected in 2013 using semi-structured interviews. The main thread in the first part of each interview was the nurse's life story, with particular focus on his/her career and learning biographies. In the second part of the interview, we focused on the learning episodes or moments that were deemed important by the participant. In the last part, they were asked to narrate their CPD strategies in the previous months: what CPD activities did they engage in and what were their motives for doing so? Finally, they were asked to describe their perceptions about work and professional development in the upcoming five years.

Ethical considerations

No ethical approval was required for this study as per national practice in the Netherlands because no patients were involved. We followed the Academy of Human Resource Development standards on ethics and integrity (Russ-Eft et al., 1999). Participants were informed of the study's purpose and approach in the invitation e-mail and at the start of the interview, and informed consent was sought. Transcripts were anonymised as far as possible using pseudonyms and removing dates.

Data analysis

The interviews were audio recorded and transcribed verbatim. The data were analysed in three steps. First, the interviews were examined for CPD motives and CPD activities. The transcripts were deductively coded by using the nine CPD motives (Table 5.1) and four CPD activities (Table 5.4), while keeping an eye open for new CPD motives and activities (Miles and Huberman, 1994). We used MAXQDA (2007) to code and retrieve the data. We refined the four CPD activities into 21 subcategories using labels mentioned by the participants. For instance, we added nine subcategories under organised learning activities (e.g. clinical teaching sessions, conferences), and four subcategories under consulting media (e.g. protocols, the Internet). In the second step, we tabulated the motives mentioned with the linked learning activity and vice versa for each interview. These 21 tables were summarised in a single table. We then analysed the relationships between CPD motives and the 21 subcategories of learning activities by inspecting the tabulated combinations. In the categories 'learning from experience', 'learning from

social interaction', and 'learning from consulting media', all the subcategories related to the same CPD motives; hence, we deleted the subcategories. In the category, 'organised learning activities', we decreased the number of subcategories from nine to three in a similar manner.

Establishing rigour

The use of transcripts of audio recordings assured accuracy. The first author coded the transcripts. To enhance reliability in coding, the third author checked a single coded interview. Differences in opinions were discussed, and codes were changed as required. Complex fragments of all texts were discussed by the full research team. Content validity was enhanced by deriving the codes from an extensive literature review and validated classifications.

Results

The analysis of the interviews showed nine motive categories similar to those obtained from the literature review (see Table 5.6). No additional categories were required. The motives 'to increase competence' and 'to comply with requirements' were mentioned in most interviews, while 'to supplement gaps in prior education' and 'to build a professional network' in only few. The analysis also revealed the four originally described categories of CPD activities; however, we considered it useful to distinguish three subcategories under organised learning activities: (1) short courses and training, including clinical teaching sessions, annual training day at the ward, retraining, etc.; (2) conferences and symposia; and (3) postgraduate training. Learning from experience, from social interaction and from organised learning activities were mentioned in most interviews, and learning from consulting media in thirteen interviews.

Table 5.6 shows the CPD activities nurses undertook or were intending to undertake for each motive. The number in a cell refers to the number of participants mentioning the combination of a motive and an activity. Nurses often had several motives to engage in a specific CPD activity. Conversely, a motive was also related to several learning activities.

To increase competence

All nurses mentioned this motive using expressions, such as 'to master a technical nursing skill', 'to be prepared to give a new medication', and 'to keep up to date'. Nursing work provided frequent triggers for learning, 'I learn (…), perhaps not every day, but frequently'. Unexpected disease patterns, non-familiar diseases and treatments, and new insights and technologies motivated nurses to increase their competence in their on-going work. The motive 'to increase competence' promoted engagement in all four types of CPD activities. Learning from experience gave nurses the opportunity to identify strategies that worked best. For instance, a nurse explained how she tried to improve

Table 5.6. Relationship between CPD motives and CPD activities.

CPD motive	CPD activity	Experience (20)*	Social interaction (21)	Consulting media (13)	Organised learning activities (21)		
					Conferences (13)	Short courses/ training (21)	Postgraduate training (21)
To increase competence in present job (21)*		12	19	11	2	17	9
To comply with requirements (19)			4			18	
To deepen knowledge (17)		3	4	6	7	3	8
To enhance career development (17)						1	15
To get relief from routine (9)		4					4
To improve healthcare (4)		1	1		3	1	
To increase self-esteem (4)				1		1	2
To supplement gaps in prior education (2)						1	1
To build a professional network (2)					1	1	

** (x) = mentioned in x interviews*

her communication skills by experimenting. Taking care of patients was perceived as crucial for increasing competence, 'The more [patients] you see, the more you know'. Nurses learned through conferring with doctors and nurses or consulting media, 'I learn a lot by talking about things, by asking doctors "Can you explain this?" or asking an experienced colleague "How do you do this? Or that?" or when it is quiet at the ward by taking a book or searching for certain subjects on the Internet'. They asked colleagues for help or instructions if they were unsure about a certain technique. Besides these self-directed, informal learning activities, nurses also updated themselves through formal learning activities, such as (online) courses, conferences, and postgraduate training.

To comply with requirements

Nineteen nurses spoke of CPD activities they were required to undertake. However, they generally perceived these activities as also necessary to improve their competence and to keep up to date. Most of these were short courses including regular retraining in resuscitation and technical nursing skills, annual retraining days, clinical teaching sessions, and courses required for additional tasks such as supervision of students at the ward. Most activities took place at the ward. Ten nurses mentioned they had to enrol in online courses and assessments that their employers had purchased. Some dreaded the

compulsory nature, however, they also indicated that nurses would not readily engage in online courses at all without minimal pressure: 'We have to make online assessments (...) about technical nursing skills. Everyone dreaded these, but it turned out to be fun. In a quiet shift you make these assessments together with colleagues, and you search for the answers you do not know, and you discuss these'. For some, mandatory online courses prompted additional learning, such as consulting media or colleagues or enrolment in non-mandatory online courses. Four nurses narrated how these e-assessments were combined with mandatory peer assessments. Colleague nurses had to observe and give feedback on performance of a technical nursing skill.

To deepen knowledge

Seventeen nurses mentioned this motive. Nurses showed an intrinsic desire to advance knowledge. They used expressions such as, 'it is interesting to sort things out', 'to gain more in-depth knowledge', and 'I want to get to know as much as possible'. Eight nurses associated this motive with postgraduate training: 'I want to stay fresh and innovative (...) that is possible with training courses or symposia, but for me it is to undertake education. Not so much for the certificate, but for the new ideas, new methods'. Seven nurses attended symposia with this motive. Six mentioned reading journals, books about patient experiences, and watching documentaries. Social interaction and experience also deepened nurses' knowledge.

To enhance career development

Seventeen interviews revealed this motive, and it was mostly with respect to postgraduate training. For some specialties, such as paediatrics, intensive care, and emergency care, both a traineeship and postgraduate training was required. For others such as oncology, specialised postgraduate training was not always required; however, some felt it necessary to ensure job assurance, 'I love my job at daytime care. I expect that if you do not undertake the education, they will tell within two years, "I'm sorry, but you did not take your education, you will have to go back to the ward". That is not what I want'. Some postgraduate programmes were for other nursing roles, such as a nurse educator. A few participants intended to leave direct patient care in future (through management training or a Master's in nursing or social sciences).

To get relief from routine

Nine participants mentioned this motive. They indicated the need for new challenges and new learning. Some sought extra or new tasks, and more challenging patients: 'Challenges, you have to grasp or create them. It makes you grow. And it keeps your work attractive'. For others, enrolment in postgraduate training brought relief from routine, 'At a certain moment I did things automatically. Then I thought, "I have learned everything here, it is time to enrol in the intensive care education programme"'.

To improve healthcare

Four nurses explained that the motive to develop professionally was related to the drive to improve healthcare at the ward. Visiting conferences was an important learning activity in this context, 'Every time, I feel challenged to think what we can improve'. Other learning activities were performing extra tasks, exchanging information with expert colleagues, and engaging in courses.

To increase self-esteem

In four interviews, this motive was specified. One nurse justified her enrolment in bachelor nursing education after secondary vocational nursing education as follows: 'People I had contact with were all enrolled in higher studies (...) I guess I wanted to be one of them'. Others desired to maintain their self-esteem by avoiding embarrassment. They wanted to be able to answer questions from patients and students, 'I think it is terrible when I don't know something (...) that's failing (...) I do not want to be inferior to younger students'.

To supplement gaps in previous education

Two nurses mentioned this motive. One had witnessed few complex situations during her postgraduate training for paediatric nursing. She took a course in paediatric life support and joined a resuscitation taskforce to be better prepared. The other nurse took up management training, because she had learned little about organisational sciences during her in-service nursing education.

To build a professional network

Two nurses cited their drive to build a professional network to have prompted their registration for a conference or a course, 'Symposia (....) I like to go there. It is nice to be involved in your profession, (...) sometimes you hear new things, and I like the contact with nurses of other institutions'.

Discussion

Our combined literature review and qualitative empirical study revealed nine CPD motives, four CPD activities, and several relationships between these motives and activities. One of our most noteworthy findings was that nurses used a spectrum of CPD activities motivated by a desire to improve their competence. In addition to formally organised learning activities, they also attained crucial learning from experience, social interaction and consulting media. These three types of CPD activities have a strong self-directed nature and take place primarily during work, underscoring the importance of work as a learning environment (Skår, 2010) that accounts for a significant portion of learning (Eraut, 2007). It supports the argument that professional development needs a broader interpretation to include more than just formally organised learning activities (Webster-Wright, 2009).

Our study also shows that it is beneficial to distinguish among different types of formal, organised learning activities. The motives for engagement in organised CPD activities on and off the ward, and of short and long durations were different. Short courses and training, such as clinical teaching sessions and retraining of technical nursing skills that were mainly organised at the ward, were essential for nurses to keep up to date and to improve competency. The need to comply with requirements also motivated them to engage in these learning activities. Employers organised a variety of learning activities at the ward to ensure nurses' professional development. This upholds the concept that workplaces cannot be considered informal learning environments (Billett, 2006). The motives to enrol in conferences and postgraduate training (activities that primarily took place off the ward) were different. Conferences were deemed to deepen knowledge and provide an impetus for improving healthcare, while postgraduate training was considered necessary to enhance career development.

We found that four motives (to increase competence, to comply with requirements, to deepen knowledge, and to enhance career development) were mentioned in most learning biographies. Other motives were mentioned only by few; these (e.g. to increase self-esteem) appeared less persuasive. Our finding that nurses engaged in organised CPD activities to comply with requirements seemed to contrast with earlier studies showing that nurses were primarily motivated by a desire for knowledge rather than by external pressure (Dealy and Bass, 1995; O'Connor, 1979, 1982; Ryan, 2003; Tassone and Heck, 1997). However, we also found that complying with requirements was never the sole reason to engage in a learning activity. Nurses perceived these mandatory activities as a means to improve competence, or had integrated these external regulations into their own values (Ryan and Deci, 2000). As most of these activities were at the ward and directly related to patient care, the acceptance may have been eased.

Limitations

The study has a number of limitations. Within the classifications of both CPD motives and CPD activities there is some overlap that is difficult to avoid (Berings et al., 2008). This could have influenced the demonstrated relationships. Nevertheless, we believe that both classifications still represent a good framework to explore the relationships between CPD motives and activities. Second, during the assessment of these relationships, purposeful learning was emphasised. The biographical nature of our study, in which nurses looked back, and tended to pay more attention to learning activities that are represented in a curriculum vitae, reinforced this. This could have biased the biographies. Learning during everyday work activities and interactions (Billett, 2014b; Eraut, 2007; Jantzen, 2008), which has been shown in previous studies to constitute a significant proportion of learning, may account for an even larger part of nurses' learning than our results indicate. Third, our sample consisted of Dutch hospital nurses. Differences in learning environments (Skår, 2010) and CPD requirements (Cutcliffe and Forster, 2010) could alter findings in other countries with different healthcare settings.

Finally, the retrospective narratives wherein nurses had to reconstruct their motives for CPD activities could possibly bias the results. Despite these limitations, our study has important theoretical and practical implications, as elaborated below.

Conclusions

Our study assesses nurses' engagement in CPD from a new perspective. Linking CPD motives to CPD activities provides new insights into nurses' CPD. CPD motives seem to influence nurses' engagement in certain learning activities. Increasing competence is an important motive to employ self-directed learning during work; engagement in courses and training is also motivated by mandatory requirements, and enrolment in post-graduate training appears to relate to career enhancement. Further research is needed to validate these findings in larger and diverse groups. The proposed classifications could aid the development of measurement questionnaires for the same.

The practical implications of our study findings extend to assisting human resource development (HRD) professionals and managers in providing learning opportunities that suit these demonstrated motives. HRD professionals and managers can enhance professional development by utilising ward-based learning and providing nurses with challenging tasks, relevant media, opportunities for interactions with colleagues, and formal learning activities. Nurses and their managers can use these classifications to create awareness of nurses' CPD motives and thus assist nurses in selecting appropriate CPD activities.

Nurses' interest and active participation is crucial for the success of professional development programmes in organizations. Careful designing of CPD approaches cannot compensate for a lack of interest or participation on the part of employees (Maurer, 2002). Our study yields useful insights on improving engagement of nurses in CPD activities.

chapter 6

Professional development across the nursing career

A cross-sectional study on motives, formal and informal learning activities, and the effect of age

This chapter is based on:
Pool I.A., Poell R.F., Berings M.G.M.C., De Leeuw R., Ten Cate O.
Professional development across the nursing career: A cross-sectional study on motives, formal and informal learning activities, and the effect of age.

Submitted for review and publication

Abstract

Background

With rapid changes in healthcare and ageing of the nursing workforce, both continuing professional development and ageing are high on the agenda of hospital managers. Although lifespan theories propose that workers' needs and motives change with ageing, little is known about the effects of ageing on nurses' professional development strategies.

Objectives

The study examines nurses' engagement in formal and informal learning activities, their motives for doing so, and the effect of age on these. The second part identifies which age-related factors (i.e. differences in calendar age, working experience and lifespan) account for age patterns in learning activities and professional development motives.

Design

A cross-sectional questionnaire study.

Participants and setting

The study was conducted at five general and two academic hospitals in the Netherlands. Sixty-four team leaders and one nursing council distributed the questionnaire to their nursing staff. In total, 728 nurses responded to the questionnaire.

Methods

Participants received an online or paper version of the questionnaire from March to April 2015. For analysis, descriptive statistics, bivariate correlations, principal component analysis, and hierarchical regression analyses were performed.

Results

Nurses engaged most frequently in ward-based formal and informal learning activities, and less frequently in activities organised outside the ward. Ageing was positively associated with a number of formal learning activities (e.g. conferences), and negatively associated with other formal (e.g. e-learning) and informal learning activities (e.g. learning by social interaction), as well as most motives (e.g. professional knowledge). Tenure had similar effects on learning activities and motives. Differences in the situation at home did not predict engagement in learning activities, but the number of working hours did.

Conclusions

The findings suggest that work experience reduces the need for nurses to engage in learning activities. More research is needed to examine whether this has an impact on job performance. Managers should address that nurses that engage less in learning activities stay employable.

Introduction

The importance of continuing professional development (CPD) in nursing is growing. This is a reaction to continuous changes in patient care, and is reinforced by an increasing demand for accountability. Pre-registration nursing education is considered the start of a long process of learning that continues throughout a nursing career (Davis et al., 2014; Gallagher, 2007). Nowadays, the notion is growing that nurses direct their own learning processes. Within the given opportunities, they direct their professional development towards the continuity of their goals and interests (Billett, 2006). In a sense, they learn strategically by deliberately or less deliberately choosing learning activities that suit their motives best (Poell and Van der Krogt, 2014a).

Although the idea of lifelong learning in nursing has been embraced, little is known about how continuing professional development strategies change across a nursing career. This is remarkable, as lifespan theories propose that motives and engagement in CPD change with ageing. Ageing serves as a proxy for several age-related changes, such as evolution in work experience or life stage, which influence work-related needs and motives (Kooij, 2010). However, few studies on nurses' CPD have examined age differences (Pool et al., 2013a) or focused on nurses 45 years and older (Laughlin, 2012). Also for workers in general, there is no consistent evidence on the relationship between age, motives, and formal and informal learning activities (Froehlich et al., 2015; Raemdonck et al., 2015). The topic seems particularly relevant given the ageing nursing workforce in many Western countries (Spinks and Moore, 2007; Stewart-Amidei, 2006; Wray et al., 2009). Here, we investigate nurses' engagement in formal and informal learning activities, their motives to do so, and whether these are affected by age. Before turning to the survey study, we first provide an overview of the literature on the issues examined in the study. As the literature on age-related changes in nurses' CPD is still limited, we also surveyed the literature on workers in general.

Lifespan development theories and the changes in workers' needs and motives

The underlying thought of this study is that younger and older nurses have different needs and attitudes in work (Buchan, 1999), which may result in different CPD needs. This proposition is elaborated in Socioemotional Selectivity theory, which posits that the perception of time affects the types of goals people select (Carstensen et al., 1999). Younger workers, who perceive time as unlimited, are more likely to prioritise future-oriented goals and to participate in training and development aimed at knowledge acquisition and expanding horizons than are older workers, who have more motivation for activities such as building relationships with colleagues than they do for learning new skills, as they perceive the time to use these skills as limited (Beier, 2008). Another theory that illuminates the changes people face when they age is Selective Optimisation with Compensation theory (Baltes et al., 1999), which states that successful develop-

ment across a lifespan is a result of maximising gains and minimising losses. As losses become more manifest in later life, the goal orientation of younger and older adults differs. Younger adults will show a primary growth orientation, while older adults will focus more on maintenance of what they have by limiting their work to domains in which they excel, and invest in training to optimise performance and compensate for losses (Baltes et al., 1999; Beier, 2008; Ebner et al., 2006).

Chronological age serves as a proxy for many changes related to ageing (Kanfer and Ackerman, 2004). During one's lifetime, changes occur in biological, psychological, and social functioning (Sterns and Miklos, 1995). Therefore, age may be viewed from five different perspectives (De Lange et al., 2006; Kooij et al., 2008; Sterns and Doverspike, 1989) – chronological, functional, psychosocial, organisational, and lifespan age – which may have different effects on CPD (Pool et al., 2013a). In this study, we will use, besides chronological age, an organisational and lifespan perspective on age. The organisational perspective recognises that an increase in age often coincides with an increase in job or company tenure (Schalk et al., 2010; Sterns and Doverspike, 1989). Longer tenure seems to have an ambiguous effect – more work experience may reduce the need for CPD, while longer tenure may also lead to obsolescence leading to a higher need for CPD (Pool et al., 2013a). The lifespan perspective focuses on the influence of family life and the roles people take during their lives (De Lange et al., 2006; Raemdonck et al., 2015). Research suggests that nurses' situation at home, particularly having young children, may influence their engagement in CPD, but few studies have examined this (Pool et al., 2013a).

Formal and informal learning activities

For professional development, nurses make use of formal and informal learning activities (Bjørk et al., 2013; Munro, 2008). We define formal learning activities as learning activities organised by others. These activities take place within a structured context, explicitly created for the purpose of learning, and often, but not always, lead to a formal recognition (Eraut, 2000; Richter et al., 2011). Formal learning activities can take place off the job – for instance, in educational institutions – but also at the ward (Pool et al., 2015). Examples of formal learning activities include training courses, symposia, and clinical teaching sessions. Formal learning activities receive the majority of attention from employers, statutory bodies, researchers, and human resource development (HRD) professionals, as they are easier to plan, observe, and document than are informal learning activities (Froehlich et al., 2015; Reich et al., 2015).

Informal learning activities are activities initiated by workers themselves, and are embedded in daily working practice (Lohman, 2006). These activities can be intentional or deliberate (e.g. when a nurse asks questions or checks media), but also unintentional and implicit (e.g. when learning from work experiences) (Berg and Chyung, 2008; Eraut, 2000). Important factors affecting workplace learning include the level of challenge in work, opportunities for feedback and support, and possibilities for encounters and rela-

tionships at work (Eraut, 2007). Informal learning activities account for a large part of the learning by nurses (Berings, 2006; Eraut, 2007; Jantzen, 2008; Pool et al., 2015).

Formal learning activities and age

Lifespan theories predict that formal learning activities, and particularly those aiming at growth, become less important with ageing. Most studies on the relation of age and formal learning activities support this, as they indicate that older workers engage less in formal learning activities (Felstead, 2010; Thangavelu et al., 2011; Urwin, 2006). This decline in participation seems to account more for late-career workers than for mid-career workers (Pool et al., 2013a). In nursing, Wray et al. (2009) found that 73% of the sample aged 50 years and over had not accessed any CPD activities in the last two years compared to 23% of those under 50. When examining age effects on engagement in formal learning activities, we must distinguish between long education programmes that target career development and short learning activities focused on increasing competence in the present job (Pool et al., submitted). Previous studies have shown that older workers are more likely to undertake short training courses (Urwin, 2006) and activities that develop focused occupational skills (Simpson et al., 2002). The decline in participation may be explained by various factors, including a lack of relevant training courses for highly experienced workers (Gould et al., 2007; Pool et al., 2013b), age-related changes in cognitive abilities discouraging older workers to participate in learning activities outside their expert domain (Lahn, 2003), or lower social support caused by negative stereotypes of older workers (Billett et al., 2011; Gray and McGregor, 2003).

Informal learning activities and age

Lifespan theories do not predict clear relationships between age and engagement in informal learning activities. Informal learning activities may be important for younger adults to reach their goals of knowledge acquisition and maximising growth, but may also be important for older workers to prevent loss and maintain their level of functioning. Moreover, informal learning activities may offer more opportunities to compensate for cognitive ageing effects than do formal learning activities (Schulz and Stamov Roßnagel, 2010).

Correspondingly, studies on the relationship between age and informal learning activities have shown inconclusive findings (Froehlich et al., 2015; Pool et al., 2013a; Raemdonck et al., 2015). Some studies revealed a decrease in informal learning activities with age. For instance, Tikkanen (2002) found that the challenge to learn at work is greater for younger than it is for mature workers in small and medium enterprises. Others found an increase in informal learning activities (Berg and Chyung, 2008). Richter et al. (2011) showed that older teachers spend more time reading professional literature than do their younger colleagues, while learning by collaborating with colleagues decreased. They concluded that older teachers do not invest less time in professional development, but preferred different learning opportunities as compared to their younger peers. Simi-

larly, Lammintakanen and Kivinen (2012) found that nurses of different ages varied in the CPD activities they engaged in. Older nurses engaged more in information meetings, pair work, and visiting other healthcare units than younger nurses did.

Motives for continuing professional development and age

Motivation is considered important for engagement in learning activities. In the literature, it is often assumed that motivation to learn changes with ageing (Raemdonck et al., 2015). However, research on age and motivation for professional development are inconclusive (Gegenfurtner and Vauras, 2012; Pool et al., 2013a). Some studies show that age is negatively related to training and development motivation (Colquitt et al., 2000; Van Vianen et al., 2011), while others found no motivational differences between younger and older workers, or revealed that middle-aged workers have a higher motivation to learn than both younger and older workers (De Lange et al., 2006). Gegenfurtner and Vauras (2012) discern two views of age-related changes in motivation to learn in the literature: a view of motivational decline with age that is predicted by theories such as Socioemotional Selectivity theory, and a view of motivational maintenance supported by the literature on adult learning, interest, and workplace curiosity.

In this debate, it may be helpful to focus on workers' motives to learn instead of the more general concept of motivation. Motives, as we use the concept, refer to reasons workers have to engage in work-related learning. Workers are motivated for professional development for different reasons such as to improve their work, career, or for personal development (Poell and Van der Krogt, 2014a). As the types of goals people have change during a lifespan (Baltes et al., 1999; Carstensen et al., 1999; Kanfer and Ackerman, 2004), their motives for professional development may also change during a working career. Some motives may become less important (e.g. career development), while investing in learning activities to optimise work performance or to meet requirements of the employer may remain important.

The reasons why adults engage in learning activities have been studied widely, but this research is merely confined to engagement in formal learning activities; research on motives for informal learning is scarce. To measure reasons for participation in adult education Boshier (1971, 1977) developed the Education Participation Scale (EPS). O'Connor (1979, 1982) modified the EPS for the nursing context and extracted six factors from the EPS data: improvement in social relations, professional knowledge, compliance with authority, relief from routine, professional advancement, and improvement in social welfare skills. Nurses' prime motivator to engage in professional development activities was the need to expand professional knowledge. This finding was confirmed by others (Murphy et al., 2006; Pool et al. submitted; Ryan, 2003; Tassone and Heck, 1997).

Few studies have examined the relationship between age and CPD motives. Staring (1995) found a weak but statistically significant relation between age and an EPS

subscale: the older the nurse, the less likely that their motivational orientation related to the need to meet formal requirements. Conversely, Dealy and Bass (1995), using several EPS items, found that nurses with more than 10 years of experience perceived interaction with professional colleagues and compliance with formal requirements as more influential than did their less experienced colleagues. However, they did not report whether these differences were statistically significant.

In summary, both theory and research give no clear direction for the relationship between age and motivation for professional development. We expect that examining age differences in motives for professional development, with a focus on both formal and informal learning activities, might contribute to this debate and provide a more nuanced view.

The present study

Lifespan theories propose that CPD strategies may change across a career, and research has provided inconclusive insights on the relation between age and CPD strategies. However, no studies have explicitly studied age differences in motives for and engagement in formal and informal learning activities in a single investigation, and in nursing. More knowledge on these issues may assist in the development of CPD approaches geared towards the needs of all age groups in a nursing team. Therefore, we first examine the learning activities in which nurses engage, and whether this engagement is affected by age. Second, we investigate why nurses engage in these activities and the effect of age. Finally, as chronological age serves as a proxy for several lifespan changes, we seek to identify age-related changes that account for the age patterns in motives and learning activities. The factors examined as possible explanations of age differences are tenure as an indicator of organisational age, and life at home as an indicator of lifespan age.

Methods

Participants and procedure

Registered nurses working in Dutch general and academic hospitals were the target population for this study. To distribute the survey, we approached nurse team leaders using HRD professionals as intermediaries. To enhance participation, we promised to send a hospital-based written report on the findings. Team leaders distributed the questionnaire to the nurses in their teams. To encourage a high response rate, nurse team leaders were able to choose the most suitable method for their team – an online or paper questionnaire. Fifty-five team leaders preferred to forward an e-mail with a link to the online questionnaire, six chose to distribute the questionnaire by paper, and four decided to use a combination. In the cover letter/e-mail, nurses were informed about the possibility to request an online or a paper version and that participation was voluntary. The questionnaire included a declaration of informed consent. In one hospital, the nursing advisory council distributed the online questionnaire directly to all nurses by e-mail. Data

were collected in March and April 2015 in five general and two academic hospitals. After two weeks, team leaders were requested to forward a reminder to their team.

Of the approximately 2100 nurses who were invited by their team leader or nursing advisory council, 728 filled in the questionnaire (34.7%). As we had to rely on the information of many intermediaries, we are not able to give exact numbers of invited nurses. Participants were mostly female (89.7%) and ranged in age from 21 to 64 years, with a mean age of 40.24 years (SD = 12.11). Professional and ward tenure varied from 0 to 44 years and 42 years, respectively, with an average of 16.82 (SD = 11.81) and 9.60 (SD = 8.39). Almost half (46.3%) had children living at home. Most nurses worked part-time, and 17% worked fulltime (36 hours a week). The average number of working hours per week was 28.31 (SD = 6.61). Of all participants, 66% were working in academic hospitals, which is not representative of the population with 65,824 nurses working in general hospitals compared to 15,172 nurses in academic hospitals, in 2012 (Dutch Hospital Data, 2013). See Table 6.1 for participant characteristics.

Table 6.1. Participant characteristics.

Demographic characteristic	Mean
Age	40.24 (SD = 12.11)
Professional tenure (years of experience as registered nurse)	16.82 (SD = 11.81)
Ward tenure (years of experience at present ward)	9.60 (SD = 8.39)
Employment in hours per week	28.31 (SD = 6.61)
Gender	%
Female	89.7
Male	10.3
Hospital type	%
Academic	66.2
General	33.8
Nursing education[1]	%
In-service	36.1
Secondary vocational (mbo)	17.5
Bachelor (hbo)	45.7
Other	0.7
Postgraduate training in nursing specialty	66.1
Children living at home	%
No	53.7
Yes, age < 4	13.87
Yes, age 4 – 11	16.6
Yes, age 12–17	15.1
Yes, age ≥ 18	14.3

[1] *In the Netherlands, nowadays two nursing education programmes exist: vocational (mbo) and bachelor (hbo). Till 1997, nurses were mainly educated in-service in a hospital.*

Measures

A four-section questionnaire was developed, including a personal data sheet, a section on formal learning activities, informal learning activities, and professional development motives. To establish the face validity of the survey, we asked six experts (researchers, nursing educators, and nursing managers) to review the pilot questionnaire (Artino et al., 2014). We conducted cognitive interviews with nine nurses 'to assess how prospective participants interpret items and the response anchors' (Artino et al., 2014, p.470); the nurses filled in the refined questionnaire, and in the interviews, it was determined how they had interpreted the questions. Based on their feedback, we changed the wording of some questions and the response scale of informal learning activities to increase the univocal interpretation of the questionnaire.

Demographic information

Chronological age was measured by asking nurses their age. Professional and ward tenure (indicators of organisational age) were measured by asking nurses how many years of work experience they had as a graduated nurse and at the current ward. Life at home (an indicator of lifespan age) was assessed by two items. One item assessed whether participants had children living at home. For the analyses, we recoded this in a dummy variable, 'Children under 18 years living at home': no = 0, yes = 1. The second item was 'My situation at home was a barrier to engage in learning activities in the last 12 months'. Responses were given on a 5-point Likert-type response scale, which ranged from strongly disagree to strongly agree. The questionnaire also contained questions about the respondent's gender, nursing education and hospital type.

Measurement of formal learning activities

Previous findings (Pool et al., 2015, submitted) were used as the basis to design the items on formal and informal learning activities. We measured participation in longer education programmes with the question, 'In how many work-relevant education programmes with a duration of at least 20 course days did you engage in the last 5 years?'. For the assessment of participation in short formal learning activities, we asked, 'Indicate how many times you engaged in the following learning activities in the previous 12 months'. We used a checklist of eight items (e.g. courses, conferences). The timeframe of 12 months was in line with previous research (Birdi et al., 1997; Blau et al., 2008; Maurer et al., 2003). For the analysis, we combined the items on clinical teaching sessions, lunch lectures, and skills training into one variable: 'short hospital-based learning activities', and included team training day and team training evening in 'team training'.

Measurement of informal learning activities

Engagement in informal learning activities was assessed by asking, 'How often have you learned something new in the previous 12 months by ... ?' Respondents rated 20 items on a 5-point Likert-type scale ranging from never to every working day. To determine the

underlying structure of the informal learning activities we conducted a principal component analysis (PCA) with oblique rotation, as this accounts for relationships between factors (Beavers et al., 2013; Field, 2013). The Kaiser–Meyer–Olkin (KMO) measure of .895 and KMO values for individual items greater than .80 confirmed the sampling adequacy for the analysis (Field, 2013). To select the number of factors, we included factors with an eigenvalue greater than 1 – Kaiser's criterion (Field, 2013). Initially, this resulted in five factors, but we removed one factor with one item, because at least two or three items must load on a factor to give a meaningful interpretation (Williams et al., 2010). To decrease ambiguity, we also removed an item with a cross loading of .40 on a second factor (Beavers et al., 2013). After removal of these two items, data were factored again (Beavers et al., 2013), yielding four factors that, in combination, explained 61.19% of the variance. We retained four factors, because of Kaiser's criterion, the scree plot, and because it resulted in a comprehensible and interpretable structure.

Table 6.2 shows the factor loadings after rotation. We labelled factor 1 *Learning by social interaction* (Cronbach's α = .91). Seven items depict learning by interaction in daily work with colleagues, patients, and their families. We labelled factor 2 *Learning by engaging in extra tasks* (Cronbach's α = .61). Three items depict nurses' learning in additional tasks not directly related to patient care, such as engaging in working groups or teaching. We labelled factor 3 *Learning by participating in meetings* (Cronbach's α = .60). The three items reflect learning in organised meetings such as team meetings and handovers. Finally, we labelled factor 4 *Learning by consulting media* (Cronbach's α = .76). Five items reflect learning activities wherein nurses read or search for information in journals, books, protocols, and the Internet.

Measurement of CPD motives

We assessed CPD motives by means of four subscales of the modified EPS (O'Connor, 1982). The items were translated into Dutch by a multi-step process (Acquadro et al., 2008; Maneesriwongul and Dixon, 2004). First, two native Dutch speakers – the first author and a professional translator – translated the items into Dutch. Three other authors checked differences in the translations and decided on the best translation. Then, a professional native English translator translated the Dutch items back into English. Finally, the Dutch version was tested among the expert panel and a group of nurses to verify that Dutch nurses would readily understand, accept, and easily respond to the Dutch version of the EPS subscales.

Participants were asked about the extent to which each motive had influenced their engagement in learning activities in the previous 12 months. Participants made ratings on a 5-point Likert-type response scale that ranged from no or very little influence to very much influence. The first subscale is *Professional knowledge* (Cronbach's α = .76). Seven items (e.g. 'To keep up-to-date professionally') reflect a desire to increase competence in the job. The second subscale is *Compliance with authority* (Cronbach's α = .77). The seven

Table 6.2. Summary of principal component analysis results for informal learning activities.

	Learning by			
In the past 12 months, how often have you learned something new by ...	social interaction	engaging in extra tasks	participating in meetings	consulting media
... consulting a colleague nurse	**.88**	.01	-.07	-.01
... consulting a physician or other healthcare professional	**.79**	.08	-.13	.10
... getting feedback from a colleague nurse	**.74**	.10	.01	.05
... observing a colleague nurse	**.78**	.12	-.03	.01
... exchanging knowledge and experience with a colleague nurse	**.82**	.03	.02	.01
... taking care of patients	**.78**	-.08	.10	-.01
... encounters with patients and their families	**.71**	.02	.19	-.07
... participating in a working group	.14	**.62**	.28	-.15
... doing research	.09	**.67**	-.16	.29
... teaching (clinical sessions)	.05	**.76**	.00	.07
... participating in handovers	.36	-.21	**.48**	.05
... participating in patient case discussions	.08	.09	**.75**	.04
... participating in team meetings	-.06	.07	**.78**	.12
... reading a professional journal	-.15	.10	.26	**.59**
... searching for information on the Internet	.23	-.17	-.05	**.72**
... searching for information in books	.12	.06	.03	**.72**
... searching for information in protocols	.38	-.15	.12	**.42**
... literature study	-.05	.16	-.02	**.74**
Eigenvalue	6.70	1.19	1.24	1.86
% of explained variance after extraction	37.18	6.70	6.94	10.38
α	.91	.61	.60	.76

Note: ***n*** *= 685; factor loadings over .40 appear in bold.*

items (e.g. 'To comply with my employers' policy') refer to the reaction to external pressures such as directions, suggestions, and expectations of employers or other persons. The third subscale is *Relief from routine* (Cronbach's α = .79). The six items (e.g. 'To have a few hours away from responsibilities') relate to an endeavour to avoid boredom and frustrations of routine by participating in a distracting activity. The fourth subscale is *Professional advancement* (Cronbach's α = .76). Eight items (e.g. 'To secure professional advancement') refer to occupational and job-related concerns, reflecting a desire to attain knowledge and skills to improve job status and permit career advancement.

Analyses

Data were analysed using SPSS version 22.0 for Mac. A missing data analysis revealed that 33% of the participants (n = 241) did not complete the questionnaire. Most (87%) missed one or two of the 118 response items among the 14 questions. Items with the highest percentage of missing values were located in the section on formal learning activities, e.g. participation in a course (6.6%) or symposium (3.2%). Our interpretation is that participants did not respond with zero when they had not participated in these activities, but just skipped the question. In the analyses, we used listwise deletion. A check on outliers revealed outliers in the same section. Although there is much debate on what to do with outliers, we decided to remove data with $z > 3$ (Costello and Osborne, 2005), varying from 0.7% from the data on education programmes to 3% on skills training. To examine motives and engagement in learning activities, we used descriptive statistics (frequency counts, means, and standard deviations [SD]) and checked for correlations with age. In a second set of analyses, we used hierarchical regression analysis to predict nurses' engagement in informal learning activities and their motives by control variables, age, and situation at home.

Results

Engagement in learning activities, nurses' motives and the influence of age

Table 6.3 provides an overview of the engagement in learning activities over the 1-year period surveyed (5 years for education programmes with a longer duration) and nurses' motives for professional development. The data on formal learning activities show that over 90% of the nurses engaged in one or more short hospital-based learning activities (M = 8.15, SD = 5.18) and team training (M = 2.63, SD = 1.83). These activities are mainly organised by and at the ward, and vary in duration between half an hour and a day. Most nurses (92.3%) also enrolled in one or more e-learning modules (M = 4.14, SD = 3.19). Participation in learning activities that predominantly take place outside the ward and the hospital, and that have a longer duration, such as conferences (M = 0.85, SD = 0.95), courses (M = 1.49, SD = 1.52), and education programmes (M = 0.60, SD = 0.88), was considerably lower. The correlations with age for formal learning activities

are inconclusive. We found significant but small negative correlations with age ($p < .01$) for education ($r = -.27$), e-learning ($r = -.14$), and short hospital-based learning activities ($r = -.10$). However, small positive relationships were found for conferences ($r = .15$) and team training ($r = .11$).

Table 6.3. Descriptive statistics and correlations with age for engagement in learning activities and motives.

	N	% not engaged in the activity in the given period[a]	Min.	Max.	Mean	SD	*r* with age
Formal learning activities							
Education	716	58	.00	6.00	0.60	0.88	-.27**
Course	668	28.1	.00	8.00	1.49	1.52	-.01
Conference	697	44.0	.00	4.00	0.85	0.95	.15**
E-learning	705	7.7	.00	16.00	4.14	3.19	-.14**
Team training	725	8.8	.00	9.00	2.63	1.83	.11**
Short hospital-based activities	726	0,8	.00	32.00	8.15	5.88	-.10**
Informal learning activities[b]							
Social interaction	728	n/a	1.29	5.00	3.12	0.78	-.28**
Participating in meetings	727	n/a	1.00	5.00	2.43	0.75	-.07
Consulting media	727	n/a	1.40	4.40	2.53	0.61	-.21**
Engaging in extra tasks	727	n/a	1.00	4.00	1.87	0.65	-.22**
Motives[c]							
Professional knowledge	721	n/a	1.00	4.86	3.29	0.64	-.33**
Compliance with authority	722	n/a	1.00	4.57	2.39	0.64	-.12**
Relief from routine	721	n/a	1.00	3.83	1.60	0.62	-.20**
Professional advancement	723	n/a	1.00	4.63	2.48	0.64	-.18**

[a] *Frequency of participation in education programmes with at least 20 course days was measured over a time period of the previous 5 years, the other learning activities over 12 months.*

[b] *Rating scale 1 = never, 5 = every working day.*

[c] *Rating scale 1 = very little influence, 5 = very much influence.*

** $p < .01$ *(2-tailed).*

The data on informal learning activities show that nurses learning something new in the previous 12 months did so most frequently by social interaction with colleague nurses, other healthcare professionals, and patients (M = 3.12, SD = 0.78). They also learned by consulting media (M = 2.53, SD = 0.61) and participating in meetings (M = 2.43, SD = 0.75), but less frequently, and even less frequently by engaging in extra tasks (M = 1.87, SD = 0.65). Age was negatively correlated with most informal learning activities, but the sizes of the effects were small. We found significant ($p < .01$) negative correlations with age for social interaction ($r = -.28$), consulting media ($r = -.21$), and learning by engaging in extra tasks ($r = -.22$).

Table 6.3 reveals that nurses were primarily motivated to engage in formal and informal learning activities in the previous 12 months by a desire to expand their professional knowledge (M = 3.29, SD = 0.64). Further, nurses engaged in learning activities to permit job advancement (M = 2.48, SD = 0.64) and comply with requirements (M = 2.39, SD = 0.64). The importance of relief from routine was considerably lower (M = 1.60, SD = 0.62). The data show negative correlations between age and all motives, with effect sizes varying from small to medium.

Age-related factors explaining differences in engagement in learning activities and motives

To answer this question, we first examined bivariate relationships between the predictor variables, control variables, and learning activities and motives (Table 6.4). Our results show strong correlations between age and years of professional tenure ($r = .92$, $p < .01$), and age and ward tenure ($r = .68$, $p < .01$). Professional and ward tenure showed similar, but sometimes smaller, correlations with motives and learning activities as those found for age. Professional and ward tenure, as indicators of organizational age, seem to measure similar differences as age, which may suggest that the age-related differences found can be explained largely by differences in tenure.

Nurses with children under 18 years living at home perceived the situation at home more often as a barrier to engage in learning activities than did nurses with no or older children ($r = .36$, $p < .01$). However, having young children at home showed a significant negative correlation only with short hospital-based learning activities ($r = -.12$, $p < .01$), and learning by consulting media ($r = -.11$, $p < .01$). Perceiving the situation at home as a barrier to engage in learning activities correlated significantly, but with small negative effects, with engagement in conferences ($r = -.14$, $p < .01$) and learning by consulting media ($r = -.10$, $p < .01$). Hence, having children under 18 living at home and perceiving the situation as a barrier to engaging in learning activities, as indicators of lifespan age, do not relate strongly to engagement in learning activities and motives for professional development.

Table 6.4. Bivariate correlations between predictor variables, control variables and participation in learning activities and motives.

	Ageing = calendar age	Ageing = organizational age		Ageing = lifespan age		Control variables		
	Age	Profes-sional tenure	Ward tenure	Children under 18 at home[a]	Situation at home was a barrier[b]	Gender[c]	Hospital type[d]	Working hours per week
Professional tenure	**.92****							
Ward tenure	**.68****	**.73****						
Children < 18 at home	.01	–.01	.02					
Situation at home was a barrier	.03	.05	.07	**.36****				
Gender	.11**	.10**	.09*	.02	.00			
Hospital type	.05	.04	.03	.02	–.01	–.06		
Working hours per week	**–.27****	**–.25****	**–.24****	**–.40****	**–.22****	**.26****	–.09*	
Formal learning activities								
Education	**–.27****	**–.26****	**–.26****	–.08*	–.06	.00	–.06	**.20****
Course	–.01	–.01	–.01	–.05	–.10*	.05	–.02	.10**
Conference	.15**	.13**	.12**	–.09*	–.14**	.01	.00	.09*
E-learning	–.14**	–.14**	–.10**	–.02	–.04	–.02	**.21****	–.02
Team training	.11**	.10*	.13**	–.01	–.03	.02	.10**	.00
Short hospital-based learning activities	–.10**	–.10**	–.05	–.12**	–.05	.03	**–.21****	.16*
Informal learning activities								
Social interaction	**–.28****	**–.28****	**–.25***	–.07*	–.04	.06	–.11**	.16**
Participating in meetings	–.07	–.06	–.06	–.06	–.07*	.08*	–.06	.10**
Consulting media	**–.21****	**–.21****	**–.22****	–.11**	–.10**	.03	–.07	**.21****
Engaging in extra tasks	**–.22****	**–.20****	–.13**	–.06	–.09*	.04	–.01	.19**
Motives								
Professional knowledge	**–.33****	**–.31****	**–.23****	–.08*	–.06	–.05	.01	.16**
Compliance with authority	–.12**	–.14**	–.12**	.01	.08*	.02	.00	.05
Relief from routine	**–.20****	–.19**	–.15**	–.04	.03	.03	–.03	.13**
Professional advancement	–.18**	–.18**	–.14**	–.07	–.06	.00	.01	.13**

*Note: n varied from 668 to 728. **p < .01 *p < .05 (2-tailed). Correlations ≥ .20 appear in bold.*

[a] *Children under 18 years living at home: 0 = no; 1 = yes.*

[b] *My situation at home was a barrier to engage in learning activities in the last 12 months. Rating scale: 1 = strongly disagree to 5 = strongly agree.*

[c] *Gender: 0 = female; 1 = male.*

[d] *Hospital type: 0 = academic; 1 = general.*

Correlations with the control variables showed that gender was barely correlated with learning activities or motives. We found one significant correlation: men learned more frequently from participating in meetings (r = .08, p < .05). However, nurses in general hospitals engaged significantly more in e-learning (r = 21, p < .01) and team training (r = 10, p < .01), and less in short hospital-based learning activities (r = –.21, p < .01) and social interaction (r = –.11, p < .01) than did their colleagues in academic hospitals. Finally, we found that nurses who worked more weekly hours engaged significantly more in education programmes (r = .20, p < .01), courses (r = .10, p < .01), and in all four informal learning activities.

Next, we investigated whether the age effects of the first part of the study were explained by situation at home. For this purpose, hierarchical regression analyses were applied with the four informal learning activities and four motives as criterion variables. Regression analyses were not performed on the data on formal learning activities, as these variables were not continuous. The first model included gender, hospital type, and working hours per week as control variables. In the second model, we added age, and in the third, the variables 'children under 18 living at home' and 'situation at home was a barrier to engage in learning activities in the last 12 months' were added as indicators of lifespan age. We could not include professional and ward tenure as indicators of organisational age in the analysis because of the high correlations with age.

The results of the analysis on informal learning activities are summarised in Table 6.5. The results on learning by participating in meetings were excluded from the table, as no significant changes (p < .01) in the R^2 of the models were found. The results show that engagement in learning by social interaction is predicted by hospital type (β = .10, p < .05) and working hours per week (β = .14, p < .01). The second model confirmed the effect of hospital type, suggesting that nurses in general hospitals engaged less in learning by social interaction than did nurses in academic hospitals, but did not confirm the effect of working hours per week. Furthermore, it revealed that higher age had a negative effect on learning by social interaction (β = –.27, p < .01). Model 3 found no effects for the two indicators of lifespan age. The models predicting engagement in learning by consulting media revealed significant positive effects of working hours per week in model 1 (β = .22, p < .01). This effect decreased slightly (β = .16, p < .01) when age was added in model 2. Model 2 showed that age negatively predicted engagement in learning by consulting media (β = –.17, p < .01). Again, no additional effects were found in model 3. The models predicting engagement in learning by extra tasks showed similar results: significant effects of working hours per week (β = .19 in model 1, β = .13 in models 2 and 3, p < .01) and age (β = –.19 in models 2 and 3), and no significant effects of 'children under 18 at home' and 'situation at home was a barrier'.

Table 6.5. Results of the regression analyses for the effects of control variables, age, and the situation at home on engagement in informal learning activities.

	Model 1		Model 2		Model 3	
	B (SE)	β	B (SE)	β	B (SE)	β
Social interaction						
Gender	.02 (.10)	.01	.15 (.10)	.06	.18 (.10)	.07
Hospital type	-.16 (.06)	-.10*	-.14 (.06)	-.09*	-.14 (.06)	-.09*
Working hours per week	.02 (00)	.14**	.01 (.00)	.06	.00 (.01)	.03
Age			-.02 (00)	-.27**	-.02 (00)	-.27**
Children < 18 at home					-.09 (.07)	-.06
Situation at home was a barrier					.00 (.03)	.01
R^2		.03		.10		.10
R^2 change		.03**		.06**		.00
F		7.77**		18.22**		12.48**
Consulting media						
Gender	-.04 (.08)	-.02	.02 (.08)	.01	.04 (.08)	.02
Hospital type	-.06 (.05)	-.04	-.05 (.05)	-.04	-.05(.05)	-.04
Working hours per week	.02 (.00)	.22**	.02 (.00)	.16**	.01 (00)	.14**
Age			-.01 (00)	-.17**	-.01 (00)	-.17**
Children < 18 at home					-.03 (.05)	-.02
Situation at home was a barrier					-.03 (.02)	-.06
R^2		.05		.07		.07
R^2 change		.05**		.02**		.00
F		11.74**		13.65**		9.66**
Engaging in extra tasks						
Gender	.00 (.08)	.00	.08 (.08)	.04	.08 (.09)	.04
Hospital type	.01 (.05)	.01	.03 (.05)	.02	.02 (.05)	.02
Working hours per week	.02 (.00)	.19**	.01 (.00)	.13**	.01 (.00)	.13**
Age			-.01 (.00)	-.19**	-.01 (.00)	-.19**
Children < 18 at home					.02 (.06)	.01
Situation at home was a barrier					-.03 (.02)	-.06
R^2		.03		.06		.06
R^2 change		.04**		.03**		.01
F		8.84**		12.55**		8.71**

*Note: n = 696, n = 695, n = 695. **p < .01 *p < .05*

The analysis on motives is summarised in Table 6.6. The results on compliance with authority were left out of the table, as the R^2 of the models did not exceed .02. The importance of the motive 'professional knowledge' was predicted by working hours per week (β = .20, p < .01), but model 2 did not confirm this effect (β = .01). Model 2 showed that higher age had a negative impact on the motive professional knowledge (β = –.29, p < .01), which was confirmed in model 3. Model 3 found no effects for the two indicators of lifespan age ('children under 18 at home' and 'situation at home was a barrier'). The models predicting the relief from routine motive revealed a similar pattern: with higher age, nurses were less motivated to engage in learning activities to get relief from routine (model 2 and 3: β = –.18, p < .01). Working hours per week had a significant positive effect in model 1 (β = .13, p < .01), but this was not confirmed in the other models. The other control variables and the lifespan age variables had no significant effects in model 3 either. The models for the motive professional advancement showed similar results: working hours per week had significant effects in models 1 and 2 (β = .15, p < .01, β = .10, p < .0), but these were not confirmed in the third model (β = .07). Higher age predicted that professional advancement became less important as a motive to engage in learning activities (β = –.16 in model 3, p < .01). 'Children under 18 at home' and 'situation at home was a barrier' did not affect the motive professional advancement.

Conclusions and discussion

Against the background of a growing interest in the continuing professional development of nurses and an ageing workforce, this study examined nurses' engagement in formal and informal learning activities, their motives for professional development, and the influence of age and age-related differences in tenure and situation at home. Three main conclusions can be drawn. First, we can conclude that the ward is an important learning environment for nurses, not just for informal learning activities that take place in and during work, but also for formal learning activities. Almost all nurses engaged in learning activities that are predominantly organised at the ward, such as team training days, skills training, and clinical teaching sessions. In general, they engaged less frequently in activities such as conferences, courses, and longer education programmes that are mainly organised outside the ward and the hospital. This pattern may be explained by the fact that activities outside the ward are often of a longer duration, focus less directly on the present job, and enrolment fee may be a barrier, while learning activities at the ward mostly have a short duration, take place during regular working hours (e.g. during lunchtime or at the end or beginning of a shift), and often have practical applicability (Pool et al., 2015). The findings provide support for literature suggesting that the workplace provides an important learning environment for nurses (Berings et al., 2008; Eraut, 2007; Jantzen, 2008).

Table 6.6. Results of the regression analyses for the effects of control variables, age, and the situation at home on motives to engage in learning activities.

	Model 1		Model 2		Model 3	
	B (SE)	β	B (SE)	β	B (SE)	β
Professional knowledge						
Gender	–.20(.08)	–.09*	–.07 (.08)	–.04	–.05 (.08)	–.03
Hospital type	.03 (.05)	.02	.05 (.05)	.04	.05 (.05)	.04
Working hours per week	.02 (.00)	.20**	.01 (.00)	.11	.01 (.00)	.08
Age			–.02 (00)	–.29**	–.02 (00)	–.30*
Children < 18 at home					–.06 (.06)	–.05
Situation at home was a barrier					–.01 (.02)	–.02
R^2		.04		.12		.12
R^2 change		.04**		.08**		.00
F		9.52**		22.45**		15.32**
Relief from routine						
Gender	.00(.08)	.00	.07 (.08)	.03	.07 (.08)	.03
Hospital type	–.01 (.05)	–.01	.00 (.05)	.00	.00(.05)	.00
Working hours per week	.01 (.00)	.13**	.01 (.00)	.08	.01 (00)	.08
Age			–.01 (00)	–.18**	–.01 (00)	–.18**
Children < 18 at home					–.05 (.06)	–.04
Situation at home was a barrier					.03 (.02)	–.06
R^2		.01		.04		.04
R^2 change		.02*		.03**		.00
F		4.20*		8.23**		5.95**
Professional advancement						
Gender	–.04 (.08)	–.02	.02 (.08)	.01	.04 (.09)	.02
Hospital type	.03 (.05)	.02	.04 (.05)	.03	.04 (.05)	.03
Working hours per week	.01 (.00)	.15**	.01 (.00)	.10*	.01 (.00)	.07
Age			–.01 (.00)	–.15**	–.01 (.00)	–.16**
Children < 18 at home					–.05 (.06)	–.04
Situation at home was a barrier					–.02 (.02)	–.03
R^2		.02		.04		.04
R^2 change		.02**		.02**		.00
F		4.81**		7.27**		5.14**

*Note: n = 689, n = 689, n = 691. **p < .01 *p < .05*

A second conclusion emerging from the study is that ageing is related to engagement in learning activities and nurses' motives for professional development, although the effects are not univocal and effect sizes are small. We found varying age effects for formal learning activities. The older the nurses were, the less they engaged in longer education programmes, e-learning, and short hospital-based learning activities, but the more they engaged in team training and conferences, while participation in courses was not related to age. This supports findings that older workers may prefer different learning activities than their younger peers (Lammintakanen and Kivinen, 2012; Richter et al., 2011). Higher age was negatively associated with engagement in informal learning activities. With age, nurses still learned new things in their work by informal learning activities, but less frequently than younger nurses did. This supports earlier findings that after rapid growth in the first years of clinical experience, learning becomes less intensive (Pool et al., 2015; Takase, 2013). Further, with increasing age, the four motives to engage in professional development activities became less important. These findings do not support our proposition that, with ageing, other motives become more important.

A third conclusion is that professional and ward tenure appear to have similar effects as age on nurses' engagement in learning activities and their motives. This supports the notion that as nurses grow older and acquire a longer working experience, they tend to engage less frequently in learning activities, and the motives for professional development become less important for them. While we have only collected cross-sectional data and this notion should be confirmed in longitudinal studies, our default hypothesis now would be that these measures of age point in that direction. This corroborates earlier findings that accumulating skills and experience may reduce the (perceived) need for professional development (Cully et al., 2000; Felstead, 2010; Kyndt et al., 2011). Differences in lifespan, measured by having children under 18 living at home and having a situation at home that prohibits engagement in learning activities, were negatively related to engagement in courses, conferences, short hospital-based learning activities, and consulting media. This might suggest that private life has more influence on learning activities that take place outside regular working hours than it does on learning activities embedded in daily work. However, when we performed a regression analysis on learning by consulting media, this effect was not confirmed when controlling for age and other demographic variables. Working more hours a week consistently influenced engagement positively in several formal and all informal learning activities. This suggests that having children as such does not predict engagement in learning activities, but may have an indirect negative influence through working hours, as many nurses over 30 with young children work fewer hours than do their younger and older colleagues (Hellenthal, 2011). This may support earlier findings that nurses working part-time have fewer opportunities for professional development (Barriball et al., 1992; Furze and Pearcey, 1999; Pool et al., 2015).

Limitations and directions for future research

The study has some limitations and implications for future research. Our method of participant selection via nurse team leaders may have biased the results. Team leaders, who volunteered to send the questionnaire to their teams, may have a more positive attitude towards continuing professional development, and thereby have a more positive influence on the learning climate at the ward, as compared to team leaders in general. Besides, the sample of nurses was not totally representative of nurses working in Dutch hospitals with nurses in academic hospitals outnumbering those in general hospitals. On the other hand, by using this recruitment method we were able to reach whole teams, and as a result, included a varied group of nurses.

The modified EPS is a valid and reliable instrument (Dia et al., 2005; O'Connor, 1979, 1982) to identify motives for formal learning activities. It may be a limitation that we used it to assess motives for informal learning activities, as it was not developed for that purpose. Future studies must extend the modified EPS to include motives for informal learning activities. Future studies also should examine the influence of age on the two other EPS subscales that we did not include to ensure the questionnaire remained sufficiently brief. Moreover, no suitable instruments were available that clearly distinguish the various formal and informal learning activities for nurses, compelling us to develop our own measures. To guard the quality of the questionnaire, we used a multi-step design process (Artino et al., 2014) including a literature review, expert validation, and cognitive interviews with prospective participants. However, nurses seemed to interpret some items on formal learning activities differently, resulting in a higher number of missing values and outliers than in the other sections. Therefore, future research should focus on further validation of measures for formal and informal learning activities.

The retrospective nature of our study might be viewed as a weakness. It is conceivable that respondents could not exactly recall the frequency with which they participated in learning activities, which may explain some of the extreme scores. Similarly, it might have been difficult to recall motives, especially because we requested nurses to recall their motives not for a single learning activity, but for a combination. To complement our results, prospective studies asking nurses to describe their motives and the learning activities they intend to undertake are suggested. These studies will also make it possible to investigate whether certain motives are related to certain learning activities, thereby furthering our knowledge on professional development strategies.

Finally, the results show that, in general, nurses engage in fewer learning activities with age. More research is needed to examine whether a decreasing engagement in learning activities affects job performance and employability.

Practical implications

The study has several implications for practitioners. As daily practice is an important learning resource for nurses, managers and HRD professionals should recognise the learning potential of daily practice. They can encourage engagement in formal and informal learning activities, e.g. by supporting the organisation of ward-based learning activities and providing opportunities for social interaction and resources to consult. Despite the importance of workplace learning, managers may also encourage nurses to enrol in learning activities outside the ward more often. A risk of workplace learning is the continuation of wrong and undesirable practices, and for innovation, looking beyond the own-ward borders is important (Poell, 2013).

Second, the study shows that both age and working hours predict engagement in learning activities. Managers should be alert on nurses who engage less in learning activities, and assess their employability for now and the future. Increasing experience may lead to a reduced need for CPD, but managers should avoid nurses limiting their work exclusively to what they already know. To keep them employable, it is important that workers occasionally have challenges in their work that keep them learning (Van Roekel-Kolkhuis Tanke, 2008). Moreover, it should be secured that nurses working part-time have sufficient learning opportunities.

In sum, ageing seems to be related to differences in nurses' strategies for professional development. Our study data are consistent with the notion that growing older and acquiring a longer working experience relate to alterations in motives and learning activities, while we acknowledge the need to confirm this notion with longitudinal data. Managers and HRD professionals should consider and address the professional development needs of nurses in different life and career stages to keep them competent and employable during their entire nursing career.

Ethical approval

The ethical approval for the study was obtained from the NVMO Ethical Review Board.

chapter 7

Summary, discussion, and future perspectives

Introduction

The overall aim of this thesis was to contribute to a better understanding of continuing professional development (CPD) across the nursing career. To that end, we conducted five studies combining a range of methods, using insights from theoretical perspectives on CPD and lifespan development. The studies aimed to clarify why and how nurses engage in CPD, and how their CPD strategies are influenced by age-related changes. More specifically, the studies focused on four topics: 1) the concept of CPD, 2) the operationalisation of ageing in the context of CPD, 3) nurses' CPD strategies, and 4) the influence of age on nurses' CPD strategies. In this final chapter, the main findings related to the four topics will be summarised, the theoretical and practical implications will be described, and the strengths and limitations will be discussed, thereby leading to recommendations for future research (see Table 7.1 for a summary).

Main findings of the thesis

Topic 1 The concept of CPD

The international literature shows that there is little consensus on the definition of the concept of CPD. We started our research in **Chapter 2** with an exploration of how Dutch nurses and managers perceive CPD (and age differences in CPD – see topic 4). Four focus group interviews were held with 22 nurses and 10 managers. Perceptions of CPD differed on three dimensions. The first dimension was the purpose of CPD. CPD can aim at development 'around the patient' by keeping up to date and maintaining core nursing skills, and aim at development 'away from the patient' by extending nursing roles and enhancing the career. The second dimension related to the level of formality of CPD activities. Some participants perceived CPD primarily as formal learning activities, such as taking a course or studying for a master's degree in nursing. Others thought of CPD as a broader concept encompassing informal learning activities as well, such as learning from work experiences. The third dimension referred to the 'scope' of development. Participants agreed that nurses must stay up to date, but they differed in their view on whether this reactive learning could count as CPD, or whether CPD is about the acquisition of new knowledge and skills aiming at growth and improvement of healthcare. Nurses felt pressure to develop, but experienced that formal learning activities and development 'away from the patient' were socially more rewarding as compared to informal learning activities and development 'around the patient'.

Topic 2 The operationalisation of ageing in the context of CPD

Next, in **Chapter 3,** we reviewed the literature to assess whether and how CPD differs across age groups. We used the five operationalisations of Sterns and Doverspike (1989) and the further operationalisations of age by De Lange et al. (2006) and Kooij et al. (2008) as a framework to review the literature. Besides chronological age (or calendar

age), we looked at age differences through the perspective of functional age (i.e. cognitive abilities), psychosocial age (i.e. social and self-perception of age), organisational age (i.e. job tenure), and lifespan age (i.e. life stage and situation at home).

We found 27 relevant studies on age differences in CPD; of these, only three were in the nursing field. Research on age differences in work-related learning was found to focus on four themes: motivation, engagement in learning activities, learning outcomes, and learning competencies. It was found that workers of approximately 55 years and over appeared less likely to participate in formal learning activities. However, no clear age patterns were found for engagement in informal learning activities, motivation to participate in CPD, or for learning outcomes.

An important finding was that different factors contribute to age differences in CPD. From a functional age perspective, changes in learning abilities may affect CPD. The research on learning abilities in work-related learning is still limited. Nevertheless, it may be expected that the influence of age, through changing learning abilities, depends on the type and content of the learning activity. From a psychosocial perspective, it may be expected that negative stereotypes affect the support nurses get to engage in learning activities. The findings, however, did not show a clear pattern, probably because of cultural differences in stereotypical behaviour: some studies found that older workers were offered less opportunities for CPD, while others found this for younger workers. From an organisational age perspective, career stage and years of experience can have contradictory effects. Specifically, more expertise, through an increase in experience, may reduce the need for CPD, but a longer work history may also increase the need for CPD through obsolescence of knowledge and skills. The findings did not show whether the need for informal learning activities decreases in a similar way as for formal learning activities. Finally, from a lifespan perspective, the situation at home – in particular, having responsibility for the care of children or older parents – may influence engagement in CPD. A lack of time and money were shown to be barriers for nurses to engage in CPD. However, it is not clear whether this affects the engagement in informal, ward-based learning activities in a similar way as participation in formal learning activities.

To summarise, different age-related factors have distinct effects on motivation for and engagement in CPD activities. However, research on age differences in work-related learning appears still to be in its infancy, and does not allow for the drawing of strong conclusions.

Topic 3 Nurses' CPD strategies

To get more insight in nurses' CPD strategies three studies were carried out (Chapters 4, 5, and 6). In **Chapter 4,** we interviewed 21 nurses in three age groups on their CPD strategies. The biographical interviews were analysed using a vertical (within-case) analysis and a horizontal (cross-case) process. For the vertical analysis, each interview

was summarised in an individual learning biography. To provide an illustration of the CPD strategies that younger, middle-aged, and older nurses use, six of the 21 learning biographies are presented in Appendix A. For the horizontal analysis, the interview transcripts were coded and analysed for themes and trends. We found that there are different triggers for nurses to engage in CPD. First, daily work provides important triggers to keep learning. Most of this learning takes place at the ward by self-directed learning activities (e.g. consulting colleagues), participation in organised learning activities (e.g. clinical teaching sessions), and spontaneous learning (e.g. learning from experiences). Second, engaging in extra tasks provided additional triggers. The learning biographies showed that CPD strategies directed at performing extra tasks were related to working motives and attitudes; nurses differed in their pursuit for a challenging and varied job. Third, the wish for career development triggered learning, which primarily took place through postgraduate training. Besides, we found that nurses have learning experiences in private life, which sometimes supported them in developing a better understanding of patients and their families.

In this interview study, we noticed relationships between CPD motives and learning activities, which needed further investigation that was beyond the scope of the study. Therefore, in **Chapter 5**, we explored these relationships further. We developed a literature-based framework of motives and learning activities to re-analyse the interview data. The framework, existing of nine motives for CPD and four categories of learning activities, was based on a review of 22 studies on CPD motives and of three studies on nurses' learning activities. The motives for professional development that were mentioned most frequently in the interviews were 'to increase competence', 'to comply with requirements', 'to deepen knowledge', and 'to enhance career development'. On CPD activities, the most noteworthy finding was that nurses appeared to use a spectrum of these to improve their competence. Adjacent to formal, organised learning activities, they had crucial learning experiences by engaging in learning by work experience, social interaction, and consulting media. Those three types of learning activities have a strong self-directed character and primarily take place during work. This emphasises the importance of work as a learning environment. In addition, the study showed the importance of distinguishing different types of formal, organised learning activities. Nurses seemed to have different motives to engage in organised learning activities at and off the ward, and activities of long and short durations. Formal learning activities at the ward were important to keep up to date, increase competence, and comply with requirements. In learning activities outside the ward (e.g. symposia), other motives also played a role, such as to improve healthcare.

In **Chapter 6,** we carried out a survey study among 728 nurses in five general and two academic hospitals. In this study, we examined the learning activities in which nurses engage and for what reasons they engage in those activities (and age-related patterns in these – see topic 4). The questionnaire consisted of four sections: personal data sheet, formal learning activities, informal learning activities, and CPD motives. To

measure CPD motives, we used four subscales of the modified Education Participation Scale (O'Connor, 1982), instead of the motives found in our earlier study, as we wanted to use established measures.

Our findings support earlier findings in Chapters 4 and 5 that nurses use a variety of learning activities. In the previous 12 months, almost all nurses had engaged in learning activities organised by or at the ward, such as team training aimed at staff development, clinical teaching sessions, and skills training. Most nurses had also engaged in e-learning modules and assessments. Participation rates in learning activities usually organised outside the ward, such as courses and conferences, were lower. Besides, less than half of the nurses had enrolled in longer education programmes (e.g. postgraduate training in a nursing specialty) in the past five years. The average number of learning activities that nurses undertook varied considerably.

Further, principal components analysis showed that informal learning activities could be categorised in four groups: learning by social interaction with colleagues and patients, consulting media, participating in meetings, and engaging in extra tasks. Nurses reported learning most frequently by social interaction and less frequently by engaging in extra tasks. We interpret this as support for the results observed in Chapter 4. In Chapter 4, we found that extra tasks were, to some extent, an additional trigger for learning, but that nurses differed in their interest to have extra tasks.

Finally, we found that nurses engaged primarily in these learning activities to enhance professional knowledge. Compliance with authority and professional advancement also had some influence. Relief from routine had the least influence. These findings corroborate the findings in Chapters 4 and 5: an interest to improve and expand professional knowledge has the strongest influence, but career enhancement and compliance with requirements also motivate nurses to engage in learning activities.

Topic 4 The influence of age on nurses' CPD strategies

In three empirical studies – the focus group study, biographical interviews, and survey – we examined the relationship between age and CPD.

In **Chapter 2**, the focus group study revealed that nurses and managers perceive differences in the CPD of younger and older nurses. They perceived differences in level of focus: older nurses were perceived as bringing more focus to their development, compared to younger nurses whose career paths remain more open. While older nurses engaged primarily in CPD 'around the patient', younger and middle-aged nurses also used CPD to create possibilities to 'leave the bedside'. Some young nurses were perceived as ambitious, which occasionally led to mutual incomprehension and annoyance. The eagerness of younger nurses for further career opportunities may give their older colleagues the impression that their work is not appealing. Younger and older

nurses were perceived to have the same resources and opportunities, but requirements were sometimes less strict for older nurses. Besides, older nurses perceived a 'ceiling' in courses: continuing education courses may provide less added value when one has a high level of expertise and many years of experience.

In **Chapter 4,** the biographical interviews showed similarities in CPD strategies of younger, middle-aged, and older nurses that were described in topic 3, as well as differences. These differences appeared to be related to differences in career and lifespan stages. The professional development of younger nurses was characterised by intensive learning periods: they were gaining expertise as a nurse and in a nursing specialty. Moreover, career development and job enrichment were motives for their development. The future seemed open to these nurses: if work would cease to be a challenge, they showed a desire to move on. These findings were in agreement with the findings of the focus group study in Chapter 2.

In the interviews with middle-aged nurses, balancing life at home and work was more of an issue than it was in the other groups. As a result, engagement in learning activities outside working hours could be less convenient for some. Life at home was a reason for several to work part-time. Very small contracts appeared to hinder nurses in keeping up to date. Furthermore, the findings revealed that some nurses in this group wondered about how to keep their work interesting and varied after years of working experience. Some enriched their work by adding extra tasks or other roles, while others created challenges by enrolling in postgraduate training.

Finally, in the group with older nurses, another theme prevailed: consistency at work. This group had previously faced similar issues as those currently faced by younger and middle-aged nurses, but had reached a point where they wanted to keep working as they did. They were not indifferent to further professional development, but that pertained to 'small things': learning of a new technical nursing skill, something to improve work, or an interesting course related to their work.

In **Chapter 6,** the survey revealed that ageing is related to engagement in learning activities and nurses' motives for professional development. The found correlations were significant, but small. We found that, with higher age, the motives for professional development that we investigated (i.e. professional knowledge, compliance with authority, relief from routine, and professional advancement) became less important for nurses. Higher age also was also negatively related to engagement in CPD activities. Older nurses kept learning new things by informal learning activities, but less frequently than their younger colleagues did. Moreover, the older nurses were, the less they participated in education programmes, e-learning, and short hospital-based learning activities. However, participation in courses was not related to age, and the older nurses were, the more they engaged in team training and conferences.

Table 7.1. Main findings, contributions, implications for practice and further research.

Main findings of the thesis	Theoretical contributions	Practical implications	Implications for further research
Topic 1 The concept of CPD			
• Perceptions of CPD differ on three dimensions: its purpose (around – away from the patient), level of formality (formal – informal learning activities), and scope (reactive – proactive). (Ch.2)	• Professional development is more than formal learning activities: daily practice provides a rich learning resource too. • Definitions of CPD should be based on what the professionals themselves define as learning, and not just on learning activities that can be planned, observed and documented.	• Managers and HRD professionals should recognise the learning potential of daily practice, and strengthen both opportunities for formal and informal learning activities. • Future CPD frameworks and regulations should be developed that also include learning embedded in everyday practice.	• Further research is needed on the similarities and differences of various stakeholders' definitions of CPD. • Studies should examine how CPD is defined in CPD frameworks worldwide, and establish which frameworks reflect genuine learning by nurses the best.
Topic 2 The operationalisation of ageing in the context of CPD			
• Five perspectives of age reveal that with ageing various age-related changes take place that have distinct effects on workers' CPD strategies. (Ch.3) • Workers in late career appear less likely to participate in formal learning activities. No clear age patterns were found for motivation, learning outcomes, and participation in informal learning activities. (Ch.3)	• Lifespan theories and different perspectives of age help in understanding the complex effect of ageing on CPD strategies.	• This topic was not aimed to yield practical implications, but to deepen our understanding of age as a concept in CPD.	• More research on work-related learning from a functional perspective is needed, focussing on age-related changes in learning abilities that predict learning outcomes of formal and informal learning activities.
Topic 3 Nurses' CPD strategies			
• Daily work, new or extra tasks, and career development provide important triggers for professional development. (Ch.4) • Nurses have various motives to engage in CPD. Specific motives appear to be related to engagement in particular learning activities. (Ch.5) • The prime motivator is to enhance professional knowledge, but compliance with authority and professional advancement also have influence. (Ch.6) • Nurses participate most frequently in CPD activities organised by and at the ward, and less in activities outside the ward. (Ch.6)	• The thesis supports claims that nurses act strategically in their CPD: they engage in learning activities that suit their motives. • Categorisations of learning activities should make distinctions between formal and informal learning activities, off and on the ward, and with a short and long duration: engagement in these different types of learning activities may be motivated by distinct reasons.	• Nurses' awareness of why and how they develop professionally can be raised by the findings, and used to direct their CPD more effectively. • Managers should be aware that obligatory participation in learning activities does not guarantee learning: they should encourage CPD by making formal learning activities more appealing and in line with nurses' needs and motives.	• More studies are needed on how motives influence workers' engagement in professional development to get more insight in their CPD strategies. • Instruments to measure nurses' motives for CPD should be updated, and be refined to measure motives for informal learning activities as well.

Main findings of the thesis	Theoretical contributions	Practical implications	Implications for further research
• Nurses learn by four categories of informal learning activities: the most by social interaction. (Ch.6)		• Managers should balance organisational needs and those of individual nurses when allocating available CPD resources. • Educators should include lifelong learning skills in nursing education programmes.	• Measures are needed that distinguish various formal and informal learning activities.
Topic 4 The influence of age on nurses' CPD strategies			
• CPD of older and younger nurses differs in focus, requirements and relevance of courses (perceived ceiling). Their opportunities and resources appear similar. (Ch.2) • Three age groups face different themes in their CPD: gaining experience and building a career (younger nurses), work-life balance and keeping work varied (middle-aged nurses), and consistency at work (older nurses). (Ch.4) • With age four motives for CPD are less important, nurses learn less frequently new things by informal learning activities, and participate less frequently in education programmes, e-learning and short hospital-based learning activities. With age nurses engage more in team training and conferences. (Ch.6) • Age-related differences appear to be explained largely by differences in work experience. Differences in private life do not seem to have a direct effect on CPD strategies, but indirect through differences in number of working hours. (Ch.6)	• Examining different types of motives and learning activities, and placing these in a lifespan perspective gives a nuanced picture of CPD across a career that challenges stereotypical views on older workers. • The thesis offers support for age-related differences in goals as proposed by lifespan theories. • Age-related changes (e.g. in tenure, situation at home) should be taken into account when examining changes in CPD across a career.	• Nurses may use the insights on age-related changes in CPD patterns to confront stereotyping in a nursing team. • Managers should be aware that nurses of different ages may differ in their CPD needs, and adapt their support to these needs. • Educators and HRD professionals should develop approaches that suit the needs of highly experienced nurses.	• Future research on the impact of learning experiences in different age groups is needed. • A distinction should be made between early, mid and late career workers. • Studies on how organisations can best foster a learning climate for different age groups are needed.

We found that an increase in professional and ward tenure had similar effects on CPD activities and motives as an increase in age. This suggests that the observed age patterns may be largely due to changes in work experiences. This supports our findings of the biographical interview study (Chapter 4) that after a rapid growth in the first years of clinical experience, learning becomes less intensive in later career stages. Changes in lifespan, i.e. having a situation at home that prohibits engagement in learning activities or having children under 18 living at home, did not predict engagement in learning activities or changes in motives. However, we found that when nurses worked more hours per week, they engaged more frequently in several formal and informal learning activities, and all motives, except for compliance with authority, became more important. This suggests that the situation at home as such does not predict changes in CPD, but may have an indirect negative influence through working hours. This appears to correspond with our earlier finding that nurses with children that choose to work few hours a week have fewer CPD opportunities than do their colleagues working more hours.

Theoretical implications and contributions

Topic 1 The concept of CPD

Our finding that the concept of CPD is perceived differently on three dimensions – its purpose, level of formality, and scope – supports earlier findings that there is confusion on the definition of CPD (Friedman and Phillips, 2004; Gopee, 2001; Peck et al., 2000). Two interwoven but sometimes conflicting notions of professional development may cause this confusion. In the first notion, professional development is inscribed in CPD frameworks, which differs substantially from the second notion, where professional development is elicited from practice (Reich et al., 2015). In the first notion, CPD is the domain of statutory registration boards, professional bodies, educators, and employers. Professional development is considered something that is 'done to the professional' (Webster-Wright, 2009, p.713): professionals are perceived as in need of training and development, which can be delivered to them through courses and other formal learning activities. To ensure continuing competence of health professionals, and to protect the public, various stakeholders put requirements on nurses' CPD (Chiarella and White, 2013; Cutcliffe and Forster, 2010; Lawton and Wimpenny, 2003). However, these frameworks, trying to capture and measure professional learning, predominantly focus on measuring participation rates in education programmes and privilege formal learning activities, often at the expense of informal learning activities (Reich et al., 2015; Skule, 2004; Webster-Wright, 2009). This was supported in this thesis, as nurses sometimes perceived a discrepancy between learning activities that were mandated and socially rewarded, and those that they valued and that contributed to their work.

In the second notion, professionals themselves define what is learning and what is not. In this thesis, we attempted to understand professional development from the perspective

of the professionals themselves, in a way that respects and retains the complexity and diversity of learning experiences in everyday professional practice (Webster-Wright, 2009). Our findings showed that nurses have various motives to engage in professional development, and that they learn by a diverse range of activities. Nurses were shown to learn in different contexts: in their every-day work processes, in human resource management processes (e.g. job rotation, annual performance interviews), and in human resource development processes (e.g. explicit learning programmes) (Poell and Van der Krogt, 2014a). The findings corroborate that much knowledge needed for work arises through everyday experiences outside of educational programs (Billett, 2010).

Overall, this thesis shows that there is more to professional development than formal learning activities. Daily practice is a rich resource for learning as well (Berings, 2006; Eraut, 2007; Jantzen, 2008; Skår, 2010). It emphasises the importance of including not just learning activities that are relatively easy to plan, observe, and document, but also informal learning activities in CPD definitions, frameworks, and empirical studies.

Topic 2 The operationalisation of ageing in the context of CPD

This thesis shows that lifespan theories help in understanding the complex effect of ageing on CPD strategies. The use of different perspectives on age showed that with ageing various age-related changes take place (De Lange et al., 2006; Kooij et al., 2008; Sterns and Doverspike, 1989) that may have distinct effects on workers' CPD strategies. These findings support claims that chronological age is in itself not a good predictor of changes in CPD strategies, but it serves as a proxy for age-related changes that may have an influence on CPD strategies (Froehlich et al., 2015; Kanfer and Ackerman, 2004). Researchers should be aware of the complexity of the concept of age (Froehlich et al., 2015), and should include other indicators of ageing in addition to chronological age when investigating age-related changes in CPD.

Topic 3 Nurses' CPD strategies

Our findings offer support for the claim that employees act strategically with regard to their professional development (Poell and Van der Krogt, 2014a). This does not mean that nurses always deliberately plan and direct their learning activities, nor does it mean that engagement in CPD is always intrinsically motivated, but the results underscore that nurses engage in learning activities that suit their motives. These motives may have a more intrinsic character, such as a desire to increase competence or to deepen knowledge, but may also be more externally pressured. Working in a context with increasing mandatory learning activities, compliance with requirements was also demonstrated as an important motive for nurses to engage in learning activities. The findings illustrate that nurses exercise agency even when workplaces intentionally regulate individuals' engagement in learning activities (Billett, 2006). Amidst the learning opportunities that work and life offer them, nurses were shown to carve their own learning paths (Poell and Van der Krogt, 2014a, 2014b) in accordance with their interests and goals (Billett, 2006, 2010).

This thesis is one of the first to examine relationships between CPD motives and CPD activities. This has provided new insights into nurses' CPD. The results suggest that motives may influence the type of learning activities employees engage in. Examining relationships between CPD motives and activities asks for an adaptation of existing classifications of learning activities (Berings et al., 2008; Eraut, 2007; Estabrooks et al., 2005). Classifications of learning activities should include distinctions between formal (organised by others) and informal learning activities (initiated by nurses themselves and embedded in daily practice), off and on the ward, and with a long and short duration, as these distinctive learning activities may be undertaken with different motives.

Topic 4 The influence of age on nurses' CPD strategies

This thesis shows that ageing is related to changes in strategies for professional development. By examining different types of motives and learning activities, and placing CPD in the context of a career and life stage a nuanced picture of CPD across a nursing career arose. This challenges stereotypical views that older workers are not motivated to learn (Gray and McGregor, 2003). The findings show that nurses keep learning throughout their career, but their motives and learning activities change and learning becomes less intensive. With ageing, career development becomes less important, while maintaining what one has increases in importance. In their early careers, nurses are building expertise in nursing, new nursing specialities, and extra tasks. This motivates them to engage in a broad range of learning activities. With age, nurses still engage in learning activities, but do so less frequently in general, with the exception of some learning activities in which they participate more frequently. Further, motives such as increasing professional knowledge and enhancing career development become less important. The findings offer support for an age-related shift in goals as proposed by the Selective Optimisation with Compensation theory (Baltes et al., 1999) and the theory of Socioemotional Selectivity (Carstensen et al., 1999).

Further, the findings confirm that it is not so much chronological age, but rather, several changes that take place when getting older (Kanfer and Ackerman, 2004; Kooij, 2010; Sterns and Doverspike, 1989) that affect CPD strategies. Tenure (i.e. years of working experience) appeared to explain most of the age differences in motives and engagement in learning activities. In addition, we found that some nurses perceived their situation at home (i.e. having young children or caring for elder parents) as a barrier to their professional development. Our findings underscore the idea of career development models and lifespan theories proposing that the needs of workers vary at different points of their career and lives (Baltes et al., 1999; Carstensen et al., 1999; Super and Hall, 1978). They also corroborate the assumption that the mid-career period is different from early and late career stages (Ng and Feldman, 2008; Simpson et al., 2002).

Practical implications

A variety of recommendations for practice can be derived from the studies in this thesis. We will address the main stakeholders: nurses, managers, educators, HRD professionals and professional bodies.

Nurses

People regularly associate learning and development with formal learning activities. Our findings can contribute to nurses' awareness that they learn and develop in more ways than they often think, even at an older age. Nurses can use the range of learning activities and motives to become aware of why and how they develop professionally, and use this knowledge to direct their CPD strategies more effectively. In addition, the thesis shows that, with ageing, motives change, and accordingly, learning activities may also change. Nurses may use these insights to confront stereotyping of younger and older nurses in a nursing team.

Managers

Employers and managers play a crucial role in creating a supportive learning climate that enhances work-related learning (Armstrong-Stassen and Schlosser, 2008; Eraut, 2007). They influence the range of learning opportunities afforded in the workplace (Billett, 2006). Therefore, this thesis has some important implications for them. First, as daily practice is an important learning resource for nurses in general, managers should recognise the learning potential of daily practice. They can encourage engagement in informal learning activities by providing feedback, job autonomy, challenging tasks, social support, and information resources such as protocols and literature. They can stimulate the uptake of formal learning activities by supporting the organisation of ward-based learning activities and enrolment in learning activities outside the ward.

Second, they should be aware that nurses of different ages may have different CPD needs, and adapt their support to these needs. Important management tools for recognising these CPD needs and planning of professional development activities are appraisals and employee reviews (Lammintakanen and Kivinen, 2012). In these talks, managers can use the range of motives described in this thesis to get a better picture of the nurse's CPD motives, and they can use the range of learning activities to assist nurses in selecting appropriate CPD activities. Managers should recognise a lifelong learner (Jarvis, 2005). The thesis shows that providing extra tasks can trigger learning. Therefore, nurses who appear to limit their work to what they always do may need encouragement to perform new tasks and accept challenging patient cases. Besides, managers play a role in ensuring that part-time nurses have sufficient CPD opportunities to keep up to date.

Finally, managers should be aware that their views and interest in nurses' CPD might differ from those of nurses themselves. Managers should find a balance in the interests of various stakeholders in nurses' CPD. We do not want to suggest that managers should never require nurses to engage in certain learning activities. Some learning activities, such as periodical retraining in resuscitation, should be mandatory. However, as time and budgets for participation in formal learning activities are limited, managers should balance the time allotted for obligatory learning activities and for learning activities chosen by individual nurses themselves. Moreover, managers should be aware that mandating participation in learning activities does not automatically guarantee learning and competence (Chiarella and White, 2013; Poell, 2013). Therefore, encouraging CPD should be more a matter of making formal learning activities more appealing to nurses and more in line with their needs and motives. Self-Determination Theory (SDT, Ryan and Deci, 2000) can be helpful in this. It posits that humans have a natural tendency to develop and that the social context can facilitate or hamper this. Intrinsic motivation regulates behaviour more strongly than extrinsic rewards or punishment. STD holds that intrinsic motivation is stimulated and maintained if three conditions are satisfied, that is the need for (a) autonomy, (b) feelings of competence and (c) relatedness to a group of significant others. This means that requests to engage in learning activities presented in a controlling way are likely to be less effective than requests providing a rationale for actions and leaving room for personal choices, satisfying the need for autonomy. A feeling of competence refers to the desire of nurses to engage in CPD that further strengthens already existing competences. Managers should ensure that learning activities are not too easy nor too difficult, and stressing the repair of lapses in competence will likely not stimulate intrinsic motivation much, but stimulating nurses to think how they can further build on what they are already good at will do this. Finally, a feeling of relatedness refers to a desire to belong and connect with others. Creating a working and learning environment where nurses feel accepted and valued by their managers and by their colleagues is likely to stimulate the intrinsic motivation to learn.

Educators and HRD professionals

A first recommendation for educators is to include lifelong learning skills in curricula of nursing education programmes. To organise and direct their learning processes, nurses need to have reflection skills, study skills, and skills in searching and assessing information. Educators play an important role in grounding self-directed learning in nurses. For older workers less familiar with these skills, educators may develop training programmes on these skills. Second, the findings show that experienced nurses may perceive a lack of courses that will teach them something new. It is a challenge for educators and HRD professionals to develop approaches that suit the needs of these groups and challenge them in further development. Third, the findings on motives may help educators and HRD professionals in understanding that participants in organised learning activities may engage in these with different reasons. A last recommendation

is to facilitate managers with means and instruments for creating supportive learning climates. As learning at the ward provides important learning opportunities, and time for learning activities is scarce, HRD professionals should develop new approaches that foster learning in and at work.

Policy makers, professional bodies, and hospital managers

Policy makers, professional bodies, and hospital managers have a responsibility for ensuring nurses' optimal performance. CPD approaches are important tools for them to ensure continued competence in nurses. They do so by making learning activities mandatory, by introducing performance assessment programmes, and by accrediting learning programmes. These approaches focus primarily on formal learning activities. However, the findings in this thesis show that crucial learning experiences also arise in everyday experiences. Regulation schemes that focus solely on ticking off participation in accredited formal learning activities provide insufficient guarantees of learning and competence. Policy makers, professional bodies, and hospital managers are challenged to develop CPD frameworks that focus on formal as well as informal learning activities and to develop approaches to assess continuing competence instead of participation rates.

Strengths and limitations

This thesis contributes to the fields of CPD, work-related learning, and HRD by examining CPD across a nursing career. The strengths of this thesis are its relevance, its theoretical framework, and the combination of research methods. First, the research is focussed on a timely and relevant topic. Rapid changes in healthcare and the increasing pressure on accountability have led to a growing interest in the CPD of nurses. Moreover, the nursing work force is ageing due to demographic changes. With an increasing retirement age, nurses' professional development will last longer. The different studies in this thesis illuminate why and how nurses develop professionally, and what the influence of age-related changes is on their CPD strategies. This can give managers, researchers, and policy makers insight into better ways to support the professional development of nurses in different age groups.

Second, the studies in this thesis are among the first to examine nurses' CPD from a lifespan perspective. By combining insights from the literature on CPD, workplace learning, and lifespan theories, the research was guided by a strong theoretical framework (Bordage, 2009). We approached CPD from the perspective of the professionals themselves, conceptualising nurses as active agents who give meaning and direction to their learning. Additionally, we used lifespan theories, which helped to understand how nurses' needs and motives change over the lifespan. This combination of perspectives did justice to the complex character of professional development during a nursing career and shed a new light on CPD.

A third strength is the combination of research methods: literature reviews, focus group interviews, biographical interviews, and a survey study. This thesis is predominantly a qualitative study, combined with a quantitative approach in the survey. This combination led to deeper answers to the research questions. By using two literature reviews and combining literature from different fields, such as healthcare, organisational psychology, and HRD, this thesis is rooted strongly in and extends upon existing understandings.

Besides the strengths of the studies of this thesis, important limitations must also be considered. First, in all empirical studies, we relied on self-reports. Moreover, in the biographical interviews and the survey, participants had to recall information, which might have been a difficult task for participants. This might have resulted in some bias. However, as we were interested in nurses' perceptions of CPD, it would have been illogical to use other methods for data collection.

Second, to be genuinely able to determine whether CPD changes across a nursing career, we should have used a longitudinal design. For practical reasons, this was not feasible. Accordingly, cohort effects and age effects are difficult to disentangle in this thesis.

Third, the studies in this thesis were conducted in the context of general and academic hospitals in the Netherlands. Accordingly, caution is warranted for generalising the findings to other contexts, such as nurses in other settings, other countries, and other professional groups. However, we support transferability by giving detailed descriptions – rich descriptive information about the research setting, participants, and processes – that 'allow readers to make inferences about extrapolating the findings to other settings' (Polit and Beck, 2010, p.1453). The extensive literature review and a sound theoretical basis may support the applicability of the findings to a broader context, but that should be tested empirically in the future.

Implications for future research

Topic 1 The concept of CPD

In this thesis, we focused primarily on nurses' perceptions of CPD. A recommendation for future research is to examine the perceptions and definitions of CPD of various stakeholders, and to examine in what respect they correspond and differ. Another recommendation relates to CPD regulations. With an increasing stress on accountability, the nursing profession is driven towards mandatory CPD programmes and regulation of nurses' CPD. In this context, a fruitful avenue for future research would be to compare national regulation schemes (c.f. Peck et al., 2000 for the medical profession), and to examine which approach best reflects genuine learning by nurses.

Topic 2 The operationalisation of ageing in the context of CPD

Our study revealed that most research on age differences in CPD is conducted from an organisational age and psychosocial age perspective. With this thesis, we tried to fill the gap in studies using a lifespan perspective, but there remains a paucity of studies from a functional perspective. Most research on the effects of cognitive ageing on learning is limited to experimental and laboratory designs, which have limited implications for learning in everyday practice (Schulz and Stamov Roßnagel, 2010). To fully understand the effect of cognitive ageing on CPD, future studies should examine whether nurses in different age groups differ in learning abilities, such as refection skills or in their ability to self-direct their learning process. More research is needed on age-related changes in learning abilities that predict learning outcomes of both formal and informal learning activities.

Topic 3 Nurses' CPD strategies

In this field, research is needed to scrutinise the process through which motives affect employees' engagement in professional development to get more insight into their CPD strategies. Further, studies on the relationship between motives and learning activities are needed: which motives relate to which learning activities? This will expand our understanding of preferences for certain learning activities. As most studies in this field are retrospective, a prospective study having employees describe their motives and the learning activities they intend to undertake is suggested. Besides, an update and extension of prevailing instruments to measure nurses' CPD motives is needed. O'Connor's modified Education Participation Scale (1979; 1982) was developed over 30 years ago and may need an update to fit contemporary nursing care and careers. The instrument should also be extended to include motives for informal learning activities. A final suggestion for future research related to this topic is the future validation of measures for learning activities. Various classifications of learning activities exist (e.g. Berings et al., 2008; Eraut, 2007; Estabrooks et al., 2005); however, validated measures are needed to measure formal and informal learning activities. These measures may need regular updating, as the importance of some learning activities may decrease, while the importance of others increases (Berings, 2006), as is the case in the rise of technology-enhanced learning. Development of validated measures of learning activities seems particularly relevant with growing attention towards the relation between age, formal, and informal learning activities (Froehlich et al., 2015; Raemdonck et al., 2015; Richter et al., 2011).

Topic 4 The influence of age on nurses' CPD strategies

In this thesis, and particularly in the survey, we focussed on the frequency of engagement in learning activities. A suggestion for future research is to study the impact of learning experiences in different age groups. Questions may include the extent to which different learning activities generate different learning outcomes, the influence of age in this, and whether certain learning activities are more appropriate for certain age groups.

Especially ripe for research is how different age groups interact with e-learning. Dutch hospitals increasingly acquire e-learning modules for nurses. The fact that e-learning is self-paced may benefit older workers, but little is known about how best to design e-learning to benefit older workers (Beier, 2008). Moreover, this thesis reveals that the mid-career period differs from late and early career. Therefore, in research on age differences in CPD, a distinction between younger and older employees is too rough – future research should consider at least three age groups. Finally, further research is needed to identify how organisations may foster a supportive learning climate for younger, middle-aged, and older workers, and how nurses can be stimulated to engage in learning activities. Studies are needed that examine whether and to what extent the learning climate at the ward impacts nurses' engagement in learning activities across their career.

In conclusion

In this thesis, we aimed to clarify why and how nurses develop professionally across a nursing career. By taking insights from the CPD literature as well as lifespan development theories, and by using a multi-method approach, this thesis adds to previous research in three important ways. First, by showing how nurses develop professionally, we have strengthened the argument for CPD approaches to include both formal and informal learning activities. Second, by focussing on motives and learning activities, our findings support the idea that employees act strategically in their professional development. Third, we have highlighted that there are similarities, but also differences, in CPD strategies between age groups. Differences in motives, formal, and informal learning activities appear to be connected with years of working experience, career, and life stage. With this thesis, we aim to contribute to further research and new developments in CPD so that nurses keep developing in such a way that, throughout their careers, they are able to provide the care that patients need and deserve.

chapter 8

Samenvatting (summary in Dutch)

Inleiding

Een verpleegkunde loopbaan kan ruim 40 jaar duren en met de huidige verschuiving van de pensioenleeftijd zelfs langer. Gedurende deze loopbaan verandert het verpleegkundig werk voortdurend. Dit maakt het noodzakelijk dat verpleegkundigen blijven leren. Continue professionele ontwikkeling (CPO) is cruciaal voor veilige en goede zorg. Hoewel de kennis over CPO groeit, is er nog weinig bekend over of en hoe professionele ontwikkelingsstrategieën van verpleegkundigen veranderen met ouder worden. Inzicht hierin wordt steeds belangrijker, mede omdat door demografische ontwikkelingen de verpleegkundige beroepsbevolking veroudert.

We onderscheiden CPO van het begrip 'continuing professional education' (CPE), dat vaak als synoniem wordt gebruikt. CPE duidt meestal op formele leeractiviteiten zoals bij- en nascholing. In dit proefschrift worden die opgevat als onderdeel van CPO. CPO is breder dan CPE doordat het ook informele leeractiviteiten omvat, zoals het leren van werkervaring of door het raadplegen van collega's. Aan de andere kant is CPO smaller dan het begrip leven lang leren (LLL), dat zich richt op leren van de wieg tot het graf en meer dan de ontwikkeling voor het werkzame leven omvat.

In dit proefschrift bestuderen we continue professionele ontwikkeling vanuit het perspectief van verpleegkundigen. Bij CPO zijn verschillende stakeholders betrokken, ieder met hun eigen belangen, zoals de individuele professional, werkgevers en beroepsverenigingen. Binnen dit krachtenveld zien we verpleegkundigen als actoren die, bewust of onbewust, de richting en intensiteit van hun leerprocessen bepalen. Hierbij maakt Billett (2001, 2006) onderscheid tussen 'affordances' en 'agency'. 'Affordances' duidt op de mogelijkheden die een werkplek biedt om te leren. Deze mogelijkheden zijn cruciaal voor de professionele ontwikkeling van verpleegkundigen. Werkplekken verschillen in de mate waarin zij deze mogelijkheden bieden, onder andere door het leerklimaat, de hoeveelheid georganiseerde leeractiviteiten, en de mate van variatie en autonomie in het werk. 'Agency' duidt op het 'besluit' van de verpleegkundige hoe om te gaan met de mogelijkheden die worden geboden. Zelfs bij verplichte leeractiviteiten kan de verpleegkundige dit bepalen door zich oppervlakkig of diepgaand te richten op het leren. Deze keuzes worden ingegeven door eigen normen, waarden, houdingen en competenties.

Daarnaast hanteren we een levensloopperspectief om de invloed van leeftijd op CPO-strategieën te onderzoeken. Mensen veranderen gedurende hun levensloop. Levensloptheorieën gaan er vanuit dat van geboorte tot dood zowel groei als verval optreedt. Tevens gaan ze er vanuit dat houding en gedrag worden beïnvloed door interne krachten (ervaringen en verwachtingen, biologische en psychologische veranderingen) en externe krachten (zoals maatschappelijke veranderingen die invloed uitoefenen op een cohort). We maken gebruik van twee levensloptheorieën (Socio-emotionele Selectiviteit theorie en Selectieve Optimalisatie met Compensatie theorie) en een loop-

baanontwikkelingstheorie. De Socio-emotionele Selectiviteit theorie van Carstensen et al. (1999) gaat er vanuit dat in de loop van een leven de perceptie van tijd als oneindig naar eindig verandert en dat daarmee toekomstgerichte doelen – gericht op kennisverwerving en horizonverbreding – plaatsmaken voor doelen die meer gericht zijn op het nu en die een emotionele betekenis hebben. De Selectieve Optimalisatie met Compensatie theorie van Baltes et al. (1999) stelt dat selectie, optimalisatie en compensatie belangrijke processen zijn voor de ontwikkeling gedurende een levensloop. Volgens deze theorie zullen ouderen bijvoorbeeld eerder gericht zijn op behoud van wat ze hebben, door het werk te beperken tot waar ze goed in zijn en het verlies van capaciteiten te compenseren, dan zich te richten op groei. De theorie over loopbaanontwikkeling van Super (1978), ten slotte, laat zien dat mensen verschillende fasen in de loopbaan doorlopen waardoor behoeften in het werk ook veranderen.

Het belangrijkste doel van dit proefschrift is beter inzicht krijgen in de dynamiek van professionele ontwikkeling gedurende een verpleegkundige loopbaan. In een serie van studies is onderzocht hoe en waarom verpleegkundigen zich professioneel ontwikkelen, en in welke mate en op welke wijze hun CPO wordt beïnvloed door leeftijdgerelateerde veranderingen. Hierbij staan vier onderzoek-topics centraal: 1) het concept continue professionele ontwikkeling, 2) de operationalisatie van leeftijd in de context van continue professionele ontwikkeling, 3) strategieën voor continue professionele ontwikkeling en 4) de invloed van leeftijd op CPO-strategieën van verpleegkundigen. Het onderzoek is uitgevoerd bij verpleegkundigen in algemene en academische ziekenhuizen in Nederland. Hieronder worden de belangrijkste resultaten van dit onderzoek in relatie tot de vier onderzoek-topics en de belangrijkste implicaties voor theorie en praktijk in het kort beschreven.

Belangrijkste resultaten van dit proefschrift

Topic 1 Het concept continue professionele ontwikkeling

Om te beginnen wilden we helder krijgen wat Nederlandse verpleegkundigen en leidinggevenden onder CPO verstaan (**Hoofdstuk 2**). Hiervoor zijn vier focusgroepinterviews gehouden met 22 verpleegkundigen en 10 leidinggevenden. Het onderzoek bevestigt eerder internationaal onderzoek, waaruit blijkt dat er geen eenduidige definitie is van het concept CPO en vult dit aan. De percepties die deelnemers hebben van CPO blijken te verschillen op drie dimensies. De eerste dimensie betreft het doel van professionele ontwikkeling. CPO kan gericht zijn op ontwikkeling 'rond de patiënt' door bij te blijven en het behouden van basisvaardigheden, en op ontwikkeling 'van de patiënt vandaan' gericht op het uitbreiden van verpleegkundige rollen en het vergroten van loopbaanmogelijkheden. Een tweede dimensie betreft de mate van formalisatie van leeractiviteiten: sommigen associëren CPO met formele leeractiviteiten, zoals cursussen of de master Verplegingswetenschap. Anderen denken bij CPO ook aan informele leer-

activiteiten zoals leren door ervaring tijdens het werk. De derde dimensie betreft de reikwijdte van professionele ontwikkeling. Allen vinden dat verpleegkundigen up-to-date moeten blijven. Men verschilt echter van mening of deze vorm van reactief leren tot CPO gerekend kan worden, of dat CPO meer gaat over nieuwe kennis en vaardigheden gericht op groei en op het verbeteren van de zorg. Uit de focusgroep-interviews blijkt dat verpleegkundigen een druk voelen om zich te blijven ontwikkelen, maar zij hebben het idee dat formele leeractiviteiten en ontwikkeling 'van de patiënt vandaan' sociaal meer aanzien hebben dan informele leeractiviteiten en ontwikkeling 'rond de patiënt'.

Topic 2 De operationalisatie van leeftijd in de context van CPO

Vervolgens zijn we in **Hoofdstuk 3** in een literatuuronderzoek nagegaan of en hoe CPO anders is voor verschillende leeftijdsgroepen. Hierbij is een raamwerk gebruikt, gebaseerd op werk van Kooij et al. (2008) en Sterns en Doverspike (1989), waarbij leeftijd op vijf manieren is geoperationaliseerd. Naast chronologische leeftijd (kalender leeftijd) hebben we naar leeftijdsverschillen gekeken vanuit het perspectief van functionele leeftijd (zoals cognitief functioneren), psychosociale leeftijd (sociale en zelf-perceptie van leeftijd), organisatie leeftijd (aantal jaren werkervaring) en levensloopleeftijd (de levensfase en thuissituatie).

We vonden 27 relevante studies waarvan er slechts drie bij verpleegkundigen waren uitgevoerd. Onderzoek naar leeftijdsverschillen bij werkgerelateerd leren blijkt zich te richten op vier thema's: motivatie, deelname aan CPO-activiteiten, leeruitkomsten en leercompetenties. Uit de literatuur blijkt dat werknemers van 55 jaar en ouder in het algemeen minder deelnemen aan formele leeractiviteiten. Er zijn echter geen duidelijke leeftijdspatronen gevonden voor deelname aan informele leeractiviteiten, motivatie voor CPO en leeruitkomsten.

Een belangrijke bevinding uit het literatuuronderzoek is dat verschillende factoren kunnen bijdragen aan leeftijdsverschillen in CPO. Vanuit het functionele leeftijdsperspectief kunnen veranderingen in cognitieve en leervaardigheden CPO beïnvloeden. Er is hier echter nog maar beperkt onderzoek naar gedaan in werkgerelateerd leren. Desondanks mag verwacht worden dat de invloed van leeftijd, via veranderingen in leervaardigheden, afhangt van het type en de inhoud van de leeractiviteit. Voor oudere werknemers zal bijvoorbeeld leren in een totaal nieuw veld lastiger zijn dan leren in het expertdomein van de werknemer. Vanuit een psychosociaal perspectief op leeftijd kan verwacht worden dat negatieve stereotype beelden van bepaalde leeftijdsgroepen invloed hebben op de ondersteuning die werknemers krijgen om aan leeractiviteiten deel te nemen. De resultaten laten hierin echter geen duidelijk patroon zien: sommige studies laten zien dat werkgevers oudere werknemers minder mogelijkheden bieden voor professionele ontwikkeling, terwijl andere juist jongeren minder mogelijkheden bieden. Dit kan mogelijk te maken hebben met culturele verschillen in sociale percepties van leeftijd tussen landen waar de studies zijn uitgevoerd. Vanuit het organisatie leeftijdsperspectief kunnen jaren werk-

ervaring een tegenstrijdig effect hebben. Meer jaren werkervaring kan, doordat expertise is toegenomen, leiden tot een lagere behoefte aan CPO, maar een langer werkverband kan ook leiden tot veroudering van kennis en vaardigheden waardoor CPO juist nodig is. De resultaten lieten niet zien of de behoefte aan informele leeractiviteiten op eenzelfde wijze afneemt als voor formele leeractiviteiten. Ten slotte, kan vanuit een levensfase perspectief de thuissituatie, en met name het hebben van zorgtaken voor kinderen of hulpbehoevende ouders, deelname aan CPO beïnvloeden. Gebrek aan tijd en geld blijken voor verpleegkundigen belemmeringen te vormen om aan CPO deel te nemen. Maar ook hiervoor geldt dat onduidelijk was of dit evenveel invloed had op deelname aan informele leeractiviteiten op de afdeling, als op deelname aan formele leeractiviteiten.

Samenvattend kunnen we op basis van het literatuuronderzoek stellen dat verschillende leeftijd-gerelateerde factoren verschillende effecten kunnen hebben op motivatie en deelname aan leeractiviteiten. Onderzoek naar leeftijdsverschillen in werk-gerelateerd leren staat echter nog in de kinderschoenen en laat daarom het trekken van sterke conclusies nog niet toe. In de vervolgonderzoeken die we hebben uitgevoerd, hebben we naar leeftijd vooral gekeken vanuit de perspectieven van chronologische leeftijd, organisatie leeftijd en levensloop leeftijd.

Topic 3 Strategieën voor continue professionele ontwikkeling

Om meer inzicht te krijgen in de professionaliseringsstrategieën van verpleegkundigen hebben we drie onderzoeken uitgevoerd (Hoofdstuk 4, 5 en 6). In **Hoofdstuk 4** interviewden we 21 verpleegkundigen in drie leeftijdsgroepen over hun professionele ontwikkelingsstrategieën. De biografische interviews werden geanalyseerd door een verticaal (binnen een casus) en een horizontaal (tussen cases) proces. Voor de verticale analyse is elk interview samengevat in een individuele leerbiografie. Als illustratie van de professionaliseringsstrategieën die jongere, middelbare en oudere verpleegkundigen gebruiken, zijn zes van de 21 leerbiografieën opgenomen in Bijlage A. Voor de horizontale analyse zijn de transcripten van de interviews gecodeerd en geanalyseerd.

De interviews laten zien dat er verschillende triggers zijn voor verpleegkundigen om zich bezig te houden met CPO. Allereerst biedt het dagelijks werk belangrijke triggers om te blijven leren. Dit leren vindt voor een belangrijk deel plaats op de afdeling, door zelfgestuurde leeractiviteiten (zoals consulteren van collega's), deelname aan georganiseerde leeractiviteiten (bijvoorbeeld klinische lessen) en spontaan leren (zoals leren door ervaring). Naast dagelijkse patiëntenzorg vormen extra taken aanvullende triggers voor leren. De leerbiografieën laten zien dat de CPO-strategieën gericht op het uitvoeren van extra taken samenhangen met werkmotieven en –houding: verpleegkundigen verschillen in hun streven naar een gevarieerde en uitdagende baan. Ten slotte vonden we dat verpleegkundigen in alle leeftijdsgroepen leerervaringen in het privéleven opdoen die hen soms ondersteunen in het beter begrijpen van patiënten en hun familie.

In deze studie signaleerden we relaties tussen motieven en leeractiviteiten die om nader onderzoek vroegen, maar buiten het bestek van de studie vielen. In **Hoofdstuk 5** hebben we daarom deze relaties nader onderzocht. We ontwikkelden een raamwerk van motieven en leeractiviteiten waarmee we de interviewdata opnieuw analyseerden. Het raamwerk, bestaande uit negen motieven voor professionele ontwikkeling en vier categorieën van leeractiviteiten, was gebaseerd op een literatuurreview van 22 studies naar CPO motieven en drie studies naar leeractiviteiten van verpleegkundigen.

De motieven voor professionele ontwikkeling die het meest zijn genoemd in de interviews zijn 'vergroten van competentie', 'voldoen aan eisen', 'verdiepen van kennis' en 'vergroten van loopbaanmogelijkheden'. Met betrekking tot leeractiviteiten is het meest opvallend dat verpleegkundigen een heel spectrum aan leeractiviteiten blijken te gebruikten om hun competentie te vergroten. Naast formele, georganiseerde leeractiviteiten doen zij cruciale leerervaringen op door te leren van werkervaringen, door sociale interactie en door het consulteren van media. Deze drie type leeractiviteiten hebben een sterk zelfgestuurd karakter en vinden vooral plaats tijdens het werk. Dit benadrukt het belang van werk als een leeromgeving. Uit de studie blijkt daarnaast dat het goed is om verschillende typen formele, georganiseerde leeractiviteiten te onderscheiden. Verpleegkundigen lijken verschillende motieven te hebben om deel te nemen aan georganiseerde leeractiviteiten op en buiten de afdeling, en aan kort- en langdurende activiteiten. Formele leeractiviteiten op de afdeling zijn vooral belangrijk om bij te blijven, competentie te verhogen en om te voldoen aan eisen. Bij leeractiviteiten buiten de afdeling, zoals symposia, spelen ook andere motieven een rol, zoals het verbeteren van de gezondheidszorg.

In **Hoofdstuk 6** beschrijven we een survey die gedaan is onder 728 verpleegkundigen in vijf algemene en twee academische ziekenhuizen. Hierbij onderzochten we welke leeractiviteiten verpleegkundigen gebruiken en met welke redenen (en wat de leeftijdspatronen hierbij zijn – zie topic 4). De vragenlijst bestond uit vier delen: een deel met persoonlijke gegevens, formele leeractiviteiten, informele leeractiviteiten en CPO motieven. Om de CPO motieven te meten maakten we, omdat we een gevalideerd instrument wilden gebruiken, gebruik van vier subschalen uit een bestaand instrument dat redenen om aan bij- en nascholing deel te nemen meet, in plaats van de motieven die we in onze eerdere studie hadden gevonden.

De resultaten ondersteunen onze eerdere bevindingen in Hoofdstuk 4 en 5 dat verpleegkundigen een variëteit aan leerervaringen gebruiken. In de voorgaande 12 maanden hebben bijna alle verpleegkundigen deelgenomen aan leeractiviteiten georganiseerd op of door de afdeling, zoals een teamdag gericht op bijscholing, klinische lessen en vaardigheidstrainingen. De meeste verpleegkundigen hebben ook e-learning modulen en toetsen gedaan. Deelnamecijfers voor leeractiviteiten die meestal buiten de afdeling plaatsvinden, zoals cursussen en congressen, zijn lager. Daarnaast nam minder dan de

helft van de verpleegkundigen de laatste vijf jaar deel aan werkrelevante opleidingen, zoals een verpleegkundige vervolgopleiding. Het gemiddeld aantal leeractiviteiten dat een verpleegkundige ondernam varieerde aanzienlijk.

Een factoranalyse liet zien dat informele leeractiviteiten in vier categorieën verdeeld kunnen worden: leren door sociale interactie met collega's en patiënten, door consulteren van media, deelnemen aan vergaderingen en door extra taken uit te voeren. Verpleegkundigen gaven aan het meest frequent te leren door sociale interactie en het minst frequent door extra taken uit te voeren. We vatten dit op als een bevestigingen van onze bevindingen in Hoofdstuk 4, waar we vonden dat extra taken zorgden voor een extra trigger om te leren, maar waarbij bleek dat verpleegkundigen verschillen in hun behoefte om extra taken te hebben.

Ten slotte vonden we dat verpleegkundigen deze leeractiviteiten vooral ondernemen om hun professionele kennis te vergroten. Voldoen aan eisen en versterken van de loopbaan hebben ook invloed. Het doorbreken van verveling of routine heeft de minste invloed. Deze resultaten ondersteunen onze bevindingen in Hoofdstuk 4 en 5: een behoefte om professionele kennis te verbeteren en uit te breiden heeft de meeste invloed, maar loopbaanontwikkeling en het voldoen aan eisen van bijvoorbeeld de werkgever motiveren verpleegkundigen ook om leeractiviteiten te ondernemen.

Topic 4 De invloed van leeftijd op CPO-strategieën

In drie empirische studies – de focusgroep studie, de biografische interviews en de survey – onderzochten we de relatie tussen leeftijd en CPO.

In **Hoofdstuk 2**, bleek uit het focusgroeponderzoek dat verpleegkundigen en leidinggevenden verschillen in CPO van jongere en oudere verpleegkundigen waarnemen. Zij zien verschillen in focus: oudere verpleegkundigen zouden meer focus aanbrengen in hun professionele ontwikkeling dan jongere verpleegkundigen voor wie de wereld nog open ligt. Terwijl oudere verpleegkundigen zich vooral richten op ontwikkeling 'rond de patiënt', gebruiken jongeren en middelbare verpleegkundigen CPO ook om mogelijkheden te creëren om 'het bed te verlaten'. Sommige jongere verpleegkundigen worden als ambitieus gezien, wat bij meer ervaren en oudere verpleegkundigen tot ergernis kon leiden. De vraag naar carrièremogelijkheden geeft hen het gevoel dat hun werk niet interessant genoeg is. Verder werd aangegeven werd dat jongeren en ouderen de beschikking hebben over dezelfde middelen, maar soms zijn de verwachtingen ten opzichte van ouderen wel lager. Oudere verpleegkundigen gaven daarnaast aan dat er een 'plafond' in cursussen kan zijn: bij veel ervaring en een hoog expertiseniveau kunnen bijscholingen een beperkte toegevoegde waarde hebben.

In **Hoofdstuk 4**, lieten de biografische interviews, naast de overeenkomsten die bij topic 3 zijn beschreven, ook verschillen zien in de CPO-strategieën die jongere, middel-

bare en oudere verpleegkundigen hanteren. Deze verschillen lijken gerelateerd aan verschillen in loopbaan- en levensfase. De professionele ontwikkeling van jongeren wordt gekarakteriseerd door intensieve leerperioden: zij zijn bezig expertise te ontwikkelen als verpleegkundige en in een verpleegkundige specialisatie. Daarnaast vormen loopbaanontwikkeling en taakverrijking motieven voor ontwikkeling. De toekomst lijkt open voor deze verpleegkundigen: als het werk geen uitdaging meer biedt, dan willen ze iets anders zoeken. Deze bevindingen ondersteunen die van Hoofdstuk 2.

Bij de middengroep is het balanceren van privé en werk meer een issue dan bij de andere groepen. Voor sommige verpleegkundigen kan deelname aan CPO-activiteiten, die met name buiten werktijd vallen, hierdoor lastiger zijn. Voor een aantal verpleegkundigen is de thuissituatie een reden om deeltijd te gaan werken. Kleine dienstcontracten blijken soms een belemmering om bij te blijven. Daarnaast speelt bij sommige verpleegkundigen in deze groep het vraagstuk hoe het werk na jaren werkervaring interessant en gevarieerd te houden. Sommigen bereiken dat door extra taken of andere rollen toe te voegen, anderen zoeken uitdaging door een opleiding te gaan volgen.

Ten slotte speelt bij de groep oudere verpleegkundigen een ander thema: 'lekker zo blijven werken'. Deze verpleegkundigen hebben vergelijkbare issues doorgemaakt als waarmee de jongeren en middelbare verpleegkundigen nu worden geconfronteerd, maar zij zijn nu op een punt beland dat ze gewoon zo willen blijven werken. Dit betekent niet dat ze onverschillig staan tegenover verdere ontwikkeling, maar dit zit voor hen vooral in kleine dingen: het leren van een nieuwe verpleegtechnische vaardigheid, iets om het werk verder te verbeteren of een interessante cursus gerelateerd aan het werk dat ze uitvoeren.

In **Hoofdstuk 6** laten de resultaten van de survey zien dat leeftijd gerelateerd is aan het ondernemen van leeractiviteiten en op de motieven voor professionele ontwikkeling. De gevonden correlaties zijn significant, maar klein. We vonden dat hoe hoger de leeftijd hoe minder belangrijk de onderzochte motieven voor professionele ontwikkeling zijn voor verpleegkundigen (professionele kennis, voldoen aan eisen, doorbreken van routine, en professionele ontwikkeling). Een hogere leeftijd is ook negatief gerelateerd aan deelname aan leeractiviteiten. Oudere verpleegkundigen blijven nieuwe dingen leren door informele leeractiviteiten, maar minder frequent dan hun jonge collega's. Daarnaast neemt de deelname aan opleidingen, e-learning en korte, in het ziekenhuis georganiseerde leeractiviteiten met verhoging van de leeftijd af. Deelname aan cursussen blijft echter gelijk, en deelname aan teamdagen en conferenties neemt toe.

We vonden dat meer werkervaring, als verpleegkundige en op de huidige afdeling, vergelijkbare effecten heeft op leeractiviteiten en motieven als leeftijd. Dit suggereert dat de gevonden leeftijdspatronen voor een belangrijk deel voortkomen uit veranderingen in werkervaring. Dit ondersteunt de resultaten uit de biografische interview-studie

(Hoofdstuk 4) dat na een snelle groei in de eerste jaren van klinische ervaring, leren minder intensief wordt in latere loopbaanfasen. Verschillen in fasen van de levensloop, dat wil zeggen een thuissituatie hebben die het ondernemen van leeractiviteiten belemmert of thuiswonende kinderen hebben die jonger zijn dan 18 jaar, blijkt geen voorspeller te zijn van deelname aan leeractiviteiten en verandering in motieven. We zagen echter wel dat als verpleegkundigen meer uren per week werken, zij frequenter formele en informele leeractiviteiten ondernemen en dat alle motieven, met uitzondering van 'voldoen aan eisen' belangrijker worden. Dit suggereert dat de thuissituatie als zodanig niet tot verschillen in CPO leidt, maar dat dit een indirect negatief effect kan hebben door het diensttaakpercentage. Dit lijkt overeen te komen met de eerdere bevinding dat verpleegkundigen met kinderen die er voor kiezen een beperkt aantal uren per week te werken, minder mogelijkheden hebben voor continue professionele ontwikkeling dan hun collega's die meer uren werken.

Theoretische en praktische implicaties

In **Hoofdstuk 7** zijn de resultaten van dit proefschrift samengevat en de theoretische en praktische implicaties, de sterke punten en de beperkingen van het onderzoek beschreven. Ook worden aanbevelingen voor vervolgonderzoek gegeven. Hieronder beschrijven we een samenvatting van de belangrijkste theoretische en praktische implicaties.

Theoretische implicaties

Ten eerste toont dit proefschrift aan dat professionele ontwikkeling meer is dan deelname aan formele, door anderen georganiseerde, leeractiviteiten. Dit bevestigt eerdere onderzoeken waaruit blijkt dat de dagelijkse praktijk een belangrijke bron voor leren vormt. Een belangrijk reden dat het begrip CPO verwarring oproept zoals ook dit proefschrift laat zien, is dat er twee verweven, maar soms conflicterende opvattingen over continue professionele ontwikkeling bestaan. In de eerste is CPO het terrein van wettelijke registratieregisters, beroepsverenigingen, opleiders en werkgevers. CPO wordt opgevat als iets dat aan de professional geboden en zo nodig opgelegd kan worden. Vanuit deze notie wordt vooral gekeken naar formele leeractiviteiten die relatief makkelijk georganiseerd, gepland en vastgelegd kunnen worden. De tweede notie gaat uit van wat de professional definieert als leren. In dit proefschrift hebben we vooral vanuit dat laatste perspectief gekeken. Dan blijkt dat er soms een discrepantie kan bestaan tussen dat wat georganiseerd, verplicht gesteld of sociaal gewaardeerd wordt, en de leeractiviteiten die volgens de verpleegkundigen hebben bijgedragen aan de ontwikkeling voor hun werk.

Ten tweede ondersteunen de resultaten in dit proefschrift de stelling dat werknemers strategisch handelen in hun professionele ontwikkeling. Dit betekent niet dat dit altijd bewust gebeurt, of dat deelname aan leeractiviteiten altijd uit intrinsieke motivatie

plaatsvindt, maar verpleegkundigen blijken hun eigen route te creëren passend bij hun eigen doelen en interesses. Dit proefschrift is een van de eerste waarin relaties tussen leeractiviteiten en motieven zijn onderzocht. Dit biedt nieuwe inzichten in de professionele ontwikkeling van verpleegkundigen. Het laat zien dat motieven invloed kunnen hebben op het type leeractiviteiten die werknemers ondernemen. Classificaties van leeractiviteiten zullen dan ook formele en informele leeractiviteiten, op en buiten de afdeling en kort- en langdurend moeten omvatten, omdat deze leeractiviteiten vanuit verschillende motieven ondernomen kunnen worden.

Ten derde draagt dit proefschrift bij aan de literatuur over leeftijdsverschillen in CPO. Het laat zien dat een genuanceerd beeld ontstaat van professionele ontwikkeling in een loopbaan als naar verschillende type leeractiviteiten en motieven wordt gekeken. De resultaten tonen dat verpleegkundigen blijven leren gedurende hun loopbaan, maar dat hun motieven en leeractiviteiten veranderen en dat leren minder intensief wordt. Dit weerlegt stereotype beelden dat ouderen niet gemotiveerd zijn om te leren. Daarnaast bieden de resultaten ondersteuning voor een leeftijd-gerelateerde verschuiving in doelen, zoals voorgesteld door de Selectieve Optimalisatie met Compensatie theorie en de Socio-emotionele Selectiviteit theorie.

Tot slot laten de resultaten zien dat levenslooptheorieën helpen bij het begrijpen van de complexe relatie tussen ouder worden en het gebruik van CPO strategieën. Hierbij bleek dat bij ouder worden niet zozeer 'een jaar erbij' telt, als wel dat ouder worden veranderingen met zich mee brengt, die van invloed kunnen zijn op de motieven die verpleegkundigen hebben voor professionele ontwikkeling en de leeractiviteiten die zij ondernemen. In onderzoek naar CPO en leeftijd moeten dan ook verschillende perspectieven op leeftijd meegenomen worden. We vonden dat vooral meer jaren werkervaring van invloed is op motieven en leeractiviteiten. Ook vormde voor sommige verpleegkundigen de thuissituatie een belemmering voor professionele ontwikkeling. Dit onderstreept het idee van loopbaan- en levenslooptheorieën dat de behoeften van werknemers op verschillende punten in hun loopbaan kunnen verschillen.

Praktische implicaties

Het proefschrift heeft een aantal belangrijke praktische implicaties voor verschillende belanghebbenden. Allereerst kunnen de resultaten bijdragen aan het besef bij verpleegkundigen dat zij leren en ontwikkelen op meer manieren dan zij zich vaak bewust zijn, ook op latere leeftijd. Het scala aan leeractiviteiten en motieven uit dit proefschrift kunnen zij gebruiken om zich bewust te worden van waarom en hoe zij zich ontwikkelen: deze kennis kunnen ze gebruiken om hun professionaliseringsstrategieën meer gericht vorm te geven.

Ten tweede hebben de resultaten implicaties voor leidinggevenden. Zij spelen een cruciale rol in het creëren van leermogelijkheden in het werk en een goed leerklimaat. Gezien de

conclusie dat het dagelijks werk een belangrijke bron voor leren vormt, zouden leidinggevenden het leerpotentieel van de dagelijkse praktijk moeten herkennen en vergroten door onder andere het informele leren te stimuleren, bijvoorbeeld door mogelijkheden voor sociale interactie te vergroten en te zorgen voor informatiebronnen die verpleegkundigen kunnen raadplegen. Ook kunnen zij deelname aan formele leeractiviteiten vergroten door de organisatie van leeractiviteiten op de afdeling te ondersteunen en deelname aan leeractiviteiten buiten de afdeling aan te moedigen. Daarnaast moeten zij zich er bewust van zijn dat verpleegkundigen van verschillende leeftijden andere behoeften kunnen hebben en daar hun ondersteuning op afstemmen. In hun gesprekken met verpleegkundigen kunnen zij het scala aan leeractiviteiten en motieven, beschreven in dit proefschrift, gebruiken om verpleegkundigen te helpen de juiste leeractiviteiten te selecteren. Zij kunnen verpleegkundigen die de neiging hebben om hun werk te beperken tot wat ze altijd doen stimuleren om nieuwe taken uit te voeren en patiënten met complexere zorg op zich te nemen. En zij moeten bewaken dat verpleegkundigen met een klein diensttaakpercentage voldoende mogelijkheden hebben om up-to-date te blijven.

Leidinggevenden dienen zich er bewust van te zijn dat hun belangen en die van verpleegkundigen in CPO kunnen verschillen. Leidinggevenden ontkomen er niet aan dat zij sommige leeractiviteiten, bijvoorbeeld reanimatietrainingen, verplicht moeten stellen, maar zij zouden zich moeten realiseren dat deelname aan leeractiviteiten niet per definitie leren en competentie garandeert. Het stimuleren van continue professionele ontwikkeling zal meer moeten zitten in het aantrekkelijk maken van het aanbod aan formele leeractiviteiten en dat goed laten aansluiten bij de behoeften en motieven van verpleegkundigen. De zelfdeterminatie theorie (ZDT) van Ryan en Deci (2000) kan hierbij behulpzaam zijn. Het stelt dat mensen een natuurlijke neiging hebben om zich te ontwikkelen en dat de sociale omgeving dit kan stimuleren of beperken. Intrinsieke motivatie reguleert gedrag sterker dan extrinsieke beloning of straf. ZDT stelt dat intrinsieke motivatie behouden en gestimuleerd kan worden als aan drie voorwaarden wordt voldaan: de behoefte aan (a) autonomie, (b) gevoel van competentie en (c) verbondenheid. Dit betekent dat een eis om deel te nemen aan leeractiviteiten minder effectief zal zijn dan een verzoek waarbij een reden wordt gegeven, er ruimte is voor eigen keuzes en zo tegemoet wordt gekomen aan de behoefte aan autonomie. Een gevoel van competentie refereert aan de behoefte van verpleegkundigen om deel te nemen aan leeractiviteiten die bestaande competenties versterken. Leidinggevenden moeten bewaken dat leeractiviteiten niet te moeilijk en niet te makkelijk zijn. Het benadrukken van het 'repareren' van tekorten zal intrinsieke motivatie niet erg versterken, maar het stimuleren van verpleegkundigen om na te denken hoe ze kunnen uitbouwen waar ze goed in zijn wel. Ten slotte refereert een gevoel van verbondenheid aan de behoefte om verbonden te zijn met en te horen bij een groep van mensen die belangrijk worden gevonden. Een werk- en leeromgeving creëren waarbij verpleegkundigen zich geaccepteerd en gewaardeerd voelen door hun leidinggevenden en collega's zal de intrinsieke motivatie om te leren stimuleren.

Een eerste aanbeveling voor opleiders is om te bewaken dat leven-lang-leren vaardigheden, zoals reflectie en leervaardigheden, een plek hebben in de curricula van verpleegkundige (vervolg)opleidingen. Het onderwijs speelt een belangrijke rol bij het opleiden van verpleegkundigen tot professionals die zelfgestuurd vorm kunnen geven aan hun leren. Voor oudere werknemers die deze vaardigheden onvoldoende bezitten, kunnen opleiders aangepaste trainingsprogramma's maken. Daarnaast is het een uitdaging voor opleiders om bijscholingen te organiseren die aansluiten op de behoeften van verpleegkundigen met veel expertise. Ten slotte moeten opleiders en human resource development (HRD) professionals nieuwe benaderingen ontwikkelen die het leren op de afdeling beter ondersteunen.

Beleidsmakers, beroepsorganisaties en ziekenhuismanagers hebben een verantwoordelijkheid om het goed functioneren van verpleegkundigen te garanderen. Benaderingen die hierbij worden gebruikt, zoals het accrediteren van leeractiviteiten, richten zich vooral op formele leeractiviteiten. Dit proefschrift laat zien dat veel cruciale leerervaringen plaatsvinden in het dagelijks werk. Reguleringsmaatregelen die zich alleen richten op het registreren van deelname aan formele, geaccrediteerde leeractiviteiten bieden onvoldoende garantie voor leren en kwaliteitsbewaking. Er zullen dus benaderingen ontwikkeld moeten worden die zich richten op zowel formele als informele leeractiviteiten, en die zich richten op het vaststellen van continue competentie in plaats van deelnamecijfers.

Tot slot

In dit proefschrift hebben we getracht te verhelderen waarom en hoe verpleegkundigen zich professioneel ontwikkelen gedurende hun verpleegkundige loopbaan. Door gebruik te maken van inzichten uit de CPO literatuur en levensloop theorieën, en door toepassing van verschillende onderzoeksmethoden draagt dit onderzoek op drie belangrijke manieren bij aan eerder onderzoek. Ten eerste, door te laten zien hoe verpleegkundigen zich professioneel ontwikkelen, onderschrijven we het pleidooi om CPO-benaderingen zowel te richten op formele als informele leeractiviteiten. Ten tweede, door te focussen op motieven en leeractiviteiten, ondersteunen onze resultaten de notie dat medewerkers strategisch handelen in hun professionele ontwikkeling. Ten derde hebben we laten zien dat er overeenkomsten, maar ook verschillen zijn in de CPO-strategieën die verschillende leeftijdsgroepen hanteren. Deze verschillen in motieven, formele en informele leeractiviteiten lijken gerelateerd te zijn aan jaren werkervaring, loopbaan- en levensfase. Met dit proefschrift willen we bijdragen aan verder onderzoek en nieuwe ontwikkelingen op het gebied van professionele ontwikkeling, zodat verpleegkundigen zich zodanig kunnen ontwikkelen dat zij gedurende hun hele loopbaan patiënten de zorg kunnen bieden die ze nodig hebben en verdienen.

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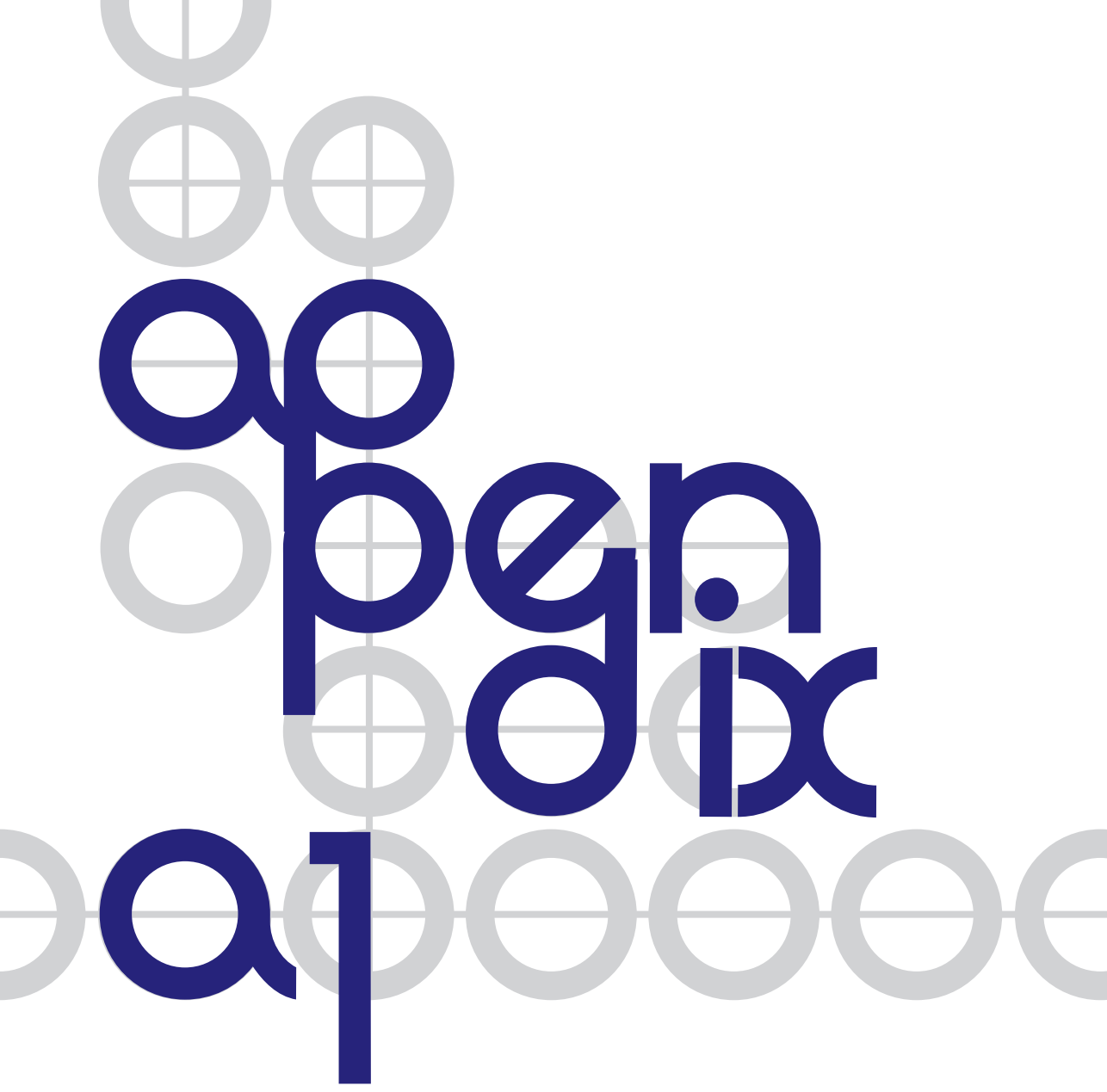
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Six learning biographies

Introduction

In this appendix, we include six of the 21 learning biographies (see Chapter 4) to provide an example of the interwoven relationships between life, work and professional development and an illustration of CPD strategies in three age groups. Nurses gave permission to include their learning biography in this thesis.

Female, 24
3 years and ongoing experience in an oncology department

> At the moment I'm learning so much that I can't think straight about what else I could learn. I am learning a great deal.

Nursing training

After primary school I went to a secondary school to do 'havo', and left after five years with a certificate in senior general secondary education. I knew I wanted to do something in healthcare, so I chose the subjects for the Science and Health exam profile. Several people in my family work in healthcare, including my mother. I found it difficult to choose between the course for anaesthetist assistant and general nurse, but when in doubt you're advised to opt for general nursing. I did the full-time bachelor's degree in nursing. If you do the dual degree programme, you're trained in the hospital, but I didn't know which specialism I wanted to follow, so I preferred to do my internships in various different healthcare settings. I did internships in psychiatry and in the hospital training department, and in a nursing home too, where I did some research together with a medical student. Newly qualified dual students have more bedside experience, but I caught up by doing a six-month internship in a practical training department. After I qualified, I could continue working in that department for the summer months. Until there was a vacancy here; I've been working here for almost three years now.

Working in an oncology department

At the time there were several vacancies, but this one appealed to me the most. Oncology was a good choice. Here, you need to use your analytical skills. Perhaps I'm biased, but I have the impression that the work is easier in a surgical ward: people come for an operation, you know what needs to be done and when they will be discharged. In this department you often don't know what's wrong with the patient when they arrive. You have a great deal of contact with the doctors, you do the ward rounds together, you contribute and think along with them. Oncology is often complex.

I have some extra duties. I'm one of the five care coordinators; we ensure that any gaps in the staffing schedule are filled, coordinate patient admissions and lend a helping hand where needed. If the team leader isn't there, you're the contact person for the department. I'm also the relocation coordinator. I spend one day a week preparing the move to the new building. It's a busy job, but I do enjoy it, it makes a pleasant

change. I work 36 hours a week, and that is quite a lot. Bedside nursing is physically demanding: it involves a lot of lifting and is always hectic. A day spent in meetings is easier physically.

Postgraduate training

When I had been working here for six months, an opportunity arose for me to indicate that I wanted to do the postgraduate training to become an oncology nurse. I had noticed that I could not do everything for patients, and I'm a bit of a perfectionist. I had plenty to learn in the department, but I wanted to get more out of it. I saw what you could learn in the training position and thought that that knowledge would serve me better now than in ten years' time. I had the impression that I would find my work more rewarding if I did the extra training because I would be able to do more for the patients. And if a patient asked me something, I wouldn't have to say "I'll ask". You know more about the treatment and you can help patients better. You also learn about the surrounding network, so that you're in a better position to refer patients. Colleagues explained that they had gained a great deal from the course. It appealed to me, but I'd only just started here. I was afraid they would think I was too ambitious if I wanted to do a postgraduate training course within a year. But other people said "don't be ridiculous, of course you should do that, see whether they'll take you on". So I applied. I did the course together with a colleague who has been working here for 25 years. We were a good combination. She could learn a lot from me when it came to writing reports and conversely, I benefitted from her knowledge. My colleague already knew a lot about the technical aspects, naturally, but for example, she learned how to look things up in scientific publications. You also get to know people from other hospitals, so you build a network that you can consult if you have queries. Whether the training course means I can make a contribution to the team? This is primarily in the form of knowledge sharing. Now it is easier for me to answer questions and coach students.

Learning within the department

The training and education department has developed a six-month oncology module encompassing six days of classes, assignments, knowledge tests and an assessment meeting. Some of the stuff covered in the lessons I knew already, because I had qualified recently, but everybody had to do the module. It was still fun. Our own doctors gave lessons; that's quite different from the postgraduate training where I didn't know the doctors. During the course you get to know the doctors in a different way, and when they referred to a case, everyone knew what it was about. The knowledge test was still nerve racking, that was a tough test. I had just completed the oncology training and, of course, I didn't want to fail.

In addition, on Mondays we have clinical reasoning. Someone presents a case which we then discuss. Everyone is expected to contribute a few times a year. I think it's good to do this. You learn from each other and sometimes it provides a confirmation of how

you tackle something yourself. On Thursdays, we give clinical lessons ourselves or have someone from outside the department come in to teach. For the nurse-plus training we can suggest topics and then someone will talk about that, for example, a technician from the lab. That's interesting too, because these sessions are usually about things you encounter in your daily work. In addition, once every two months we have a referral evening and if we've had a difficult case, we have an intervision session. Once a year we have a mandatory general intervision session, because oncology is a tough discipline.

I've also done a course for restricted activities. You have to do a CPR course every year. If you don't feel confident about something, you can do extra training in the skills lab. I get the impression that much is organised for continuous learning here and that the doctors also consider it important that people have additional qualifications. If you have an idea, you're given the space and time, and they invest in you.

Learning outside the department

A training plan is drawn up each year. Within a specified budget, there are places available for seminars, conferences and courses. You can indicate where you would like to go and then it's decided who attends what. Afterwards, you're expected to give a presentation to colleagues. I saw a three-day course on immunotherapy. That appeals to me, but I've already done so much this year. My turn will come.

But I did go to the oncology conference. The presentations were informative. Not everything is new, but that's okay. For instance, it was about the cost of a treatment: that can be quite a shock. Sometimes you also learn little things, such as a drug for patients who are dying to alleviate death rattle. Now I know I can mention this to the doctors at some point. I also followed a workplace trainer course. I've just qualified and I know the educational system, but I need to be able to take on the role of coach. You learn lots of tips during this course.

Important learning moments

My career is still young. The nursing bachelor's was an important phase. You learn a lot at secondary school, but you make a conscious choice for the nursing degree. You learn for your profession. You don't have to do that all your life, but you do choose for the future. Everything I've done since is a sequel to my nursing degree. This is the foundation on which I am building. I can understand that sometimes people change courses. You're 16, 17 and you have to choose something for the rest of your life.

Actually, I think life is all one big learning experience. I'm someone who looks up a great deal during a course. I'm a little less fanatic about that now, but I think that as a nurse you should continue to learn. When I'm at home I use the computer to look things up, for example about clinical conditions or treatments, because I find it interesting. The library sends me the tables of contents of journals, and so I can request an article that interests me. Sometimes I will mail that on to my team leader, so it can be included in the weekly e-mail to the team.

You have to keep learning, because patients are becoming more complex and there are so many innovations. If you consider how many new treatments have been introduced in the few years that I've been working here, you really have to delve into the details, otherwise you lose track. Some developments come to you automatically, such as a new protocol that you have to learn. But I also think you should take a proactive approach to keeping up with professional aspects. Other professions have to keep abreast with developments in their sector, and the same applies to nursing. I receive the 'Nurse Academy' journal four times a year, the hospital offers this service; it's not something you let pass you by. It's good to read about what interests you, your job, and the journal contains practical articles.

Important learning moments for current work

You do internships during the postgraduate training. In this period you have more time to grasp learning experiences. Even now you go and sit with a patient, but if you're a student having more time, you do that more consciously and you really make time to chat with someone. Then you can go more in-depth into something. That was important to me. I've learned what people may be going through and I can now act more appropriately. We also had to work out certain cases and assignments in detail. This is when you discover more than you had imagined. If you've never done that, you don't know that you can go to that depth, and when you've done that a few times, you have a tendency to do that more frequently. I can see that I'm developing. I remember thinking when I just started: those nurses know a lot. Now, two and a half years later, I notice that I know quite a lot too. When I'm 40, I'll know just as much as they do now and I realise that I don't have to know everything.

Milestones

It's not easy to say what the milestones are. Perhaps getting qualifications counts, but I wonder whether that's a true milestone. I don't have a specific goal that I want to achieve. I'll stay here as long I still get satisfaction from this job. I think I can be proud of myself that I've got this far already. If you see what responsibility I'm given, then I'm not doing badly considering I've only been qualified for two and a half years. But that doesn't feel like a milestone either. A milestone is something grand.

When did I get given other responsibilities? When I became care coordinator and relocation coordinator. You have a great responsibility towards the patients when nursing on the ward, but working on the new building project or for the department involves a totally different kind of responsibility. This involves meetings with the team leaders.

In healthcare, we work with junior and senior staff on duty. You always have to have a senior on duty during the evening and night shifts. If you're a junior, that means you're on the oncology ward, but not yet on haematology. When you first start working here you follow the familiarisation programme. When you're ready, you're planned on well-staffed shifts for three weeks and so you'll have time to familiarise yourself with the ins and outs of the haematology ward. After that you'll be scheduled as senior in the shifts.

By then, you're able to do everything, except if you don't feel competent. There are some procedures that I do so infrequently that I prefer to have someone watch what I'm doing, or I want to be trained to do this first.

A few months ago my job title changed to 'oncology nurse', this also means a higher salary scale. You're not automatically appointed to this position if you've done the oncology postgraduate training. You have to show that you're using what you've learned. It's not sufficient to indicate that things aren't going well, you should make suggestions to improve the situation. Also that is another type of responsibility: not so much towards patients, but for the department. You feel appreciated; because they see what you're doing. <

Because I'm busy with the relocation, I'm getting to know the organisation from a completely different point of view. Normally, you just focus on your own department, but now I'm building a network in the whole hospital. You also see how other people do certain things and I can apply that to our department. You learn to look further. Here, we occasionally grumble if something hasn't been replenished, but now that I know that the logistics department can't fix everything at the drop of a hat.

I still feel that I don't have much experience yet, I'm still learning a lot. For example, when I've done an ECG and still don't fully understand how it works. So I ask the doctor to explain it to me. You also learn when a patient arrives from another specialism that you don't know so well, and it's then that you learn most by looking things up or asking the doctor.

Future

I've no idea what I'll be doing in five years' time. That was something I was asked during my appraisal. I like working in healthcare, but 36 hours of bedside nursing a week is quite demanding. It's nice to occasionally have a day doing something else. I think that if I only do patient care, my job satisfaction will eventually diminish. I need to do something extra. It's interesting to think along with others about matters. Here, we have 'plussers'. They do patient care and in addition they arrange all sorts of things, for instance regarding quality or training. Such a combination appeals to me. When we've moved, I won't have any extra tasks, but I'm sure something will cross my path when the time is ripe.

How do I want to develop further? I could become a nurse practitioner, but I don't think I'm ready for that yet. Perhaps that's something for the future. I've already done quite a lot and now I want to take things easy. I'll just carry on here and see what appeals to me. There's so much I'm still learning at the moment. I'm right in the middle. I don't have the peace of mind to think about what else I would like to learn. I more or less rolled into this job, and I'm enjoying it tremendously. I think I'll stay here as long as I'm still enjoying it, and then I'll see what opportunities cross my path.

Female, 27
4 years and ongoing experience on a paediatric ward

> Some of my colleagues like the idea of going home at four o'clock and closing the door behind them. They basically do what is required, but nothing more. I like going the extra mile.

Student years

I started secondary school in pre-university education (vwo). I wanted to become a doctor, but when I stranded in the fourth year of vwo and had to take a step back to senior general secondary education (havo), I knew soon enough that nursing was the next-best option. In hindsight, I would never have wanted to become a doctor. Doctors have much less personal contact and limited time for patients. Another factor was my mother, she used to be a paediatric nurse, that may have influenced me somewhat. It took me a while to accept that I wasn't going to become a doctor, but in the end I've found that this suits me well. I went to do a degree in nursing (hbo-V) and moved into lodgings after one year. When I first started studying, I had a part-time job as a caregiver in a residential care facility. I thought this was a good opportunity to gain some extra experience. After that, I worked part-time for three years in a group home for mentally handicapped after I had done an internship there. In 2008, I met my partner. While I was studying, I was actively involved in the faculty's students' association. I took a pro-active approach and organised events. That is what I do for our ward as well; I think I make more effort than my average colleague who has been here just as long as I have. I enjoy taking part in things and I attend as many events as possible.

Postgraduate training

After I qualified as a nurse (hbo-V) I could stay on and work in the department where I had done my fourth internship. I wanted to work on an adult ward for a year or so to gain experience. After a year, I was ready to choose my specialism and postgraduate training. I had always wanted to become a paediatric nurse. During my time with the group home I had thought about what I wanted to do once I had qualified. I didn't want to continue working there, because I'd be one of the few people with a bachelor's. I really enjoyed the hospital too, and after a day on the paediatric ward I knew for sure. As paediatric nurse you have a lot of contact with patients. Babies generally stay in the neonatal ICU for quite a long time, sometimes up to two months. Children in paediatric wards don't stay that long, but an average of five days is usual. If you work full time, you see your patients for several days.

Specialising within a position

Pretty soon after the postgraduate training, I decided to take the EPLS (European Paediatric Life Support) course. After the postgraduate training you become shift supervisor. During these shifts you have a high level of responsibility, especially because there are

many students working there at the same time. When a child in a bad condition arrives, you have to be able to act on a lot of things. I didn't experience that much during my time as a student. I joined the CPR working group and took the EPLS and in-house emergency response (BHV) courses. This was my opportunity to specialise. I want to be well prepared and be able to say: I don't mind having the pager. As a member of the working group, I teach colleagues. We keep the CPR policy up to date and have a rucksack, equipped for child CPR, readily available. Some of my colleagues like the idea of going home at four o'clock and closing the door behind them. I like going the extra mile. Especially because it is so rewarding. Patient care is directly rewarding, of course. Going the extra mile on the ward isn't necessarily, but teaching is. Colleagues are pleased with the fact they get trained extensively once a year.

What I like about our department is that all this is possible. So, when someone was needed to do a week's CPAP internship with a neonatal intensive care unit in a university hospital, I jumped at the chance. Once or twice a month, we have a child admitted to the hospital that requires CPAP respiratory support. I more or less automatically joined the CPAP working group afterwards. In practice, I have rarely had to give CPAP treatment to a child, but when you teach, you get to practice and brush up your experience a few times per year.

Recently, I stood in for the preceptor during her maternity leave. The preceptor is responsible for everything to do with training. I went to a train-the-trainer course for preceptors and took a course for workplace trainers too.

Important learning moments

You have to do the paediatric training: but during this course I couldn't excel in anything specifically. However, the EPLS course and the teaching have made a difference to my performance on the ward and increased my knowledge. I was really glad that I was given the opportunity to be preceptor for four months. I can include that in my CV, should I ever aspire to apply for a similar position. It's good to know that I like the job, but I just don't fancy an office job like that just yet.

Because of my role as preceptor, I'm very much aware of what's going on. I love being involved in everything. Sometimes I wish I didn't, because you don't make things easier for yourself. If you go beyond taking care of infants and parents, you're under more pressure. The more you take on, the more e-mails you receive.

Becoming an expert through experience

Important learning moments that have enabled me to do a good job in my current position? Actually, time has been one of them. One of the things I like most about our department is that you can become an expert nurse in a short time. That isn't possible, for instance, at a university hospital because it's so specialised. When you keep up with everything and dedicate yourself to your job, you keep abreast with everything. People who only work three days sometimes miss things. The more time you spend at work, the more you know. The first year after I had graduated, I already had a lot

more experience, but now, four years later, I really do have a lot more experience. That makes it challenging. I feel that I'm able to anticipate exceptional situations better now and know the answers to questions students may have.

On-the-job learning

I keep up to date by following the e-learning modules for restricted activities. You need to follow these every three years in order to remain qualified and competent. Some just involve a theory assessment whereas others involve a practical test as well. They are easier now than they were the first time round, because I'm experienced. I think they're good refresher courses. Each year, everyone has to attend one symposium and teach one clinical lesson. That is what we strive for, but that's not what everyone does. I've been to a few symposiums. Two of them were about newborns and covered two different clinical conditions that I now know a bit more about. You get your expenses reimbursed, but you do have to teach a clinical lesson about it.

I've started to maintain my own dossier in the V&VN[1] quality register. When starting out as a paediatric nurse, you do so many things without really noticing, such as these modules. You get loads of credits for doing a paediatric training course, but you also get credits for attending symposiums and teaching clinical lessons. It's difficult to keep track of all this yourself. If I ever apply for a different job, I'll have a good overview of what I've done.

You do learn every day, but you learn the most from exceptional things. Recently, a baby was born after a normal length pregnancy, so you would expect the baby to do well, but in this case, it didn't. So, you have to work closely with the junior doctor and the paediatrician. The girl is one week old now. Yesterday, we talked about her during the ward round and that's when you can see the progression. You can put the pieces of the puzzle into place and see the whole picture. You do that together with the junior doctor and your colleagues. After the event I think about whether or not I could have started something up or reduced treatment sooner. If it's all blossom and flourish with a baby, you just work on your routine. But I did have do a lot of hard thinking for this girl. To me, this is all experience. Some nurses know a lot, because they do a lot. When the work gets distributed at the start of a shift, they're willing to admit a new patient or take on the care of specific infants, whereas others choose what they're familiar with.

The quality register doesn't enable you to keep track of your experience, but colleagues know what to expect of you. Some colleagues are of more use in a night shift than others because they're more experienced, have more in-depth knowledge and keep calm. You don't need to have years of experience. I prefer a shift together with a student, who still looks up a lot and is open to information, to a shift with someone who has worked for thirty years, comes two days a week and is less enthusiastic about new things or emergency situations. If someone says, "It has been a long time since I last put a child on CPAP", I think they could have done something about that themselves.

1. The professional association in the Netherlands for nurses and carers.

Milestones

This is my first real position as a paediatric nurse. I still have 40 years ahead of me, so I don't want to start aiming for the highest level too soon. I see small milestones such as the courses I have taken. Everybody does these e-learning modules, but because I'm an in-house emergency response team member, EPLS-trained and because I've been a preceptor, I have gained a lot of knowledge. If I were to explain to my team leader what else I do, it would be these three things.

Whether I can sketch a picture of major milestones? If I look at getting ahead, then I've been in a general hospital for more than four years now. After my internship, I realised that I didn't want to move to a neonatal intensive care unit (NICU) just yet, but at the same time I don't expect to be working on a general hospital paediatric ward for the next 40 years either. Moving to a NICU or PICU (paediatric intensive care unit) means you're in a specialist hospital as well as in a department giving the most acute care. I consider that to be the most challenging job, but when you get tired of that, then going back to a normal department would be boring. I think it would be a shame to move there too soon. And to be honest, I'm not quite sure in which direction I want to go.

If moments when I was given different responsibilities count as milestones, that would count for my position as preceptor too. I was between the team and the team leader. My scope of work was broader and I had meetings with team leaders, the training department as well as other hospitals.

As a paediatric nurse I was given more responsibilities three months after qualifying. You run responsible shifts, you're the day-coordinator and during weekends and nights, you're in contact with the doctor about whether or not another child can be admitted. You may also be running a night shift together with a student. In that case you carry all the responsibilities of a registered paediatric nurse.

Who have I learned a lot from?

I've learnt a lot from my workplace trainers. The workplace trainer I had in the neonatal ICU department has retired now. She was such an experienced NICU nurse. She taught me all the useful little things. There was another workplace trainer I thought highly of. She was pretty strict and told me I couldn't go ahead and do something unless I really knew the ins and outs. That makes you take your responsibilities seriously and so look things up to check before you do a procedure. That's how I approach students myself now; it's not a cross-examination, but I do ask them to tell me what they will pay special attention to.

Future

I'm not sure yet in which direction I want to go. When I held the position of preceptor, I thought it would be a good job for later in life, when I'm done with the chaos and pressure in health care. My internship at the university hospital made me realise that

this hospital suits me well. You're in contact with parents and baby from delivery to discharge and you're looking ahead, whereas in the other hospital, it's more a matter of life and death and that's not what I want right now. I enjoy the emergency aspect as much as I enjoy coaching parents and trying to get destabilised children back on track. I may decide to go and work at a local clinic for infants.

I'm considering my private life here too. I'm getting married in September and I would like to have my own children. I feel you shouldn't want to do everything at once. Some people decide to get on with their careers first, but when you get round to wanting a family, you might not be able to conceive. Right now, I'm putting my own life first. There's still so much to do and learn in my department. I enjoy teaching and being the colleague who knows a lot. So I think I'll stay here for the next five years, but that also depends on my private life. Once I have children, I'd like to work part-time, 2 or 3 days a week.

What I would like to see change, is the salary. After you've completed the paediatric training course, you move to a different scale where you start at the bottom. You take on a lot, but you have to do that for yourself, for your personal satisfaction. My 42-year-old student earns more than I do, because she has more than 10 years' nursing experience. One doesn't have to be a paediatric nurse to earn more.

Whether there are any areas in which I would like to develop myself further? That is the danger. Although I can't say: that's what I want to achieve. There's enough going on in our department, there's always something to get my teeth into or improve, but these small things are dealt with in small working groups. Whereas in health care, it's the bigger things that could do with improvement. Whether you can keep developing yourself after ten years in this department? No, I don't think so. You can broaden your experience. If I'm still working here in ten years' time, then that will be just to make a living and because I like the job. Looking after infants and parents is very rewarding. A university hospital offers more opportunities for career development. Where I work now, I'd be able to work in high care neonatology (HCN). That would be an enrichment, but it wouldn't offer me any added value, because the daily care consists mainly of medium care, and high care only every so often. And I know so many additional things already thanks to the EPLS course.

Female, 37
9 years and ongoing experience in an oncology department

> Eventually, I'd like to do another training course, but I'm waiting until my children are a bit older.

Career

I started my nursing degree when I was 24 after I had left some other courses prematurely. I didn't really know what I wanted to do. My mother recommended nursing; she was a nurse, but I didn't think it would be for me. But when I was working in a restaurant, I thought it would be good to do more for these women using walkers than to just serve them food. I will never forget that someone said to me during a job interview that I shouldn't quit immediately if things didn't run smoothly. So when that happened in my second year and quitting was the only thing I could think of, that's what I remembered.

After qualifying, I was able to start work here. This was a team I thought I could I could learn a lot from. People here are quite outspoken and I'm not, so I can lean heavily on them. The first year was difficult, but it went well. After a year, I was promoted to a higher scale and was given responsible shifts. When senior positions came available here, I openly maintained a high profile and within six months, I was asked to become a senior. Although it was what I wanted, it soon became too much for me. I didn't feel fully at ease in the department, I was doing the postgraduate training oncology and I also had a miscarriage at the same time. After a year, I quit my position as a senior. I completed the oncology training just before my first baby arrived.

I wanted to work elsewhere, but when it transpired that they couldn't guarantee fixed working days, I chose for peace of mind in my family and work. I decided to stay here. My second baby was born 18 months ago. I haven't done any more courses, although I did do refresher courses and I've gained a lot of experience here as a nurse and I've developed personally too. This is a safe environment for me, because I have known everybody for a long time.

The decision to become a nurse has been a good one. I like working with people and looking after them. You're responsible, but you never have the final responsibility. I enjoy working in a team: you can always discuss things with someone else. And the structure of the day forces you to do what's needed. I have good ideas, but I'm a bit of a procrastinator. As senior I have noticed that I'm alright managing things, but I'm not the one to take the lead.

Work–life balance

My work and private life are intertwined. When things are going well at home, I'm doing well myself and that is reflected in my work. I find it difficult to see it all separately. I desperately wanted to be pregnant, so when I was expecting, things went well. Later on, when my second baby didn't sleep through the night, things went wrong at work.

I haven't been on sick leave, but I did have to take a step back and to a certain extent, I now disassociate myself a little from what is going on at work. I couldn't quite handle nursing patients who were dying while I was having a baby. It's difficult to take care of this type of patient time and time again and hold my own at the same time. I do try to develop myself as a person all the time.

My partner works split shifts. When I get home, he comes home for dinner and goes back to work again afterwards. I put the children to bed. It's all running smoothly. I work three days a week, but at the moment, I'm on parental leave so I only work two and a half days a week. I want to see my children grow up and I like to keep our house tidy. I can't work four days a week and still do everything I want to do at home. When my youngest goes to school, I'd like to work more hours and perhaps take on something else. I'll give myself some more space again, then.

Whether I need to focus extra on keeping abreast because I only work two days a week? That's the feeling I used to have, but my mum said: "You've worked full-time for so long and you have so much experience, you'll keep up". And I do. And if something does change, a protocol or medication, I actually pick that up quite quickly, so I don't have any difficulty keeping abreast. Working two days a week does mean I'm working a bit more in the background. I've just done two weeks of four days a week and I must admit I'm more in the flow then, I speak up more and thanks to continuity, I can actually do more.

Postgraduate training oncology

In our department you can choose either the oncology or medium-care training. Oncology appealed more to me, so I had my name put on the waiting list. When I became a senior, they thought I shouldn't embark on this training, but I thought I couldn't become a senior without doing the oncology course. In hindsight, they may have been right and I probably would have been better off doing one after the other. But I wanted to do the postgraduate training, so I would have the qualification. I wanted to have that knowledge and the diploma. I like doing courses, looking things up and discussing them with a group of like-minded people.

Changes in the department

When I first came to work here, half of the patients had cancer and the other half had Crohn's disease, a colostomy, or minor stomach operations. I opted for the combination, but these days we only have surgical oncology patients. It's technical nursing with a lot of psychosocial care. The fact that everybody here has cancer is a burden, as is the fact that people die in a relatively short period of time. It's all existential, and that's fascinating, but demanding at the same time. Sometimes I fear I would get bored in a less demanding department.

Important learning moments

You learn something new here every week! Often just small things. You pick up a lot from what the doctors say and that helps you put the picture of the patient's clinical condition together. And you're learning all the time from your colleagues, too. On a personal level, I learn every day from patients too, and I keep experimenting with the best way to approach them. It was important for me to learn that I can engage myself as an instrument in patient care. And it was an eye-opener to me that I can come across empathically without actually taking things to heart too much. That's something I've learned through experience. There was this 35-year-old man who had about six months to live and he had an 8-year-old boy. I would typically have to leave the ward crying or it would cause me sleepless nights. Then, I just told him I was very sorry and talked with him like you're taught during the training and I tried not to take it to heart too much. Later on, I received a thank-you note and thought: "See, that's another way of doing it". I can keep my distance better now, not let things worry me so much. I'm able to just go home to my sons again singing out loud on my bike knowing I've provided good care today.

Each year, we have to take a number of e-learning tests about technical procedures. Nobody was looking forward to these, but actually, it's great fun. We take these tests together during a quiet shift. If there's a question you don't know the answer to, you look it up and discuss it. Together you delve deeper into your daily activities and the background to what it is you're actually doing. It's fun to find out that you know quite a lot already. You get credits for every test you pass, and you're given half an hour overtime. Whether I learn something new from this? Yes. Not much, but enough. It just makes you aware again of what you're doing. All small things. It confirms that you've been doing things right over the past few years. I still have to do the medical maths test, but I'm not looking forward to that, because I'm no good at arithmetic. But I do think it's important because you're working with people here.

You hear about clinical conditions, treatments and medication from the doctors. You hear things, without having to read it up in the journals yourself. I accept what doctors say, because I hold them in great esteem. Every so often, I read the nursing literature in our coffee room, but I don't subscribe and don't find it really interesting either. I actually do think I should keep abreast of nursing literature, but I don't make the time to read at home.

Whether I learn more from the information I'm supplied than from the information I actively look up myself? Yes, I do. And that shouldn't be the case, because I know how to look things up. Recently, I've become an active member of a working group again, but I can't say I'm very productive. They should actually make better use of my time, but to be honest I'm fine the way I am. I know the things you're supposed to know, like the site with patient care folders and procedures. And when students turn to me with their questions, I know most of the answers as well. But being innovative myself or making suggestions, I don't get round to that. What I would need for that? Maybe a talk like for this interview. Or a meeting with my team leader, but during those

meetings, these types of things don't usually get discussed. They ask you whether you do your e-learning and whether you're a member of a working group and that's about it. Due to the fact that I almost had a burnout last year, I also think: "There's a time for everything". But doing some extra reading or looking something up, doesn't really need a lot of extra energy, of course. However, you don't really get challenged to do that.

Crucial learning experiences to do current job

I did a dual degree programme and during the first year, I worked on a surgical trauma ward. That was one big learning experience. I had to touch people's bodies, and there were people with such extreme injuries that it made me cry. I also learnt a lot during my internship in psychiatry. I remember rounding it off and thinking: "Now, I'm starting to become a good nurse". What I've learned is to create order from chaos and to keep the overview. I learnt a lot in the four years between 24 and 28. That's when the foundations were laid for who I am today. And now I'm still learning because motherhood was added to my life bringing in different emotions again. It's overwhelming in a positive way, but also in a way that all of a sudden you're so vulnerable. I'm learning all the time, becoming more and more confident and less afraid to speak up. My colleagues are sticking up for patients and go against what the doctors say. I wasn't like that, but I wanted to learn how to be like that. Then I would stand next to my colleagues, because it made me feel stronger. At the same time, I could sometimes slow them down. I see that they achieve things. But I also see that for many things speaking up is not necessarily the way to go. I notice now that I'm getting older and being a familiar face around here, I can get doctors to do things for me too.

Milestones

I don't see any milestones. I think everything just progresses slowly but steadily. If milestones are moments when I was given new responsibilities, then the first time I was the responsible person during a night shift would count. I thought that was quite something at that time. Another milestone was my taking care of a dying patient. These first times are real milestones. I talk about them when I get home. Even now I appreciate the fact that – even though I'm only here for a couple of days a week – I get to look after a dying patient. These are the moments I feel appreciated. And when my team leader says she would like to keep me in the department, that too feels like I'm appreciated. Completing the oncology training felt like a milestone, too. The training as such wasn't difficult, but it had grown into a big thing, because I kept postponing working on my final assignment. Otherwise there are smaller milestones, for example just being aware of the fact that you've made steps in your personal development. But that happens gradually. It's more about the details. And I'm really happy that I do this work.

Future

Our youngest child is eighteen months old now, so I'll carry on like this for another two and a half years. By then I'll have taken all my parental leave and I'll go back to working three perhaps even four days a week. I will definitely start working on my personal development again, but I won't rule out that I start doing that beforehand. How do I want to develop myself? Preferably by doing another training course. I can see myself sitting at the table with a laptop in the evenings looking up things again. That's all on hold right now. I wouldn't mind some training right now, but if it takes more time than my current working hours, I don't fancy that. I have my life under control at the moment. You do learn from the e-learning modules and doctors, but I would like it all to be a bit more extensive and better structured and finishing with a good diploma. That diploma does matter in the end; it's something you can put on your CV and it gives you status. When I hear my partner explain to others that I'm an oncology nurse, that truly sounds good. What I do will also depend on what they're willing to sponsor from here. I wouldn't mind doing it all in my own time in the future, but I don't have the money to pay for it myself. I've spent my personal development budget for this year on the gym, but perhaps I could spend it on something else.

Of course you can develop yourself in different ways, but I like courses because you go back to a more school-like environment where you learn new things. And you get to meet other people. I can see myself specialising in one particular area, but I'm not quite sure which area that should be. There are many opportunities, but I must have to have the time to invest in those. Whether I will remain at the bedside? I think so. Nursing science or something sounds interesting, but then you're no longer part of a bedside team and I already know I'm not suited for working at a desk. Managing a team appeals to me too, but then – as the driving force – you have to be able to manage people and that's not me. Whether this is a department where people develop themselves a lot? I do have that impression, yes. We have quite some turn-over of staff in this department. If you've gained experience here for a few years, you can apply to the intensive care or the emergency room. There's a limit to the new things you can learn here. The new things that get introduced, come to you in small bits and pieces. They're easy to integrate into your normal work routine. The medi-um-care training appeals to me as well. Perhaps I'll be doing that between now and five years. Here, you can apply what you learn on the medium-care course, you attend during working hours, and you get to a few days internship. So, eventually, I'd like to do another training course, but I'm waiting until my children are a bit older. When they both go to school and we don't have a toddler running around the house anymore, I won't have to be at home either.

Female, 45
13 years and ongoing experience on a dermatology ward

> I always want to be challenged. That may not seem consistent with the length of time I've been working in this department, but I always look for my own challenges. And if it's not at work, then I look for them at home. Now that my children are grown up, I can move on.

Youth

I'm the youngest from a family of five. My father was often ill, so I visited the hospital frequently. Since I was nine, I've known I wanted to become a nurse. After five years at secondary school, I left with my havo (senior general secondary education) certificate and I consciously chose the in-service nursing education. I was under the impression that nursing was a profession that you mainly learn by doing, a practical training. If I were to start now, I would probably have done the full-time nursing bachelor's degree. As an 18-year-old in a hospital you're rather young to be faced with the many confrontational aspects of the work and in hindsight, a student life would have been great fun too. When I was 17, I wasn't only a student, I was also an employee and that sometimes conflicts with your own development. I think it would be a shame if my son, who is now that age himself, would start working full-time now.

Nursing training

I did my training in a military hospital and I had a great time there. I met my husband and I still have many friends from that period. Because many of the employees there were conscripts, the turnover was considerable and new people with new ideas were arriving all the time. I learnt the profession well there. I had always thought that it was very hierarchical in the military, but when I joined my current department, it felt like going back in time. The relationships at the university hospital were more hierarchical than those in the military hospital.

Nursing career

After I qualified I continued to work in the military hospital for eighteen months until they started downsizing. An open application landed me a job in the dermatology department, and in that same year I got married. I then worked full-time for four years and I did the postgraduate training dermatology. When my son was born, I resigned. After nine months of being a full-time mother, I started working again on an on-call basis. Two years later my second son was born. After four years of working on-call, during which time I had gained much new knowledge and experience because I worked in many different departments, my manager asked whether I wanted a permanent contract. I did want that, but only as long as I could plan my shifts in with those of my husband. Because of this we never needed childcare. I worked 40%, slightly less than two days a week. Later, I started to work more hours.

Last year, there was a vacancy for a senior nurse for three days a week. By then, my sons were 14 and 17 and I felt that it was my time again. I applied and did the assessment.

Dermatology

What is it about dermatology that appealed to me? It's an area in which people are generally independent. Here patients don't often need help to use the bathroom or wash themselves. This work is mainly about supporting the chronically ill, which is something I like to do. Physically, it's a field that you can keep up for a long time. The care is reasonably easy to plan, so you have time to spend with people, and I like that. What I like about a university hospital is that you get so many opportunities. I've been able to do all the courses I wanted to do.

In the past, I worked many evening shifts. Then you're less involved with the latest developments, those are mainly introduced during the day. And during the day, you have more meetings with doctors and you're more concerned with policy issues. Yet, I never had the impression that I was out on a limb. I've always read up on new developments and I did do some day shifts.

Postgraduate training and refresher courses

Before my son was born, I completed the postgraduate training dermatology and in the period that I worked two days a week, I did all sorts of short training courses and the medical foot care training. My husband had taken parental leave so that I could go back to school one day a week. I then went on to do a specialisation in foot care for diabetics. The department wanted a second person with this expertise. I was allowed to do the course during working hours and the costs were reimbursed. With my pedicure training I now have my own foot care surgery.

When I became a senior, I also did the corresponding training course. Before starting, you had to do an assessment to see if you had the bachelor level. That wasn't very good for my self-confidence. I did the five-year senior general secondary school (havo) and I know I can manage the bachelor's level, but I had to show that in an assessment. It was nerve-racking, but I passed with flying colours. And that was confirmation to me: 'see, you can do it.' At my age, you need that occasionally. I'm always nervous whenever I'm assessed.

The senior training course was given in-house and consisted of three training days and six intervision meetings. I learned a lot from this. I'm a real doer and from this I have learned to be more contemplative. I've learned a new way of thinking. How did I learn that? You have to read a lot of literature and do all kinds of assignments. A key learning moment was the analysis report that I had to write about how to safely prepare oral medication for distribution. Initially I thought to myself: "I'll buy one of those yellow hazard vests, put it on when I'm preparing the medication and then do the work according to the protocol". But my assignment was to analyse what actually happed in the department and to determine whether there were other solutions. That

yellow vest came to nothing. But that research was great fun and quite an eye-opener for me. I had never learned this during my in-service training. These days, students are taught how to get more out of the literature.

Important learning moments

I'm glad I continued working when my kids were small, even though it was only for a few hours a week. Some of my friends have had great difficulty returning to work after a few years' break. Much has changed in those few years, due to computers in healthcare and patients don't stay as long so you have to ensure that things happen more quickly. You become aware of what has changed when you realise how difficult it is for the others to re-join the profession. I've learned a lot just by doing my work.

That I've always continued working has made a big difference to me keeping abreast with developments. If there's something I don't know, I call a colleague. And you keep up by reading the specialist literature. In the department we have loads of journals, and you can read a lot on the Internet. During the past two years, the hospital has developed many e-learning modules. If there's something you don't know, you look it up. If fact, if you want to know something you can always find it.

Even during the years that I wasn't really concerned with my development as a nurse, besides doing the mandatory things such as refresher courses and keeping up with the literature, I still managed to keep abreast. I want to continue to develop but I do need new challenges. During that time, I did a lot in my private life. I was on the committee of a dance and theatre club and I helped organise events and manage large groups of people. Those were learning moments for me too.

Learning within the department

We're currently working hard on the maths for nurses e-learning module. The test is mandatory. These are the moments that I'm triggered to delve in and remind myself of the theory and when I get stuck, I seek out someone who can help me. I hate it when there's something I don't know – that is a form of failure, I think. I'm 45 and did my training a long time ago, but I want to be able to level with the young students. As a senior, I think I have to set an example. In the intervision sessions we had during the senior training, others often said they admired my enthusiasm and drive. I do have the drive to learn things, but I also take a vulnerable stance. I explain to students that my training was different, but that I want to learn.

What do I think of the e-learning being mandatory? Sometimes it's a good thing, because otherwise you can just avoid training, but the test at the end, that's not so enjoyable. It's also my own responsibility to ensure that I distribute the medication properly, but I understand that we have to pass tests because they have to be able to demonstrate what people do. I think it should be sufficient to show that you've done the module.

Crucial learning experiences to do my current job well

I can do my work well now because I've done the postgraduate training dermatology. What's more, we have refresher courses every year. Last year, I did courses about coaching students. Those were important learning moments too. I have developed a certain way of observing students. In the past I occasionally did a shift with a student, but now I coach a student from start to finish. You learn a lot from doing that. I assess their assignments and sometimes I get behind my computer to check the facts behind their claims. This year I did the venepuncture refresher course and I want to do the peripheral infusion training too. We have to do more and more for the doctors and then it's fine if I can do these procedures too.

Milestones

I think all the courses I've done are milestones: qualifying as a nurse, the postgraduate training dermatology and the pedicure course. The senior training was a big milestone for me. These are things that I've had to work hard for, that I've put a great deal of effort into and it's great that they result in a diploma. In addition, it's nice to notice that patients are comfortable being cared for by me. Enabling people to go home with a good feeling: those are the smaller milestones, I think. And sometimes you have those days that you can work comfortably in a flow.

All the courses are milestones, but the step from nurse to senior nurse feels like the biggest step. You're given other responsibilities as a senior. I really have learned a lot during the past year. I think it's an important position, because you're in between the team leader and the nurses. You have to set an example and you have to take the lead in new developments. My team leader treats me differently now: I'm better informed about everything that's going on. And because I've done the pedicure course, I do quite different work. Sometimes I may be with one patient for an hour and a half. There's only one other colleague in the department who can do this work. So when I got this qualification, that was a milestone too. I was very pleased.

People who have made a lasting impression

As a student I always looked to see which nurses I respected and then I adopted things from them. Those were people who were skilful or had a pleasant way of dealing with people. And there were some people who I didn't want to be like. This way I had created a picture for myself of a nurse. I encourage students to observe others in the same way. You can learn a lot from watching and listening. It's the same in this department. I have my way of working and others work differently, but their way is just as good. I endeavour to remain open to these differences. Through peer consultation and by discussing patients with colleagues I'm still learning from them. And from the multidisciplinary meetings, consultations with doctors, social workers and the like, you also learn a lot.

Future

How I see the next five years for myself? I hope to be in good health. As a common theme through everything, I know I can develop myself if things are well-organised at home. If something is missing at home, like there's no one to care for the children, or one of them is ill, then my comfortable world falls apart. During the past year I spent a lot of time with my mother. She was ill and had many hospital appointments; she died last January. This is one of the reasons why I didn't work longer hours in recent years. The boys are older now and need me less, but my mother needed a great deal of care too. That time is mine now. I'm getting more and more space to consider what I want.

As long as everything continues to go well, I see myself growing in the role of senior. I do that by doing the job and by bouncing ideas off colleagues. Perhaps I will do another course, but right now I don't know what. I've considered a management course, but I don't want to be a team leader of a team that I've been working in for so long. That would mean I'd have to move jobs, and I don't know if that's what I want either.

Why do I want to do another course? I want to carry on developing myself and I don't want to stagnate. My first thought is a nursing course, but perhaps I could learn a language. Now that everything is running smoothly at home, I would like to invest in myself again, perhaps I could work as a volunteer in a hospice. I really don't know – the opportunities are endless. I'll see what comes my way, but I'm not going to sit and wait, because then nothing will happen.

Whether I'd continue bedside nursing until I retire? I really don't know. I think I could stay in this department for a while, because it isn't so physically demanding. But whether I'll still be enjoying the work by then, I don't know. I like what I do, and it is challenging enough. Every day is different.

Female, 54
30 years and ongoing experience in ICU neonatology

> I don't work that much, just seven days a month. Because of that, keeping abreast is sometimes a little more difficult. If you work full-time, you take in new things automatically.

From when I was four years old, I wanted to be a missionary nurse. I went to a convent school; I wanted to work with children and go into nursing. However, the idea of becoming a missionary soon vanished, but the combination of children and nursing appealed to me. Some of my cousins went into nursing too. I did the four-year junior general secondary school (mavo) followed by two more years to obtain my senior general secondary education (havo) diploma and then I started working in a children's hospital. Now, that was a unique training. You started with a two-and-a-half year training course in the children's hospital followed by in-service training (A-nurse) in a general hospital. After that, you'd be able to qualify as a registered children's nurse within half a year. After qualifying, I worked at the children's hospital for about six months. Due to my husband's job we moved house and I applied for a job with a general hospital in a department that was called the climate chamber at that time. I was really fond of babies. I could have applied to any children's department, but this is where they were looking for staff.

Thirty years in a department that's continually changing

I've been working here for thirty years now. Over the years, the department has changed considerably. It used to be a normal neonatal department. We did give respiratory support, but we weren't a full NICU; however, we have been so for about twenty years now. Most people think it's boring to work in one department for thirty years. But a department like this is never boring. There's always something going on, like the introduction of new insights and new equipment. Since I've worked here, the age restriction has gone down from 28 to 24 weeks. That makes a huge difference. We have new respiratory equipment that you have to learn to work with. A lot of work has gone into implementing the electronic health records system, and of course, in a department like ours, there's always a lot of research being conducted.

I never thought I would join an ICU. It's just something you grow into. I started in the climate chamber and liked the fact that they had all these special things going on. But I enjoyed bottle-feeding a baby just as much. I'm not your typical ICU nurse; they are even more interested in equipment and techniques than I am. I'm more the caring type, I like giving patients attention and coaching parents too. And it's not always possible to do that in a department like this. When a child is doing badly, you don't have much time for the parents, although you do at other times. Sometimes, if I have to work in a different department, I notice that I enjoy bottle-feeding for an evening, but that my preference lies in the ICU.

Working part-time and keeping abreast

During my first three years, I worked full-time. Since we've had our own children – three in all, the eldest is twenty-seven and the youngest eighteen – I've worked seven days a month: in principle only evening shifts in blocks of three or four days. Because I don't work that much, keeping abreast is sometimes a little more difficult. If you work full-time, you take in new things automatically; for instance, you learn how to work with the respiratory equipment a lot quicker. If I've just been on holiday and I'm back at the machine for the first time, I find myself wondering exactly how it works again. In that case, I don't hesitate to ask a colleague to remind me.

Postgraduate training and refresher courses

When our department became a NICU, we had to do the Intensive Care Neonatology (ICN) training course. Because we were all so experienced, we didn't have to do an internship, like the other people on the course. The training course was held in the hospital. Recently, I took a three-afternoon course to become an ergonomics coach. A colleague of mine worked as a so-called ergo coach. They were looking for a second person and it really appealed to me. We try to convince colleagues to sit while doing their work at the incubators. That's better for your legs and your back. I notice them actually doing that more often now. It's great to be able to give tips that really help them. I also enjoyed meeting other people. I now receive a journal about ergo coaching on a regular basis and I get to go to refresher courses, although they're mainly about adults.

Committees

For a number of years, I was on a committee that was introducing working in a methodical manner. That was frustrating. I thought it had good points, but it was difficult to get colleagues involved. I don't really have the skills either to explain things properly. That's not the way I was taught. And that's when the idea of becoming an ergo coach came up. This is very practical, they listen to me and it's effective as well. I'm also on the committee that organises the follow-up day. This means that we organise an afternoon for the children who were our patients. I feel you should go the extra mile every now and then, as well as just doing your job. There are so many other little jobs. Maybe I feel additional pressure, because I don't work that much. There are always times that colleagues think I don't work enough and think I've got an easy life. So, I feel I should do something extra. I used to think: when my children are older, I'll go and work more hours and take irregular shifts again. But these days, it's hard to know until what age you'll actually have to work. And I know I can keep up this pace, working seven days a month, probably even until I'm sixty-seven.

Learning in the department

It's great that we have so many training days. During these days, we discuss things that are really relevant to you. A big advantage is that you can ask each other a lot. We consult

each other often and that's what I learn from. One person knows this, and another that. When I'd just started, that wasn't the case. Nobody knew everything and at night there were no doctors; they were asleep at home,. You were very much on your own. Maybe that was a learning experience too, but I enjoy work a lot more these days. There are more doctors around and most of the time there's an assistant or nurse practitioner as well. What do you learn? Many insights have changed. We used to think, for instance, that you had to see the saturation gauge get to 100, but we didn't know that you would perhaps be giving too much. These days, 86 is fine. This is how insights have changed by just a number.

We have what we call 'quarter past three moments': these are clinical lessons of some sort that last for just half an hour. These are very informative. This is when new equipment is introduced, or the nurse practitioner tells us about the research she's going to do. A colleague explained, for instance, how the new respiratory machine works and which settings are best to use with different types of clinical conditions or test results. If you're not on duty, you're very welcome to attend, but there aren't many people who do. The hospital has given us all a folder which you can use to keep track of clinical lessons, symposiums etc. We haven't really done anything with it so far, but later on it will be digitally and you will have to get credits. I'm not updating it on a regular basis, but we'll have the digital version soon. Slowly but surely I'm being forced to keep better track.

At home we get Nurse Academy , a journal that contains tests which allow you to collect credits. Recently, I've received an email from the training department that I still had to take the tests. I wasn't aware of the fact that you actually have to take the tests in this journal. A colleague of mine told me that she always gets all the credits. That's when I thought: I'll go for that too. And now I've registered. It sounds useful. I don't mind reading and you may just as well answer the questions about the content at the same time. Although I do wonder whether or not I'm supposed to do the tests about Parkinson's disease, for instance. I feel that as long as you're working, you have to try to keep abreast. You can't say at 55 or so: "I'll be fine".

I find the fact that it's all done digitally, quite complicated. I more or less know how to use an iPad, but using a desktop computer is something else altogether. Recently, my husband found out that I didn't even know the difference between the left and right mouse button. I'm behind in that respect, but soon, when we have to do everything on the computer, I'll have to be able to cope with it.

We also have e-learning modules, for instance about body cooling. That came up in a talk recently during a training day and it turned out that we had to take a test on it via e-learning. If you fail a certain test three times, they talk to you about it and you get extra lessons. That hasn't happened often. A disadvantage of the tests is that those multiple choice questions are mainly about how well you understand your Dutch. It's almost like reading comprehension at school. I don't find the tests that difficult, but some of my colleagues do. When I spoke to a colleague about it, she mentioned that if you fail again, 'there would be no room for you at the inn'. I really felt bad about this. Maybe things are too easy without these tests, but the tests don't really tell that much.

My husband is in education and we speak about this quite often. Tests, marks and things like that are not at all that good for children either. It would be much better if everybody studied the same material to be discussed with each other afterwards. But that's not the way people study. You take the test at home with your book open so you can look things up. It should be possible to structure this knowledge exchange.
After the CPR course, or later after the e-learning about the PKU test, you'll take a practical test. ICN students have to nurse a baby during their internship while three to four people are observing. They then have to show what they're doing and explain why they do the things they do. Of course, this is many times better than one of these e-learning tests, but I would be very nervous and so would my colleagues. Showing how to do a PKU test is not so bad, but nursing a child for a full day and explaining why I'm doing what I'm doing, that I would find difficult and scary. Not because they can see how I work, but more because I would have to explain the technical stuff about the lungs or the respiratory machine. But that's what's expected of students these days: they have to be capable of more things than were required of us in the past. The CPR course confronts you with different cases; all include a doll in an incubator and you explain what you're going to do. Some are not looking forward to that. It's very useful; you learn to focus even more on what you're doing. And maybe there's nothing wrong with somebody watching what you're doing. After all, we do work together, but you're on your own a lot as well.

Important learning moments

During the training course you'd be confronted with your own limitations. Maybe these are the moments you learn from the most. I worked in a department with children suffering from leukaemia. I couldn't handle working there on a full-time basis. Working with children who are slightly older and so ill was very difficult from a psychological point of view. I've learned a lot from that. I don't think I could have worked there until my retirement, but maybe you learn how to deal with it as time goes by.
Whether there have been certain key moments, is difficult to say. There have been times that were more difficult than others. Once on a Sunday morning, when I worked in the general hospital as a fourth-year student, I was all by myself in that enormous department. That's when you learn! It's what you remember. It wasn't a pleasant experience, but it wasn't that bad in the end either. You're always capable of more than you think. That's what you learn from it, I think.

Milestones

I'm proud to be working in this department. That gives me a good feeling. It's an enormous challenge and that's what I enjoy. Seen the fact that I'm not a purebred ICU nurse, I have to always be ahead to keep up. If I succeed and people are satisfied, then I'm pleased. Every now and then you're in an evening shift with a child who's terribly ill. When things go well then, that gives a feeling of contentment and that counts as a milestone.

Whether there are moments when I was given other responsibilities? We all have the same responsibilities. Everybody does something extra, for one colleague that's training, for another it's materials and I do the follow-up day and ergo coaching. But my responsibilities are the same.

Future

A number of new things are about to take place. E-learning is one of them. I want to keep abreast with this. Otherwise, I just want to continue working the way I do and expand ergo coaching a little. I still want to learn a number of technical things, such as putting someone on a drip. Some of my colleagues know how to do that and I think I can do that too. They start learning how to take blood samples now, but I do that already. If you know how to do these procedures, the disadvantage may be that colleagues ask you to help with the children under their care. So I'm drawing the line with the PKU test and the drip. You learn these procedures in practice. The PKU test is dealt with in an e-learning module. Up until now I used to be taught by a colleague. You can ask him to check on you. That's your own responsibility.

Whether I want to continue working here? If I remain healthy, yes. I work seven days a month, so that's very doable. Sometimes I work in the normal neonatology department. I like it, but I wouldn't want to be working there right now. If I can no longer cope with the stress in this department, because it's hectic and the illnesses are so serious, I may consider making a switch to the other department. I hope that they'll allow me to take that step back, but the question will be whether they'll want somebody who can't cope. And otherwise, I just have to think of something else. That would be a pity, though, because I enjoy what I'm doing.

Male, 57
20 years and ongoing experience in geriatrics

> I am convinced that you are always learning. If you no longer learn and you're not open to learning, you're not being effective and you'll get frustrated. There are plenty of people like that; people who can't wait to retire. They have a very hard time, I think.

Choice for nursing

After secondary school, I went to teacher training college, which is now the pabo (university for teacher education), to become a primary school teacher. I enjoyed teaching, but after eighteen months I stopped. I couldn't see myself doing that for the rest of my life. One of my friends told me enthusiastic stories about nursing, so after my military service, I went into nursing. That surprised everyone, and initially, it was a bit of a disappointment for my parents. My father had his own building contracting business and it was his dream that I, his only son, should one day take over the company. It was also in the time when there were hardly any men in nursing. When his mother died, my father's opinion changed. She had been admitted to the department where I worked and I had nursed her. From then on, he thought highly of the nursing profession.

Major life events

I got married in 1980. We wanted to have children, but that didn't work out. I can't exactly explain how, but it did affect my career. Several years later, my in-laws died and my wife became seriously ill. That was an intense period. For a while, I was very unproductive and I began to understand more fully that it's important to enjoy things in life. Nursing is a wonderful profession and I enjoy my work but and I want to do things that I like. I don't necessarily have to have a flourishing career. It did influence my decision to take a step back from team leader to senior nurse. I was in hospital myself in 2005. That was dramatic. In the same year my father died and last year, my youngest sister died too.

Training, postgraduate training and nursing career

I did the in-service training (A-nurse) in a military hospital. That's where I met my wife. I also did the postgraduate training cardiac care and for three years, I enjoyed the work until it became more technical. I still wanted to learn and it seemed interesting to go into the managerial side, so I took a management course. I then worked as team leader in a lung department and after two years I went to work in a military revalidation centre. I followed a NDT course for treating CVA patients. I enjoyed working there for seven years. When plans were announced to close the revalidation centre, I thought, I must move on before I'm forced out of here.

They were looking for 25 nurses to staff a new geriatric department. I was one of them. The management position was already taken, but later, I didn't mind. I worked for two

years as a nurse and so I learnt a great deal about the discipline. When I started there, I did the postgraduate training in clinical geriatrics. Subsequently, I've been manager for twelve years, the first eight of which I was more or less a colleague and foreman. Gradually, my job took me further and further away from the bed. And it was exactly the caring for patients that I increasingly began to miss. I thought, I have to make a choice. So I indicated that I wanted to become a senior nurse.

As senior nurses we are the nurse coordinators: we coordinate, facilitate, consult with doctors about the allocation and provision of beds and we coach people; we are the spider in the web. You also have an area of responsibility. Considering my background – mobility – lifting and transfer is my area of responsibility. Together with a colleague, I've developed a clinical pathway and I teach about this, give on-the-job coaching, pay attention to working height and transfers of patients and I give presentations at symposiums. I really enjoy making others enthusiastic and conveying my knowledge.

On-the-job learning

What am I learning now that I didn't learn when I was team leader? I remain focused, I'm continually observing and I see things in people. Clinical conditions can present themselves in different ways, particularly in older patients. Then you see things you've never seen before. I'm learning a great deal about new medications, clinical conditions and new treatments.

And there are other developments that I'm learning about too, such as the electronic health records system. I'm from the era in which the word reflection was never mentioned during nursing education. When I returned to bedside nursing and hadn't coached students for many years, I had to familiarise myself with the new education system with all the books about practical training . I was teamed up with a nurse who had more experience in coaching students. We also received training about the curriculum and we were coached in evaluating students' reflection reports and their performance.

The hospital is currently in the middle of an accreditation process. Irrespective of what you think about that, you do learn from the mirror that is held up in front of you. You become more aware of certain things – patients privacy for example. The rules are becoming stricter. Sometimes that can make things awkward or overdone, but nevertheless, it gets you thinking. Hand hygiene for example: I wasn't very strict about that, but now I do use alcohol.

I attend all kinds of refresher courses, such as for restricted activities. These are courses that are given repeatedly. I'll be going to a symposium about mobility and the elderly soon, this is being facilitated by the department. Occasionally I give a presentation, sometimes I go to listen. Now and then I hear new things, but it doesn't always have to be innovative. You can also learn by hearing about something again, and it's good to get confirmation that we're already quite far advanced here. You shouldn't hear that too often, but it is sometimes reassuring. I also get a great deal from the professional journals. I read all kinds of journals, particularly articles related to geriat-

rics. And the journal my wife receives is also interesting to read. That's about a different type of patient, but sometimes there are articles relevant to my area. I also learn from students. They hold up the mirror for you. For example, one student noted that I wasn't wearing gloves when I was dissolving the antibiotics. I remember to do that now. You also learn from the specialist wound nurse. Whether there are new insights that I don't really know about? I hope not! And if that were so, then I would adjust my way of working. I know enough people who would say: "Don't be ridiculous, I've done it this way for years." I think that is a dangerous attitude.

Learning to cope with change at work

Our work is constantly changing. We're currently working on a project 'one nurse to four patients'. We have to examine various care processes and look at what we could do less or have someone else do. You learn from this this too, you have to set correct priorities. At the same time, you learn about yourself. Sometimes the workload is so high, that I feel frustrated. Inside I could explode – this shocks me, that's not the person I know. I'm positive. If you go round the department feeling frustrated, patients will notice. I have to learn to deal with those frustrations. As nurse coordinators, you have to set the example. You can't howl along with the other wolves. I think that's correct, but sometimes it's awkward. Only this week, I was so busy that I couldn't get a man out of bed – that's extremely frustrating. And so it should be – if it wasn't, then you'd become sluggish. But I realise I have to find another way of expressing that frustration, because I know what a bad atmosphere can do to the department.

Important learning moments

A key learning experience was when I realised that I wasn't happy anymore in a management position. It was a logical step for me to become senior nurse again. From other peoples' reactions I realised that they didn't see the logic in my action, but that they respected my choice. What's more, I'm still pleased with my choice for geriatrics, but certainly also about my decision to go into nursing in the first place. That has turned out to be a good choice. I'm not someone to move on to something new quickly. If the threat of the revalidation centre closing had not happened, then I would probably still be working there. I think I would still be enjoying that, but I've learned so much more here. That was quite a different discipline. And this is a large hospital and so there are many more opportunities for education and training. Education is an important aspect, for which more money is made available.

Learning periods critical to current work

My training and experience are important. You learn a great deal in practice. Geriatrics is a complex discipline. Over the years you develop a kind of sensitivity thanks to the experience you gain and everything you read about it. Through working with older people, through observing them, by bouncing ideas around during doctors' ward rounds and through the clinical lessons, you start to make links. That's how you learn

clinical reasoning. It's nice when you read something in a journal and think, hey, Mr Jansen had precisely the same thing. Then it really sticks.
The first few months of the nursing education are also crucial. You either take to nursing or you don't. I was always quite squeamish and I was brought up with Calvinistic values, but I soon began to enjoy it. Apparently, all this wasn't as embarrassing to me as I thought it might be. I also enjoyed caring for people. The atmosphere was pleasant and it was a good hospital. Another decisive factor was the first patient who died. I can still remember his name and I can see him vividly in my mind's eye. After that I worked in an oncology department where young people died. That shaped me considerably. Until then, we always had fun at work, but because of the nature of that department, you realise that there is a serious side too. If you had asked me when I started what I would like to do most, then just as many young guys, I would undoubtedly have replied – the ambulance. Now I consider providing good terminal care to be one of the most beautiful aspects of my work. The responses received from relatives have formed my actions. If they show that they've benefitted from your support, then you know that you're on the right track.
Another decisive factor that I have certainly benefitted considerably from is my experience in the revalidation centre. There, I learned to cope with patients' frustration, but also to keep the end goal in mind so you can get the most from these kinds of patients too. Being able to get out of bed on your own can mean the difference between your own home and a care home.

Milestones

Whether there are milestones in my development? It sounds strange to hear myself talk about these things. It's more a matter of your strengths and weaknesses. What I like, call it a milestone if you wish, is that I enjoy teaching so much and that I'm good at it. After all, there must have been a good reason for me wanting to be a school teacher. Apparently I still enjoy doing that. And I'm glad I'm a tidy type. That's not something to necessarily be proud of: you either have it in you, or you don't. But I'm glad that I can usually make a positive contribution to the department. That's important to me because I work better in a pleasant atmosphere. And when patients go home and their family come and thank you, I get a kick out of that. You've done that as a team. That's one of the great things about this profession, it's one continuous milestone.
Whether there were times when I was given different responsibilities? That was when I no longer wanted to be in a managerial position. And in my work as a nurse, there are certain restricted activities, such as venepuncture, in which you have to be trained before you can do that. In principle, as nurse with geriatric training, you are allowed to do all the procedures.

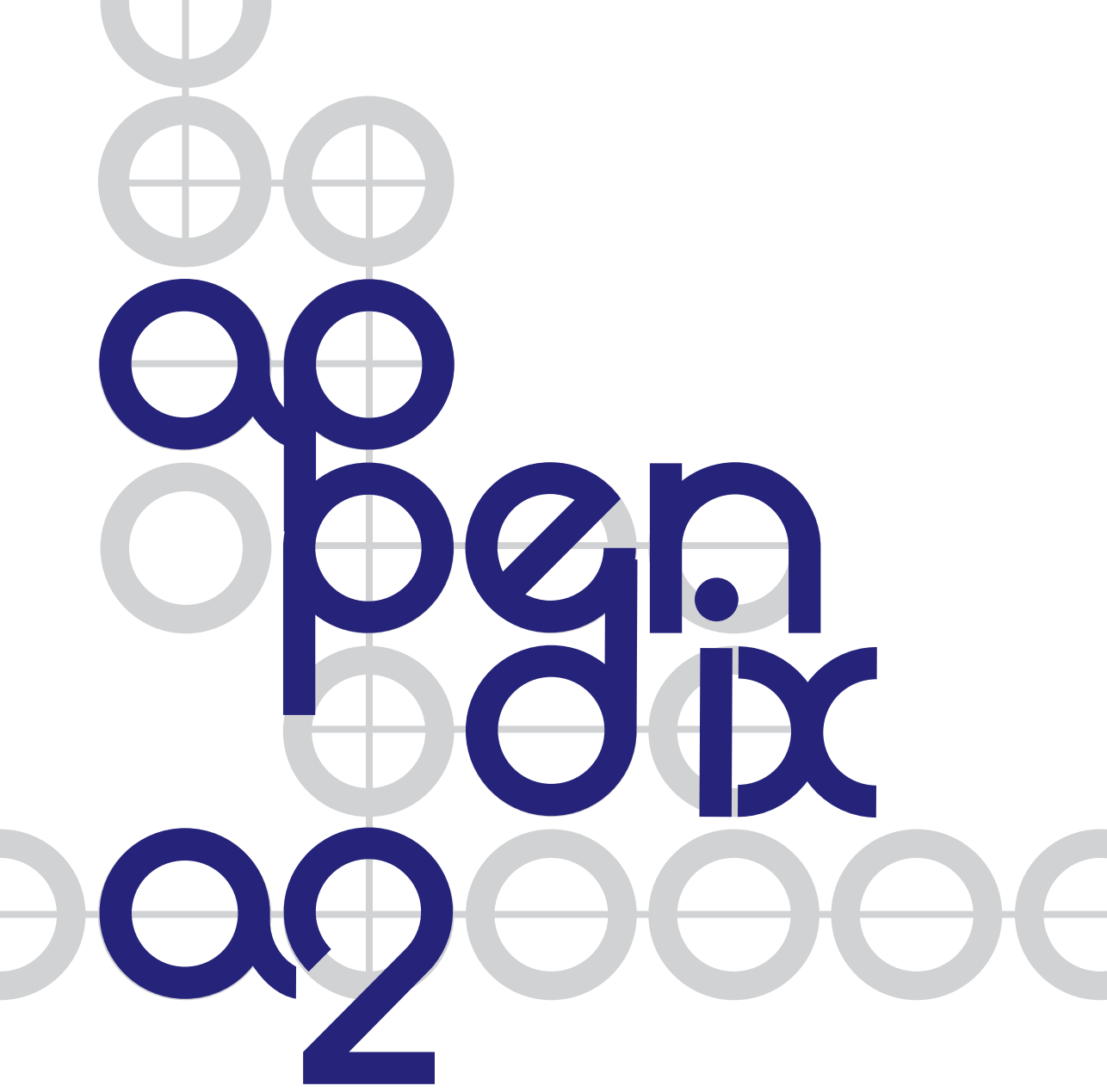
Who have I learned a lot from?

There must be loads of people I've learned from: good things and things that you think "I wouldn't do it like that". Various team leaders. By talking to people who think more or less the same way that you do, you also develop your ideas about what you consider to be high quality.

Future

I've got to the point where I just want to do my best and enjoy my work for the next few years. I'd like to do some projects and to teach. In which areas do I want to develop myself? In small things. I don't see myself doing any more substantial training course. For me it's more about learning extra things, keeping abreast and getting up to speed with the electronic health records and I'd also like to make PowerPoint presentations for my lessons. You learn a lot by doing things in practice, giving a clinical lesson and then getting feedback from the audience.

We'll be moving soon. I'm not looking forward to leaving here, but I see it as a challenge. We don't have a say in this, and you can only do your utmost to get the best facilities so that you can provide the best possible care. For me, there's also a learning moment in holding on to my job satisfaction even if we have to work with fewer facilities. I learn that too by watching out for myself and recognising my own signals.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Zes leerbiografieën (in Dutch)

Introductie

In deze bijlage hebben we zes van de 21 leerbiografieën (zie Hoofdstuk 4) opgenomen als een voorbeeld van de verweven relaties tussen leven, werken en professionele ontwikkeling en als illustratie van CPO strategieën in drie leeftijdsgroepen. Verpleegkundigen gaven toestemming om hun leerbiografie op te nemen in dit proefschrift.

Vrouw, 24 jaar
3 jaar werkzaam op een oncologie-afdeling

> Ik leer op dit moment zo veel, dat ik nog niet goed kan nadenken over wat ik verder kan leren. Ik ben heel erg lerende.

Opleiding tot verpleegkundige

Na de basisschool heb ik de havo gedaan. Ik wilde de gezondheidszorg in en heb gericht voor het profiel Natuur en Gezondheid gekozen. In mijn familie werken meerdere mensen in de zorg, waaronder mijn moeder. Ik heb getwijfeld over de opleiding tot anesthesiemedewerker, maar bij twijfel kon je beter de verpleegkunde-opleiding doen. Ik heb de hbo-V voltijd gedaan. Als je de duale opleiding doet, word je in het ziekenhuis opgeleid, maar ik wist nog niet goed welke kant ik op wilde en vond het leuk om in verschillende zorgsettingen te komen. Ik heb stage gelopen in de psychiatrie en bij de afdeling opleidingen van het ziekenhuis. In een verpleeghuis heb ik samen met een medisch student onderzoek gedaan. Duaal-studenten zijn als ze klaar zijn wel beter aan het bed, maar door een half jaar durende stage op een leerafdeling heb ik de schade een beetje ingehaald. Na afstuderen kon ik in de zomer een paar maanden op de afdeling blijven werken. Tot er hier een vacature kwam. Ik werk hier nu bijna drie jaar.

Werken op een oncologie-afdeling

Op de vacaturelijst stonden meerdere vacatures, maar deze sprak me het meeste aan. De oncologie is een goede keus geweest. Het doet een beroep op je analytisch vermogen. Misschien is het een vooroordeel, maar ik heb bij de chirurgie het idee dat het duidelijker is: mensen komen voor de OK, je weet wat er allemaal gedaan moet worden en wanneer mensen naar huis gaan. Op deze afdeling weet je bij sommige patiënten niet wat er aan de hand is als ze binnenkomen. Je hebt veel contact met de artsen, doet samen visite, brengt dingen in en denkt mee. Oncologie is vaak complex. Ik heb een aantal extra taken. Ik ben één van de vijf zorgcoördinatoren en zorg dat gaten in het rooster worden opgevuld, coördineer de opnames van patiënten en verricht hand- en spandiensten. Als de leidinggevende er niet is, ben je aanspreekpunt voor de afdeling. Daarnaast ben ik verhuiscoördinator. Eén dag in de week bereid ik de verhuizing naar de nieuwbouw voor. Het is een drukke, maar hele leuk taak. Voor de afwisseling is het prettig. Ik werk 36 uur en dat is pittig. Werken aan bed

is lichamelijk zwaar: veel tillen en veel hectiek. Een dag vergaderen maakt het fysiek makkelijker.

Vervolgopleiding

Toen ik hier een half jaar werkte, was er een mogelijkheid om aan te geven dat ik de verpleegkundige vervolgopleiding oncologie wilde doen. Ik had gemerkt dat ik niet alles voor de patiënt kon doen. Ik ben een beetje perfectionistisch. Op de afdeling had ik genoeg te leren, maar wilde er meer uithalen. Ik zag wat je op de opleidingsplek allemaal kon leren en bedacht dat ik daar nu meer aan zou hebben dan over tien jaar. Ik had het gevoel dat ik door de opleiding meer voldoening van mijn werk zou hebben doordat ik meer voor patiënten zou kunnen betekenen. Bij een vraag van een patiënt zou ik niet hoeven te zeggen, dat vraag ik even na. Je weet meer over behandelingen en kan patiënten beter begeleiden. Je leert ook over het hele netwerk eromheen, zodat je patiënten beter kan doorsturen. Collega's vertelden dat ze echt iets met de opleiding konden. Het leek me dus heel leuk, maar ik was hier net. Ik was bang dat ze zouden vinden dat ik het hoog in de bol had als ik na een jaar al een vervolgopleiding wilde doen. Maar anderen vonden dat onzin en gaven aan dat ik het wel zou horen als ik niet geschikt was. Dus heb ik gesolliciteerd. Ik deed de opleiding samen met een collega die hier al 25 jaar werkt. Dat was een goede combi. Zij kon veel van mij leren, omdat ik heel makkelijk verslagen schreef en ik had veel aan haar qua kennis. Vakinhoudelijk wist mijn collega natuurlijk al veel, maar zij leerde bijvoorbeeld wetenschappelijke literatuur zoeken. Ook leer je mensen uit andere ziekenhuizen kennen, waardoor je een netwerk opbouwt dat je kan benaderen bij vragen. Of ik door de opleiding een bijdrage aan het team kan leveren? Dat zit vooral in kennisdelen. Ik kan nu makkelijker vragen beantwoorden en studenten begeleiden.

Leren op de afdeling

De afdeling opleidingen heeft voor de afdeling een oncologiemodule ontwikkeld van een half jaar, met zes lesdagen, opdrachten, kennistoetsen en een eindgesprek. Het was voor mij een beetje herhaling, omdat ik net de opleiding had gedaan, maar iedereen moest de module doen. Het was ook wel heel leuk. Je kreeg les van de eigen artsen; dat is toch anders dan bij de vervolgopleiding waar ik de artsen niet kende. Je leert de artsen dan op een andere manier kennen en als ze een casus noemden wist iedereen waar het over ging. De kennistoets was nog wel spannend. Het was een pittige toets. Ik had net de oncologie-opleiding gedaan en wilde natuurlijk niet zakken.

Verder hebben we op maandag klinisch redeneren. Dan werkt iemand een casus uit die we bespreken. Er wordt verwacht dat je een paar keer per jaar iets inbrengt. Ik vind het goed om dit te doen. Je leert van elkaar en soms biedt het een bevestiging van hoe je zelf iets zou aanpakken. Op donderdag worden er klinische lessen gegeven door onszelf of iemand van buiten de afdeling. Aan de verpleegkundige-plus-educatie kunnen we onderwerpen doorgeven en dan regelt ze bijvoorbeeld iemand

van het lab. Ook dat is leuk, want het gaat vaak over dingen waar je in het dagelijks werk tegenaan loopt. Daarnaast hebben we één keer in de twee maanden een refereeravond en als er een heftige casus is geweest intervisie. Jaarlijks hebben we een verplichte algemene intervisie, omdat de oncologie een pittige afdeling is.
Ik heb ook trainingen voorbehouden handelingen gedaan. Je moet jaarlijks de training reanimeren doen. Als je je ergens niet bekwaam in voelt, kan je een training volgen in het skills lab. Ik heb het idee dat hier veel georganiseerd wordt om te leren en dat ook artsen het belangrijk vinden dat mensen een vervolgopleiding hebben. Als je zelf een idee hebt, dan krijg je daar de ruimte voor en er wordt in je geïnvesteerd.

Leren buiten de afdeling

Jaarlijks wordt er een opleidingsplan geschreven. Binnen een bepaald budget zijn dan plaatsen beschikbaar voor cursussen, congressen en opleidingen. Je kan opgeven waar je heen wilt en dan wordt gekozen wie waar heen gaat. Er wordt verwacht dat je daarna een presentatie geeft aan collega's. Ik zag een driedaagse cursus immunotherapie. Dat lijkt me heel interessant, maar ik heb dit jaar al zo veel gedaan. Dat komt nog wel.
Ik ben wel naar het oncologie-congres geweest. De presentaties waren leerzaam. Niet alles is nieuw, maar dat hoeft ook niet. Het ging bijvoorbeeld over de kosten van een behandeling: daar schrik je toch even van. Soms leer je ook kleine dingen, bijvoorbeeld over een middel voor een stervende patiënt tegen reutelen. Dat kan ik dan een keer aankaarten bij de artsen. Verder heb ik een cursus werkbegeleiding gedaan. Ik kom zelf net van de hbo-V en ken het onderwijssysteem, maar ik moet een begeleidende rol kunnen nemen. In de cursus krijg je daarvoor extra handvaten.

Belangrijke leermomenten

Mijn loopbaan is nog niet zo lang. De hbo-V is een belangrijk moment geweest. Op de havo was je ook bezig met leren, maar voor de hbo-V kies je heel bewust. Je leert voor je beroep. Je hoeft dat niet je hele leven te doen, maar je kiest wel voor de toekomst. Wat ik daarna heb gedaan, is allemaal een vervolg op de hbo-V. Het is de basis van waaruit ik verder ga. Ik snap wel dat mensen soms switchen van opleiding. Je bent 16, 17 en kiest iets voor de rest van je leven.
Eigenlijk vind ik alles één groot leermoment. Ik ben iemand die veel opzoekt tijdens een opleiding. Dat heb ik nu wel minder, maar ik vind dat je als verpleegkundige moet blijven leren. Thuis zoek ik achter de computer dingen uit, zoals ziektebeelden of behandelingen, omdat ik het interessant vind. De bibliotheek stuurt me inhoudsopgaven van tijdschriften. Een interessant artikel kan ik dan opvragen. Soms mail ik dat door aan de leidinggevende, zodat die het kan opnemen in de wekelijkse e-mail aan het team.
Je moet blijven leren, omdat patiënten steeds complexer worden. Er zijn veel vernieuwingen. Als je nu al kijkt hoeveel behandelingen er zijn in die paar jaar dat ik werk. Daar moet je je echt in verdiepen, anders kan je het niet volgen. Sommige ontwikke-

lingen word je in meegenomen, zoals een nieuw protocol dat je moet leren. Maar ik vind dat je vakinhoudelijk zelf ook wel wat mag doen. Een ander moet ook bijblijven in zijn vak en dat geldt ook voor ons. Vier keer per jaar valt thuis het tijdschrift de 'Nurse Academy' op de mat. Dat krijgen we aangeboden door het ziekenhuis. Dat laat je niet liggen. Je hebt interesse in je vak en daar staan artikelen in waar je wat mee kunt.

Belangrijke leermomenten voor huidige werk

Tijdens de opleiding loop je stages. Je hebt dan meer rust om leermomenten te pakken. Nu ga je ook wel bij een patiënt zitten, maar als je over gepland staat doe je dat bewuster en heb je echt de tijd voor een gesprek met iemand. Je kan dan de verdieping zoeken. Dat was belangrijk voor me. Ik heb geleerd wat er in mensen kan omgaan en kan daar nu beter op inspelen. We hebben ook bepaalde casussen en opdrachten moeten uitwerken. Dan ontdek je meer dan je van te voren had gedacht. Als je dat nooit gedaan hebt, weet je niet dat je die diepte in kan gaan. Als je dat een paar keer hebt gedaan, krijg je de neiging dat vaker te doen. Ik merk dat ik groei. In het begin dacht ik weleens, wat weten die verpleegkundigen veel. Ik ben nu tweeën-eenhalf jaar verder en merk dat ik ook al best veel weet. Als ik 40 ben, zal ik net zo veel weten als zij en ik realiseer me dat ik niet alles hoef te weten.

Mijlpalen

Het is lastig om aan te geven wat mijlpalen zijn. Misschien diploma's halen, maar ik vraag me af of dat echt een mijlpaal is. Ik heb niet echt voor ogen wat ik wil bereiken. Ik blijf hier zolang ik hier voldoening uit haal. Ik mag best trots zijn dat ik dit allemaal al heb gedaan. Als je ziet welke verantwoordelijkheid ik krijg, dan doe ik het niet slecht als ik tweeëneenhalf jaar klaar ben. Maar dat voelt niet als een mijlpaal. Een mijlpaal is iets groots.

Wanneer ik andere verantwoordelijkheden heb gekregen? Toen ik zorgcoördinator en verhuiscoördinator werd. Aan bed heb je een grote verantwoordelijkheid richting de patiënt, maar met de nieuwbouw of afdeling bezig zijn, is een totaal andere verantwoordelijkheid. Ik overleg hierover veel met de leidinggevenden.

In de zorg werken we met jongste- en oudste-diensten. In de avond- en nachtdienst moet altijd een oudste-dienst aanwezig zijn. Jongste-dienst betekent dat je op de oncologie staat en nog niet op de hematologie. Als je hier komt werken, volg je een inwerkplan. Als je er aan toe bent, word je drie weken over gepland en ingewerkt op de hematologie. Daarna word je in de dienst als oudste ingepland. Dan mag je in principe alles doen, behalve als je je niet bekwaam voelt. Sommige handelingen doe ik zo weinig dat ik wil dat iemand meekijkt, of ik wil daar eerst in getraind worden.

Sinds een paar maanden heb ik de functie van oncologieverpleegkundige. Je gaat dan omhoog in salarisschaal. Die functie krijg je niet automatisch als je de oncologie-opleiding hebt gedaan. Je moet laten zien dat je iets met de opleiding doet. Het is niet voldoende dat je aangeeft dat dingen niet goed lopen, maar moet ook met verbetervoorstellen komen. Ook dat is een andere verantwoordelijkheid: niet zozeer

richting patiënten als wel richting de afdeling. Het voelt ook als een waardering; ze zien wat je doet.
Doordat ik met de verhuizing bezig ben, leer ik de organisatie op een heel andere manier kennen. Normaal ben je op je eigen afdeling gericht, maar nu bouw ik een netwerk op in het hele ziekenhuis. Je ziet ook hoe anderen bepaalde dingen doen en dat kan ik weer meenemen naar de afdeling. Je leert breder kijken. Hier mopperen we weleens als een bak niet is bijgevuld, maar nu weet ik dat ze bij logistiek het ook niet een, twee, drie kunnen regelen.
Verder ben ik nog altijd een beginnend verpleegkundige. Ik leer nog steeds veel. Bijvoorbeeld, als ik een ECG heb gemaakt en eigenlijk niet weet hoe die in elkaar zit. Dan vraag ik de arts om me dat uit te leggen. Je leert ook als er patiënten komen van een specialisme dat je minder kent. Op zo'n moment leer je door dingen op te zoeken en het de arts te vragen.

Toekomst

Waar ik over vijf jaar sta, weet ik echt niet. Dat is me ook bij het functioneringsgesprek gevraagd. Ik vind de zorg heel leuk, maar 36 uur aan bed veel. Ik vind het prettig om af en toe een dag niet in de zorg te staan. Als ik alleen aan het bed sta, dan raak ik mijn voldoening wel een keer kwijt. Ik moet er iets bij doen. Ik vind het interessant om mee te denken over zaken. We hebben hier 'plussers'. Zij werken in de zorg en regelen daarnaast allerlei dingen gericht op bijvoorbeeld kwaliteit of educatie. Dat lijkt me een leuke combi. Straks als de verhuizing voorbij is, dan valt er een gat, maar er komt altijd wel weer wat op mijn pad.
Hoe ik me verder wil ontwikkelen? Ik zou verpleegkundig specialist kunnen worden, maar daar ben ik nu niet aan toe. Misschien is dat iets voor de toekomst. Ik heb nu veel gedaan en dan mag ik ook wel even rust, gewoon aan het werk en kijken wat ik leuk vind. Op dit moment leer ik nog zo veel. Ik zit er middenin. Ik heb niet de rust om te bedenken wat ik verder zou willen leren. Ik ben hier ingerold en vind het hartstikke leuk. Ik blijf hier net zolang als ik het leuk vind en daarna zien we wel verder.

Vrouw, 27 jaar
4 jaar werkzaam op een kinderafdeling

> Sommige collega's gaan graag om vier uur naar huis en dan is het klaar. Die doen gewoon wat nodig is. Ik vind het erg leuk om me ergens voor in te zetten.

Studietijd

Ik ben met het gymnasium gestart. Ik wilde dokter worden, maar toen ik in vier vwo strandde en overstapte naar de havo, wist ik al snel dat verpleegkunde de tweede optie was. Achteraf had ik nooit dokter willen worden. Het persoonlijke contact is veel minder en je hebt minder tijd voor patiënten. Wat meespeelde, was dat mijn moeder vroeger kinderverpleegkundige is geweest. Zij heeft me misschien wel een beetje gestuurd. Het heeft even geduurd voor ik kon accepteren dat ik geen dokter werd, maar uiteindelijk past dit goed bij mij. Ik ben de hbo-V gaan doen en na een jaar op kamers ben gegaan. Als bijbaantje werkte ik in het begin van de opleiding als verzorgende in een woonzorgcentrum. Dat leek me goed als extra ervaring. Vervolgens heb ik drie jaar als bijbaantje gewerkt op een woongroep voor verstandelijk gehandicapten nadat ik daar stage had gelopen. In 2008 heb ik mijn partner leren kennen. Tijdens mijn studietijd ben ik actief geweest bij de studievereniging van de faculteit. Daar stelde ik me actief op en organiseerde dingen. Dat doe ik hier op de afdeling ook; ik zet me voor meer dingen in dan een gemiddelde collega die hier even lang is. Ik vind het leuk om overal aan mee te doen en aanwezig te zijn.

Vervolgopleiding

Na afronding van de hbo-V mocht ik blijven op mijn vierde stageafdeling. Ik wilde een jaar werken op een volwassenafdeling om werkervaring op te doen. Na een jaar werkervaring was ik klaar om mijn specialisme en vervolgopleiding te kiezen. Ik wilde altijd kinderverpleegkundige worden. Op de woongroep had ik nagedacht over wat ik na de opleiding wilde doen. Ik wilde daar niet blijven, want dan ben je ben één van de weinige hbo-ers. Ik vond het ziekenhuis ook te leuk, en na een dagje werken op de kinderafdeling wist ik het zeker. Als kinderverpleegkundige heb je veel contact met patiënten. Op de couveuseafdeling liggen kinderen over het algemeen lang, soms wel twee maanden. Op de kinderafdeling liggen ze korter, maar gemiddeld ook wel vijf dagen. Als je fulltime werkt dan zie je patiënten een aantal dagen.

Specialiseren binnen functie

Vrij snel na de vervolgopleiding ben ik de cursus kinderreanimatie EPLS gaan doen. Na de vervolgopleiding heb je oudste diensten. Je hebt dan een grote verantwoordelijkheid, zeker omdat er veel leerlingen werken. Als er een heel slecht kind komt, moet je veel kunnen. In mijn leerlingentijd heb ik niet zoveel meegemaakt. Ik heb me aangesloten bij de reanimatie-werkgroep en de EPLS- en BHV-cursussen gedaan. Dit was de kans om me daarin te specialiseren. Ik wil goed voorbereid zijn en kunnen

zeggen: ik wil de pieper wel. Als lid van de werkgroep geef ik les aan collega's. We houden het reanimatiebeleid actueel en hebben een rugzak ingericht voor kinderreanimaties in huis. Sommige collega's gaan graag om vier uur naar huis en dan is het klaar. Ik vind het leuk om me ergens voor in te zetten. Vooral ook omdat je er veel voor terugkrijgt. Via de patiëntenzorg krijg je natuurlijk direct dankbaarheid. Als je meer doet op de afdeling, dan krijg je niet direct iets terug, maar voor het lesgeven wel. Collega's zijn blij dat er één keer per jaar zo goed geoefend wordt.

Het leuke van de afdeling vind ik dat dit allemaal kan. Zo heb ik ook gereageerd op de vraag wie een CPAP-stage van een week wilde lopen bij een neonatale intensive care unit van een academisch ziekenhuis.. We hebben één of twee keer per maand een kind dat ademhalingsondersteuning met CPAP nodig heeft. Automatisch kwam ik daarna in de CPAP-werkgroep. In de praktijk heb ik een kind met CPAP nog weinig meegemaakt, maar als je lessen geeft, dan haal je het een aantal keer per jaar weer op.

Recent heb ik de praktijkopleider vervangen tijdens haar zwangerschapsverlof. De praktijkopleider gaat over alles wat met opleiden te maken heeft. Ik heb een training voor praktijkopleiders en een werkbegeleiderscursus gevolgd.

Belangrijke leermomenten

De kinderopleiding moet je doen: daar heb ik niet iets specifieks kunnen laten zien. Maar de EPLS-cursus en het lesgeven hebben er voor gezorgd dat ik anders functioneer op de afdeling en dat ik net even iets meer weet. Ik vond het erg leuk dat ik vier maanden de praktijkopleidersfunctie mocht doen. Dat kan ik op mijn CV zetten, mocht ik dat ooit later willen gaan doen. Het is goed om te weten dat ik het leuk vind, maar zo'n kantoorbaan wil ik nu nog niet.

Door de praktijkopleidersfunctie weet ik goed wat er speelt. Ik ben graag bij alles betrokken. Soms zou ik het niet willen, want je maakt het jezelf moeilijker. Als je meer dingen doet dan de zorg voor kinderen en ouders, heb je meer tijdsdruk. Hoe meer je doet, hoe meer mailtjes je ontvangt.

Door ervaring expert worden

Leermomenten die belangrijk zijn geweest om mijn huidige werk goed te kunnen doen? Eigenlijk is dat de tijd geweest. Eén van de leukste dingen aan de afdeling vind ik dat je in korte tijd een expert-verpleegkundige kunt zijn. Dat kan bijvoorbeeld niet in een academisch ziekenhuis, omdat het zo specialistisch is. Als je alles goed bijhoudt en je inzet voor je werk, ben je heel goed op de hoogte. Mensen die drie dagen werken, missen soms dingen. Hoe meer je op de afdeling bent, hoe meer je weet. Het eerste jaar nadat ik klaar was had ik al heel wat meer ervaring, maar nu vier jaar later echt nog meer. Dat maakt het uitdagend. Ik merk dat ik nu beter kan inspelen op uitzonderlijke situaties en antwoorden weet op vragen van leerlingen.

Leren in het werk

Ik blijf up-to-date door de e-learning modulen voor voorbehouden handelingen te doen. Elke drie jaar moet je deze doen om bevoegd en bekwaam te blijven, sommige alleen met een theorietoets, andere ook met een praktijktoets. Ze zijn nu wel makkelijker dan de eerste keer, omdat ik ervaring heb. Ik vind ze goed als opfrisser. Iedereen moet één symposium volgen per kalenderjaar en één klinische les geven. Dat is waar we naar streven, maar niet iedereen doet dat. Ik ben naar een paar symposia geweest. Twee gingen over pasgeborenen; ik weet daardoor net wat meer van twee ziektebeelden. De kosten krijg je vergoed: je moet er wel een klinische les over geven.

Ik ben het V&VN kwaliteitsregister gaan bijhouden. Als beginnend kinderverpleegkundige doe je onbewust al heel veel, zoals die modulen. Voor een kinderopleiding krijg je veel punten, maar ook voor symposia en het geven van klinische lessen krijg je punten. Zelf hou je dat niet zo bij. Als ik ooit ergens ga solliciteren, heb ik een mooi overzicht van wat ik heb gedaan.

Je leert elke dag wel, maar van uitzonderlijke dingen leer je het meest. Pas was er een kindje geboren na een zwangerschapsduur waarvan je verwacht dat het goed zou gaan. Maar het ging niet goed. Je bent dan veel met de arts-assistent en de kinderarts bezig. Het meisje is nu een week oud. Gisteren hadden we het er tijdens de visite over en dan zie je het verloop. Je kunt de puzzelstukjes leggen en het geheel zien. Dat doe je met de arts-assistent en met je collega's. Achteraf bedenk ik ook of ik iets eerder had kunnen afbouwen of starten. Als het gewoon groeien en bloeien is bij een baby, dan hoef je niet hard na te denken. Maar hier heb ik wel hard over nagedacht. Dit valt voor mij onder ervaring. Sommige verpleegkundigen weten veel, doordat zij veel doen. Bij de verdeling aan het begin van de dienst staan zij open om een nieuwe opname of bepaalde kinderen te doen, terwijl anderen kiezen voor wat ze al kennen. Ervaring kan je niet in het kwaliteitsregister opnemen, maar collega's weten wat ze aan je hebben. Aan de ene collega heb je in een nachtdienst meer dan aan een ander, doordat ze meer ervaring heeft, zich meer heeft verdiept en rustig blijft. Je hoeft geen jaren ervaring te hebben. Ik heb liever dienst met een leerling die nog veel dingen opzoekt en openstaat voor informatie, dan met iemand die al 30 jaar werkt, twee dagen in de week komt en minder zin heeft in nieuwe dingen of acute situaties. Als iemand zegt, "Ik heb al lang geen kind aan de CPAP gelegd", dan denk ik dat ze daar zelf iets aan had kunnen doen.

Mijlpalen

Dit is mijn eerste echte werkplek als kinderverpleegkundige. Ik moet nog 40 jaar, dus wil nog niet te snel richting het hoogste gaan. Ik zie kleine mijlpalen zoals de cursussen die ik heb gedaan. Die e-learning modules doet iedereen, maar doordat ik BHV'er ben, EPLS geschoold ben en praktijkopleider ben geweest, heb ik veel kennis gekregen. Als ik mijn teamhoofd zou moeten vertellen wat ik extra doe, dan zijn het die drie dingen.

Of ik beelden van grote mijlpalen heb? Als je kijkt naar carrière maken, dan zit ik toch al

vier jaar in een algemeen ziekenhuis. Na mijn stage wist ik wel dat ik nu nog niet naar een neonatale intensive care afdeling wil, maar ik verwacht niet dat ik de komende 40 jaar op de kinderafdeling van een algemeen ziekenhuis blijf. Als ik naar een ICN of ICK zou gaan, dan zit je in een specialistisch ziekenhuis én op de meest acute afdeling. Dat zie ik als het moeilijkste, maar als je het dan niet meer leuk vindt, dan is teruggaan naar een gewone afdeling saai. Ik vind het zonde om daar te snel heen te gaan. En eerlijk gezegd weet ik ook niet welke kant ik op wil.

Als mijlpalen momenten zijn waarop ik andere verantwoordelijkheden kreeg, dan geldt dat voor de praktijkopleidersfunctie. Ik stond tussen het team en het teamhoofd in. Ik was breder bezig en had overleg met teamhoofden, de afdeling opleidingen en andere ziekenhuizen.

Als kinderverpleegkundige kreeg ik drie maanden na afronden van de opleiding ook meer verantwoordelijkheden. Je draait dan verantwoordelijke diensten, bent dagcoördinator en in het weekend en de nacht overleg je met de arts of er een kind bij kan. Ook kan je dan alleen met een leerling in de nachtdienst staan. Dan heb je alle verantwoordelijkheden van een gediplomeerd kinderverpleegkundige.

Mensen waarvan veel is geleerd

Van mijn werkbegeleiders heb ik veel geleerd. Ik had een werkbegeleidster op de couveuse-afdeling die nu met pensioen is. Zij had veel ervaring en was ICN-verpleegkundige. Alle kleine weetjes heb ik van haar geleerd. Een andere werkbegeleider vond ik ook heel goed. Ze was best streng en zei dat ik iets pas mocht doen als ik het ook echt wist. Daardoor neem je wel je verantwoordelijkheid en ga je dingen opzoeken voor je het gaat doen. Dat doe ik ook naar leerlingen toe; het is geen kruisverhoor, maar ik vraag wel om te vertellen waar ze op gaan letten.

Toekomst

Ik weet nog niet welke kant ik op wil. Toen ik de praktijkopleidersfunctie deed, dacht ik dat is leuk voor later, als ik de chaos, de drukte van de zorg zat ben. Door de stage in het academisch ziekenhuis heb gemerkt dat ik pas in dit ziekenhuis. Hier heb je contact met ouders en kind van geboren worden tot ontslag en ben je met stappen vooruit bezig. Daar heb je meer met leven en dood te maken en daar zit ik nu niet op te wachten. Ik vind het acute leuk, maar ook het coachen van ouders en om bij ontregelde kinderen te kijken hoe je hen weer op de rit kunt krijgen. Misschien ga ik wel bij een consultatiebureau werken.

Mijn privéleven speelt ook een rol. In september ga ik trouwen en ik zou graag kinderen willen. Ik denk dat je het niet allemaal tegelijk moet willen. Sommige mensen kiezen eerst voor een carrière, maar misschien lukt kinderen krijgen wel helemaal niet. Ik stel mijn privéleven nu even voorop. Op de afdeling is nog zoveel te doen en te leren. Ik vind het leuk om les te geven en om de collega te zijn die veel weet. Dus ik denk dat ik de komende 5 jaar blijf, maar dat ligt ook aan mijn privéleven. Als ik kinderen heb, wil ik 2 of 3 dagen werken.

Wat ik graag anders zou zien, is het salaris. Na de kinderopleiding ga je naar een andere schaal waar je op nul begint. Dan doe je van alles, maar dat moet je voor jezelf doen. Mijn leerling van 42 verdient meer dan ik, omdat ze ruim 10 jaar werkervaring had. Iemand hoeft geen kinderverpleegkundige te zijn om meer te verdienen.
Of er dingen zijn waar ik me verder in wil ontwikkelen? Dat is wel het gevaar. Ik kan niet zeggen: dat wil ik nog. Er gebeurt genoeg op de afdeling, er is steeds iets dat ik kan aangrijpen of verbeteren, maar dat zijn kleine werkgroepjes, kleine dingen. Het gaat om onderdelen van de zorg die beter kunnen. Of je hier als je 10 jaar werkt, je kunt blijven ontwikkelen? Nee, dat denk ik niet. Je kan je ervaring verder uitbreiden. Als ik hier over 10 jaar nog werk, dan is het gewoon om geld te verdienen en omdat ik het werk leuk vind. Uit de zorg aan kinderen en ouders haal je veel voldoening. In een academisch ziekenhuis kan je doorgroeien. Hier zou ik nog de HCN kunnen doen. Dat is een verrijking, maar biedt voor mij geen toegevoegde waarde omdat de dagelijkse zorg vooral medium care is en maar af en toe high care, en door mijn EPLS–cursus weet ik al veel extra.

Vrouw, 37 jaar
9 jaar werkzaam op een chirurgische oncologie-afdeling

> Op termijn heb ik wel weer zin in een opleiding, maar dan moeten de kinderen wat groter zijn.

Loopbaan

Op mijn 24ste ben ik de verpleegkundeopleiding begonnen, nadat ik eerst met andere opleidingen was begonnen. Ik wist niet echt wat ik wilde. Mijn moeder adviseerde me de verpleging in te gaan, dat had zij ook gedaan, maar ik dacht dat het niets voor mij was. Tot ik in een restaurant werkte en bedacht dat het leuk zou zijn om meer te doen voor die vrouwen met rollators, dan eten brengen. Ik zal nooit vergeten dat iemand bij het sollicitatiegesprek zei dat ik niet gelijk moest stoppen als het niet lekker liep. Toen het in het tweede jaar even niet lekker ging en ik wilde stoppen, moest ik daar weer aan denken.

Na afronding kon ik hier komen werken. Dit leek me een team waar ik veel van kon leren. Mensen hebben hier een grote mond en ik niet, dus daar kan ik me aan optrekken. Het eerste jaar was zwaar, maar ging goed. Na een jaar mocht ik een schaal omhoog en kreeg ik verantwoordelijke diensten. Toen hier seniorfuncties kwamen, heb ik mij meer geprofileerd en binnen een half jaar werd ik gevraagd senior te worden. Dat wilde ik wel, maar het werd me al snel te veel. Ik was nog niet helemaal thuis op de afdeling, deed de oncologieopleiding en kreeg een miskraam. Na een jaar ben ik gestopt met de seniorfunctie. Vlak voor de bevalling van mijn eerste kindje heb ik de oncologieopleiding afgerond.

Ik wilde ergens anders gaan werken, maar toen bleek dat ze me geen vaste werkdagen konden garanderen, heb ik gekozen voor rust in mijn gezin en werk. Ik ben hier gebleven. Anderhalf jaar geleden heb ik mijn tweede kindje gekregen. Ik heb geen opleidingen meer gedaan, wel bijscholingen gevolgd en hier veel ervaring als mens en als verpleegkundige opgedaan. Dit is een veilige omgeving voor mij, omdat ik iedereen lang ken.

De keuze voor de verpleging is een goede geweest. Ik vind het leuk dat ik met mensen werk en voor hen zorg. Je hebt verantwoordelijkheid, maar nooit de eindverantwoordelijkheid. Het werken in een team vind ik fijn: je kan altijd even overleggen. En de structuur van de dag dwingt je om de dingen te doen. Ik heb goede ideeën, maar ik ben van het uitstellen. Als senior heb ik gemerkt dat ik de boel kan aansturen, maar ik moet niet de lead hebben.

Verwevenheid privé en werk

Mijn privé en werk lopen door elkaar. Als het thuis goed gaat, gaat het goed met mij en gaat mijn werk ook goed. Ik kan het moeilijk los van elkaar zien. Ik wilde heel graag zwanger worden, dus toen ik kinderen kreeg, ging alles goed. Later toen de tweede niet doorsliep, ging het op het werk mis. Ik heb niet thuis gezeten, maar moest wel

een stapje terugdoen en me niet alles wat hier gebeurt zo aantrekken. Ik kon het niet goed aan om bij patiënten te staan die doodgaan en een baby hebben. Het is zwaar om steeds opnieuw voor deze patiëntengroep te zorgen en mezelf daarbij staande te houden. Ik probeer me als persoon daarbij steeds te ontwikkelen.

Mijn vriend heeft gebroken diensten. Als ik naar huis ga, komt hij thuis eten en gaat daarna weer werken. Ik doe de kinderen naar bed. Alles loopt lekker. Ik werk drie dagen per week, maar heb nu ouderschapsverlof en werk 2,5 dagen per week. Ik wil mijn kinderen zien opgroeien en het huishouden op orde hebben. Ik kan niet vier dagen werken én thuis alles doen wat ik wil doen. Als de kleinste naar school gaat, wil ik meer gaan werken en misschien ook wat anders. Dan geef ik mezelf weer meer ruimte.

Of ik me extra moet inspannen om bij te blijven doordat ik twee dagen werk? Dat gevoel heb ik wel gehad, maar toen zei mijn moeder: 'Je hebt zo lang fulltime gewerkt en je hebt zoveel ervaring, jij blijft wel bij'. En dat is ook zo. En verandert er een keer iets, een protocol of een medicijn, dan pik ik dat eigenlijk snel op. Dus ik heb geen moeite om bij te blijven. Met twee dagen ben ik wel wat meer op de achtergrond. Ik heb nu net twee weken vier dagen per week gewerkt en dan zit ik er wel weer meer in, heb ik een grotere mond en kan ik ook meer dingen oppakken door de continuïteit.

Oncologieopleiding

Op de afdeling heb je de keuze tussen de oncologie- of medium care-opleiding. De oncologie sprak me meer aan. Dus heb ik me op de wachtlijst laten zetten. Toen ik senior werd, vonden ze dat ik de opleiding niet moest doen, maar ik vond dat ik geen senior kon zijn zonder oncologieopleiding. Achteraf hadden ze misschien gelijk en had ik het beter één voor één kunnen doen. Maar ik wilde de opleiding graag doen, dan had ik die in mijn zak. Ik wilde die kennis en het diploma hebben. Ik vind het leuk om opleidingen te volgen, om met een groep dingen te onderzoeken en bespreken.

Veranderingen op de afdeling

Toen ik hier kwam werken, was de helft oncologisch en de andere helft waren mensen met stoma's, Crohn of kleine maagoperaties. Ik koos voor de combi, maar nu is het alleen nog chirurgische oncologie. Het is technisch met veel psychosociale zorg. Het is een last dat iedereen hier kanker heeft en dat regelmatig mensen overlijden in korte tijd. Het is allemaal existentieel, dat is boeiend, maar ook pittig. Soms ben ik bang dat ik me op een minder heftige afdeling zou gaan vervelen.

Belangrijke leermomenten

Eigenlijk leer je elke week wel iets bij. Het zijn de kleine dingen. Je pikt veel op van wat artsen zeggen en dat probeer je te plaatsen in het plaatje van het ziektebeeld van de patiënt. Ook van je collega's leer je steeds. Ik leer ook elke dag op persoonlijk vlak van patiënten en blijf experimenteren met hoe je patiënten benadert. Belangrijk was dat ik leerde dat ik mezelf kan inzetten als instrument bij de patiëntenzorg. En het was een

eyeopener dat ik betrokken kan overkomen zonder dat ik me de dingen erg aantrek. Dat heb ik geleerd uit ervaring. Er was een man van 35 die niet langer dan een half jaar zou leven, met een jochie van acht. Normaal zou ik naar de gang moeten om te huilen of zou ik er niet van kunnen slapen. Toen heb ik gewoon gezegd dat ik het erg vond en heb ik met hem gepraat zoals je in de opleiding leert en geprobeerd me er niet zo veel van aan te trekken. Later kreeg ik een bedankkaartje en dacht: 'Zo kan het dus ook". Het lukt me om het minder binnen te laten komen. Ik kan gewoon weer hard zingend op de fiets naar huis met mijn zonen, terwijl ik toch goede zorg heb geleverd.
Jaarlijks moeten we een aantal e-learning toetsen maken over technische handelingen. Iedereen zat daar tegenaan te hikken, maar het is eigenlijk hartstikke leuk. In een rustige dienst maken we gelijktijdig die toetsen. De vragen die je niet kent, zoek je op en bespreek je. Met elkaar ben je bezig om uit te zoeken waar je mee bezig bent en wat de achterliggende gedachte is van wat je doet. Het is leuk om te merken dat je al best veel weet. Je krijgt er accreditatiepunten voor en voor elke behaalde toets krijg je een halfuur overtijd. Of ik er nieuwe dingen van leer? Ja. Niet veel, maar wel genoeg. Je leert gewoon weer even waar je mee bezig bent. Allemaal kleine dingen. Dan zie je dat je iets wat je al jaren deed, toch goed deed. Het medisch rekenen moet ik nog doen. Daar zit ik tegenaan te hikken, omdat ik rekenen moeilijk vind. Ik vind het wel belangrijk, want je werkt hier met mensen.
Van de artsen hoor je over ziektebeelden, behandelingen, medicijnen. Je hoort dingen, zonder dat je zelf de bijbehorende artikelen hoeft te lezen. Waar artsen mee komen, neem ik voor waar aan omdat ik hen hoog acht. De verpleegkundige vlakbladen in de koffiekamer lees ik weleens, maar ik ben er niet geabonneerd op en vind het niet erg interessant. Eigenlijk vind ik dat ik de verpleegkundige literatuur wel bij zou moeten houden, maar ik ga er thuis niet voor zitten.
Of ik meer leer van wat me aangereikt wordt, dan dat ik zelf actief op zoek ben? Ja, dat klopt. Ik zou het wel moeten, want ik kan het wel. Sinds kort ben ik weer actief lid van een werkgroep, maar ik kan niet zeggen dat er veel uit mijn handen komt. Eigenlijk zouden ze wat meer gebruik van mij moeten maken, maar ik ben zo ook wel lekker aan het werk. De dingen die je geacht wordt te kennen, zoals de site met zorgmappen en protocollen, ken ik. En als studenten met vragen komen, dan weet ik het ook allemaal wel. Maar mezelf vernieuwen of met dingen komen, dat gebeurt eigenlijk niet. Wat daarvoor nodig zou zijn? Misschien een gesprek als dit. Of een gesprek met mijn teamleider, maar daarin wordt dat niet besproken. Er wordt gevraagd of je wat doet aan e-learning en of je meedoet in een werkgroep en dat was het. Doordat ik vorig jaar bijna overspannen ben geweest, denk ik ook wel: 'Alles op z'n tijd'. Maar een keer iets extra lezen of onderzoeken, kost natuurlijk niet veel extra energie. Daartoe word je eigenlijk niet echt uitgedaagd.

Cruciale leermomenten om huidig werk te doen

Ik heb een duale opleiding gedaan en het eerste jaar op een chirurgische trauma-afdeling gewerkt. Dat was één groot leermoment. Ik moest aan het lichaam van mensen zitten, en er waren mensen met zulke erge dingen dat ik er van moest huilen. In de psychiatriestage heb ik ook veel geleerd. Ik weet dat ik eruit kwam en dacht: 'Ik ben een goede verpleegkundige aan het worden'. Wat ik geleerd heb, is om in de chaos orde te scheppen en overzicht te houden. Van mijn 24e tot mijn 28e heb ik heel veel geleerd. Toen is de basis gelegd voor wie ik nu ben. Nu leer ik nog steeds omdat het moederschap erbij is gekomen en er weer andere emoties zijn. Het is overweldigend in positieve zin, maar ook in die zin van dat je zo kwetsbaar bent opeens. Ik leer steeds, word zekerder en minder bang om mijn mond open te doen. Mijn collega's komen op voor de patiënt en gaan tegen de dokter in. Zo was ik niet, maar dat wilde ik leren. Dan ging ik er naast staan, dat sterkte mij en aan de andere kant kan ik hen soms ook remmen. Ik zie dat zij dingen voor elkaar krijgen. Maar ik zie ook dat voor veel dingen helemaal geen grote mond nodig is. Ik merk dat ik, nu ik ouder word en een vast gezicht hier ben, ook van alles voor elkaar krijg bij de dokters.

Mijlpalen

Ik zie geen mijlpalen. Het gaat gewoon geleidelijk. Als mijlpalen momenten zijn waarop ik andere verantwoordelijkheden kreeg, dan was een mijlpaal de eerste keer dat ik een verantwoordelijke nachtdienst mocht draaien. Toen vond ik dat heel wat. Een mijlpaal was ook dat ik voor een stervende patiënt mocht zorgen. De eerste keren zijn echte mijlpalen. Die vertel ik thuis. Ook nu vind ik het fijn dat ze me, ondanks dat ik maar een paar dagen werk, neerzetten bij een stervende patiënt. Dan voel ik me erkend. En als mijn teamleidster zegt dat ze graag wil dat ik hier blijf werken, voelt dat ook als erkenning. Afsluiten van de oncologieopleiding vond ik ook een mijlpaal. Het was geen zware opleiding, maar het was inmiddels wel een groot ding geworden, doordat ik de eindopdracht steeds voor me uit schoof. Verder zijn het kleine mijlpaaltjes, dat je je er bewust van bent dat je een stukje verder bent in je ontwikkeling. Maar dat gaat geleidelijk. Het zijn meer de details. En ik ben heel blij dat ik dit werk doe.

Toekomst

De jongste is anderhalf jaar, dus ik ga nog tweeëneenhalf jaar zo door. Dan is mijn ouderschapsverlof op en ga ik weer gewoon drie dagen werken en misschien wel vier. Ik ga mezelf zeker weer ontwikkelen, maar ik sluit ook niet uit dat het voor die tijd al gaat gebeuren. Hoe ik mezelf wil ontwikkelen? Ik zoek ontwikkeling vooral in een opleiding doen. Ik zie mezelf dan weer 's avonds met de laptop op tafel dingen opzoeken. Dat ligt nu even stil. Ik zou nu best wel een opleiding willen doen, maar zodra het meer kost dan de uren die ik werk, heb ik daar geen zin in. Ik heb het nu allemaal onder controle. Van de e-learning en artsen leer je ook, maar ik zou het wel wat groter en gestructureerder willen en dat er een leuk papiertje bij zit. Dat papiertje is toch ook belangrijk; dat kan je vertellen en geeft status. Als ik mijn vriend

hoor vertellen dat ik oncologieverpleegkundige ben, dan klinkt dat toch goed. Wat ik ga doen, hangt ook af van wat ze vanuit hier willen sponsoren. Ik zou het in de toekomst wel in eigen tijd willen doen, maar ik heb geen geld om het zelf te betalen. Mijn persoonlijk ontwikkelbudget heb ik dit jaar opgemaakt aan de sportschool, maar misschien kan ik dat ook aan iets anders besteden.
Je kan je natuurlijk ook op andere manieren ontwikkelen, maar ik vind een opleiding leuk omdat je dan weer in een schoolse situatie komt waar je nieuwe dingen leert. En je ziet weer andere mensen. Ik zou me ook wel kunnen specialiseren in één aandachtsgebied, maar dan weet ik niet goed welk gebied dat zou zijn. Er zijn heel wat mogelijkheden, maar ik moet de tijd hebben om daar in te investeren. Of ik aan het bed blijf? Dat denk ik wel. Verplegingswetenschappen ofzo lijkt me interessant, maar dan werk je niet meer in een team aan bed en achter een bureau gaat niets worden. Leidinggeven lijkt mij ook leuk, maar dan moet je sturend en stuwend zijn en dat ben ik niet. Of dit een afdeling is waar mensen zich erg ontwikkelen? Dat gevoel heb ik wel. Het is een doorstroomafdeling. Als je hier een paar jaar ervaring hebt, kan je solliciteren bij de IC of de SEH. Het aantal nieuwe dingen is hier beperkt. Dat wat er aan nieuwe dingen bijkomt, wordt in kleine brokjes aangeleverd. Dat kan je makkelijk in je gewone werk integreren. De medium care-opleiding lijkt me ook nog wel leuk. Misschien ga ik dat nog wel doen voor de vijf jaar om zijn. Dat kan je hier toepassen, je gaat gewoon onder werktijd en je loopt een paar stagedagen. Op termijn heb ik dus wel weer zin in een opleiding, maar dan moeten de kinderen wat groter zijn. Als ze allebei naar school zijn en er thuis geen kleintje meer rondloopt, dan hoef ik ook niet meer thuis te zijn.

Vrouw, 45 jaar
13 jaar werkzaam op een afdeling dermatologie

> Ik wil altijd prikkels hebben. Dat lijkt niet te rijmen met hoe lang ik op de afdeling werk, maar ik haal er altijd mijn eigen prikkels uit. En was het niet op het werk dan was het thuis. Nu mijn kinderen groot zijn, kan ik weer verder.

Jeugd

Ik ben de jongste uit een gezin van vijf. Mijn vader was veel ziek, waardoor ik vaak in het ziekenhuis ben geweest. Vanaf mijn negende wist ik dat ik verpleegkundige wilde worden. Na de havo heb ik bewust gekozen voor de inservice-opleiding. Ik had het idee dat de verpleging een vak was dat je vooral in de praktijk goed kon leren. Nu zou ik waarschijnlijk de hbo-V voltijd gedaan hebben. Als 18-jarige kom je in een ziekenhuis wel jong met confronterende dingen in aanraking en achteraf gezien was een studentenleven ook leuk geweest. Ik was op mijn 17de niet alleen student, maar ook werknemer en dat botst weleens met je eigen ontwikkeling. Ik zou het jammer vinden als mijn zoon, die nu die leeftijd heeft, al fulltime gaat werken.

Opleiding tot verpleegkundige

Ik heb de opleiding in een militair hospitaal gedaan en daar een erg leuke tijd gehad. Ik heb er mijn man leren kennen en veel vrienden aan overgehouden. Doordat er dienstplichtigen werkten, was er veel verloop en kwam er steeds nieuw bloed met nieuwe ideeën. Ik heb ik het vak daar goed kunnen leren. Ik had altijd gedacht dat militairen hiërarchisch waren, maar toen ik op mijn huidige afdeling kwam, kreeg ik het gevoel terug te gaan in de tijd. In het academische ziekenhuis waren de hiërarchische verhoudingen meer aanwezig dan in het militaire hospitaal.

Verpleegkundige loopbaan

Na diplomering heb ik nog anderhalf jaar in het militair hospitaal gewerkt totdat het ging inkrimpen. Met een open sollicitatie ben ik op de dermatologie-afdeling terecht gekomen. In hetzelfde jaar ben ik getrouwd. Ik heb vervolgens vier jaar fulltime gewerkt en de dermatologie-opleiding gedaan. Toen mijn zoon werd geboren, heb ik ontslag genomen. Ik heb negen maanden kunnen moederen en ben daarna als oproepkracht begonnen. Twee jaar later is mijn tweede zoon geboren. Na vier jaar als oproepkracht gewerkt te hebben, waarbij ik nieuwe kennis had opgedaan omdat ik op verschillende plekken werkte, vroeg mijn manager of ik geen vast contract wilde. Dat wilde ik wel als ik mijn diensten kon afstemmen op die van mijn man. We hebben hierdoor nooit kinderopvang nodig gehad. Ik werkte 40%, iets minder dan twee dagen per week. Later ben ik iets meer gaan werken.

Vorig jaar kwam er een vacature voor senior-verpleegkundige voor drie dagen in de week. Mijn zonen waren inmiddels 14 en 17 en ik had het gevoel dat het weer een beetje tijd voor mezelf werd. Ik heb gesolliciteerd en het assessment gedaan.

De dermatologie

Wat mij trok in de dermatologie? Het is een vakgebied waar mensen over het algemeen zelfstandig zijn. Ondersteunen bij wassen, op de po helpen en zo doe je hier niet zo heel veel. Het gaat vooral om het ondersteunen in het chronisch ziek zijn. Ik vind het leuk om daarmee bezig te zijn. Lichamelijk is het een vakgebied dat je lang kan volhouden. Het is redelijk planbare zorg, waarbij je tijd kan besteden aan mensen. Dat vind ik prettig. Wat ik van een academisch ziekenhuis leuk vind, zijn de mogelijkheden die je krijgt. Ik heb alle opleidingen die ik wilde doen, kunnen doen.

Voorheen werkte ik veel late diensten. Dan heb je wel minder met de nieuwste ontwikkelingen te maken. Die gebeuren toch vooral overdag. Overdag heb je vaker gesprekken met artsen en ben je meer met beleidszaken bezig. Toch had ik niet het gevoel dat ik er buiten stond. Ik heb me altijd wel ingelezen en koos er voor om af en toe dagdiensten te draaien.

Vervolgopleidingen en bijscholingen

Voordat mijn zoon werd geboren heb ik de dermatologie-opleiding gedaan en in de periode dat ik twee dagen per week werkte allerlei kortdurende scholingen en de opleiding medische voetverzorging. Mijn man had ouderschapsverlof genomen, zodat ik één dag in de week naar school kon. Daarna heb ik een specialisatie behaald voor voetverzorging diabetici. Op de afdeling wilden ze een tweede persoon met deze expertise. De opleiding mocht ik in werktijd doen en de kosten heb ik vergoed gekregen. Met mijn pedicure-opleiding heb ik nu een eigen spreekuur voor voetverzorging.

Toen ik senior werd heb ik de bijbehorende opleiding gedaan. Je kreeg eerst een assessment om te kijken of je wel het hbo-niveau had. Dat was voor mijn eigenwaarde niet zo goed. Ik heb de havo gedaan en kan het bbo-niveau aan, maar moest dat laten zien in een assessment. Het was zweten, maar ik heb het goed gehaald. Dat was voor mij een bevestiging: zie je dat ik het kan. Op mijn leeftijd heb je dat af en toe nodig. Als er getoetst wordt, dan vind ik het wel weer spannend.

De senior-opleiding werd in huis gegeven en bestond uit drie scholingsdagen en zes intervisie-bijeenkomsten. Ik heb er veel van geleerd. Ik ben een echte doener en heb geleerd meer beschouwend te zijn. Ik heb een andere manier van denken gekregen. Hoe ik dat geleerd heb? Je las veel literatuur en kreeg allerlei opdrachten. Een belangrijk leermoment was het analyserapport dat ik moest maken van veilig orale medicatie klaarzetten. In eerste instantie dacht ik: 'Ik koop zo'n geel vestje, dat doe je aan als je medicatie moet bereiden en dan gaan we het allemaal netjes uitvoeren zoals het hoort'. Maar ik kreeg de opdracht om te analyseren wat er op de afdeling gebeurde en om na te gaan of er ook andere oplossingen waren. Dat gele vestje is er niet meer gekomen. Dat onderzoek was heel leuk en voor mij een eyeopener. Dit had ik tijdens mijn inservice-opleiding nooit geleerd. Studenten van nu leren veel meer de literatuur in te duiken.

Belangrijke leermomenten

Het is goed dat ik altijd ben blijven werken, ondanks mijn kleine contract. Bij vriendinnen die er een aantal jaren uit zijn geweest, heb ik gezien hoe moeilijk het is om terug te komen. In die jaren is er veel veranderd, bijvoorbeeld door de computers in de zorg en opnames duren veel korter waardoor je dingen sneller moet regelen. Je word je bewust van wat er allemaal is veranderd, als je ziet hoe anderen er niet meer in komen. Ik heb veel al doende geleerd.

Voor mij is belangrijk dat ik ben blijven werken en altijd bijgebleven ben. Als ik iets niet weet, dan haal ik er een collega bij. En je blijft bij door de vakliteratuur bij te houden. We hebben veel tijdschriften op de afdeling. Ook kan je veel op internet doen. De laatste twee jaar zijn de e-learning modulen in het ziekenhuis sterk ontwikkeld. Als je iets niet weet, zoek je het op. Eigenlijk kan je alles vinden als je iets wilt weten.

Ook in de jaren dat ik naast de verplichte dingen, zoals bijscholingsdagen, en het bijhouden van literatuur niet zozeer met mijn ontwikkeling als verpleegkundige bezig was, ben ik niet stil blijven staan. Ik wil me blijven ontwikkelen en heb nieuwe prikkels nodig. In die tijd heb ik veel in mijn privé dingen opgepakt. Ik heb in het bestuur gezeten van een dans- en theatergebeuren en daarbij grote groepen aangestuurd en evenementen georganiseerd. Dat waren voor mij ook leermomenten.

Leren op de afdeling

We zijn nu druk met de e-learning verpleegkundig rekenen. Daar moeten we verplicht een toets over doen. Dat zijn momenten dat ik getriggerd wordt er weer in te duiken, om na te gaan hoe het ook al weer zat en als ik het niet weet dan zoek ik iemand op die mij kan helpen. Ik vind het vreselijk als ik iets niet weet. Dat is een vorm van falen. Ik ben 45 en lang geleden opgeleid, maar ik wil niet voor jonge studenten onder doen. Ik vind dat ik, zeker als senior, een voorbeeldfunctie heb. Bij intervisie tijdens de senior-opleiding kreeg ik vaak terug dat anderen mijn enthousiasme en drive bewonderenswaardig vonden. Ik heb een drive om dingen te leren, maar stel me ook kwetsbaar op. Ik vertel studenten dat ik anders opgeleid ben, maar dat ik graag wil leren.

Wat ik er van vind dat e-learning verplicht is? Ik vind het soms wel goed, omdat je er anders voor weg kan lopen. De toets die er aan zit, vind ik wat minder. Het is ook mijn eigen verantwoordelijkheid dat ik medicatie goed uitdeel, maar ik begrijp dat er getoetst moet worden omdat ze moeten kunnen aantonen wat mensen doen. Voor mij zou het voldoende zijn om te laten zien dat je de module gedaan hebt.

Cruciale leermomenten om huidige werk goed te doen

Door de dermatologie-opleiding kan ik mijn werk hier goed doen. Daarnaast hebben we ieder jaar een bijscholingsdag. Afgelopen jaar heb ik cursussen gedaan voor het begeleiden van studenten. Dat zijn ook belangrijke leermomenten geweest. Ik heb een bepaalde kijk naar studenten ontwikkeld. Ik draaide wel eens een dienst met een student, maar nu heb ik een student van begin tot eind begeleid. Daar leer je van. Ik

kijk hun opdrachten na en dan duik ik af en toe de computer in om te kijken of het klopt wat ze beweren. Dit jaar heb ik ook de bijscholing venapunctie gedaan en ik wil nog de scholing perifeer infuus doen. We nemen steeds meer over van artsen en dan is het prettig als ik het ook kan.

Mijlpalen

Alle opleidingen die ik doe, vind ik een mijlpaal: gediplomeerd zijn als verpleegkundige, de dermatologie-opleiding en de pedicure-opleiding. De senior-opleiding was voor mij een grote mijlpaal. Dat zijn dingen waar ik hard voor heb moeten werken, veel energie in heb gestopt en dat is het leuk als er iets van een diploma aanhangt. Daarnaast is het prettig als ik merk dat patiënten het fijn vinden om door mij verzorgd te worden. Mensen met een goed gevoel weer naar huis laten gaan: dat zijn voor mij de kleinere mijlpalen. En soms heb je van die dagen dat je lekker in een flow kan werken. Alle opleidingen zijn mijlpalen, maar de stap tussen verpleegkundige en senior-verpleegkundige voelt wel als de grootste stap. Als senior heb ik andere verantwoordelijkheden gekregen. Ik heb echt veel geleerd het afgelopen jaar. Ik vind het een belangrijke functie, omdat je tussen de leiding en de verpleegkundigen instaat. Je bent iemand met een voorbeeldfunctie en je moet de kar trekken bij nieuwe ontwikkelingen. Ik word nu ook anders benaderd door mijn leidinggevende: ik krijg meer te horen over dingen die spelen. Daarnaast doe ik door de pedicure-opleiding heel ander werk. Ik zit dan anderhalf uur met één patiënt. Naast één andere collega, kan verder niemand dat werk op de afdeling. Toen ik dat haalde, was dat ook een mijlpaal. Ik was daar erg blij mee.

Mensen die me zijn bijgebleven

Als leerling keek ik altijd welke verpleegkundige ik hoog achtte en daar nam ik dingen van over. Dat waren mensen die heel kundig waren of een prettige manier van omgang met mensen hadden. En er zaten ook mensen tussen die laten zien hoe je niet wilt worden. Zo had ik voor mezelf een plaatje gemaakt van een verpleegkundige. Ik stimuleer studenten ook zo te kijken. Je kunt veel leren van kijken en luisteren. Ook op deze afdeling werkt dat zo. Ik heb mijn manier van werken en een ander heeft soms een andere manier die goed werkt. Ik blijf daar voor openstaan. Door intercollegiaal overleg en door met elkaar de patiënten te bespreken, leer ik nog steeds van mijn collega's. Ook van het multidisciplinair overleg, overleg met artsen, maatschappelijk werk e.d. leer ik veel.

Toekomst

Hoe ik de komende vijf jaar voor mij zie? Ik hoop in goede gezondheid. Als rode draad door alles heen, zie ik dat ik mezelf kan ontwikkelen als thuis alles goed is geregeld. Als er thuis iets ontbreekt, ik heb geen opvang of de kinderen worden ziek, dan valt het mooie plaatje in duigen. Ik ben het afgelopen jaar druk geweest met de zorg voor mijn moeder. Ze was ziek en ik heb veel ziekenhuisbezoeken afgelegd. In januari is ze

overleden. Ik ben mede daarom de afgelopen jaren niet meer uren gaan werken. De jongens werden wel groter, maar mijn moeder had veel zorg nodig. Die tijd heb ik er nu bij gekregen. Ik krijg nu meer de ruimte om te denken wat ik wil.
Zolang het goed blijft gaan, zie ik mezelf meer groeien in de rol van senior. Dat doe ik door de functie uit te voeren en door te sparren met collega's. Eventueel zou ik nog wel een opleiding willen volgen, maar ik weet nog niet wat. Ik heb weleens aan de kaderopleiding gedacht, maar ik wil geen leidinggevende worden van een team waar ik al lang werk. Dan zou ik hier weg moeten en ik weet niet of ik dat wil.
Waarom ik een opleiding zou willen doen? Ik wil mezelf blijven ontwikkelen en niet stil blijven staan. Ik denk dan toch als eerste aan een opleiding, maar dat zou ook een taal kunnen zijn. Nu het thuis allemaal loopt, vind ik het leuk om een opleiding te gaan doen of misschien als vrijwilliger in een hospice werken. Eigenlijk weet ik het nog niet en ligt het helemaal open. Ik kijk wat er op mijn pad komt, maar ga niet zitten wachten, dan gebeurt er niets.
Of ik tot mijn pensioen aan bed blijf, weet ik niet. Ik denk dat het op deze afdeling redelijk vol te houden is, omdat het lichamelijk minder zwaar is. Maar of ik het nog leuk vind tegen die tijd weet ik niet. Nu vind ik het werk nog steeds leuk en uitdagend genoeg. Elke dag is toch weer anders.

Vrouw, 54 jaar
30 jaar werkzaam op een intensive care neonatologie–afdeling

> Ik werk niet zo heel veel, zeven dagen per maand. Dat maakt het soms net iets lastiger om bij te blijven. Het is makkelijker als je alle dagen werkt, dan gaat het vanzelf.

Vanaf mijn vierde wilde ik missiezuster worden. Ik zat bij de nonnen op school, wilde met kinderen werken en de verpleging in. Het idee van missiezuster verdween al snel, maar kinderen en verpleging leken mij een mooie combinatie. Een aantal nichtjes ging ook de verpleging in. Na de mavo en de havo ben ik begonnen in een kinder–ziekenhuis. Dat was een bijzondere opleiding. Je deed eerst tweeëneenhalf jaar een opleiding in het kinderziekenhuis en vervolgens moest je naar een algemeen zieken–huis om de A–opleiding te doen. Daarna kon je in een half jaar de kinderaantekening halen. Ik heb daarna nog een half jaar in het kinderziekenhuis gewerkt. Vanwege het werk van mijn man zijn we verhuisd en heb ik bij een algemeen ziekenhuis gesollici–teerd bij wat toen nog de klimaatkamer werd genoemd. Ik was dol op baby's. Het had ook een andere kinderafdeling kunnen zijn, maar hier was er een vacature.

Dertig jaar op een afdeling die steeds verandert

Hier werk ik nu dertig jaar. De afdeling is in die jaren heel erg veranderd. Het was eerst een neonatologie–afdeling. We pasten al wel beademing toe, maar waren nog geen NICU ; dat zijn we nu ongeveer twintig jaar. Iedereen denkt dat dertig jaar op dezelfde afdeling saai is. Maar zo'n afdeling is nooit saai. Er gebeurt altijd iets, zoals de introductie van nieuwe apparatuur en nieuwe inzichten. In de tijd dat ik hier werk, is de leeftijdsgrens verschoven van achtentwintig weken naar vierentwintig weken. Dat is een enorm verschil. We hebben een nieuw beademingsapparaat waar je je in moet verdiepen. De invoering van het elektronisch patiëntendossier is een heel proces, en er wordt natuurlijk veel onderzoek gedaan op zo'n afdeling.
Ik had nooit bedacht dat ik naar een IC–afdeling zou gaan. Daar rol je in. Ik ging naar de klimaatkamer en vond het leuk dat ze van die bijzondere dingen deden, maar vond het ook leuk om gewoon de fles te geven. Ik ben niet echt een IC–verpleegkundige, die hebben nog meer belangstelling voor apparatuur en techniek. Ik ben meer van de zorg, begeleiding en aandacht. Dat kan niet altijd op zo'n afdeling. Als het slecht met een kind gaat, dan heb je minder tijd voor ouders, maar op andere momenten wel weer meer. Als ik op een andere afdeling werk, merk ik dat ik de fles geven leuk vind voor een avond, maar dat ik liever op de IC werk.

Parttime werken en bijblijven

De eerste drie jaar werkte ik fulltime. Sinds we kinderen hebben – we hebben er drie, de oudste is zevenentwintig en de jongste achttien – werk ik zeven dagen per maand: in principe late diensten in blokken van drie en vier dagen. Ik werk niet zo heel veel, dat maakt het soms lastiger om bij te blijven. Als je fulltime werkt dan gaat het vanzelf.

Als je alle dagen werkt, dan krijg je het beademingsapparaat sneller in de vingers. Ik heb net vakantie gehad en dan sta ik bij het apparaat en vraag me af hoe het ook al weer precies werkte. Dan vraag ik even een collega om het me weer even te vertellen.

Vervolgopleiding en bijscholing

Toen de afdeling een NICU werd, moesten wij de ICN-opleiding doen. Wij hadden al zo veel ervaring dat we niet, zoals onze collega's, stage hoefden te lopen. De opleiding werd in het ziekenhuis gegeven. Recent heb ik een cursus voor ergo-coach gedaan van drie middagen. Een collega was ergo-coach. Ze vroegen er iemand bij en dat leek me heel leuk. We proberen om collega's meer te laten zitten bij de couveuses. Dat is beter voor je benen en je rug. Ik merk dat ze dat nu ook meer doen.. Het is leuk om tips te kunnen geven waar ze echt wat mee kunnen. Het was ook leuk om andere mensen te ontmoeten. Ik krijg nu een blad over ergo-coaching en kan naar bijscholingscursussen, maar die gaan vooral over volwassenen.

Commissies

Ik heb een paar jaar in een commissie gezeten om methodisch werken in te voeren. Dat was frustrerend. Ik zag er iets in, maar het was moeilijk om collega's te motiveren. Ik heb ook niet echt de skills om het goed uit te leggen. Zo ben ik niet opgeleid. En toen kwam de vraag voor ergo-coach. Dit is heel praktisch, hier luisteren ze naar en het heeft effect. Ik zit ook in de commissie van de terugkomdag. Dan organiseren we een middag voor de kinderen die bij ons gelegen hebben. Ik vind dat je af en toe iets meer moet doen dan alleen je werk. Er zijn zoveel klussen. Misschien voel ik wel extra druk, omdat ik vrij weinig werk. Er zijn altijd perioden dat collega's vinden dat ik te weinig werk en het maar mooi voor elkaar heb. Ik heb het gevoel dat ik iets extra's moet doen. Vroeger dacht ik: als de kinderen groot zijn, ga ik meer werken en onregelmatig. Maar het is nu zo onzeker hoelang je moet werken. Zeven dagen kan ik heel lang volhouden, misschien wel tot zevenenzestig jaar.

Leren op de afdeling

Het is prettig dat we veel cursusdagen hebben. In die dagen komen er allemaal dingen aan de orde waar je wat aan hebt. Een groot voordeel is dat je elkaar veel kunt vragen. We overleggen veel en daar leer ik van. De een weet dit en de ander dat. Toen ik hier net was begonnen, was dat minder. Niemand wist zo veel en de dokters sliepen thuis. Je stond erg alleen. Misschien was dat ook een leermoment, maar ik werk nu veel prettiger. Er zijn meer dokters in de buurt en er is altijd wel een assistent of nurse practitioner. Wat je leert? Veel inzichten zijn veranderd. Vroeger dachten we bijvoorbeeld dat je met de saturatiemeter 100 moesten halen, maar wisten niet dat je dan misschien wel teveel gaf. Nu mag het 86 zijn. Zo zijn de inzichten veranderd bij een getal.

We hebben kwart over drie momenten: een soort klinische lessen van een half uur. Die zijn heel informatief. Daarin wordt een nieuw apparaat uitgelegd, of de nurse

practitioner vertelt over het onderzoek dat ze gaat doen. Een collega vertelde bijvoorbeeld hoe het nieuwe beademingsapparaat werkt en welke instellingen je het beste kan gebruiken bij verschillende ziektebeelden of uitslagen. Als je geen dienst hebt, kan je wel komen, maar dat doen niet veel mensen.
We hebben een map van het ziekenhuis gekregen, waarin je klinische lessen, symposia en zo kan bijhouden. Daar wordt nog niet echt iets mee gedaan, maar straks wordt het digitaal geregistreerd en moet je accreditatiepunten halen. Ik houd het niet goed genoeg bij, maar het registreren komt steeds dichterbij. Ik moet dus langzaamaan beter mijn best gaan doen.
Thuis krijgen we Nurse Academy, daarin staan toetsen waarmee je punten kunt behalen. Pasgeleden kreeg ik een e-mail van de afdeling Opleidingen dat ik de toetsen nog moest doen. Blijkbaar moet je de toetsen uit dat blad doen. Een collega vertelde me dat ze altijd alle punten behaalde. Toen dacht ik, laat ik dat ook eens gaan doen. Ik heb me nu aangemeld. Het lijkt me wel goed. Ik vind het leuk om te lezen en dan kan je de vragen erover ook wel maken. Al vraag ik me af of ik ook toetsen over bijvoorbeeld Parkinson moet maken. Ik vind dat je zolang je werkt, moet proberen bij te blijven. Je kunt niet met 55 of zo al zeggen 'Het zal mijn tijd wel duren'.
Het digitale vind ik best ingewikkeld. Met een Ipad kan ik aardig uit de voeten, maar een gewone computer vind ik nog wel lastig. Laatst kwam mijn man erachter dat ik niet eens het verschil wist tussen de linker en rechter muisknop. Daarin loop ik achter, maar als alles straks via de computer gaat, heb ik dat toch nodig.
We hebben ook e-learning modules zoals body cooling. Dat kwam aan de orde in de cursusdag en via e-learning moest je daarover een toets maken. Als je een toets drie keer niet haalt, wordt er met je gesproken en krijg je bijles. Dat is nog niet vaak gebeurd. Een nadeel van de toetsen is dat die multiple choice vragen vooral gaan over hoe goed je Nederlands kunt lezen. Het is bijna tekst verklaren. Ik heb niet zo'n moeite met de toetsen, maar sommige collega's wel. Toen ik het hierover met een collega had, gaf ze aan dat bij een onvoldoende er 'in deze herberg geen plaats meer zou zijn'. Dat vond ik heel vervelend. Misschien maak je je er zonder toetsen wel iets te makkelijk vanaf, maar de toetsen zeggen natuurlijk niet zo veel. Mijn man zit in het onderwijs en we hebben het hier wel vaker over. Toetsen, cijfers en dat soort dingen zijn helemaal niet zo goed voor kinderen. Het zou veel beter zijn om allemaal hetzelfde te bestuderen en dat met elkaar te bespreken. Nu doe je dat bijna niet. Je doet de toets thuis met een boek erbij. De uitwisseling zou je kunnen structureren.
Na de reanimatiecursus, of straks na de e-learning over de hielprik, wordt er een praktijktoets afgenomen. ICN-studenten moeten op de afdeling een dag een kind verzorgen met drie, vier mensen erbij. Dan moeten ze laten zien wat ze doen en erbij vertellen waarom ze dingen doen. Dat is natuurlijk beter dan zo'n e-learning toets, maar ik zou het doodeng vinden en mijn collega's ook. Zo'n hielprikje laten zien, is niet erg. Een hele dag een kind verzorgen en vertellen waarom ik dingen doe, zou ik wel moeilijk en eng vinden. Niet omdat ze dan mijn werk zien, maar omdat ik dan een technisch verhaal zou moeten houden over de longen of het beademingsapparaat.

Van studenten wordt dat verwacht: die moeten meer kunnen dan wij toen moesten. Bij de reanimatiecursus krijg je verschillende casussen met een pop in een couveuse en moet vertellen wat je gaat doen. Sommigen zien daar erg tegenop. Het is wel leerzaam; je leert nog beter na te denken bij wat je doet. Het is misschien ook wel goed dat iemand meekijkt, want ook al werken we met elkaar, je doet toch veel alleen.

Belangrijke leermomenten

Tijdens de opleiding liep je wel eens tegen je grenzen aan, misschien leer je daar het meeste van. Ik heb op een afdeling gewerkt met kinderen met leukemie. Daar kon ik fulltime werken niet aan. Psychisch was het heel zwaar om met grotere kinderen die zo ziek zijn, te werken. Daar heb ik van geleerd. Ik geloof niet dat ik daar tot mijn vijfenzestigste had kunnen werken, maar misschien leer je dat in de loop der jaren beter hanteren.

Of er bepaalde momenten belangrijk waren, is lastig aan te geven. Er waren wel periodes dat je het zwaarder had. In het algemeen ziekenhuis stond ik opeens, als vierdejaars, op zondagmorgen alleen op zo'n enorme afdeling. Daar leer je een hoop van. Het blijft bij, omdat het niet leuk is én omdat het uiteindelijk wel mee viel. Je blijkt dan meer te kunnen dan je denkt. Dat leer je ervan, denk ik.

Mijlpalen

Ik ben trots om op zo'n afdeling te werken. Dat geeft me een goed gevoel. Het is een enorme uitdaging en dat is leuk. Aangezien ik geen rasechte intensive care verpleegkundige ben, moet ik steeds een stapje meer zetten om het te halen. Als dat lukt en mensen zijn tevreden, dan is dat leuk. Af en toe heb je een avond met een heel ziek kind en het is allemaal goed gedaan. Dat geeft dat een goed gevoel en is een mijlpaal. Of er momenten zijn waarop ik andere verantwoordelijkheden kreeg? We hebben allemaal dezelfde verantwoordelijkheden. Iedereen doet er wel iets bij, de één onderwijs, de ander materialen en ik doe de terugkom en ergo-coaching, maar dat geeft geen andere verantwoordelijkheid.

Toekomst

Er gaan een aantal nieuwe dingen gebeuren, zoals de e-learning. Daar ga ik in mee. Verder wil ik gewoon zo blijven werken en het ergo-coachen iets uitbreiden. Ik wil een aantal technische dingen leren, zoals infuus inbrengen. Een aantal collega's kan dat en volgens mij kan ik dat ook wel. Zij beginnen nu met bloed afnemen, maar dat deed ik al. Als je die handelingen kan, kan het nadeel zijn dat collega's je vragen om die handelingen ook bij hun kinderen uit te voeren. Dus de hielprik en een infuus inbrengen vind ik genoeg. Die handelingen leer je in de praktijk, en voor de hielprik ontwikkelen ze een e-learning. Tot nu toe leerde ik het van een collega. Je kan hem vragen mee te kijken of het goed gaat. Dat is je eigen verantwoordelijkheid.

Of ik hier wil blijven werken? Als ik gezond blijf wel. Ik werk zeven dagen, dus dat is goed te doen. Ik werk wel eens bij de gewone neonatologie. Dat vind ik leuk, maar ik

zou er nu niet willen werken. Als ik de stress hier, door de hectiek en de ernst van de ziekten, niet meer aankan, dan zou ik daar misschien wel kunnen gaan werken. Dan hoop ik dat ik een stapje terug kan doen, maar de vraag is of zij zitten te wachten op alle mensen die afvallen. En anders moet ik andere dingen verzinnen. Ik zou het wel jammer vinden, want ik vind dit leuk.

Man, 57 jaar
20 jaar werkzaam op een geriatrie-afdeling

> Ik ben van mening dat je blijft leren. Als je dat niet meer hebt en je stelt je er ook niet meer voor open, dan ben je niet goed bezig, dan raak je gefrustreerd. Die zijn er ook genoeg; mensen die uitkijken naar hun pensioen. Dan zijn het tropenjaren volgens mij.

Keuze voor de verpleging

Na de middelbare school ben ik naar de kweekschool, wat nu de pabo is, gegaan. Het lesgeven vond ik leuk, maar na anderhalf jaar ben ik gestopt. Ik zag het toch niet als mijn toekomstige baan. Een vriendin had enthousiaste verhalen over de verpleging. Na de dienstplicht ben ik de verpleging in gegaan. Daar keek iedereen van op. Voor mijn ouders was het in eerste instantie een beetje teleurstellend. Mijn vader had een aannemersbedrijf en zijn droom was dat ik, als enige zoon, het bedrijf over zou nemen. Het was ook de tijd dat er nog weinig jongens de verpleging in gingen. Mijn vader veranderde van mening, toen zijn moeder overleed. Zij had bij ons op de afdeling gelegen en ik had haar ook verpleegd. Vanaf dat moment vond hij verpleging een mooi beroep.

Belangrijke levensgebeurtenissen

In 1980 ben ik getrouwd. We hadden een kinderwens, maar het is niet gelukt. Ik kan niet goed traceren hoe, maar het heeft invloed gehad op mijn loopbaan. Een aantal jaren later overleden mijn schoonouders en werd mijn vrouw ernstig ziek. Dat was heftig. Er kwam weinig uit m'n handen en ik realiseerde me meer dat het belangrijk is om te genieten van dingen. Ik heb een fantastisch vak en heb het naar m'n zin, maar ik wil dingen doen die ik leuk vind. Ik hoef niet perse carrière te maken. Het heeft me beïnvloed bij mijn beslissing om een stap terug te doen van teamleider naar senior-verpleegkundige. In 2005 heb ik zelf in het ziekenhuis gelegen. Dat was ingrijpend. In hetzelfde jaar overleed mijn vader en vorig jaar mijn jongste zus.

(Vervolg)opleidingen en verpleegkundige loopbaan

Ik heb de A-opleiding gedaan in een militair hospitaal. Daar heb ik ook mijn vrouw leren kennen. Ik heb de cardiac care-opleiding gedaan en er met veel plezier drie jaar gewerkt tot het technischer werd. Ik had nog zin om te leren en het leek me leuk om de leidinggevende kant op te gaan, dus heb ik een managementopleiding gedaan. Vervolgens ben ik als teamleider op een longafdeling gaan werken en na twee jaar in een militair revalidatiecentrum. Voor de benadering van CVA-patiënten heb ik een NDT-opleiding gevolgd. Ik heb er zeven jaar met veel plezier gewerkt. Toen er plannen kwamen om het revalidatiecentrum te sluiten, dacht ik, dat moet ik voor zijn. Er werden 25 verpleegkundigen gezocht voor een nieuw op te richten afdeling geriatrie. Ik ben aangenomen. De leidinggevende functie was al bezet. Achteraf vond ik dat niet zo erg. Ik heb twee jaar als verpleegkundige gewerkt en daardoor veel van het

specialisme geleerd. Bij binnenkomst heb ik de vervolgopleiding klinische geriatrie gevolgd. Vervolgens ben ik twaalf jaar leidinggevende geweest, de eerste acht jaar min of meer als meewerkend voorman. Van lieverlee kwam de functie steeds verder van het bed af te staan. En juist die zorg ging ik steeds meer missen. Ik dacht, ik moet een keuze maken. Ik heb aangegeven dat ik seniorverpleegkundige wilde worden.
Als seniorverpleegkundigen zijn we regieverpleegkundigen: we coördineren, faciliteren, overleggen met de artsen over de bedden en coachen mensen. We zijn een spin in het web. Daarnaast heb je een aandachtsgebied. Ik heb, gezien m'n achtergrond, mobiliteit, til en transfer als aandachtsgebied. Met een collega heb ik een klinisch pad ontwikkeld en ik geef er les over, geef coaching on-the-job, let op werkhoogte en transfers van patiënten en geef presentaties bij symposia. Dat is leuk, mensen enthousiasmeren, kennis overbrengen.

Leren in het werk

Wat ik nu leer en niet leerde toen ik leidinggevende was? Ik blijf scherp, blijf observeren en dingen zien bij mensen. Zeker bij oudere patiënten kunnen ziektebeelden zich op verschillende manieren presenteren. Dan zie je dingen die je nooit hebt gezien. Ik leer veel op het gebied van nieuwe medicatie, ziektebeelden en nieuwe behandelingen.
Waar ik ook van leer is van alle ontwikkelingen, zoals het elektronisch patiëntendossier. Ik kom uit de tijd dat het woord reflectie in de opleiding niet voorkwam. Toen ik weer als verpleegkundige ging werken en jaren geen studenten had begeleid, moest ik het nieuwe onderwijsstelsel leren kennen met alle praktijkopleidingsboeken . Ik werd gekoppeld aan een verpleegkundige met meer ervaring in het begeleiden van studenten. Ook hadden we scholingen over het curriculum en we worden begeleid bij het beoordelen van reflectieverslagen en van het functioneren van studenten.
In het ziekenhuis zitten we in een accreditatietraject. Los van het feit hoe je daarover denkt, leer je wel van de spiegel die je wordt voorgehouden. Van sommige dingen word je je meer bewust, zoals de privacy van patiënten. De regels worden aangescherpt. Dat kan soms lastig zijn of overdone, maar het zet je ook aan het denken. Bijvoorbeeld handhygiëne, daar ging ik niet zo streng mee om, maar ik gebruik nu toch alcohol.
Ik volg allerlei bijscholingen, zoals trainingen voorbehouden behandelingen. Dat zijn scholingen die telkens weer gegeven worden. Binnenkort ga ik naar een symposium over mobiliteit bij ouderen, dat wordt door de afdeling gefaciliteerd. Soms houd ik een presentatie, soms ga ik om te luisteren. Af en toe hoor ik nieuwe dingen, maar het hoeft niet altijd vernieuwend te zijn. Je kan ook leren van dingen nog een keer horen. En het kan ook leuk zijn om bevestigd te krijgen dat we al vrij ver zijn. Dat moet je niet te vaak hebben, maar het is weleens leuk. Ik haal ook veel uit vakbladen. Ik lees allerlei bladen, met name artikelen die de geriatrie aangaan. Ook het vakblad dat mijn vrouw ontvangt is leuk om te lezen. Het gaat over ander type patiënten, maar soms staan er ook relevante dingen in. En ik leer van studenten. Zij houden je de bekende spiegel voor. Een leerling merkte bijvoorbeeld op dat ik geen handschoenen droeg bij het

oplossen van antibiotica. Dat ben ik toen toch gaan doen. Ook leer je van bijvoorbeeld de wondverpleegkundige. Of het zo kan zijn dat er nieuwe inzichten zijn, die ik niet weet? Ik hoop het niet, en als dat zo zou zijn, dan zou ik me aanpassen. Ik ken genoeg mensen die zeggen: dat is onzin, ik doe het al jaren zo. Dat vind ik een gevaarlijke dooddoener.

Leren omgaan met veranderingen in het werk

Er verandert veel in het werk. We zijn nu bezig met een project van één verpleegkundige op vier patiënten. We moeten nu diverse zorgprocessen tegen het licht houden en kijken wat we eventueel minder of door anderen kunnen laten doen. Daar leer je van, je moet op een goede manier prioriteiten gaan stellen. Tegelijkertijd leer je ook over jezelf. Het komt voor dat de werkdruk zo hoog is, dat ik me gefrustreerd voel. Binnensmonds kan ik dan uit m'n slof schieten. Ik schrik dan, zo ken ik mezelf niet. Ik ben positief. Als je gefrustreerd rondloopt, merken patiënten dat. Ik moet leren om met die frustraties om te gaan. Als regieverpleegkundige heb je een voorbeeldfunctie. Dan moet je niet meehuilen met de wolven. Dat vind ik reëel, maar ook weleens lastig. Deze week was het zo druk dat ik een meneer niet uit bed kon halen. Dat frustreert ontzettend. Dat moet ook blijven frustreren, anders zou je afvlakken. Maar ik moet dat op een andere manier uiten, want ik weet wat een slechte sfeer doet met de afdeling.

Belangrijke leermomenten

Een belangrijk leermoment was toen dat ik besefte niet meer gelukkig te zijn in de functie van leidinggevende. Voor mij was het een logische stap om senior-verpleegkundige te worden. Uit de reacties merkte ik dat anderen het niet zo logisch, maar wel knap, vonden. Daarnaast ben ik nog altijd heel gelukkig dat ik de keus heb gemaakt om de geriatrie, maar zeker ook de verpleging in te gaan. Dat is een goede keus geweest. Ik ben niet iemand die snel ergens weg zou gaan. Als die dreiging bij het revalidatiecentrum er niet was geweest, had ik er misschien nog gezeten. Daar zou ik het ook naar m'n zin hebben gehad, maar ik heb hier zoveel meer geleerd. Het was weer een heel ander specialisme. En het is een groot ziekenhuis, waar ook veel meer kan qua opleiding. Onderwijs is een belangrijke poot, waar meer geld voor vrij wordt gemaakt.

Leerperioden cruciaal voor huidige werk

Mijn opleiding en ervaring zijn belangrijk. In de praktijk leer je veel. Geriatrie is een complex vakgebied. In de loop der tijd ontwikkel je door ervaring en doordat je er over leest een soort fingerspitzengefühl. Door het werken met oudere mensen, door hen te observeren, in visites met artsen te sparren en door klinische lessen, ga je verbanden leggen. Zo leer je klinisch redeneren. Het is leuk als je iets leest in een vakblad en denkt, hé meneer Jansen die had precies hetzelfde. Dan beklijft het goed. Het begin van de opleiding is ook cruciaal. Pakt het je of pakt het je niet? Ik was altijd vrij vies van aard en calvinistisch opgevoed, maar ik vond het al snel erg leuk. Blijk-

baar had ik in de praktijk niet die gêne die ik dacht te hebben. Ook vond ik mensen verzorgen leuk. En er was een gezellige sfeer en het was een goed ziekenhuis. Wat ook bepalend is geweest: de eerste patiënt die overleed. Ik ken zijn naam nog en zie hem zo voor me. Daarna heb ik op een oncologische afdeling, waar jonge mensen overlijden, gewerkt. Dat heeft me sterk gevormd. Tot dan toe was het gezellig geweest, maar daardoor realiseer je je wel, het is niet altijd leve de lol. Als je aan het begin had gevraagd wat ik het leukst zou vinden, dan zou ik, als zoveel jonge jongens, de ambulance geantwoord hebben. Nu vind ik op een goede manier stervensbegeleiding geven één van de mooiste dingen. Daar ben ik in gevormd door de reacties van nabestaanden. Als zij laten merken dat ze veel steun hebben gehad, dan weet je dat je op de goede weg bent.

Wat ook bepalend is geweest, en waar ik veel profijt van heb, is mijn ervaring binnen de revalidatie. Ik heb geleerd om om te gaan met de frustratie van patiënten, maar ook om het doel voor ogen te houden. Om ook juist bij deze patiëntencategorie het maximale eruit te halen. Zelf nog uit bed kunnen komen, kan net het verschil maken tussen wel of niet naar een tehuis moeten.

Mijlpalen

Of er mijlpalen zijn in mijn ontwikkeling? Ik vind het altijd raar om over mezelf dat soort dingen te zeggen. Het is meer het verhaal van je sterke en minder sterke punten. Wat ik leuk vind, je kunt het een mijlpaal noemen, is dat ik lesgeven zo leuk vind en dat het me goed afgaat. Mijn keuze voor de kweekschool was niet voor niets. Ik vind dat blijkbaar toch leuk. En ik ben blij dat ik een opgeruimd type ben. Daar ben ik niet trots op: je bent zoals je bent, maar ik ben blij dat ik meestal een positieve bijdrage aan de afdeling kan leveren. Ik vind dat belangrijk omdat ik zelf ook prettig werk in een goede sfeer. En verder geeft het een kick als mensen met ontslag gaan en de familie bedankt je. Dat heb je met z'n allen gedaan. Dat is het leuke van het vak, dat is een doorlopende mijlpaal.

Of er momenten zijn geweest dat ik andere verantwoordelijkheden kreeg? Dat was toen ik geen leidinggevende meer wilde zijn. En in mijn werk als verpleegkundige zijn er bepaalde voorbehouden handelingen, zoals venapunctie, waarin je geschoold moet zijn, voordat je ze mag doen. Verder mag je als verpleegkundige met de opleiding geriatrie in principe alles doen.

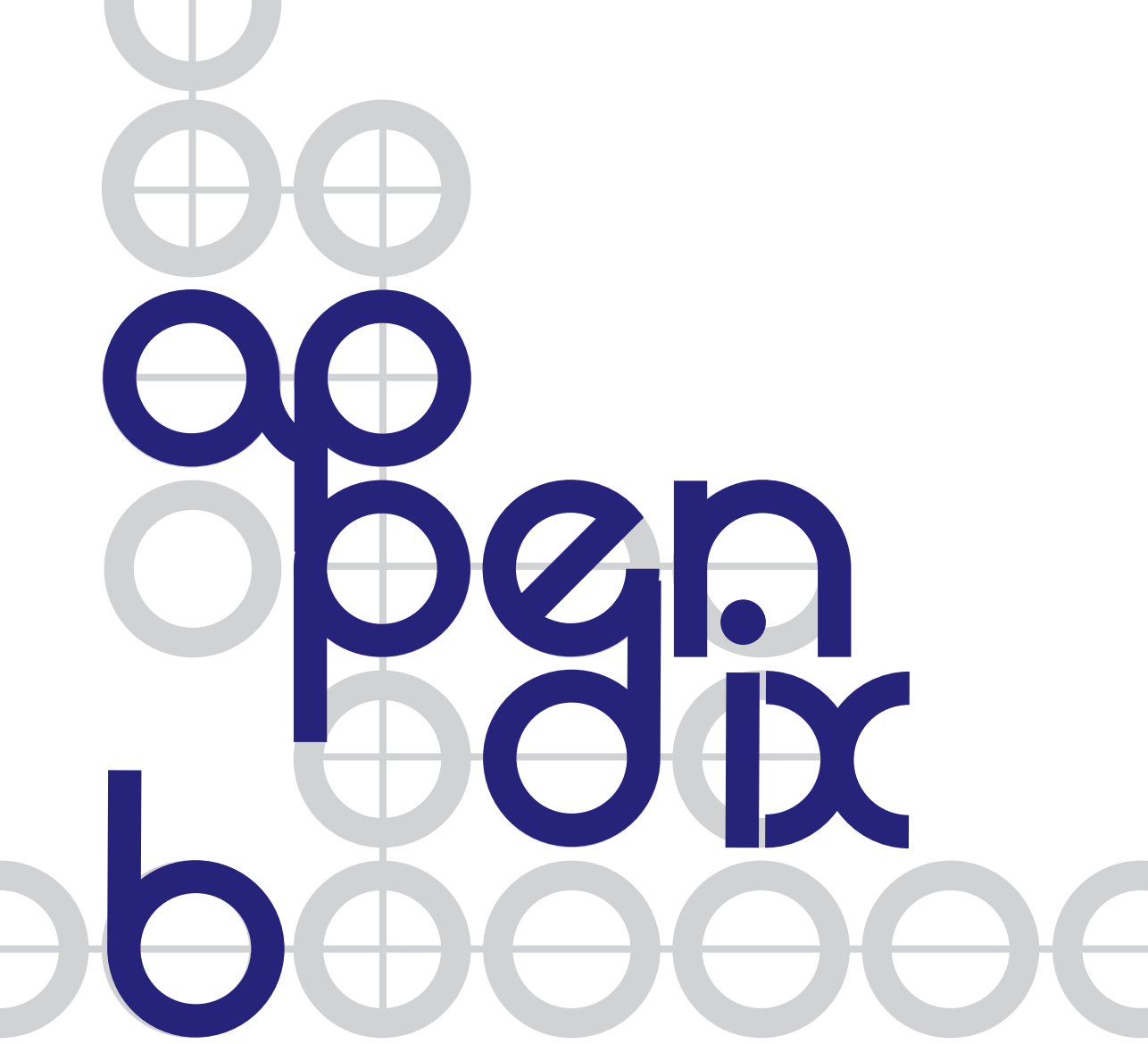
Mensen waarvan veel is geleerd

Er zijn veel mensen geweest van wie ik heb geleerd: goede dingen of dingen waarvan je denkt zo moet je het niet doen. Diverse leidinggevenden. Door met mensen te praten, die er een beetje hetzelfde over denken, word je ook gevormd in je ideeën over wat je kwaliteit vindt.

Toekomst

Ik ben op een punt gekomen dat ik gewoon met al m'n inzet de komende jaren lekker wil werken. Ik wil wat projecten doen en lesgeven. Waar ik mezelf verder in wil ontwikkelen? Dat zijn kleine dingen. Ik heb geen grote opleidingen voor ogen. Het gaat meer om dingen bij te leren, bij te blijven, me verder te bekwamen in het elektronisch patiëntendossier en het maken van een PowerPointpresentatie voor mijn lessen. Dat leer ik door te oefenen, een klinische les te geven en daarop feedback van de toehoorders te krijgen.

Binnenkort gaan we verhuizen. Dat is minder leuk, je gaat hier weg, maar ik zie het wel weer als een uitdaging. We hebben er geen zeggenschap over en dan kan je alleen je uiterste best doen om de faciliteiten te krijgen waarmee je zo goed mogelijk zorg kunt verlenen. Voor mij zit er een leermoment in het vasthouden van mijn arbeidssatisfactie ook als we eventueel moeten werken met minder faciliteiten. Dat leer ik door goed op mezelf te letten, signalen in mezelf te herkennen.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Questions for focus groups

Questions for focus groups (Chapter 2)

The questions for nurses and managers are the same, except for question 9, which was not posed to managers.

1. Think of a nurse who develops continually, according to you.
   What do you see?

2. Think of a nurse who does not develop continually, according to you.
   What do you see?

3. Why does the one develop continually while the other does not?

4. How does the ward staff react to nurses who develop continually?

5. How does the ward staff react to nurses who do not develop continually?

6. Do you see any differences in the way younger and older nurses develop continually?

7. Do the same CPD standards apply to younger and older nurses?

8. To what extent do nurses need to be stimulated to develop continually?

9. What motivates you to develop continually?

Final questions

10. If you were in charge, what would you do to guarantee that every nurse is competent in her/his work?

11. Are there any things that you think are of importance, which we have not asked?

Vragen voor focusgroeponderzoek (Hoofdstuk 2) in Dutch

De vragen zijn voor verpleegkundigen en leidinggevenden hetzelfde m.u.v. vraag 9, die werd niet aan leidinggevenden gesteld.

1. Neem in gedachten een verpleegkundige die zich naar jouw idee continu/ regelmatig ontwikkelt. Wat zie je dan?

2. Neem in gedachten een verpleegkundige die zich naar jouw idee niet continu ontwikkelt. Wat zie je dan?

3. Wat maakt dat de één zich blijft ontwikkelen en de ander niet?

4. Welke reactie(s) heeft de afdeling op verpleegkundigen die zich continu ontwikkelen?

5. Welke reactie(s) heeft de afdeling op verpleegkundigen die zich niet continu ontwikkelen?

6. Zie je een verschil in hoe jongere en oudere verpleegkundigen zich continu blijven ontwikkelen?

7. Gelden voor jongere en oudere verpleegkundigen dezelfde normen m.b.t. continue professionele ontwikkeling?

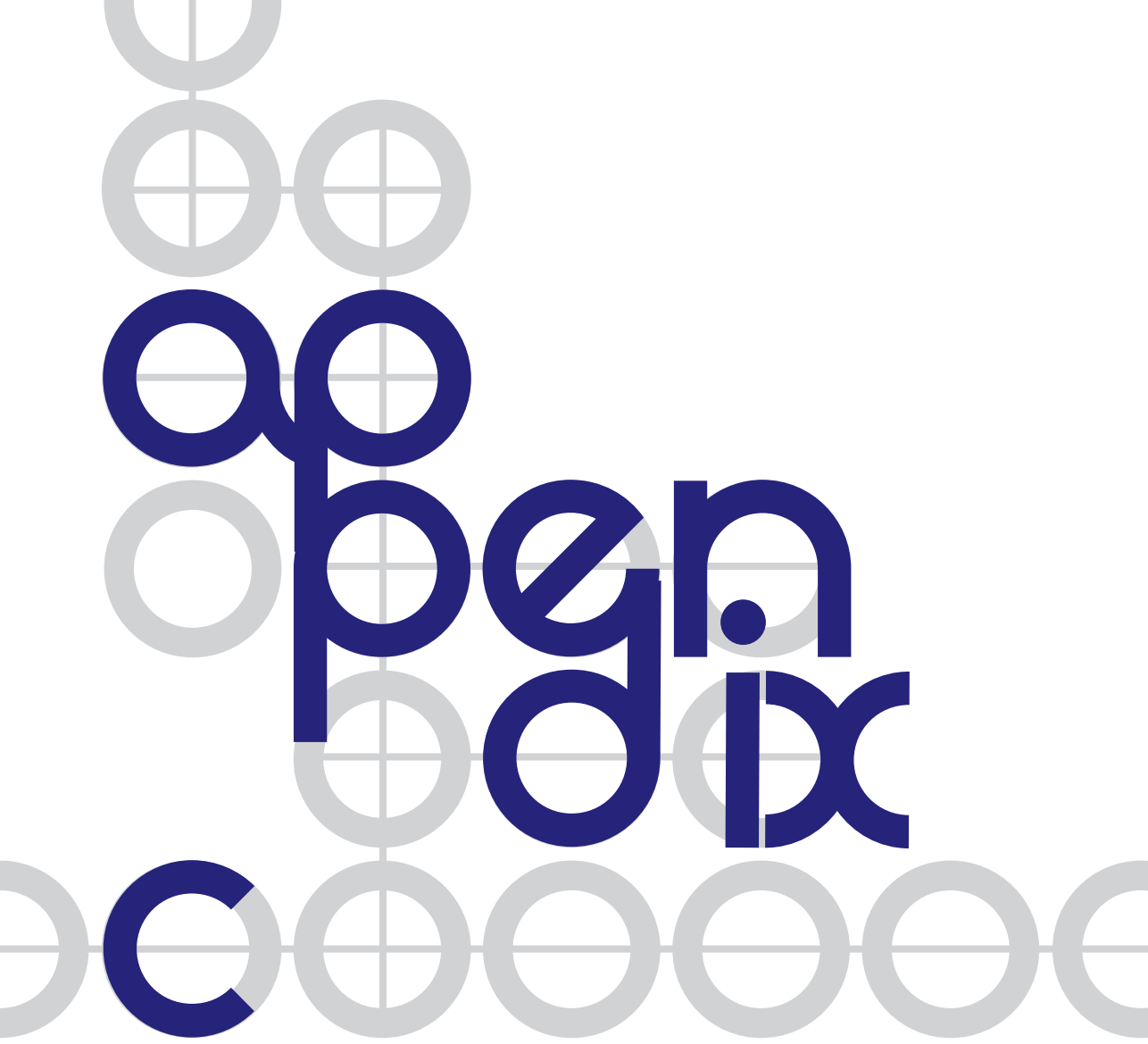
8. In hoeverre moeten alle verpleegkundigen, volgens jou, gestimuleerd worden om zich continu te ontwikkelen?

9. Wat motiveert jou om je continu te ontwikkelen?

Slotvragen

10. Als jij het voor zeggen had, wat zou je doen zodat gewaarborgd wordt dat iedere verpleegkundige voldoende competent is voor het werk?

11. Zijn er punten die jij in dit kader belangrijk vindt, maar die we niet hebben gevraagd?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Protocol for interviews

Protocol for interviews (Chapter 4)

Preparations for the interview: filling in the biography

In the interview, we will talk about your career as a nurse, and in particular how you direct and give content to your continuing professional development (CPD). CPD is understood as all learning activities you have engaged in to get/keep competent, to improve your work, to enhance your career and for personal development. This can be by various (formal and informal) learning activities, varying from education programmes, courses, and symposia to learning from your colleagues and work experiences.

Can you please fill in the following biography (it resembles a resume), in preparation for the interview? Of course, you are free in what you do want to share and what you do not. Can you:

- in the first row, describe important dates in your private life;
- in the middle row, specify your career: when did you have which job and in which organisation;
- in the last row, indicate your education and training. In the interview, we will also talk about important learning moments that extend beyond education and training.

Questions

1. You have written your biography. Can you elaborate on this?
2. What were the important learning moments in your career?
3. Nowadays, you work as a nurse at the [...] ward. Can you describe which learning moments or episodes have been crucial to do your current job properly?
4. What are the milestones in your development as a nurse? (moments you are proud of, or that give you a positive feeling)
5. So far, we have mainly looked back at your learning and career. Now, I would like to focus on your present work and learning. To what degree have you been engaged in professional development, in the preceding months?
6. Finally, I would like to look forward with you. Could you describe your ideas regarding work and professional development in the next five years? What do you want to do, what do you want to achieve?

Lifespan (example of 1 page)

	1975–1979	1980–1984	1985–1989	1990–1994	1995–1999	2000–2004
Events in private life	Important life events, e.g. own birth date, marriage, children's birth dates (if relevant), illness					
Career	When which job/ function, in which organisation					
Education and training	Education, post-graduate training, courses					

Protocol voor interviews (Hoofdstuk 4) – in Dutch

Voorbereiding interview: invullen biografie

In het interview bespreek ik met u, uw loopbaan als verpleegkundige en met name de wijze waarop u inhoud en vorm geeft aan uw continue professionele ontwikkeling (CPO). CPO wordt hierbij opgevat als alle leeractiviteiten die u heeft ondernomen om competent te worden/blijven, uw werk beter te kunnen doen, en voor uw carrière en persoonlijke ontwikkeling. Het kan hierbij gaan om allerlei (formele en informele) leeractiviteiten, variërend van opleidingen, cursussen, congressen, tot leren van uw collega's en van werkervaringen.

Kunt u ter voorbereiding op het interview uw biografie hieronder invullen (dit lijkt op een curriculum vitae (CV)). Het staat u uiteraard vrij om aan te geven wat u wel en niet wilt beschrijven. Het invullen kan gewoon met pen. Kunt u:

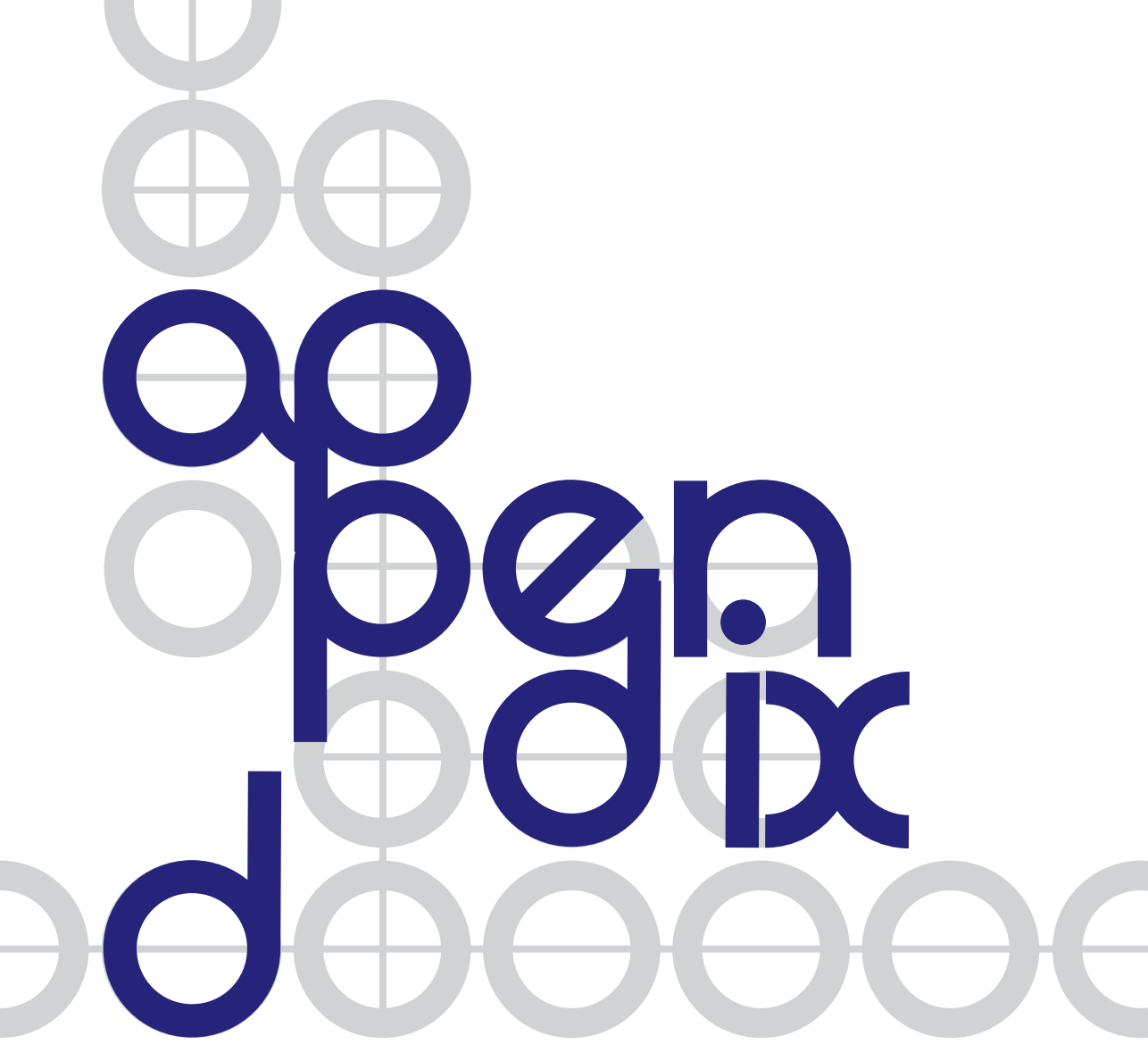
- in de bovenste rij belangrijke data in uw privésituatie beschrijven.
- in de middelste rij uw loopbaan weergeven: wanneer heeft u welke functie gehad en in welke organisatie.
- in de onderste rij gevolgde scholingen en opleidingen aangeven. In het interview zullen we vervolgens ook belangrijke leermomenten die buiten onderwijs/scholing vallen bespreken.

Vragen

1. U heeft uw leven en loopbaan uitgeschreven. Kunt u dit toelichten?
2. Wat zijn in uw loopbaan belangrijke leermomenten geweest?
3. U werkt nu als verpleegkundige op afdeling….. Kunt u beschrijven welke leermomenten of leerperioden cruciaal zijn om uw huidige werk goed te kunnen doen?
4. Wat zijn mijlpalen in uw ontwikkeling als verpleegkundige? (momenten waarop u trots bent, die u een positief gevoel geven)
5. We hebben in het gesprek tot nu toe vooral teruggekeken op uw leren en loopbaan. Nu zou ik vooral naar uw huidige werk en leren willen kijken. In hoeverre bent u de afgelopen maanden bezig geweest met uw ontwikkeling als verpleegkundige?
6. Ten slotte, zou ik met u vooruit willen kijken. Kunt u een beeld schetsen van hoe u de komende 5 jaar voor u ziet? Wat wilt u doen, wat wilt u realiseren?

Levensloop (Voorbeeld van 1 pagina)

		1975–1979	1980–1984	1985–1989	1990–1994	1995–1999	2000–2004
Gebeurtenissen privé	Belangrijke privé gebeurtenissen, bv. eigen geboor-tedatum, huwelijk, geboortedata evt. kinderen, ziekte, etc.						
Loopbaan	Wanneer welke functie/baan, in welke organisatie						
Onderwijs en opleiding	Gevolgd onderwijs, opleidingen en cursussen						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Questionnaire

Questionnaire (Chapter 6)

Background information

1. What is your gender?
   - ☐ Male
   - ☐ Female

2. What is your age? (*...years*)

   .....

3. In which hospital do you work?
   (response options relate to the 7 hospitals. These are left out for anonymity reasons)

4. How many years of working experience as a registered nurse do you have?
   (... years, round off to whole years)
   If you have less than one year of working experience, enter '0'.

   .....

5. How many years have you worked as a registered nurse at your present ward?
   (... years, round off to whole years)
   If you have less than one year of working experience, enter '0'.

   .....

6. Which nursing education did you finish?
   If you graduated from more than one nursing education programme, enter the last education programme you finished.
   - ☐ inservice nursing education (A, B, Z)
   - ☐ mdgo nursing
   - ☐ mbo nursing
   - ☐ hbo nursing
   - ☐ different, namely .....

7. Did you finish postgraduate training? (*multiple responses possible*)
   - ☐ no
   - ☐ yes, postgraduate training in a nursing specialty (with a duration of at least 20 course days)
   - ☐ yes, nursing science
   - ☐ different, namely .....

8. What is the extent of your appointment? (*... hours a week, round off to whole hours*)

   .....

9. Do you have children living at home? (*multiple responses possible*)
   - ☐ no
   - ☐ yes, younger than 4 years
   - ☐ yes, in the ages of 4–11 years
   - ☐ yes, in the ages of 12–17 years
   - ☐ yes, in the ages of 18 years and older

   Room to expand on your answers: (*optional*)

   .....

   .....

Learning activities part 1

The following questions are about the learning activities you have engaged in lately.

10. In how many work-relevant education programmes with a duration of at least 20 course days did you engage in **the past 5 years**? (e.g. postgraduate training in a nursing specialty, for nursing educator)
    Note: reply with a number, enter 0 if this is not applicable to you.

    .....

11. Indicate how many times you engaged in the following learning activities in the **past 12 months**.
    Note: reply with a number, enter 0 if this is not applicable to you.

    Clinical teaching session (*... times*)
    Note: no patient case discussions

    .....

    Team training during the day (*... times*)

    .....

    Team training in evenings (*... times*)

    .....

    Lunch lecture (*... times*)

    .....

    Skills training (e.g. technical nursing skill, resuscitation, feedback training) (*... times*)

    .....

    Refresher course (*... times*)

    .....

    E-learning module and/or e-assessment (*... times)*

    .....

    Conference and/or symposium (*... times*)

    .....

12. My situation at home was a barrier to engage in learning activities in the last 12 months.
    - ☐ strongly disagree
    - ☐ disagree
    - ☐ do not disagree/do not agree
    - ☐ agree
    - ☐ strongly agree

    Room to expand on your answers: (*optional*)

    .....

    .....

Learning activities part 2

13. How often did you learn **something new in the past 12 months** by …
    (Likert-scale: never, several times a year, several times a month, several times a week, every working day)
    - .....consulting a colleague nurse
    - .....consulting a physician or other healthcare professional
    - .....getting feedback from a colleague nurse
    - .....observing a colleague nurse
    - .....exchanging knowledge and experience with a colleague nurse
    - .....taking care of patients
    - .....encounters with patients and their families
    - .....participating in a working group
    - .....supervising students (e.g. by learning from the questions they ask)
    - .....doing research
    - .....teaching (clinical sessions)
    - .....job rotation (temporarily working at another ward, or taking over the work of someone else)
    - .....participating in handovers
    - .....participating in patient case discussions
    - .....participating in team meetings
    - .....reading a professional journal
    - .....searching for information on the Internet
    - .....searching for information in books
    - .....searching for information in protocols
    - .....literature study

    Room to expand on your answers: (*optional*)

    .....

    .....

Motives

14. Please recall the learning activities you engaged in, in the **past 12 months**. With **which reasons** did you engage in these learning activities? Indicate for each reason how much influence it had on your engagement.
(Likertscale: no/very little influence, little influence, some influence, much influence, very much influence)
    - To learn something new
    - To keep up with competition
    - To meet the expectations of my supervisor
    - To secure professional advancement
    - To comply with the suggestions of someone else
    - To keep up with others
    - To escape television
    - To supplement a narrow previous training
    - To satisfy my curiosity
    - To overcome the frustrations of everyday life
    - To keep up–to–date professionally
    - To meet some formal requirements
    - To increase my competency in my job
    - To act under the responsibility of a senior person
    - To give me higher status in my job
    - To seek knowledge for it's own sake
    - To respond to the fact that I am surrounded by people who continue to learn
    - To be accepted by others
    - To comply with instructions from someone else
    - To get relief from boredom
    - To have a few hours away from responsibilities
    - To learn for the sake of learning
    - To comply with my employer's policy
    - To acquire knowledge that will help with other learning activities
    - To do something different from what I normally do in my life
    - To improve my potential to serve humankind
    - To become eligible for benefits (such as a pay increase) I could not otherwise receive
    - To get a break in the daily routine

    Room to expand on your answers: (*optional*)

    .....

    .....

Vragenlijst (Hoofdstuk 6) – in Dutch

Achtergrondinformatie

1. Wat is uw geslacht?
   - ☐ Man
   - ☐ Vrouw

2. Wat is uw leeftijd? (*...jaar*)

   .....

3. In welk ziekenhuis bent u werkzaam?
   (antwoordopties betroffen de 7 ziekenhuizen. Deze zijn hier weggelaten i.v.m. anonimiteit).

4. Hoeveel jaar werkervaring heeft u als gediplomeerd verpleegkundige?
   (... jaar, afgerond op hele jaren).
   Indien u korter dan één jaar werkervaring heeft, vul dan '0' in.

   .....

5. Hoeveel jaar werkt u als gediplomeerd verpleegkundige op uw huidige afdeling?
   (... jaar, afgerond op hele jaren).
   Indien u korter dan één jaar werkervaring heeft, vul dan '0' in.

   .....

6. Welke verpleegkundige basisopleiding heeft u afgerond?
   Als u meerdere opleidingen heeft afgerond, vul dan de opleiding in die u het laatst heeft afgerond.
   - ☐ inservice verpleegkunde (A, B, Z)
   - ☐ mdgo verpleegkunde
   - ☐ mbo verpleegkunde
   - ☐ hbo verpleegkunde
   - ☐ anders, nl .....

7. Heeft u een vervolgopleiding afgerond? (*meerdere antwoorden mogelijk*)
   - ☐ nee
   - ☐ ja, verpleegkundige vervolgopleiding/specialisatie (met een duur van minimaal 20 lesdagen)
   - ☐ ja, verplegingswetenschappen
   - ☐ anders, nl.....

8. Wat is de omvang van uw huidige aanstelling? (*... uur per week, afgerond op hele uren*)

   .....

9. Heeft u thuiswonende kinderen? (*meerdere antwoorden mogelijk*)
   - ☐ nee
   - ☐ ja, jonger dan 4 jaar
   - ☐ ja, in de leeftijd van 4 – 11 jaar
   - ☐ ja, in de leeftijd van 12 – 17 jaar
   - ☐ ja, in de leeftijd van 18 jaar en ouder

   Ruimte om uw antwoorden toe te lichten: (*optioneel*)

Leeractiviteiten deel 1

De volgende vragen gaan over leeractiviteiten die u de afgelopen tijd heeft ondernomen.

10. Aan hoeveel werkrelevante opleidingen met een duur van minimaal 20 lesdagen heeft u **de afgelopen 5 jaar** deelgenomen? (Bijvoorbeeld een verpleegkundige vervolgopleiding, lerarenopleiding)
    Let op: beantwoord deze vraag met een getal, vul in '0' als deze vraag niet op u van toepassing is.

11. Geef bij onderstaande leeractiviteiten aan hoeveel keer u de afgelopen **12 maanden** hier aan heeft deelgenomen.
    Let op: beantwoord deze vraag met een getal, vul in '0' als deze vraag niet op u van toepassing is.

    Klinische les (*... keer*) *Let op: geen patiëntenbespreking/casusbespreking*

    Teamdag en/of afdelingsbijscholingsdag gericht op deskundigheidsbevordering (*... keer*)

    Teamavond gericht op deskundigheidsbevordering (*... keer*)

    Lunchlezing (*... keer*)

    Vaardigheidstraining (bijv. verpleegtechnische vaardigheid, reanimatie, feedback-training) (*... keer*)

    Cursus en/of bijscholing (*... keer*)

    E-learning module en/of e-learning toets (*... keer*)

Congres en/of symposium (... *keer*)

.....

12. Mijn situatie thuis was een belemmering om de afgelopen **12 maanden** aan leer-activiteiten deel te nemen.
    - ☐ zeer oneens
    - ☐ oneens
    - ☐ niet eens/niet oneens
    - ☐ eens
    - ☐ zeer eens

    Ruimte om uw antwoorden toe te lichten: (*optioneel*)

    .....

Leeractiviteiten deel 2

13. Hoe vaak heeft u de afgelopen **12 maanden iets nieuws geleerd** door .....
    (Likertscale: nooit, paar keer per jaar, paar keer per maand, paar keer per week, iedere werkdag)
    - .....een collega verpleegkundige te raadplegen
    - .....een arts of andere zorgprofessional te raadplegen
    - .....van een collega verpleegkundige feedback te krijgen
    - .....een collega verpleegkundige te observeren
    - .....kennis en ervaring met een collega verpleegkundige uit te wisselen
    - .....zorg te dragen voor patiënten
    - .....contacten met patiënten en hun familie
    - .....deel te nemen aan een werkgroep
    - .....studenten/stagiaires te begeleiden (bijvoorbeeld door de vragen die zij stellen)
    - .....onderzoek te doen
    - .....(klinische) les te geven
    - ..... job rotatie (tijdelijk op een andere afdeling werken of het werk van iemand anders doen op de eigen afdeling)
    - .....deel te nemen aan overdrachten
    - .....deel te nemen aan patiëntenbespreking/casusbespreking
    - .....deel te nemen aan teamoverleg
    - .....een vakblad te lezen
    - .....informatie op internet op te zoeken
    - .....informatie in boeken op te zoeken
    - .....informatie in protocollen op te zoeken
    - .....literatuurstudie

    Ruimte om uw antwoorden toe te lichten: (*optioneel*)

    .....

Motieven

14. Denk a.u.b. terug aan de leeractiviteiten die u de afgelopen **12 maanden** hebt ondernomen. Met **welke redenen** heeft u deze activiteiten ondernomen? Geef bij iedere reden aan hoeveel invloed deze had op uw deelname.
(Likertscale: geen/heel weinig invloed, weinig invloed, enige invloed, veel invloed, heel veel invloed).
    - Om iets nieuws te leren
    - Om de concurrentie bij te houden
    - Om te voldoen aan de verwachtingen van mijn leidinggevende
    - Om mijn loopbaanontwikkeling zeker te stellen
    - Om tegemoet te komen aan de suggesties van iemand anders
    - Om anderen te kunnen bijbenen
    - Om aan televisie te ontsnappen
    - Om een eerdere, beperkte, opleiding aan te vullen
    - Om mijn nieuwsgierigheid te bevredigen
    - Om de frustraties van het dagelijks leven te overwinnen
    - Om op professioneel gebied up-to-date te blijven
    - Om aan een aantal formele eisen te voldoen
    - Om mijn competentie in mijn werk te verhogen
    - Om te handelen onder de verantwoordelijkheid van een hoger geplaatste
    - Om mijn status in het werk te verhogen
    - Om kennis te vergaren om de kennis
    - Om te reageren op het feit dat ik ben omringd door mensen die blijven leren
    - Om door anderen geaccepteerd te worden
    - Om te voldoen aan de instructies van iemand anders
    - Om verveling te doorbreken
    - Om een paar uur geen verantwoordelijkheden te hebben
    - Om te leren omwille van het leren
    - Om het beleid van mijn werkgever te volgen
    - Om kennis op te doen die helpt bij andere leeractiviteiten
    - Om iets anders te doen dan ik normaal doe in mijn leven
    - Om mijn vermogen om de mensheid te dienen te verbeteren
    - Om in aanmerking te komen voor beloningen (zoals loonsverhoging) die ik anders niet zou ontvangen
    - Om de dagelijkse routine te doorbreken

    Ruimte om uw antwoorden toe te lichten: (*optioneel*)

    .....

Dankwoord (acknowledgements in Dutch)

Dankwoord

‘Zou jij geen promotieonderzoek gaan doen?’, vroeg mijn begeleider me meer dan 20 jaar geleden bij mijn afstuderen. Dat wilde ik niet: ik wilde eerst praktijkervaring opdoen. Maar het zinnetje zette zich vast in mijn hoofd en kwam steeds weer boven als ik behoefte aan uitdaging had. Begin 2008 kriebelde het weer. Ik wilde meer inhoudelijke expertise en verdieping. Met een zoon van vijf die ’s avonds vroeg naar bed ging, dacht ik dat het een goed moment was (me onvoldoende realiserend dat kleine kinderen snel groot worden en hij een stuk later naar bed zou gaan tegen de tijd dat ik met de afronding bezig was).

Een onderwerp voor mijn onderzoek was gauw gevonden. Leren op de werkplek staat centraal in mijn loopbaan. Ik vind het interessant om na te gaan hoe volwassenen zich in, en met name buiten schoolbanken ontwikkelen en hoe je dat kunt stimuleren. In ziekenhuizen ontstond in toenemende mate belangstelling voor het vraagstuk hoe zorgprofessionals continu bekwaam kunnen blijven om zo patiëntveiligheid te waarborgen. Massaal zijn om die reden portfolio’s, leermanagementsystemen en e-learning geïntroduceerd. Dit riep bij mij de vraag op wat dit betekent voor verpleegkundigen – de groep zorgprofessionals waar ik me in mijn loopbaan het meest mee heb bezig-gehouden – met jarenlange werkervaring. In eerste instantie richtte ik mij op de link tussen medicatieveiligheid en werkplekleren. Toen ik merkte dat het te verpleegkundig-inhoudelijk voor mij werd en er, door het verleggen van de pensioenleeftijd, steeds meer belangstelling kwam voor langer doorwerken, heb ik mijn bakens deels verzet. De richting voor dit proefschrift werd steeds duidelijker: continue professionele ontwikkeling gedurende een verpleegkundige loopbaan gezien vanuit een levensloopperspectief.

Combineren van werk, privéleven en onderzoek vond ik niet altijd makkelijk, maar het heeft me veel gebracht. Net voor de start van het promotieonderzoek vroeg iemand me of ik niet op een makkelijkere manier inhoudelijke expertise zou kunnen ontwikkelen. Dat had vast gekund, maar mijn professionele ontwikkeling was dan nooit in zo’n versnelling terecht gekomen. Zonder iemand tekort te willen doen, wil ik in het bijzonder de volgende mensen bedanken die mij direct of indirect hebben geholpen bij deze ontwikkeling en dit proefschrift.

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Bijzonder veel dank en waardering gaat uit naar mijn promotoren: Olle ten Cate en Rob Poell. Olle, ik heb het weleens lastig gevonden dat we uit een verschillende 'onderzoeksschool' komen. Enigszins gechargeerd wil de dokter in jou een 'onderwijsbehandeling' geven en dan het effect meten, terwijl de antropoloog in mij liever observeert en de wereld bekijkt en beschrijft vanuit verschillende perspectieven. Dat botste weleens, maar ik waardeer enorm dat je altijd openstond voor nieuwe inzichten en andere ideeën: over continu ontwikkelen gesproken. Ik heb veel van je geleerd, ben je dankbaar voor de altijd opbouwende feedback en het vertrouwen dat je me gaf. Dank ook dat je mij wegwijs hebt gemaakt in de wereld van de medische onderwijskunde; dat heeft me veel gebracht zowel in onderzoek als in werk. Rob, in de beginfase hoorde ik een keer hoe je je aan anderen voorstelde: je schetste jouw beweging van onderwijskunde richting personeelswetenschappen. Je verwoordde de reden waarom ik je als tweede promotor had benaderd. Ik zocht iemand die me kon begeleiden in de move naar HRD. En dat is gelukt! Je hebt veel kennis van het HRD-veld en ik ben je dankbaar dat je me op het spoor hebt gezet van een aantal experts die grote invloed hebben gehad op mijn proefschrift. Tot mijn geluk zitten twee daarvan nu in de beoordelingscommissie. Ik waardeer je precieze feedback, je methodologische kennis, de humor in de kantlijn en zal de inspirerende Skype-gesprekken gaan missen. Vragen als 'Vanuit wiens perspectief doe je dit onderzoek eigenlijk?' gaven me richting.

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Dit onderzoek had niet tot stand kunnen komen zonder de medewerking en inzet van vele verpleegkundigen. Ik wil alle verpleegkundigen die ik mocht interviewen, individueel of in focusgroepen, bedanken voor de interessante en vaak openhartige gesprekken. De gesprekken hebben me meer geleerd dan in dit proefschrift beschreven staat. Ook wil ik de leidinggevenden die ik heb geïnterviewd en de verpleegkundigen die de vragenlijst hebben ingevuld, bedanken. Ik had al deze verpleegkundigen niet kunnen bereiken zonder de bemiddeling van vele leidinggevenden en opleiders. Jullie inzet en enthousiaste reacties op het onderzoek deden me goed. In het bijzonder wil ik hierbij (zonder achternaam om de anonimiteit van ziekenhuizen niet prijs te geven) Gerdienke, Ellen, Conny, Jettie, Netty en Arianne noemen.

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Utrecht, september 2015

Curriculum vitae

Curriculum vitae

Inge Pool (1969) grew up in Berkenwoude and Krimpen aan den IJssel. After finishing University preparatory education (vwo) at the Comenius College in Capelle aan den IJssel, she started studying Educational Sciences in 1987 and Cultural Anthropology in 1991, both at University Utrecht. She obtained her MSc degrees in 1992 and 1995 respectively.

After graduation, she worked subsequently as an educationalist at the ROC Midden Nederland (senior secondary vocational nursing education) and the KNCV Tuberculosis Foundation. In this period, she combined her job with several additional tasks, such as member of the audit committee of nursing education at Curacao, and teacher at the training for nurse educator, Hogeschool Rotterdam.

Since 2004, she has been working at the Academy of the University Medical Centre in Utrecht, initially as programme–manager of the postgraduate nursing education and training department, and since 2008 as policy advisor and project manager. Among other things, she was involved in developing workplace curricula for several (post–graduate) education and training programmes. In 2008, she also started her PhD project. Currently, one of her main tasks is to advise managers and educators on issues concerning continuing competence of health professionals. She is editor of the journal 'Onderwijs en gezondheidszorg' and, since September 2015, lecturer in the (pre)master programme of Clinical Health Sciences.