Continuing Professional Education: Exploring the Experience of Community Nurses Working on a Small Remote Island

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Abstract

Qualified nurses require equitable access to continuing professional education (CPE) that is responsive to the needs of learners, employers and most importantly clients. There is scant attention paid to the CPE custom of community nurses, with research in the experience of island-based nurses mainly limited to the Mediterranean and under-developed islands, or of nurses working in the Scottish Isles. The community nurses in question are employed by a charity working outside the National Health Service (NHS), based on an island with a unique model of healthcare that is more medicalised and institutionalised than the United Kingdom NHS.

Semi-structured, one-to-one interviews were conducted with sixteen community nurses, and two focus groups undertaken, one with nurse managers and the other with qualified nurses. Interview data were analysed using Interpretative Phenomenological Analysis, a method new to education research, and not yet recorded in relation to nurse education. Findings indicated an ageing workforce, with ageism hindering access to CPE. Geographical isolation coupled with a lack of access to tertiary education dictated CPE to fulfil professional development. Charitable status and limited CPE funding resulted in a third of nurses applying for sponsorship via local or national agencies, this was not found elsewhere in the current literature.

This research contributes to the knowledge relating to nurse CPE, confirming the transferability of existing literature relating to geographical remoteness, barriers and outcomes of formal study to community nurses. It advances the current knowledge base with regard to small island infrastructure effecting access to CPE, funding formal education for nurses working outside the NHS, and silo working within the community setting. Further research is required to explore the experience of community nurses under the age of 30 years not represented within this study, who will be the future workforce when older nurses retire. These findings are of particular significance to the Jersey Health and Social Services Department who are currently redesigning the future health and social care system on the island based on a community model, nurse educators, the charity and its qualified nurse employees, and finally the island population.

Acknowledgements

Contents

List of Figures

List of Tables

List of Appendices

List of Acronyms

AfC	Agenda for Change
ANA	American Nurses Association
CAQDAS	Computer Assisted Qualitative Data Analysis Software
CEO	Chief Executive Officer
CPD	Continuing Professional Development
CPE	Continuing Professional Education
DA	Discourse Analysis
DfEE	Department for Education and Employment
DH	Department of Health
ECDL	European Computer Drivers Licence
EdD	Doctorate in Education
ENB	English National Board
GMC	General Medical Council
GP	General Practitioner
GT	Grounded Theory
HEE	Health Education England
HEI	Higher Education Institute
HRSA	Health Resources and Services Administration
HSS	Health and Social Services
IPA	Interpretative Phenomenology Analysis
KPMG	Klynveld, Peat, Marwick and Goerdeler
KSF	Knowledge and Skills Framework
LETBs	Local Education and Training Boards
MCQ	Multiple Choice Questions
MEE	Medical Education England
MESCH	Maternal Early Childhood Sustained Home Visiting
MMR	Mixed Methods Research
MPET	Multi-professional Education and Training
NIACE	National Institute of Adult Continuing Education
NHS	National Health Service
NMC	Nursing and Midwifery Council
NTS	National Triage Scale
PACT	Pacific Association for Clinical Training

PARN	Professional Associations Research Network
PCT	Primary Care Trust
PDP	Personal Development Plan
PREP	Post Registration Education for Practice
QNI	Queen's Nursing Institute
RCN	Royal College of Nursing
SCPHN	Specialist Community Public Health Nurse
SHA	Strategic Health Authority
SLA	Service Level Agreement
SoJ	States of Jersey
UK	United Kingdom
UKCC	United Kingdom Central Council
UNESCO	United Nations Educational, Scientific and Cultural Organisation
USA	United States of America
WDC	Workforce Development Confederation
WHO	World Health Organisation

CHAPTER 1: INTRODUCTION

This research examines the continuing professional education (CPE) experiences of primary care nurses living and working on the island of Jersey. These community nurses and health visitors are employed by a third sector provider, referred to throughout this thesis as 'the Charity' [1] for purposes of anonymity. In 2010, the States of Jersey (SoJ) Health and Social Services (HSS) Department commissioned Klynveld, Peat, Marwick and Goerdeler (KPMG), an international management consultancy firm, to undertake a major review of the island's healthcare provision, with a view to making recommendations for a more cost-effective and efficient means of delivery (KPMG, 2011). The subsequent report culminated in an island-wide consultation to consider: future healthcare for the increasing number of older people, the lack of service integration, and the high number of older people cared for in institutions and the management of those with complex care needs (SoJ, 2011). The professional development of practice nurses and community midwives is pivotal to ensuring the Jersey Health and Social Services White Paper *'Caring for Each Other, Caring for Ourselves'* achieves the availability of more services in clients' homes, in the community and within primary care settings (SoJ, 2012a). However, continuing professional development (CPD) and CPE of the Charity's workforce is also critical to the success of any proposed future health service, and appears to be overlooked in the proposed developments (SoJ, 2011).

This chapter places the research in context, providing a brief outline of Jersey, its health service and the problems associated with being a small geographically isolated island.

Aim of the Research

The aim of this research is to explore the community nurses experience of CPE as a means of professional development and the concomitant effect on the improvement of island primary care nursing services. The thesis centres around the experiences of sixteen qualified community nurses gathered by semi-structured interviewing on a one-to-one basis. Two focus groups were also held, one for senior managers and one consisting of nursing staff, to

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[1] Psuedonym

further explore CPE and provide triangulation of findings. The main aims of the research are:

1. To establish the community nurses perceptions of CPE and its relevance to practice.

2. To investigate the types of CPE accessed by geographically isolated community nurses.

3. To explore the community nurses' personal experience CPE.

4. To discover how each community nurse develops their professional knowledge and practice.

This doctoral thesis presents an exploratory study of the experiences and opinions of community nurses' involved in CPE. The views of the Charity's senior management team also contribute another perspective to the formal educational needs of nurses working in primary care.

Context of the Thesis

Jersey is the largest and most southerly of the Channel Islands with a land area of 118 km^2 (States of Jersey Statistics Unit, 2011, p. iii), although in international terms it is considered a small island (Beller, 1986). The population in 2011 of 97,857 (States of Jersey Statistics Unit, 2012, p. 5) fulfills the criteria of the 'smallest of the small' given to islands with populations below 100,000 (Bray, 2011, p. 40). The Channel Islands are situated in the Bay of Saint Malo, with Jersey located 23 km from France and 137 km from England (States of Jersey Statistics Unit, 2011, p. iii). The acclaimed French novelist, Victor Hugo, resided in Jersey from 1852-1855 then moved to Guernsey until 1870 (Baldacchino, 2008a) and considered '*the Channel Islands are pieces of France fallen into the sea and picked up by England*' (Hugo, 1866/2002, p. 42). Figure 1.1 overleaf shows the geographical location of the Channel Islands in relation to England and France.

Figure 1.1 Geographical location of Jersey, Channel Islands (Jersey Tourism, 2010)

Jersey has a unique healthcare system fashioned on the United Kingdom's (UK) National Health Service (NHS) (SoJ, 2011) however, whilst secondary care is free at the point of access, primary care is delivered privately (KPMG, 2011), with patients having to pay to visit their general practitioner (SoJ, 2013a). The Charity provides nursing, specialist community public health nursing and social care, employing: district nurses, community staff nurses, health visitors, community paediatric nurses, school nurses, health care assistants and home care assistants to deliver health and social care packages to the Jersey population (McNeela, 2007). The States of Jersey pay approximately £6 million annually to the Charity under the terms of the Service Level Agreement (SLA), with fundraising, membership fees and legacies bringing the total operating balance to seven and a half million pounds (The Charity, 2011).

Health and social care services in Jersey have been described as 'relatively comprehensive' (KPMG, 2011, p. 3). Nevertheless, there is some concern with regard to the models of care, which are medicalised and more institutionalised than in other jurisdictions (SoJ, 2012a). The private model of

primary care consists of a high proportion of General Practitioners (GPs) relative to the size of the population, with primary and community care settings employing low levels of nursing and allied health professional staff to support them (KPMG, 2011). The consequence is that General Practitioners undertake procedures, which in other countries would be safely delegated to different healthcare professionals (SoJ, 2011).

On the island, primary care does not refer to the healthcare provided in the community by nurses, health visitors and health care assistants, but instead refers only to the services provided by a GP (SoJ, 2012a; KPMG, 2011; SoJ, 2011). Services provided in the United Kingdom by the primary health care team are instead delivered on Jersey by a third sector provider, 'the Charity', via a SLA (The Charity, 2011) causing integration and communication problems with local government health care provision (KPMG, 2011). GPs are not allocated patients geographically, with patients registering at the family doctor of their choice (SoJ, 2013a). Unlike their colleagues in the UK, community nurses employed by the Charity are not linked to GPs surgeries, thereby limiting the opportunity to build up professional relationships.

The structure of the States of Jersey Health Service is depicted in Figure 1.2 overleaf.

Figure 1.2: Structure of the States of Jersey Health Service (Adapted from Oliver, 2005)

| Key: | → Finance flow | ⇢ Service provision | → Accountability flow |
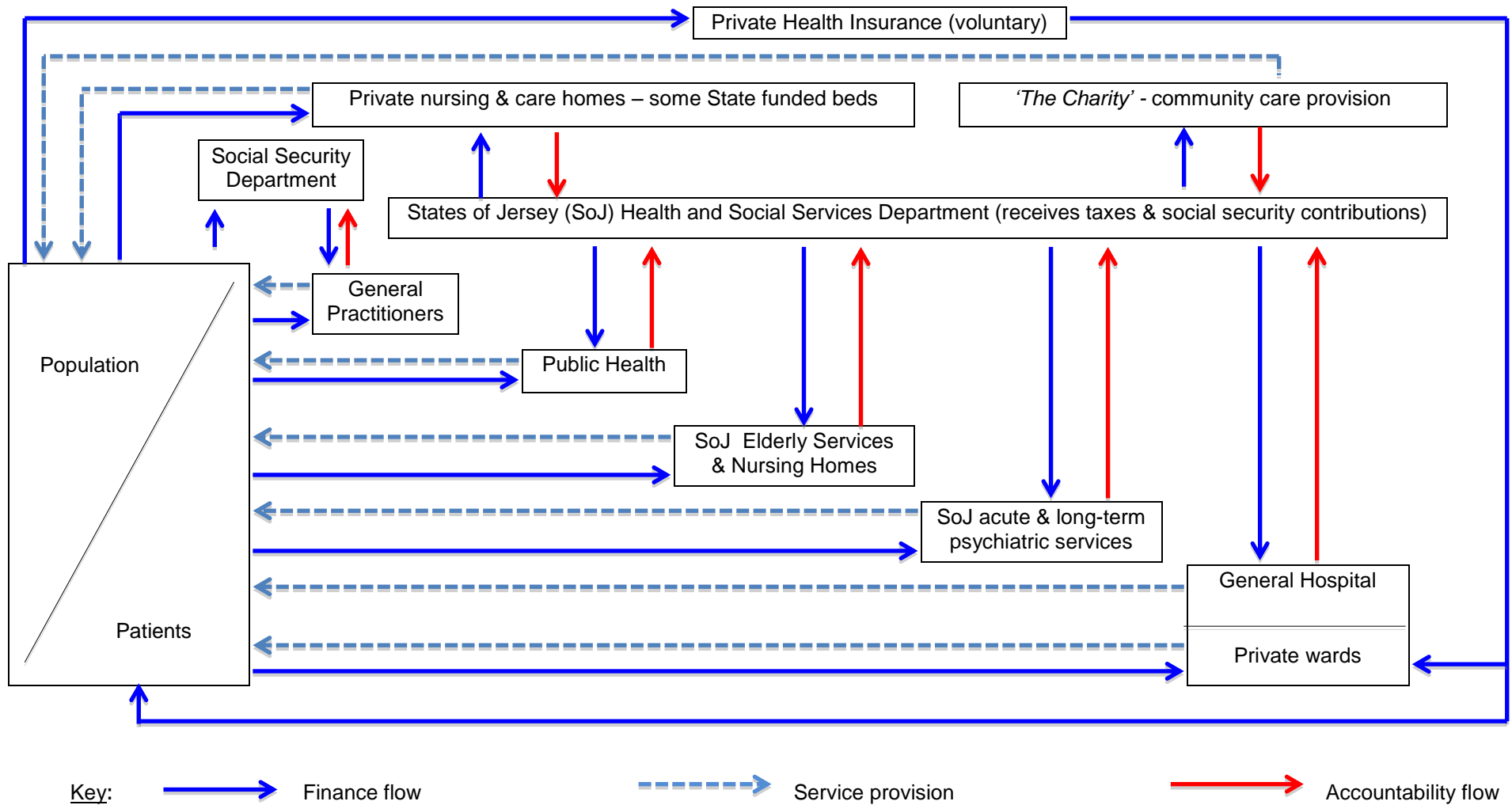
Community Nursing

Historically the public image of the community nurse has not always been a positive one, as exhibited by Sarah Gamp in the Charles Dickens novel '*Martin Chuzzlewit*' set in Victorian Britain (Dickens, 1843). Based on a nurse who was employed by a friend of Dickens, Gamp worked in patients' homes as an untrained independent practitioner providing various nursing services to the poor and rich alike (Summers, 1989). Gamp is depicted as an incompetent alcoholic who administers midwifery services, sick-nurse duties and laying-out the dead, thereby casting community nursing an unfavourable light (Summers, 1997). However, by 1864 nursing started to become more reputable when twenty young women were trained as nurses at St Thomas and Kings College Hospitals in London, ultimately taking up posts as private nurses, hospital nurses and District Nurses (Heggie, 2011).

The focus of contemporary nursing is moving from hospital-based provision to a more public health model with a strong focus on health improvement (SoJ, 2012a; Department of Health (DH), 2011a; SoJ, 2011; DH, 2010a; DH, 2008a). In the UK primary health care workers, such as Health Visitors and School Nurses are tasked with delivering the Healthy Child Programme (DH, 2009) in an attempt to lay the foundations of a good healthy life for the nation's future adults, whilst in Jersey, the focus is on providing the Maternal Early Childhood Sustained Home Visiting (MESCH) programme (SoJ, 2012a). This enhanced way of working has educational implications for current Health Visitors and School Nurses, requiring leadership skills, inter-professional collaboration and the promotion of on-going learning and development (DH, 2011b).

Care of the older person has also come under the spotlight in recent years with more health care provision delivered in the patient's own home by District Nurses or Community Matrons (The Queen's Nursing Institute (QNI), 2009). Increasing numbers of older people (SoJ, 2012a; SoJ, 2011; DH, 2010a; DH, 2008a), coupled with the advances in health care technology, has resulted in an increase in people with chronic health problems requiring the delivery of complex care packages within the home managed by specialist community nurses (DH, 2013a; Barrett, Latham & Levermore,

2007). Clinical work such as prescribing medication, intravenous therapy and end of life care that would have historically been carried out in hospital or by doctors has now become commonplace among District Nursing duties, along with risk assessment, medication reviews and patient advocacy (DH, 2013a; QNI, 2009). This enhanced role necessitates community nurses to continually update their knowledge and nursing skills, especially in relation to their role as nurse prescribers and complex care managers (DH, 2010b; DH, 2008b).

My Interests in Relation to CPE

I am a white, female, Specialist Community Public Health Nurse (SCPHN), who has spent the past ten years of my career involved in various aspects of nurse education. Initially, I started out as a Practice Teacher to Health Visitor students on their practice placements before moving into Higher Education as a Senior Lecturer in Specialist Community Public Health Nursing. My position within the aforementioned charity is that of Education and Development Coordinator and as such I was curious to explore any issues surrounding CPE, especially in relation to being geographically isolated from mainland Britain.

The undertaking of a professional doctorate in education has been mainly driven by the desire to extend my professional knowledge (Burgess, Sieminski & Arthur, 2006) with regard to the lifelong learning that nurses are required to undertake in order to retain their professional registration with the Nursing and Midwifery Council (NMC) (2010b). The decision to research an area within my place of work has given me the dual role of practitioner-researcher and one that can be seen to have distinct advantages as well as disadvantages. The advantage of having pre-existing knowledge of the work situation leads to a likely reduction in implementation problems, with practitioner insight ensuring an appropriate study is designed and carried out (Robson, 2002). The tacit knowledge of the insider-researcher produces different knowledge than that available to the outsider (Gibbs, 2009). The disadvantages of researching one's workplace can be the time constraints of undertaking research whilst in full-time employment and problems with the way the researcher is viewed by colleagues within the workplace (Robson,

2002). However, the role conflict of being a nurse-researcher conducting studies involving patient care or with nurse colleagues may also raise professional issues (Colbourne & Sque, 2004). As a healthcare professional there is a duty of care to patients and therefore any competency or '*fitness to practise'* issues discovered during the course of the research must be reported to the NMC (2008c).

So far this chapter has provided the background to this doctoral research from a geographical, island healthcare and professional perspective. The following section summarises the contents of the remaining chapters of the thesis.

Overview of the thesis
The concept of lifelong learning forms the first part of the literature review and is introduced in Chapter 2. This explores how lifelong learning has been adopted within society and its integration into the NHS. Lifelong learning is investigated from its initial application as a means of personal self-fullfilment to its contemporary political importance in keeping people in employment and contributing to the economy. The knowledge economy is discussed in relation to the importance of employees' skills and knowledge within the workforce in economic terms, referred to as human capital. The concept of social capital is explored in relation to lifelong learning and examined in relation to human capital. Continuing professional development (CPD) and CPE are defined and investigated in relation to nursing, with an examination of the theory / practice gap and the outcomes of CPE on nursing practice considered.

Chapter 3 contains the second element of the literature review, exploring CPE and the classification of professionals in relation to the adoption of innovations. Investigation into personal factors which impact on the motivation to undertake CPE, and family issues that can either facilitate or thwart participation in formal study are discussed. The role of the healthcare organisation is critiqued in relation to sponsoring the participation of nurse registrants in formal education. Geographical factors are explored, with a debate on the definition of a 'small island', investigating how geographical

factors such as professional isolation and lack of infrastructure can impinge on CPE.

The methodology and methods for the research are presented in Chapter 4, which considers the appropriateness of the qualitative approach and the use of Interpretative Phenomenological Analysis (IPA). The methods used for data collection, analysis and ethical considerations are presented and their relevance to this research highlighted. The research findings from interviews with 16 community nurses are presented within Chapter 5. Participants' demographic data are presented and analysed, revealing an ageing workforce with a lack of promotional opportunities for locally trained nurses. A visual representation of the research findings is presented, identifying four superordinate themes: undercurrents affecting CPE, getting underway with CPE, making headway with CPE and knowing the ropes following CPE. These findings provide insight into community nurses' idiographic perceptions of CPE with the wider implications discussed in Chapter 6.

Discussion of the findings in accordance with the research questions and with reference to the superordinate themes is located within Chapter 6. Geographical issues are considered, including the necessity to adopt various means of CPE due to the limited provision of local tertiary education. The charitable status of the organisation is explored in relation to workforce development and funding for CPE. Island healthcare culture, workplace and medical culture are discussed, exploring the relation of human capital and social capital to the community nurses' experience of lifelong learning. The final chapter draws on the findings from the 16 participants and the 2 focus groups to present recommendations gathered from this research. Methodological issues including the role of the insider-researcher are presented, future research proposals suggested, with policy and practice implications discussed. Finally, the originality of the research and its contribution to the body of knowledge is explored.

This research is a relevant and original area of investigation concerning the CPE experiences of community nurses employed by a charity on a small remote island. This addresses an identified gap in the nursing literature and

contributes to the body of knowledge regarding community nurse professional development. The following chapter is a literature review exploring the concept of lifelong learning and its role in society.

CHAPTER 2: LIFELONG LEARNING

The speed of change within contemporary society has put greater emphasis on the need to learn during the whole course of one's lifetime (Jarvis, 2009). In particular, technological changes have driven the need for workers to acquire or renew knowledge, skills and attitudes (Tight, 1998) in order to keep up with changes in the workplace (Alfred & Nafukho, 2010). For professional workers such as nurses these factors have culminated in the need to study throughout their career in order to remain competent to attend to their nursing duties (Houle, 1980). Indeed, in recent years an increased emphasis has been placed on the significance of compulsory continuing professional development (CPD) for nurses by the United Kingdom (UK) Government and professional regulatory bodies (DH, 2012a; DH, 2011c; DH, 2010b; NMC, 2008c; RCN, 2007; DH, 2006c; DH, 2006a; DH, 2004b; DH, 2004a; RCN, 2002; Audit commission, 2001; DH, 2000a; DH, 1999). This focus on self-development sits within the framework of clinical governance, ensuring the delivery of a safe, effective and efficient health service that analyses current practice and is responsive to change (Garcarz, Chambers & Ellis, 2003).

Since the 1960s the UK general public have demanded greater public accountability from professionals (Houle, 1980) with regulatory bodies not only identifying pre-qualifying education standards for initial entry into a profession, but also highlighting the post-qualification education deemed necessary to maintain registration (Jeris, 2010). In relation to healthcare, the public have a right to be safeguarded against malpractice and therefore nurses have to exhibit competency in carrying out their nursing duties (Quinn, 1998). The introduction of mandatory CPD to renew UK nurse registration (United Kingdom Central Council (UKCC), 1994) brought the nursing profession in line with its American counterparts where accreditation of continuing nurse education to maintain registration was established in 1974 (American Nurses Association (ANA), 1974).

Rapid advances in healthcare technology have resulted in the concomitant need to develop the nursing workforce to undertake patient assessments, deliver complicated clinical nursing procedures, and manage patients with

complex care needs (DH, 2012a; RCN 2010). The importance of remaining competent to undertake these nursing duties has resulted in compulsory professional updating as a requirement of nurse registration (NMC, 2008b). Lifelong learning has been identified as the method by which nurses will continue to meet patient need, deliver NHS care priorities and fulfil their professional potential (DH, 2012a; DH, 2010a). Therefore, this chapter considers the concept of lifelong learning, CPD, CPE; and considers how lifelong learning has been embraced by the health service, culminating with investigating the impact of CPE on nursing practice.

Lifelong Learning

The concept of lifelong learning is not new, with ancient texts making reference to the necessity of continued learning throughout life (Dave, 1976). Up until the early twentieth century education was thought to be something delivered to schoolchildren, furnishing them with knowledge that would be valid and sufficient to last their entire lifetime (Whitehead, 1931). However, in the early 1930s Leigh (cited in Knowles, 1990) identified the concept of education as a lifelong process, from birth to death, with the individual actively participating as opposed to being a passive recipient. Lifelong learning has more recently been defined as:

> *… a process of accomplishing personal, social and professional development throughout the life-span of individuals in order to enhance the quality of life of both individuals and their collectives…*
> *(Dave, 1976, p. 34).*

The origins of current lifelong learning and lifelong education can be traced back to the second part of the twentieth century (Jarvis, 1995), when these concepts gained distinction in the 1960s (Tight, 1998). In 1970 the United Nations Educational, Scientific and Cultural Organisation (UNESCO) proposed '*lifelong education as the master concept for educational policies in the years to come*' (Faure 1972, p. 182). Lifelong learning includes formal, non-formal and informal education enabling individuals to attain the fullest possible development at all stages of their life (Dave, 1976). Recognition

that the aptitude to learn continues throughout one's life (Knowles, 1990) has resulted in the public promotion of increased participation in lifelong learning to enable individual development and fulfilment of potential (National Institute of Adult Continuing Education (NIACE), 2012). UK government policies (DBIS, 2010; DfEE, 1998; DfEE, 1997b; DfEE, 1997a) support the belief that participation in lifelong learning will create opportunities benefitting individuals, families, neighbourhoods and ultimately the nation.

The rise of lifelong learning as a universal concept has occurred in parallel with the globalisation of work practices, whereby large multinational companies move resources between countries in order to reduce expenses whilst increasing productivity (Field, 2008). This has resulted in the mass production of goods and relocation of services in newly industrialising countries that pay low-cost wages (Brown & Lauder, 1997). No longer able to compete economically within the heavy goods industry, Britain has become more reliant on contributing to markets in high technology goods and services, dependent upon a flexible workforce able to keep updated with the latest innovations (Ainley, 1998). Therefore, to participate in the global economy, UK employees are required to adopt new professional skills and acquire the resilience to cope with economic recession and possible threat of unemployment (Schuller & Watson, 2009).

The skills, knowledge and capabilities of people, especially within the workforce, have been labelled 'human capital' by economists and recognised as an important source of generating economic wealth (Becker, 1993; Schultz, 1961). Investment in people is necessary in order for their potential to be realised; Becker's seminal text explores the effect of educational input on potential individual earnings, thereby identifying education as a determinant of economic growth (Burton-Jones & Spender, 2011). However, human capital exists in the individual worker and is not owned by the employer, but is on loan from the employee and leaves with them when they depart the organisation (Covell, 2008). Drucker (1969) developed the concept of the 'knowledge economy', which refers to the application of human capital for the advancement of economic development. Moreover, the role of knowledge and the importance of Information and Communication

Technologies (ICT) in the economies of advanced industrial societies inform policy makers of the comprehensive role of education in the success of the economy (Castells, 2010).

Faure (1972) views lifelong learning as a humanistic concern enabling personal fulfilment by widening access to health education, cultural education and environmental education. However, Ainley (1998) voices his concern that in the UK lifelong learning was being used to reform the welfare state, with the unemployed re-labelled as 'Job Seekers' obliged to attend compulsory government training schemes. This was underpinned by the Labour Government's belief that the best way to avert poverty and social exclusion was 'to rebuild the welfare state around work' (Department of Social Security, 1998, p. 23). Successive UK governments have viewed growth in terms of economic development; consequently lifelong learning has been seen as the means to train a flexible and adaptable workforce, as opposed to learning for personal change (Field, 2008).

A consultation on lifelong learning undertaken by the Labour Government (Secretary of State for Education and Employment, 1998) received criticism for its narrow focus on vocational education and training (Tight, 1998). Likewise, the *Leitch Review of Skills* (2006, p. 3) highlights the importance of increasing adult vocational skills to facilitate mobility for individuals within the labour market and equip the UK with a 'world-class' skills base by 2020. However, by 2009 the UK Commission for Employment and Skills (UKCES) reported that the British economy was unable to offer sufficient high-skilled jobs to suitably qualified workers, due to a lack of employer ambition to enter the competitive quality goods market. The Coalition Government's '*Skills for Sustainable Growth*' (Department for Business, Innovation and Skills (DBIS), 2010, p. 5) re-iterates the perspective of the previous government, ensuring that people are appropriately skilled in order to 'transform their life chances' and enhance their social mobility. However, the aforementioned lack of business enterprise, coupled with a reduction in state funding, means that individuals and employers must be willing to undertake and pay for more training (Payne & Keep, 2011). Within professional groups such as nurses the concept of lifelong learning has been informed by educationalist

Professor Cyril Houle, an academic interested in adult and continuing education (Houle, 1980).

By the twentieth century professionalisation of the workforce was a central feature in advanced societies (Cervero, 2001). Houle (1980) identified fourteen characteristics of the professionalisation process indicating subsequent educational goals that need to be addressed throughout the professional's working career (see Table 2.1 overleaf).

Table 2.1

Fourteen characteristics of the professionalisation process (Houle, 1980, pp. 34-75)

	Characteristic	Educational Goal
1.	Clarify defining function	Central mission (constantly evolving due to modernisation & acceptance of new ideas)
2.	Mastery of theoretical knowledge	All practitioners must master the rudiments of their professional knowledge
3.	Problem Solving	Need for practical wisdom acquired by experience
4.	Use of practical knowledge	On-going analysis of problem-solving to enhance practice
5.	Self-enhancement	Continued learning related to work-life, home and community
6.	Formal training	Formal procedures in place to transmit essential body of knowledge & techniques to all practitioners
7.	Credentialing	Formal means of testing capacity of individual practitioners to perform duties at an acceptable level
8.	Creation of a sub-culture	Further education required to support areas of specialist practice
9.	Legal reinforcement	Awareness of legal requirements
10.	Public acceptance	General public aware and accepting of role
11.	Ethical practice	Governed by a formal code of practice
12.	Penalties	Established & enforced by the professional regulator if professional fails to remain competent
13.	Inter-professional relations	Complex patterns of inter-professional relationships aided by inter-professional education
14.	Relations to service users	Awareness of professional body requirements on general rules of practitioner/client relationship

As the table overleaf illustrates, pre-service professional education is no longer sufficient for a lifetime of professional work (Cervero, 2001), with the emphasis placed on knowledge contributing to a culture where one is expected to be a lifelong learner (Jensen, 2007).

The lifelong learner is a diverse being, with each person exhibiting an individual learning style that is influenced by character traits, past experiences and their current unique personal circumstances (Houle, 1980). Hansman and Mott (2010) concur, asserting that adult learners are not typical but represent a diverse set of individuals with distinctive demographics, personal aspirations and differing levels of educational achievement. However, despite these assertions, Knapper and Cropley (2000, p. 47) have reported five traits common to lifelong learners:

1. A strong relationship between learning and their life
2. Appreciation of the need for lifelong learning
3. Highly motivated to learn
4. Possession of a self-concept beneficial to learning
5. Acquisition of necessary skills needed to participate in learning

The English National Board (ENB) for Nursing, Midwifery and Health Visiting (ENB, 1995) were more prescriptive, obliging nurse lifelong learners to be innovative, flexible, resourceful, change agents, disseminators of good practice, knowledgeable, adaptable, creative, self-reliant, responsible and accountable.

The Dearing Report (DfEE, 1997b) identified that education is desirable, life enriching and fundamental to the achievement of an improved quality of life in the UK. This is underpinned by the need to increase UK economic competitiveness within the global market by developing a more knowledgeable and skilled workforce (Tight, 1998). These sentiments are echoed by the States of Jersey Government in the island strategy for lifelong learning (SoJ, 2002). It proposes that all adults should adopt a personal commitment to self-directed learning to cope with the continual changes occurring throughout life (SoJ, 2002; Knapper & Cropley, 2000; DfEE,

1997a). However, it must be acknowledged that not everyone believes in the concept of lifelong learning or indeed has the qualities required to be a lifelong learner (Gopee, 2001; Knapper & Cropley, 2000). The challenge to both the UK and Island government is to ensure that every citizen realises their full potential by participating in lifelong learning (SoJ, 2012b; SoJ, 2002; DfEE, 1997a). However, it has been suggested that the progressive vision of lifelong learning has been forgotten (Coffield, 1999), with individual self-fulfilment being usurped by the requirement to learn for economic competitiveness (Ecclestone, 1999). Indeed, lifelong learning now appears to be inextricably entwined with globalisation, competition and the broader society (Tight, 1998).

In the UK people study less as they age, whilst those in lower socio-economic classes are less likely to engage in learning beyond initial education (Aldridge & Hughes, 2012). The 2011 Jersey census (States of Jersey Statistics Unit, 2012) does not include comparable data but it is likely that the population will follow similar trends. Census data collected about Jersey working age adults indicated that 20% had no formal qualifications, 46% achieved secondary level education and the remaining 34% had attended higher education resulting in a diploma, degree or higher qualification (States of Jersey Statistics Unit, 2012). However, due to island economic pressures coupled with a rising unemployment rate, the focus of lifelong learning turned primarily towards increasing the chances of the unemployed in obtaining employment (SoJ, 2012b), thus fulfilling the island strategy for economic success (SoJ, 2009). Therefore, it would appear from an island viewpoint, that Ecclestone's (1999) aforementioned prophecy is being fulfilled.

Both the UK government and local island schemes for lifelong learning make the assumption that people want to continue learning after compulsory education (SoJ, 2012b; SoJ, 2002; DfEE, 1998; DfEE, 1997a; DfEE, 1997b). However, most people are experiencing more frequent and less predictable life transitions as a result of globalisation, technological and social change (McNair, 2009). The disposition of people to learn is not immutable and can be affected by life events, previous experiences at school and access to

technology (Feinstein, Vorhaus & Sabates, 2008). Findings from the National Institute of Adult Continuing Education reveal that 56% of people aged 17 and over indicated that they were unlikely to undertake any learning in the near future (Aldridge & Tuckett, 2003), and this indifference towards lifelong learning persists (Aldridge & Hughes, 2012). Deciding factors against participating in lifelong learning include: entering and leaving the labour market, migration, childbearing, family commitments, divorce, caring for others and bereavement (McNair, 2009). NIACE has also revealed geographical location as a major influence on whether people are likely to participate in lifelong learning (NIACE, 1999). This finding is of particular interest to this dissertation, which was conducted on an island where people had limited access to further and higher education.

The UK government is committed to the concept of lifelong learning and aims to help people of all ages access learning, whether via apprenticeship schemes or by attending further or higher education (Hughes, 2011). However, as already highlighted, over half the working age population has no intention of undertaking learning in the near future (Aldridge & Hughes, 2012). It has been recognised that the National Health Service (NHS) has its share of reluctant learners (Garcarz, Chambers & Ellis, 2003) suggesting that lifelong learning may not be integrated into NHS culture despite the recommendations of the UK government (DH, 2012a).

Lifelong Learning and the National Health Service
UK Government recommendations for lifelong learning within the population (DfEE, 1998; DfEE, 1997b; DfEE, 1997a) are also reflected within the nursing profession with the enforcement of compulsory Post-Registration Education for Practice (PREP) (NMC, 2010a). The UK Department of Health recognises the importance of lifelong learning within the NHS, enabling all healthcare workers to continually update and extend their knowledge and skills thus maintaining competent practice (DH, 2001). Subsequently, this has been reflected through the years by successive governments. The Labour Government promoted lifelong learning as one of the core principles of NHS staff development in '*A High Quality Workforce*' (DH, 2008b), whilst the current Coalition Government acknowledges the importance of lifelong

learning to enable the transfer of new developments and technologies into practice, thereby improving patient care (DH, 2012a).

It is acknowledged that employees are the most important asset of any business, possessing the necessary knowledge, skills and experience to undertake the work of their employer, and as such are referred to as 'human capital' (Covell, 2008; Schuller & Field, 1998). Within healthcare, lifelong learning is considered essential for developing the workforce and thus ensuring the delivery of high quality patient care (Willis, 2012). The financial sponsorship to undertake professional development of human capital refers to the monetary support by the employer, or self-financing by employees (Gopee, 2002). This investment in employees' knowledge and skills occurs through formal and informal learning, thereby increasing the Charity's overall knowledge (Covell, 2008). Alongside this are the social networks with family, friends and peers that facilitate educational performance (Field, 2003), with these people and the resources embedded within these relationships termed 'social capital' (Schuller, Baron & Field, 2000).

Social capital is a conceptual framework that considers how mutual goals are achieved via social networks and the interchanges that occur within them (Schuller, Baron & Field, 2000). Moreover, Field (2005) asserts that the utilisation of social capital to enhance our collaboration with others augments personal goal achievement. However, social capital is a contested term that is open to debate (Schuller, 2000a). It is in this respect the work of Bourdieu, Coleman and Putnam is instructive.

Bourdieu considers social capital as a means of reproducing relationships between groups and classes of people over time (Bourdieu & Passeron, 1977). Bourdieu defines social capital as:

> *the aggregate of the actual or potential resources*
> *which are linked to possession of a durable network*
> *of more or less institutionalised relationships of*
> *mutual acquaintance and recognition – or in other*
> *words, to membership of a group – which provides*

each of its members with the backing of the collectively-owned capital.
(Bourdieu, 1997, p.51).

Thus, social capital is reliant on the number of people within the network membership, the social capital of others within the system, and is subject to change (Smith & Kulynych, 2002). As one of the first proponents of social capital in contemporary sociological discourse, Bourdieu's work is considered the most theoretically refined (Portes 1998). However, Bourdieu's theory is subject to criticism as social capital is seen as the exclusive property of privileged people and did not allow for the possibility for less privileged individuals to benefit from their social connections (Field, 2003). Bourdieu's work on social capital mainly focused on its role in the reproduction of social class relations, whilst the work of Coleman explores social capital and educational achievement (Schuller, Baron & Field, 2000).

Coleman's work on social capital was based around schooling and his interest in the sociology of education (Schuller, 2000a). Coleman's work selects middle-class families, exploring the significance of social capital as a way of comprehending the relationship between social inequality and a child's educational achievement (Schuller, Baron & Field, 2000). He defines social capital from an educational context, as 'a particular kind of resource available to an actor', consisting of a 'variety of entities' which contains two elements: 'they consist of some aspect of social structures, and they facilitate certain actions of actors – whether persons or corporate actors – within the structure' (Coleman, 1988, p. 98). This definition describes social capital according to its functions and has been criticised as vague. Portes (1998) asserts that Coleman's definition fails to separate the resources of social capital from the ability to obtain them by membership in social structures. Field (2003) is also critical of Coleman's work, arguing that by choosing to focus on school education he omits the discussion of social capital within higher education or in informal workplace learning. Nonetheless, within the context of the human and social capital debate, Coleman challenges individualism by questioning the value of human capital in the absence of wider social relations (Schuller & Field, 1998).

The concept of social capital was popularised by Putnam with his work on the perceived decline of civic engagement in the United States of America (USA) (Schuller, Baron & Field, 2000). He defines social capital as 'the features of social life – networks, norms and trust – that enable participants to act together more effectively to pursue shared objectives' (Putnam, 1996, p. 66). In his study '*Bowling Alone*', Putnam (1995) observes a drop in civic engagement despite the growth in educational levels (human capital), and claims that the increased consumption of television is responsible for the decline in social capital. Portes (1998) critiques Putnam's underlying assumption that the masses are responsible for the alleged degeneration of social capital, whilst Schuller & Field (1998) question Putnam's exclusion of environmentalist movements in his indicators for civic engagement.

Consequently, social capital has a profound ability to influence how people acquire ideas, information and new skills throughout their lifespan (Field, 2005). Expanding on Woolcock's (1998) work exploring social capital and economic development, Field (2005) identifies three types of social capital: bonding, bridging and linking, and explores their effects on lifelong learning (Table 2.2, overleaf). Bonding social capital is characterised by high levels of trust resulting in the liberal exchange of ideas, knowledge and skills within the group (Field, 2005). Bridging capital and linking capital are considered to have looser ties within the network exposing agents to a multiplicity of information and knowledge, which in turn fosters ingenuity and creativity (Field, 2005). Lifelong learning results in increased knowledge, skills and capabilities, and this improvement in human capital is more readily achieveable when linked to social capital (Schuller, 2000a). Nevertheless, on occasion social capital can be detrimental, especially when used to exclude or limit participation in education (Field, Schuller & Baron, 2000). Thus, due to their inextricable links with lifelong learning, the theoretical concepts 'human capital' and 'social capital' underpin the thesis.

Table 2.2 Bonding, bridging and linking social capital, and their possible effects on lifelong learning (Field, 2005, p. 34).

Type of social capital	Possible effects on lifelong learning
Bonding: • Dense but bounded networks • Homogeneity of membership • High levels of reciprocity and trust • Exclusion of outsiders	• Free exchange of ideas, information & skills within group • Strong influence on identity formation among children • High trust placed in information received • Limited access to new & varied knowledge from outside group, & low trust of knowledge from outside group • Relationship to education system likely to be highly traditionalist in orientation
Bridging: • Loose & open-ended networks • Heterogeneity of membership • Shared norms & common goals • Levels of trust and reciprocity may be more limited	• Relatively free exchange of a variety of ideas, information, skills & knowledge within group & between own & other groups • Potential resources for identity maintenance & renewal among adults • High trust information & knowledge from within group • Relationship with formal education system highly context-dependent
Linking: • Loose & open-ended networks • Variety of membership • Shared norms & common goals • Levels of trust & reciprocity may be circumscribed by competing demands	• Relatively free exchange of ideas, information, skills & knowledge within group & between own & other groups • Some trust in information & knowledge from within group • Open resources to support identity change among adults • Relationship with formal education system highly conditional

The States of Jersey Department of Health and Social Services has not made lifelong learning a particular focus of its recent White Paper (SoJ, 2012b), which explores the need to update local health and social services provision. The proposed scenario for improved healthcare delivery for the island involves a new model of health and social care, with greater emphasis on community provision, telehealth, telecare and the development of practice nurses (SoJ, 2012b; SoJ, 2011). However, the need for lifelong learning is implicit in these future changes, as nurses will need to be developed to undertake new roles within the changing health service (SoJ, 2012b). Therefore, Jersey-based nurses will need to undertake both CPD and CPE in order to fulfil these proposed new roles in a competent manner.

Distinctions Between CPD and CPE

It is commonplace for the terms CPD and CPE to be used interchangeably (Lawton & Wimpenny, 2003), with the USA favouring 'CPE' whilst the UK tends to prefer the term 'CPD' (Jeris, 2010). Richard Gardner (1978) is the founder of the term 'CPD', utilising it to encapsulate informal, experiential and formal learning undertaken by professionals. However, it has been noted that CPD is an ambiguous concept with differing meanings for the professional, the workplace and society (Friedman & Phillips, 2004). For the UK nurse practitioner, CPD is a means of ensuring continued professional registration with the NMC (2010a). Employers equate CPD with the ability of the workforce to constantly evolve to sustain high quality health services and thus continue to improve health of the population (DH, 2012a) and maintain the safe delivery of quality patient care (RCN, 2007). For the general public, CPD is a means of reassurance that nurses are up-to-date and that the professional regulatory body can verify that standards are being upheld (Friedman & Phillips, 2004). Nurses are required to undertake 35 hours of CPD every 3 years, and failure to comply results in sanctions whereby the nurse would be removed from the NMC register and unable to legally practice as a qualified practitioner (NMC, 2010a).

Research undertaken by the Professional Associations Research Network (PARN), combined with a range of definitions from other researchers and

organisations, resulted in a definition of CPD that is pertinent across various professions:

> *CPD is any process or activity of a planned nature that provides added value to the capability of the professional through the increase in knowledge, skills and professional qualities necessary for the execution of professional and technical skills, often termed competence. It is a lifelong tool that benefits the professional, client, employer, professional association and society as a whole, and is particularly relevant during periods of rapid technological and occupational change*
> (Friedman, Davis & Phillips, 2001, p. 47).

Definitions of CPD within the nursing profession tend to focus on its impact on healthcare improvement; however, more recently benefits to practitioners have also been acknowledged (ANA & National Nursing Staff Development Organisation (NNSDO), 2010). The ANA defines CPD as 'the lifelong process of active participation in learning activities that assist in developing and maintaining their continuing competence, enhancing their professional practice, and supporting achievement of their career goals' (ANA, 2000, p. 1). The NMC have elaborated upon this, further establishing that CPD can comprise all informal and formal learning within nursing including reflection, clinical supervision, journal clubs, and attendance at local study days as well as courses undertaken at higher education institutions (NMC, 2010a).

The term CPE came into general use in the late 1960s when it was apparent that less formal studies were no longer sufficient to develop occupational knowledge, as the focus was on 'every professional carrying out their duties to the highest standard of competence' (Houle, 1980, p. 7). The explosion of research-based knowledge and technological innovation meant that professionals had to be continually updated throughout their careers (Cervero, 2000). Thus, CPE was the term denoted to the formal education undertaken by professional practitioners that followed their initial period of

instruction and which extended their learning throughout their working life (Queeny, 2000). This enabled professionals to keep up with new developments in their field, gain mastery of their craft and understand the inter-connectedness to related disciplines (Jeris, 2010). Indeed, within community nursing it has been necessary to undertake further periods of formal education in order to develop as a specialist practitioner (NMC, 2004) or to become an independent nurse prescriber (NMC, 2006). Thus, practical experience and informal learning are not sufficient to develop nurses to undertake enhanced roles.

In nursing literature there is no consensus around a definition for CPE (Barriball, While & Norman, 1992). Nevertheless there is some agreement that CPE refers to post-registration formal education undertaken following initial nurse qualification (Tame, 2009; DeSilets, 2006; Murphy, Cross & McGuire, 2006; Gopee, 2005; Parker, 1998; Jarvis, 1987). Many nurses undertake CPE to simply keep up with newly qualified staff, sensing that their qualification undertaken some years earlier is somehow obsolete (Watkins, 2011; Tame, 2010; Murphy, Cross & McGuire, 2006) since the introduction of nursing degrees (NMC, 2010b). Others state that they are motivated to participate in CPE in order to increase their employability and enhance their professional career (Richards & Potgieter, 2010). There are also a number of new and extended roles that were once performed by medical staff which are now becoming nurses' responsibilities, resulting in the need for nurse CPE (RCN 2010; Drey, Gould & Allan, 2009). Hence, CPE allows practitioners to undertake study in identified areas of need, facilitating professional development and the delivery of competent healthcare within a rapidly evolving healthcare system (DH, 2012a).

Lifelong learning, CPD and CPE are all terms used to define the various types of learning that take place during the professionals' lifespan following initial nurse education. These concepts can be envisioned as 'Russian Dolls' (Figure 2.1, overleaf) with lifelong learning containing CPD, and CPD containing CPE (Tame, 2009). Discrete differences exist between CPD and CPE. CPD is the broad term incorporating all learning for professional development, whether formal, informal or experiential that occurs either

within the workplace or elsewhere (NMC, 2010a; ANA, 2000). Whereas CPE can been pictured as a sub-category of CPD only referring to the formal education, which usually takes place in a higher education institution and is often associated with gaining an academic qualification (Tame, 2009; DeSilets, 2006; Murphy, Cross & McGuire, 2006; Gopee, 2005; Parker, 1998; Jarvis, 1987).

Figure 2.1
The relationship of CPE and CPD to lifelong learning (Tame, 2009)
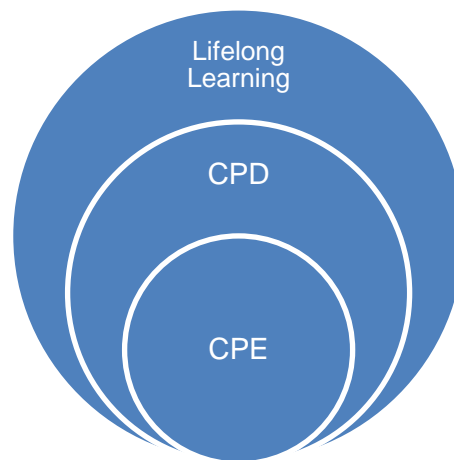
Neither CPD nor CPE is considered as a more effective means of improving knowledge and skills, with the variety of learning approaches available suitable to the varied learning styles of the individual professional (Houle, 1980). However, whilst the NMC (2010a) consider that informal, formal and experiential learning are appropriate to achieve Post Registration Education for Practice, this view is not widely accepted amongst managers and nursing staff (Tame, 2009; Chiarella, 1990). Employers tend to regard CPD more favourably (RCN, 2002) as it can be undertaken without the difficulties associated with releasing staff from the workplace to attend university and necessitating the employment of bank nurses to provide 'back-fill' of absent employees (Cooley 2008; Bahn 2007a; Adami & Kiger 2005; Gopee 2003; Audit Commission 2001). Nurses have a preference for CPE with its associated opportunities for promotion and career development (Cooley, 2008; Gould & Fontenla, 2006; Spencer, 2006; Davey & Robinson, 2002) as

opposed to undertaking formal study just for the intrinsic reward (Murphy, Cross & McGuire, 2006).

The Integration of Lifelong Learning into the National Health Service

The integration of lifelong learning into the NHS has been facilitated by various policy documents supporting the development of both registered and non-registered healthcare employees (DH, 2012a; DH, 2008b; DH, 2004b; DH, 2001). In 2001 the Department of Health introduced '*Working Together – Learning Together*' a framework for lifelong learning that aimed to offer all levels of NHS staff access to education, training and development. Strategic Health Authorities (SHAs) replaced the Workforce Development Confederations (WDCs), taking responsibility for implementing lifelong learning to the NHS through the commissioning and funding of CPE for non-medical healthcare employees (DH, 2001). However, by 2006 a potential crisis in post-registration educational programmes and CPD was highlighted by the Council of Deans and Heads of UK University Facilities for Nursing and Health Professions, with cuts in funding of up to 30% resulting in a reduction in community nurse training (Council of Deans for Nursing and Health Professions, 2006). These cuts coupled with the introduction of Staff Nurses and Care Assistants in community nursing teams, have reduced the number of District Nurses, eliciting a response from the QNI to bring district nursing back on to the health agenda once more (QNI, 2009). There has also been a concomitant fall in the number of Health Visitors (Unite, 2009) and insufficient School Nurses to cope with young people's issues (Ly, 2010).

Mindful of past education funding issues, the role of the ten regional SHAs ended in April 2013. Since then thirteen Local Education and Training boards (LETBs) have taken over the responsibility for managing the local Multi-professional Education and Training (MPET) budget (DH, 2012a). Health Education England (HEE), the new national body for the education, training and development of the health workforce (DH, 2012a), oversees the authorisation of LETBs. Set up as a shadow Special Strategic Health Authority in June 2012, HEE will support the new NHS education and training system implemented by the Coalition Government (DH, 2012b). Medical

Education England (MEE) was the largest of the three bodies being absorbed into HEE. This has led to concerns from within the nursing profession that medical education may dominate HEE (Santry, 2010). To date HEE have appointed both a Director of Medical Education and a Director of Nurse Education (HEE, 2012a). The *modus operandi* of HEE is to ensure that the NHS in England is able to deliver high quality healthcare into the future by recruiting the right people and focusing on their subsequent education, training and development needs (HEE, 2012b). Consequently, the general public can be assured that the NHS is committed to the continual education of its workforce in a bid to provide a proactive healthcare service to the British population (DH, 2012b).

Following the revelations of the Shipman inquiry (Smith, 2004a), both the Foster Review (DH, 2006b) and the Chief Medical Officer's Report (DH, 2006a) considered how best to regulate health care professionals and restore public faith in the National Health Service. For its part in professional self-regulation, the NMC as regulatory body for nurses, midwives and specialist community public health nurses requires all registered nurses to participate in 35 hours of compulsory PREP every three years in order to retain their currency as practitioners and thus remain eligible for re-registration (NMC, 2010a). The General Medical Council (GMC) Statute '*Licence to Practise and Revalidation Regulations Order of Council*', 2012, introduced a new process for the revalidating of medical doctors. The GMC does not take a prescriptive approach, instead advising doctors that it is their 'responsibility to do enough appropriate CPD to remain up to date and fit to practise' (GMC, 2012, p. 14) thereby allowing unscrupulous practitioners the opportunity to undertake a minimum amount of CPD. Moreover, a recent audit of current nurse PREP arrangements has revealed that the process is no longer fit for purpose since it fails to give adequate assurance of registrants' continued fitness to practise (NMC, 2012). With this loss of confidence in PREP, the NMC (2012) is currently proposing the development of a new system for revalidating nurse practitioners and anticipates that it will be in place by 2015.

The Report of the Willis Commission (2012) explores the benefits of having a graduate nursing workforce, focusing on the need to improve the quality of care, deliver and manage complex skilled care within the fast-paced healthcare system. The Department of Health introduced the *Knowledge and Skills Framework* (KSF) into the NHS, focusing on six core dimensions covering the key areas that apply to every healthcare job; identifying the knowledge, skills and development needed by healthcare workers to undertake their role (DH, 2004c). However, a conflict exists between the NMC expectations of keeping one's nursing skills up to date and the innate principles within the KSF (DH, 2004c) of continual renewal and development of skills and knowledge allowing career progression along the '*Skills Escalator*' (DH, 2001). Although the introduction of a graduate nursing workforce may encourage non-graduate nurses to upgrade their nursing diplomas (Willis, 2012), not all nurses wish to tread this path and are simply content with keeping their practice up to date (Audit commission, 2001). Whilst a commitment to lifelong learning is deemed a prerequisite for on-going competence (World Health Organisation (WHO), 2003), there appears to be no correlation between improved patient care and the acquisition of skills (Cotterill-Walker, 2012; Ellis & Nolan, 2005; Pelletier, Donoghue & Duffield, 2003; Cervero, 2001; Jordan et al. 1999; Barriball, While & Norman, 1992). The Royal College of Nursing (2002) and the Audit Commission (2001) acknowledge the assumption that knowledge and skills are developed by CPE, thereby retaining professional competence and enhancing patient care (DH, 2012a; Willis, 2012; DH, 2010b; NMC, 2010a; DH, 2008b; NMC, 2008a; DH, 2006a; DH, 2006b; DH, 2001) may be inaccurate (Queeny, 2000).

The NMC, as the professional regulatory body for nursing and midwifery, has subscribed to a sanctions model of CPD, whereby failure to comply results in sanctions being brought against the registrant in question by not allowing them to re-register annually (NMC, 2010a), or removal from the register in the case of incompetence (NMC, 2004). However, the introduction of *Agenda for Change* (AfC) (DH, 2004a) into the NHS has now initiated the conflict of a mixed benefits and sanctions model of CPD for nurses (Morgan, Cullinane & Pye, 2008; Madden & Mitchell, 1993). Under *AfC* (DH, 2004a) if

employees achieve their annual appraisal fulfilments corresponding to the *Knowledge and Skills Framework* (KSF) (DH, 2004c) for their role and outlined in their personal development plan, they stand to gain a financial incremental reward. Whilst some people may be motivated by financial reward for undertaking CPD (Wallace, 1999), others regard job satisfaction as a far greater motivator and rationale for employment (Gould & Fontenla, 2006). Nevertheless, we should be mindful that financial reward for skills and competencies does not ensure that these will be put into practice (Tame, 2009).

The move to commit pre-registration nurse education to degree level (NMC, 2010b) is seen as a cause of celebration for the nursing profession (Willis, 2012) with the hope of producing nurses with a heightened desire to undertake CPE (NMC, 2010b). However, many nurses in the current workforce undertook their training in the days before nursing was integrated into higher education and thus do not even hold a Diploma in Higher Education (Tame, 2009). Their training was based on traditional teacher-centred pedagogical methods and this passive approach to education has not equipped them for self-directed learning (Timmins & Nicholl, 2005; Hewitt-Taylor, 2002; Sparling, 2001). Whilst it is not impossible for these nurses to become lifelong learners despite their initial socialisation in to passive learning, this process is gradual, laborious and one to which some nurses fail to adjust (Hinchliff, 1998; Fleck & Fyffe, 1997). This lack of socialisation into lifelong learning can leave some nurses feeling vulnerable by the prospect of undertaking CPE due to their lack of study skills (Gopee, 2001; Platzer, Blake & Ashford, 2000a) and may be central to them leaving NHS employment (Hewison, 1999).

Whilst the DH maintains that it is the personal responsibility of all nurses to participate in CPD, it also acknowledges that their employers are also accountable (DH, 2012a). However, this bottom-up approach to professional development is not evident in government policies, which adopt a top-down approach to nurse CPD (DH, 2006a; DH, 2006c) and where professional sanctions exist for failure to comply (NMC, 2010a). To fulfil the KSF (DH, 2004c) an annual development review between manager and staff member

is undertaken, leading to the joint production of a personal development plan (PDP) for the forthcoming year, enabling professional development to meet local healthcare needs (RCN, 2006). Crisp (2005) states that the challenge here is ensuring that appropriate learning and development opportunities are available for everyone. However, tensions can exist between the individual aspirations of the nurse and the requirement of the health service thereby causing a dilemma in drawing up a PDP when conflicting priorities occur (Berridge, Kelly & Gould, 2007). Thus, it can be construed that the PDP is often far from 'personal', instead focusing on what further educational requirements are needed in order for the nurse to meet service provision (Tame, 2009).

In reality no NHS healthcare trusts have attained 100% achievement of staff PDPs, with figures ranging from 60% to 'nearly all' (Buchan & Evans, 2007), whilst the figure in the private sector has been identified as only 56% (Aoki & Davies, 2002). The main reason for failure to achieve full implementation of PDPs is attributed to the volume of paperwork and the overly complicated process involved (Douglass & Ruddle, 2009). Recent figures reveal that fewer than half the staff in a third of trusts have received annual performance appraisal and development reviews, yielding an average of only three quarters of staff in trusts with PDPs in place (Brown et al. 2010). In light of these findings the NHS has implemented a more simplified KSF process ensuring that staff may acquire and apply the knowledge and skills which they need to perform their role effectively (The NHS Staff Council, 2010). This indicates that the NHS still considers the KSF as the best instrument for professional development in order to meet health service requirements (Brown et al. 2010).

Rapid technological innovations in worldwide disease prevention and management have impacted the NHS, resulting in the advancement of healthcare management and provision, with nurses undertaking advanced roles that were once the remit of medical colleagues (DH, 2012a). The NMC imposes lifelong learning in the form of CPD as a mandatory requirement of nurse registration in order to ensure that public protection is safeguarded (NMC, 2010a). However, conflict exists between professional commitment to

CPD and the political, economic and social forces that influence individuals' values and beliefs (Tobias, 2003). Contradictory viewpoints occur between different stakeholders as to whether CPE is for the achievement of new skills and knowledge to enable the delivery of complex healthcare (DH, 2012a) or to safeguard the public by ensuring that nurses maintain their skills and knowledge (NMC, 2010a). These differing views of CPE along with the mandatory introduction of lifelong learning within the NHS (DH, 2004b) have undoubtedly had an effect on nurse perceptions of lifelong learning (Tame, 2009). These difficulties are further compounded by the problems that surround the translation of theory and research findings into nursing practice (Maben, Latter & Clark, 2006).

CPE and the Theory / Practice Gap

The UK government has put policy in place to bring together health, education and the research sector under LETBs to facilitate the transfer of new healthcare technologies into practice (DH, 2012b). This enables nurses who are mandated by their professional nursing bodies to undertake CPE vital to the provision of high quality patient care, to ensure that patient safety is provided throughout the duration of their nursing careers (ANA & NNSDO, 2010; NMC, 2010a; NMC, 2008a). The development of an Education Outcomes Framework by the Department of Health (DH) provides a system of quality governance and educational outcomes supporting the delivery of enhanced patient care and improved public health outcomes (DH, 2012b). However, the continued existence of the theory / practice gap may thwart the transfer of healthcare research and theory into the practice setting (Maben, Latter & Clark, 2006; Gallagher, 2004).

The theory / practice gap appears to be a global phenomenon and not just a concern grappled with by UK nurses and educators (Maben, Latter & Clark, 2006). The relationship between nursing practice and theory has been likened to that of a greyhound chasing a hare, with theory taking the role of the hare, identifying ideas for practice development (Lindsay, 1990). However, Allmark (1995) observes that the theory / practice gap is usually identified as problematic where practice fails to live up to the theory (Cook, 1991). The concept of a 'gap' between nursing theory and nursing practice

seems more pronounced since the entry of UK nurse education into the higher education system (Elkan & Robinson, 1993). Jasper (1996) concurs with this view, stating that although UK nurse education reforms were designed to address the differences in education and nursing value systems, the gap between the two may have actually increased. The physical separation of the organisations that deliver nurse education from those providing health care is also seen by some as tangible evidence of the distance between education and practice (Hewison & Wildman, 1996). Despite these negative connotations surrounding the theory / practice gap, there are those who celebrate its existence and view it in a positive light (Haigh, 2008; Rafferty, Allcock & Lathlean, 1996; Allmark, 1995).

The longstanding challenge of integrating subject-based and work-based knowledge has historically focused on how learning can be transferred from theory into practice (Evans et al. 2010). This process is often fraught with issues and subjected to sabotage from both the organisation with work overload and role constraints, and by professionals working in a pressurised environment within a nursing culture of covert rules and task-orientated working practices (Maben, Latter & Clark, 2006). However, some researchers refute the claim that the theory / practice gap is a negative concept, asserting that a space needs to be preserved in order to generate possibilities of new ways of working (Moss, Grealish & Lake, 2010). The future of practice development within nursing relies upon fostering the relationship between academics and practitioners and the space they need to inhabit so as to promote knowledge production (Gravani, 2008). Indeed, Haigh (2008) dares us to consider that the theory / practice gap is indicative of an evolving profession, which is challenging current norms and moving practice forward. For example, care providers for people with long-term conditions have utilised the 'community of practice' to bring together practitioners and academics in a bid to close the gap between theoretical models and the delivery of complex care within challenging circumstances (Tee & Böckle, 2012). Therefore, notwithstanding entrenched views to the contrary, it is possible that the theory / practice gap can be embraced as a place where collegial collaboration occurs between academics and practitioners for the benefit of improving healthcare practice (Haigh, 2008).

The effect of undergraduate and postgraduate educational qualifications on client care will now be considered.

Outcomes of CPE on Nursing Practice

Nurses perceive that CPE benefits patient care (Lee, 2011; Spencer, 2006; Adriaansen, van Achterberg & Borm, 2005; Pelletier, Donoghue & Duffield, 2003; Davey & Robinson, 2002; Smith & Topping, 2001; Furze & Pearcey, 1999; Wood, 1998). Nevertheless, proof that CPE directly affects patient care is difficult to determine (Cotterill-Walker, 2012; Furze & Pearcey, 1999; Wood, 1998). The impression that CPE improves professional performance (Cervero, 2001) following successful completion of formal study does not always translate into changes in practice (Spencer, 2006; Ellis & Nolan, 2005; Cervero, 2001; Furze & Pearcey, 1999; Wood, 1998). Only three research studies could be located that have focused on the clinical practice outcomes of formal nurse education (Considine, Botti & Thomas, 2005; Aiken et al. 2003; Considine, Ung & Thomas, 2001).

Undertaking a correlational study, Considine et al. (2001) utilised survey methods to collect data from qualified nurses working in two Australian emergency departments in order to assess the accuracy with which they were using the National Triage Scale (NTS). The aim of the study was to identify any relationships between triage nurses' decisions on triage allocation and the level of educational preparation of the triage nurse. Forty-two registered nurses met the inclusion criteria and convenience sampling was used resulting in thirty-one triage nurses volunteering to participate in the research, giving a response rate of 74%. The self-administered questionnaire contained a section collecting demographic details enquiring about the participant's years of experience in emergency and triage nursing, including their level of educational attainment in nursing. Participants were then required to allocate a NTS category to each of the ten patient scenarios contained within the questionnaire, enabling the researcher to elicit responses from all participants based on the same information. Spearman's correlation was used to identify the existence of correlations between triage decisions and the type and length of nursing experience and educational attainment. Chi-square was utilised to discover significant differences in

35

triage decisions for each of the five NTS categories. No correlation was reported between triage decisions and length of experience in emergency nursing or triage. However, there was a positive correlation between nurses with a tertiary level education qualification and 'expected triage' decisions (P= 0.012). This study is limited by the sample size of 31 participants and its findings are restricted to emergency department settings.

Research undertaken in the United States used cross-sectional analysis of hospital outcome data to examine if hospitals with nurses trained to Baccalaureate or higher level qualification were associated with a decreased surgical patient mortality (Aiken et al. 2003). The study reported the results of 168 adult general Pennsylvania hospitals generating data for general, orthopaedic and vascular surgery patients. A random sample of registered nurses was sent questionnaires, which resulted in a 52% (n=10,184) response rate. This captured demographic data relating to age, whether the nurses worked full-time or part-time, workload, experience and highest educational attainment. Patient discharge abstracts (n=232,342) were analysed for outcomes data including death rates of surgical patients within 30 days of admission and death rates within 30 days of admission among patients who experienced complications. The research also took into consideration whether or not a board-certified surgeon performed the surgery. The study found that years of nursing experience did not predict patient outcomes following surgery. However, a statistically significant relationship was identified between the proportion of nurses in a hospital with Bachelor's and Master's degrees and positive patient outcomes (P=0.008). The researchers conclude that a 10% increase in the proportion of hospital nurses holding a bachelor's degree was associated with a 5% decline in both the likelihood of patients dying within 30 days of admission and deaths of patients with serious complications. Whilst the research provides a detailed account of the impact of nurse CPE on subsequent patient outcomes, the study is limited by the low response rate of nurses surveyed (n=52%). This, coupled with the fact that the study only examined hospitals from one state, limits the generalisability of the findings. This research has also been the subject of debate in relation to the adjustments in variables between hospitals (Cotterill-Walker, 2012).

An Australian quasi-experimental multi-centre study aimed to examine how emergency nurses' knowledge of assessment of oxygenation and the use of supplementary oxygen was affected by specific educational input (Considine, Botti & Thomas, 2005). All registered nurses (n=196) working in four emergency departments in Melbourne hospitals were invited to participate in the research with an uptake of 88 nurses agreeing to take part in the research. Two of the emergency departments were designated as experimental sites whilst the remaining two became control sites, with 51 participants in the experimental group and 37 in the control group. No statistical differences in baseline characters were found between the control group and the intervention group. Nurses in the experimental group completed a self-directed learning programme covering the indicators of hypoxia. Multiple choice question (MCQ) tests were administered to both groups of nurses for completion without collaboration outside of work time. Non-parametric data were compared using chi-squared test for independence with parametric data subject to t-test or the Mann-Whitney U-test. No statistically significant differences in age, years of experience, qualifications or level of appointment were ascertained. Mean pre-test scores indicated that both groups of nurses had a similar baseline level of knowledge with regard to the assessment of oxygenation and use of supplemental oxygen (P=0.091). However, the experimental group's mean post-test score was significantly higher than the control group's mean post-test score (P=< 0.0001). This indicates that educational preparation had a positive effect on emergency nurses' knowledge of assessment of oxygenation and use of supplemental oxygen, thereby enhancing their clinical decision-making. A major potential limitation of this research lies in the use of MCQs whereby participants could either guess the answer or use the resource material to find the answers. The findings of this research are also limited to emergency department settings.

The findings from these 3 studies indicate a positive correlation between nurse CPE and the positive impact on patient care, highlighting the significance and importance of lifelong learning on the improvement health care services. Other research considers the positive effects of CPE including increased confidence and self-esteem, enhanced communication skills,

personal and professional growth and application of theory to practice (Cotterill-Walker, 2012). However, numerous constraints such as: lack of time, unsupportive managers and unhelpful colleagues prevent nurses putting their newly acquired knowledge into practice (Lee, 2011; Griscti & Jacono, 2006; Spencer, 2006; Hardwick & Jordan, 2002).

Increased confidence and self-esteem are associated with the ability to empower nurses to deal with assessing complex situations and with the management of patient care (Cotterill-Walker, 2012). In a UK study exploring the effectiveness of systems supporting CPE, fifty in-depth interviews were conducted on a one-to-one or small group basis with nurse educators, nurse managers and nurses undertaking certificated modules (Nolan, Owens & Nolan, 1995). Nurses were found to be more assertive and self-confident following CPE, enabling them to contribute more effectively to multi-disciplinary teams (Nolan, Owens & Nolan, 1995). Armstrong & Adam (2002) concur, with their respondents claiming to be more assertive and confident in taking charge of clinical care. Increased nurse confidence following CPE was a common finding (Stanley, 2003; Davey & Robinson, 2002; Hardwick & Jordan, 2002; Whyte, Lugton & Fawcett, 2000; Hogston, 1995), with some proclaiming that this directly benefited patients (Daley, 2001; Nolan et al. 2000).

Qualified nurses are required to have excellent communication and interpersonal skills (NMC, 2010b). The ability to express opinions and confidently challenge and question the practice of colleagues is vitally important (Cotterill-Walker, 2012). In a review of literature considering the effects of CPE on nursing practice, Wood (1998) concludes that communication skills are improved following education. In a ten-year longitudinal UK study exploring the effects of post-graduate studies on nurses' professional development, respondents identified increased confidence in expressing their opinions especially when debating professional issues with colleagues (Whyte, Lugton & Fawcett, 2000). Other researchers agree that CPE has a significant effect on nurses' ability to communicate confidently with other professionals (Pelletier, Donoghue & Duffield, 2003; Armstrong & Adam, 2002; Ashworth, Gerrish & McManus,

2001). However, it is worth noting that nurses did not discuss the development of their interpersonal skills in relation to clients and their families (Ashworth, Gerrish & McManus, 2001). In one study it was noted that CPE had no effect on nurses' ability to communicate with clients, although the researchers postulated that this could be due to their respondents possessing highly developed communication skills before entering the course (Pelletier, Donoghue & Duffield, 2003).

The ethos behind nurse CPE is to enable the practitioner to enhance their personal and professional skills (DH, 2012b) and this has been uncovered in a number of research studies (Cotterill-Walker, 2012). Undertaking research as part of a larger study, Wildman et al. (1999) analysed 113 questionnaires received from nurses who had recently completed a Diploma in Professional Studies in Nursing at a UK Higher Education Institution. Respondents indicated that their values and beliefs had altered following completion of their studies, augmenting their ability to be non-judgmental of difficult clients. Other research indicates that following CPE, managers are more likely to use nurses as a resource (Armstrong & Adam, 2002; Hardwick & Jordan, 2002).

Qualified nurses who had recently undertaken CPE valued their increased ability to support junior staff and facilitate their development (Spencer, 2006), with 80% of nurses more likely to act as a role model after attending CPE (Pelletier, Donoghue & Duffield, 2003). The mentor role within nursing requires nurses to develop their professional knowledge and keep updated in order to supervise student nurses within the workplace (NMC, 2008,b). Likewise, Nurse Lecturers and Practice Teachers are required to be registered with the NMC and have a duty to remain knowledgeable regarding contemporary nursing (NMC, 2008b), especially with respect to teaching practical nursing skills to student nurses (Borneuf & Haigh, 2010).

Professional growth following CPE centred mainly on improvements and changes to practice (Lee, 2011; Aitken et al. 2008; Davey & Robinson, 2002; Whyte, Lugton & Fawcett, 2000). Increased care delivery was noted (Hardwick & Jordan, 2002; Smith & Topping, 2001) with some research indicating that nurses felt more knowledgeable in relation to their practice

(Bahn 2007a; Wildman 1999). However, we are urged by Griscti & Jacono (2006) to treat these claims with caution, as many of these research studies rely on nurse perceptions of change and this does not always translate into improved patient care.

Healthcare professionals need to embrace new and innovative techniques to provide optimal care to their patients and the use of evidence-based practice assists nurses in achieving this worthy goal (Majid et al. 2011). Using mixed research methods with nurses (n=44) who had completed a part-time diploma in nursing, Jordan & Hughes (1998) found that knowledge learnt on the course was being used to increase clinical effectiveness. Subsequent research reports that following CPE, nurses are able to deliver research-based practice (Aitken et al. 2008; Whyte, Lugton & Fawcett, 2000; Wildman et al. 1999), applying their knowledge to practice (Pelletier, Donoghue & Duffield, 2003; Johnson & Copnall, 2002; Smith 2001). However, an exploratory study assessing changes in practice following a pharmacology module highlights that changes in the way clients were monitored lapsed six months following CPE (Jordan & Hughes, 1998). Indeed, on successful completion of a post-registration degree course, increased knowledge and research awareness was not always reflected in the graduates' subsequent nursing care (Hardwick & Jordan, 2002). This may be indicative of a lack of clarity in the relationship between CPE and its impact on clinical practice (Armstrong & Adam, 2002).

Despite the government focus on CPE as a means of developing healthcare workers to cope with the complexity of patient care (DH, 2012a), several constraints have been identified that hinder nurses' ability to put newly acquired knowledge into practice (Cotterill-Walker, 2012). It has been recognised that nursing personnel shortages and underfunding both contribute to difficulties in accessing lifelong learning opportunities (Griscti & Jacono, 2006). If able to access CPE, some nurses find their workplaces so busy on their return that they just have to slot back into their 'old' ways of working (Armstrong & Adam, 2002). The findings of a recent study considering how CPE can positively influence changes in practice suggest that the fast pace of professional work is hindering the development of

innovative practice (Lee, 2011). The practice environment has been identified as the most influential factor when nurses contemplate putting knowledge into practice (Jordan et al. 1999). Therefore, if the workplace setting is not conducive, nurses will not feel supported to implement their new skills and knowledge to improve patient care (Ellis & Nolan, 2005; Stanley, 2003; Hardwick & Jordan, 2002; Beatty, 2001; Schuller, 2000b; Jordan et al. 1999).

Professional jealously has been cited as a possible obstruction to CPE being translated into improved nursing practice, especially when senior nurses lack advanced qualifications and perceive more qualified junior colleagues as a threat to their authority (Nolan et al. 2000; Jordan & Hughes, 1998). In one study nurses who attended CPE felt unsupported by both their colleagues and managers, limiting their ability to apply their newly acquired knowledge to the practice setting (Hardwick & Jordan, 2002). Medical colleagues have also proved resistant to the changes that nurses have tried to initiate following CPE (Nolan et al. 2000). A study undertaken by Spencer (2006) found that medical colleagues adopted a dismissive attitude towards nurses undertaking postgraduate study, indicating that they did not see the point of nurses studying at this level. Therefore, whilst the government is advocating the professional growth and development of nurses (DH, 2012a), it would seem that their work colleagues are not so encouraging.

Research undertaken in the UK by Gerrish, Ashworth & McManus (2000) established that the ability to act as a change agent and instigate innovative practice in one's workplace was influenced by the position held in the organisational hierarchy. Prior to this date senior nurses and managers had been viewed as erecting barriers to impede changes in clinical practice (Jordan & Hughes, 1998; Nolan, Owens & Nolan, 1995). Unfortunately, recent research reiterates the message that managers remain one of the greatest barriers to implementing skills acquired through CPE (Hardwick & Jordan, 2002), being perceived as unsupportive by nurses who had recently completed some further education (Cooley, 2008). Line managers were castigated by Lee (2011) for failing to explore their facilitative role in learning, which is having a detrimental effect on positive changes in nursing practice.

Therefore, the research seems to suggest that the hierarchical structure within the NHS is actively thwarting the transition of new knowledge into innovative nursing practice.

The findings of both qualitative and quantitative research have contributed to the development of the body of knowledge concerning the effect of CPE upon nursing practice. However, there are limitations and weaknesses with both these approaches to researching the effectiveness of formal education on nursing practice (Bryman, 2012) and these should be contemplated when using research findings to underpin the current investigation.

Methodological Considerations

Two quantitative research articles exploring the effects of nurse CPE on nursing practice have been considered in this chapter (Adriaansen, van Achterberg & Borm, 2005; Davey & Robinson, 2002). Adriaansen, Van Achterberg & Borm (2005), adopted a pre- and post-test quasi-experimental design to measure the effects of a post-qualification course in palliative care on two well-matched convenience samples of nurses. The researchers developed two valid and reliable instruments for data collection, using covariance analyses to scrutinise the data. Post course data analysis indicated an increase in knowledge, insight and self-efficacy in relation to pain and symptom management, yet this was not found to be statistically significant compared to the control groups ($p > 0.20$). However, Murphy-Black (2006) identified that one of the data collecting instruments turned out to be unsuitable for showing the differences between the groups of nurses, questioning the validity of the research. Adriaansen, van Achterberg & Borm (2005) also established that the convenience sample and selection method for the control group might have distorted their results. Finally, the research evaluated the knowledge gained but not the impact of CPE on practice.

An eight-year longitudinal survey undertaken by Davey & Robinson (2002) examined whether a purposive sample of traditionally trained nurses were tempted to undertake an undergraduate degree in the years following nurse qualification. Data gathered by this method is reliant upon shared assumptions and comprehension of the questions and their response

categories (Bowling, 2009), ultimately affecting the reliability of the research (Topping, 2006). The design and preparation of the questionnaire was important for yielding rich data (Murphy-Black, 2006) and in this instance the questions were carefully honed, using semi-structured interviews, testing draft questions via interviews and piloting the questionnaires by post. The researchers do not specify the format of the enquiries although the presentation of findings indicates a mixture of closed and multiple-choice questions (Denscombe, 2010). Whilst targeting a large number of participants this approach lacks opportunity for elaboration and clarification by the respondent and limits the possibility of responses when closed questions are used (Parahoo, 1997). Research findings indicated perceived benefits of nurse CPE on personal and professional growth, however there is a lack of direct evidence to indicate improved patient care.

Qualitative research was undertaken from an interpretivist perspective, with emphasis on the meaning and understanding of human actions and behaviour (Topping, 2006). The research took place in the participants' natural setting, where the researcher made no attempt to manipulate the phenomenon being studied (Patton, 2002). An in-depth understanding of the participants' world was possible by utilising flexible and sensitive methods of data generation (Ritichie & Lewis, 2003) such as interviews (Lee, 2011; Spencer, 2006; Ellis & Nolan, 2005; Stanley, 2003; Daley, 2001; Hogston, 1995), focus groups (Bahn 2007a; Armstrong & Adam 2002), or a combination of both (Cooley, 2008; Ashworth, Gerrish & McManus, 2001; Gerrish, Ashworth & McManus, 2000; Jordan et al. 1999). Adopting this approach enables researchers to gather rich data (Ritichie & Lewis, 2003), and subsequent analysis can clarify how CPE may influence nurses' professional practice. The trustworthiness and credibility of the research (Parahoo, 1997) was enhanced by the use of direct quotes reflecting the research participants' experiences and viewpoints (Richards, 2009). The small numbers of participants involved in the aforementioned qualitative studies limits the representational generalisation of the research findings (Lewis & Ritchie, 2003). But several researchers opted to undertake case studies using multiple data collection methods (Cooley, 2008; Ashworth, Gerrish & McManus, 2001; Gerrish, Ashworth & McManus, 2000; Schuller,

2000b; Jordan et al. 1999) in order to overcome the generalisational issue and validate their findings (Bowling, 2009).

Some researchers used mixed methods research (MMR) in a bid to avoid perceived methodological failings (Aitken et al. 2008; Hardwick & Jordan, 2002; Nolan et al. 2000; Whyte, Lugton & Fawcett, 2000; Wildman et al. 1999; Jordan & Hughes, 1998; Nolan, Owens & Nolan, 1995). MMR has been hailed as the third methodological and research paradigm as it combines the beliefs, data collection, analysis and interpretations of both quantitative and qualitative research (Johnson, Onwuegbuzie & Turner, 2007). Triangulation is the core principle of MMR, working on the assumption that the generation of different perspectives gives a fuller, more informed picture of what is occurring (Torrance, 2012). By triangulating methods, the researcher aims to minimise research bias, testing the consistency of their findings obtained by different methods to enhance the validity of the results (Bowling, 2009). Nevertheless, some researchers are critical of this approach, advocating that MMR is not viable because quantitative and qualitative paradigms are not compatible with each other (Bergman, 2011; Creswell & Tashakkori, 2007). Leahey (2007) also notes that time constraints and financial costs would cause difficulties in attempting to replicate MMR studies.

Chapter Summary

The importance of lifelong learning in UK contemporary society is being driven by the need for Britain to remain economically viable within the global market (DBIS, 2010). Within the knowledge economy, lifelong learning is considered the means to improve human capital in order to advance economic development in the UK (Drucker, 1969), requiring workers to keep up with technological innovations in their workplace (Alfred & Nafukho, 2010). Participating in lifelong learning is viewed as essential to attain maximum development throughout one's life (Dave 1976), however not all adults are willing or able to engage in such a commitment (McNair, 2009). UK government policies support participation in lifelong learning, believing that this will create beneficial opportunities for all concerned (DBIS, 2010; Leitch, 2006; DfEE, 1998; DfEE, 1997b; DfEE, 1997a), sentiments echoed by

the Jersey Government (SoJ, 2002). Social capital considers how social networks and interchanges enable mutual goals to be achieved, whilst also augmenting personal goal achievement (Field, 2005, Schuller, Baron & Field, 2000). However, human capital cannot exist in the absence of relationships, therefore social capital is necessary to maximise learning opportunities throughout the lifespan (Field, 2005). Thus, the thesis is grounded in the conceptual theories of lifelong learning, human capital and social capital.

The NHS has embraced lifelong learning, recognising that healthcare workers should continually update their knowledge and skills (DH, 2001), enabling the transfer of new technologies into practice to improve patient care (DH, 2012a). CPE is also at the heart of developing a highly skilled graduate nursing workforce capable of managing complex care needs (Willis, 2012). It has been difficult to find evidence that CPE directly affects patient care, with only three studies located. Financial constraints have impeded the access to formal post-qualifying nurse education (Council of Deans for Nursing and Health Professions, 2006), with a resultant crisis in community nurse staffing levels (Ly, 2010; QNI, 2009; Unite, 2009). The advancement of healthcare development is also being held back, with some attributes of workplace culture thwarting the ability of nurses to put newly acquired knowledge gained from CPE into practice (Cotterill-Walker, 2012; Ellis & Nolan, 2005; Stanley, 2003; Hardwick & Jordan, 2002; Beatty, 2001; Schuller, 2000b; Jordan et al. 1999).

The concept of lifelong learning has been explored relative to the UK population, with a particular focus on NHS employees. CPD and CPE have been defined, with CPE investigated in relation to its effect on patient care, for which there has been minimal evidence of positive results. The following chapter will examine CPE with a particular focus on the personal, organisational and geographical factors affecting nurses employed by a charity on a small remote island.

CHAPTER 3: CONTINUING PROFESSIONAL EDUCATION

Rapidly increasing technological advances in health care alongside the concomitant changes in the role of the nurse (Penz et al. 2007) have meant that qualified nurses cannot rely on what they have learned in their basic nurse education to furnish them with knowledge that will last their nursing career (Dickerson, 2010). In 2003 the useful lifespan of health care learning was estimated to be only between one to three years (Garcarz, Chambers & Ellis, 2003) and with accelerated knowledge obsolescence it is most likely to be even less than that (Hansman & Mott, 2010). Within the UK it is compulsory (NMC, 2008a) for nurses to retain their currency with post-registration education and practice (PREP) (NMC, 2010a), continually advancing their knowledge and nursing skills in order to remain competent. Failure to fulfil 35 hours of PREP every three years results in removal from the NMC register of qualified nurses with the subsequent forfeiture of qualified nurse status leading to job loss (NMC, 2010a). Hence, participation in CPE is the main vehicle through which members of professional groups remain in good standing (Jeris, 2010).

Health care professionals undertake regular continuing education in order to remain up to date with the latest knowledge and developments in 21st century health care (Dickerson, 2010). This lifelong education incorporates formal, informal and incidental learning, with the former being delivered by higher education institutes (Gopee, 2011). Formal learning tends to be certificated (Ginsberg & Wlodkowski, 2010), can result in post-registration qualification (Munro, 2008; Ellis & Nolan, 2005; Stanley, 2003) and often leads to enhanced career prospects (Cooley, 2008). Hence, formal education is deemed essential in providing a highly skilled and educated workforce to proactively meet the health care needs of the population (RCN, 2012).

The main focus of this critical review of the literature is to investigate the formal CPE experiences of qualified nurses by thoroughly exploring the nursing publications (Hart, 1998). This chapter identifies the search strategy undertaken to yield the literature exploring personal, organisational and geographical factors, and endeavours to ascertain how these influence the professional development of the nurse.

Search Strategy

A thorough search was undertaken for literature pertaining to nurse CPE of the various Internet gateways, databases, on-line journals and websites (Blaxter, Hughes & Tight, 2006) from the early 1990s before the NMC (2010b) implemented PREP, to the end of 2010 when data collection commenced. Key search terms were defined from the research aims and by reading widely about islands as well as lifelong learning for nurses. This created a strategy for searching that was highly sensitive and yet had low specificity, enabling the location and retrieval of many relevant articles. A manual search of pertinent journals was also conducted, as electronic searches are not infallible and can lead to a retrieval rate as low as 10% (Randolph, 2009). Heeding the advice of Magarey (2001) the reference lists of all retrieved articles were also checked in order to elicit any further relevant studies. Applying this multi-faceted approach to the literature search enabled the collection of numerous articles for review (Appendix 1).

The literature search yielded no results relating to English or Welsh island-based community nurses however, one article was located relating to nurse CPE in the Highlands and Western Isles of Scotland (Boyd, 1998). This necessitated the parameters to be widened to include international island-based nursing articles yielding a small number of studies exploring the CPE experiences of nurses working on tropical, European or Pacific small islands (Chen et al. 2007; Markaki et al. 2006; Ogalesco, 2006; Adami & Kiger, 2005; Berteloot, 2004; WHO, 2001). The review of these studies and their application to this research project was undertaken with the knowledge that nurse training, CPE and cultural practices within these islands may vary greatly from UK nurse training and re-registration practices (NMC, 2010a) and the transferability of the findings is used with caution.

To avoid bias the literature search was conducted without any language restriction (Hart, 1998), yielding one article published in French (Berteloot, 2004) that was translated and included. Culturally, the current research project was professionally grounded within community nursing and geographically located within an island having status as a self-governed British Crown territory with a strong Norman heritage (Johnson, 2010).

Studies conducted both within and outside the United Kingdom were reviewed to gain a full understanding of CPE; however, their transferability to the island was made with due attention to local contextual differences (Adami & Kiger, 2005), where nurses are regulated by the NMC but work outside the NHS.

Sente 6, an electronic academic reference manager, was used to store journal articles, electronic books, Department of Health (DH) publications and 'grey literature', cataloguing the references in a library for ease of use when writing the thesis. Although the process was time consuming, the central database holding all the citations has facilitated the speedy accurate retrieval of references (Dunleavy, 2003). Sente's search function has enabled targeted browsing of both PubMed and the web of knowledge with the ability to automatically perform an update every seven days (Third Street Software, 2011), yielding potential new articles for the research project.

In order to define the study it was important to clearly determine what was, and was not, within the scope of the research (Boote & Beile, 2005). Although the review identified articles exploring strategies that assist the effectiveness of CPE, such as clinical educators (Dickson, Walker & Bourgeois, 2006; Milner, Estabrooks & Humphrey, 2005; Gillespie, 2002), practice educators (Stevens, 2003) and mentors (Pellatt, 2006; van Eps et al. 2006), these were outside the scope of this literature review. The role of inter-professional education in health care improvement (Wilcock, Janes & Chambers, 2009; Stew, 2005) was also beyond the constraints of this research project. Hence, the parameters for the research project were to explore the formal CPE experiences of island-based qualified community nurses and consider evidence of increased skills and knowledge in their subsequent nursing practice (Levett-Jones, 2005).

The literature review focuses upon the motivators and barriers to CPE, which have been categorised into: personal, organisational, and geographical factors. The influence of CPE on the professional development of nurses and a critique of the methodological weaknesses of the reviewed articles brings the chapter to a close. Each area is explored in detail, commencing

with the personal factors that may impede or facilitate the qualified nurse in deciding to undertake CPE.

Personal Factors

Within the nursing profession the expectation is that nurses are destined to be lifelong learners (Dickerson, 2010; NMC, 2008a). However, not all nurses possess a positive attitude to continuing education (Gopee, 2003; Beatty, 2001; Furze & Pearcey, 1999) with claims of more significant priorities in life, such as family commitments, as the reason for disengagement (Schweitzer & Krassa, 2010). For some nurses, a lack of motivation and interest stems from the fact that they view nursing as just a job and therefore do not see the need to participate in CPE (Gopee, 2003; Hogston, 1995). Others have identified a lack of information and guidance with regards to CPE as the reason for poor motivation (Aoki & Davies, 2002; Barriball, While & Norman, 1992). Personal factors are therefore an important aspect in influencing whether a nurse decides to participate in CPE or not, and are worth exploring in more detail.

Research conducted by Rogers and Shoemaker (1971) explored the rate at which practitioners adopted innovations and is seen an indicator of participation in CPE (Houle, 1980). On synthesising the results of 1,500 investigations Rogers and Shoemaker (1971) determined that the speed at which people adopted an innovation could be plotted along a normal distribution curve. The subsequent five identified groups are defined as:

- 2.5% innovators (adventurous when applying innovations to practice)
- 13.5% early adopters (progressive, but not keen to be first to try a new idea)
- 34% early majority (embrace new practice once they are in place
- 34% late majority (sceptical and slow to adopt new practices)
- 15% laggards (resistant to new ideas)

In pioneering research exploring the CPE of professionals, Houle (1980) utilised the work of Rogers and Shoemaker (1971) to describe four groups of practitioners according to the extent they adopted innovations in professional

practice. The identified practitioners were classified as: innovators, pacesetters, middle majority and laggards (Houle, 1980). A fifth group recognized by Houle (1980) are the facilitators who are no longer found in practice, but instead have taken up employment in education, research, government or other positions that enhance the development of the profession. However, Houle (1980) acknowledged that professionals are not destined to stay permanently in one category and movement between categories may be due to changes in one's work situation or even as a result of the ageing process.

Table 3.1

Classification of the members of a profession (Houle, 1980, pp. 155-163)

Classification of Professional	Description
Facilitators	Can belong to any of the groups below
Innovators	Continually seek to improve performance, keen to try new ideas, participate extensively in education and study independently
Pacesetters	Progressive in practice, but not the first to act on new ideas, strongly support group learning and professional principles
Middle majority	The majority of practitioners who adopt innovation at varying rates from rapid to sluggish, rate of participation in education varies from eagerness to indifference
Laggards	As skills deteriorate they are not keen to adopt new ones, high resistance to learning

The motivation to undertake continuing education is dependent upon many factors including prior educational attainment, age, employment and ethnic origin (Ginsberg & Wlodkowski, 2010; Alejandro, 2001). Adults who have low levels of education are less likely to participate in work-related courses (Sparling, 2001), reducing the likelihood that their participation in CPE will result in personal gain or upward mobility (Hansman & Mott, 2010). Conversely, those who participate in adult education have a better standard

of education, often have higher incomes and are likely to be younger, Caucasian and in full-time employment (Ginsberg & Wlodkowski, 2010).

The prior educational achievement of close family members can be an influential factor on whether a professional participates in continuing education (Gopee, 2003; Alejandro, 2001). Immediate family members who are well educated and supportive of on-going learning are more likely to encourage and support their nurse relatives to participate in CPE (Alejandro, 2001). Kinship relationships are part of 'social capital' and these networks can affect the exchange of ideas and nurture personal capabilities (Field, 2005, Coleman 1988). Moreover, Field, Schuller and Baron (2000) identify that informal support to undertake continuing education can also be found within local neighbourhoods, the workplace and amongst friends.

It has been identified that the traditional teacher-centred pedagogic training delivered via the hospital school of nursing does not equip nurses with critical thinking skills or the ability to reflect (Platzer, Blake & Ashford, 2000). The resultant lack of independent learning abilities (Timmins & Nicholl, 2005; Hewitt-Taylor, 2002; Sparling, 2001), concerns regarding academic ability (Evans et al. 2007; Ellis & Nolan, 2005) and poor computer skills (Doyle, 2006; Cook et al. 2004; Dowswell, Hewison & Millar, 1998) are a distinct disadvantage when considering embarking on formal education. Having proficiency in the use of information and communication technologies is paramount to accessing formal education, especially if undertaking a distance-learning route (Field, 2008). Likewise, although family support is crucial to motivation in undertaking CPE, evidence gathered by NIACE indicates that 42% of adults identified family responsibilities as a barrier to learning (Schuller & Watson, 2009). Thus, prior educational experiences and family background can have either a profound positive or negative impact on the motivation to undertake CPE.

In an unpublished doctoral thesis Gopee (2003) undertook research into nurses' perceptions of lifelong learning. Using a purposive sample, he conducted two focus groups with 11 nurses and semi-structured interviews with 26 nurses, who had completed at least one module at diploma level.

Participants were recruited from both primary and secondary care within an identified geographical area in the Midlands. Gopee's (2003) findings are supported by documentary analysis and reveal that motivations and deterrents to lifelong learning are related to personal, organisational and socio-political factors. Influencing factors include prior study at university, individual levels of motivation, attitudes of colleagues and managers, and access to funding. Some nurses perceived mandatory professional development as ineffective and if pressed into study, would only pay lip service to personal development. However, the model of lifelong learning proposed by Gopee, whilst comprehensive, does not appear to take into consideration the effect that geographical location can have on the ability of nurses to undertake continued learning.

A more recent qualitative study identified the importance of personal motivation in undertaking CPE (Spencer, 2006). Using a phenomenological approach to explore CPE, she interviewed twelve professionals enrolled onto a Master of Science programme in the UK. The non-convenience sample consisted of qualified nurses, midwives and health visitors with eight of the sample educated to graduate level. The resulting transcripts revealed that all participants were internally motivated to study with half the respondents mentioning previous successful post-registration study as the motivator. Workplace pressure to undertake study at post-graduate level was also identified by 83% (n=10) of the participants. However, external factors such as time constraints (n=11; 92%) and career advancement with the resultant loss of client contact (n=5; 42%) did leave respondents questioning whether it was worth studying at this advanced level. Three quarters (n=9) of the participants identified that Level 7 studies had a negative impact on their family life, resulting in a dereliction of housework duties and limited time to spend with their children. The small number of participants taking part in this research potentially limits the generalisability of the findings, although subsequent research has confirmed that personal motivation is one of the drivers for undertaking CPE (Cooley, 2008).

Balancing home life with work and study commitments is a dilemma identified by many nurses undertaking CPE (Richards & Potgieter, 2010; Cooley, 2008;

Morgan, Cullinane & Pye, 2008; Penz et al. 2007; Gould & Fontenla, 2006; Ellis & Nolan, 2005; Lee et al. 2005; Timmins & Nicholl, 2005; Aoki & Davies, 2002; Barriball, 2002; Davey & Robinson, 2002; Gopee, 2002; Schuller, 2000b; Barriball & While, 1996; Sheperd, 1995). Some nurses highlight that the pressure of juggling studying with family commitments had the potential to cause them to abandon their formal studies (Bahn, 2007a). Nurses undertaking formal CPE frequently identify a negative impact on their families, with usual standards of domestic life deteriorating, and childcare duties relinquished to spouses (Cooley, 2008; Stanley, 2003; Dowswell, Bradshaw & Hewison, 2000; Dowswell, Hewison & Millar, 1998). Nurses also note that their ability to study is disrupted by time constraints due to work commitments (Richards & Potgieter, 2010; Nicholl & Timmins, 2005; Ryan, 2003; Aoki & Davies, 2002; Francke, Garssen & Huijer Abu-Saad, 1995; Nolan, Owens & Nolan, 1995). However, despite all these difficulties many nurses remain committed to undertake formal education as the likelihood of promotion and career development is enhanced (Cooley, 2008; Gould & Fontenla, 2006; Spencer; 2006).

Thus, it can be concluded that the personal and social factors influencing the nurse's decision and ability to undertake formal CPE are complex and interwoven. Somehow the nurse must overcome personal and educational barriers to ensure that professional requirements are achieved (NMC, 2010a). Moreover, the nurse is also subjected to organisational factors; therefore the motivators and challenges to nurse CPE that may exist within the workplace are now explored.

Organisational Factors

Nurses are the largest single professional body working within the health service and crucial to the provision of a high standard of patient care, therefore it is imperative the NHS provide a comprehensive training programme to ensure that staff are fit for practice and able to work in new and enhanced roles (DH, 2012a). However, tension exists within the health service due to the dual role of CPE as both a means of facilitating nurses to remain competent, whilst also being used as a means of implementing organisational reform via human resource management policies (Morgan,

Cullinane & Pye, 2008). Consequently, the needs of patients, individual nurses, and employing organisations should be acknowledged in order to provide CPE in a systematic and planned approach that benefits all stakeholders (Ellis, 2003).

The literature indicates that in the past many nurses have had to rely on self-funding as a means of procuring their CPE (Alejandro, 2001; Audit Commission, 2001; Dowswell, Hewison & Hinds 1998; Barriball 1992). More recently however, within the NHS, Strategic Health Authorities (SHAs) have funded approved nurse CPE (DH, 2000a) resulting in fewer public sector nurses self-funding (Davey & Robinson, 2002). In Ireland from 2001-2005 public sector nurses were aided by free university places enabling them to catch up academically with new nurse graduates (Cooley, 2008). However, during the same period, some UK-based community nurses highlighted that the financial difficulties of their Primary Care Trust was perceived as a threat for future funding of CPE (Banning & Stafford, 2008). Similarly, nurses working in secondary care have identified a lack of financial support for staff development by their employers (Bahn, 2007a). Conversely, qualified nurses working within the private sector (Huges, 2005; Aoki & Davies, 2002) and those employed outside the UK may experience far greater difficulties in securing CPE funding by their employers (Nalle, Wyatt & Myers, 2010; Richards & Potgieter, 2010; Schweitzer & Krassa, 2010).

A quantitative study undertaken by Aoki and Davies (2002) explored the CPE experiences and perceptions of nurses working outside the NHS for private care homes in a large UK northern city. A purposive sample of 145 qualified nurses was sent self-completion questionnaires with a 71% (n=103) response rate. Only 56% (n=54) of respondents had received regular appraisal or individual performance review as a means of identifying their learning needs, with one nurse claiming to have had only one appraisal since qualifying in 1984. Over half the nurses (59%, n=44) felt that the cost of CPE was prohibitive, whilst 37% (n=27) acknowledged a lack of available information concerning forthcoming programmes of study. Inequalities existed between the opportunity for staff members to attend study days, with 25% (n=10, sample=40) of senior staff able to attend compared to 14% (n=8,

sample=56) of junior staff, confirming that lower grade staff were statistically disadvantaged (χ^2=8.87, P=0.003). A further finding was that 13% of the participants did not see the need to undertake CPE at all, a figure very similar to the 'laggards' identified by Rogers and Shoemaker (1971). Limitations of the study include the failure to collect data regarding the nurses' confidence in using computers and the Internet, which would impact on their ability to participate in CPE; also using a questionnaire as the data collection method could be seen to influence the participants' responses (Robson, 2002).

Alongside difficulties in securing funding to undertake CPE there is also the problem of obtaining protected study time. Various researchers have identified that insufficient study leave is granted to nurses undertaking CPE due to a variety of factors including: CPE not prioritised by managers (Hogston, 1995), staff shortages (Sheperd, 1995) and lack of policy regarding study leave (Nolan, Owens & Nolan, 1995). Despite the claims of the '*Improving Working Lives Standard*' (DH, 2000b, p.3) 'to support personal and professional development and enable employees to achieve a healthy work-life balance', the NHS has failed to deliver the promise to ensure that all staff are given time off and support for training. Post-registration courses often have the expectation that additional study time is necessary (McVeigh, 2009). However, research has established that a third of staff do not receive any study leave (Davey & Robinson, 2002; Hardwick & Jordan, 2002; Dowswell, Bradshaw & Hewison, 2000), whilst nurse managers were perceived as unsupportive due to the reduced amount of study time they grant for CPE (Cooley, 2008; Murphy, Cross & McGuire, 2006). CPE competes with work commitments (Munro, 2008; Bahn, 2007a) and often workloads are not reduced to compensate for time taken out of the workplace when attending professional education (Spencer, 2006). Thus, there appears to be an increased expectation within the NHS that nurses will undertake CPE in their own time (McVeigh, 2009) and this is causing resentment amongst qualified nurses (Munro, 2008; Murphy, Cross & McGuire, 2006).

Community nurses' continuing education experiences were explored in a phenomenological study undertaken by Banning and Stafford (2008). Ten participants were purposively selected to give a diverse sample based on age and nursing discipline and included: two district nurses, two health visitors, two school nurses, two community staff nurses and two managers. Personal motivation was highlighted as essential when undertaking CPE, although the ability to access continuing education was dependent upon the support and backing of senior colleagues and managers. CPE was viewed as a positive concept, helping to accept new innovations in healthcare, improving job motivation and helping to realise career aspirations. However, staff shortages and heavy work commitments meant that community nurses experienced difficulties attending CPE due to the inability to cover work on their caseload. This confirms previous research with regard to organisational difficulties in financing staff to backfill nurses who wish to attend CPE (Cooley 2008; Bahn 2007a; Adami & Kiger 2005; Gopee, 2003; Audit Commission 2001). More recently, the problem of staff shortages has come to add another barrier to facilitating the release of nurses from the workplace to participate in continuing education (Watkins, 2011; Schweitzer & Krassa, 2010).

Despite Department of Health policy (DH, 2000b) instigated to create equality of opportunity between NHS employees, discrimination still exists with regards to undertaking CPE. Studies undertaken in the UK have revealed that part-time nurses, permanent night staff and bank staff widely reported feeling disadvantaged compared to their full-time counterparts when trying to obtain CPE sponsorship from their employers (Kelly, Berridge & Gould, 2009; Levett-Jones, 2005; Nolan et al. 2000; Barriball & While, 1996; Sheperd, 1995). Age has been identified as another factor where disparity seemed to exist in relation to CPE. The NHS has an ageing workforce especially within community nursing where many nurses are over the age of 50 (Watson, Andrews & Manthorpe, 2004), and their work options and educational needs have been subject to qualitative research by the Joseph Rowntree Foundation (2003). This research found that older nurses experienced ageism from their employers with regard to practice, highlighting that CPE courses were not geared up to their needs and often did not take into

account their lack of experience with modern technology including use of computers and the Internet (Watson, Andrews & Manthorpe, 2004). The failure to provide equitable access to CPE for all nurses could result in missing the opportunity to maximise qualified nurses' expertise with the potential to have a knock-on effect in the provision of client care.

It has been argued that the culture surrounding CPE has been far from positive (Hinchliff, 1998), with anti-intellectualism limiting the progress of nurse professional development (Miers, 2002). In some instances practical knowledge is privileged above theoretical knowledge, with easy access to practical skills training compared to obtaining funding for academic studies (Tame, 2009). This dichotomy between nurse education and practice is acknowledged as the theory / practice gap and frequently viewed as problematic (Maben, Latter & Clark, 2006; Allmark, 1995; Cook 1991). Ward managers require nurses who are able to perform nursing duties, hence a tendency to favour practical skills training over formal learning (Maben, Latter & Clark, 2006).

Nurse managers are gatekeepers to accessing CPE (Gould, Drey & Berridge, 2007) and can be seen to either pressure staff into participation (Spencer, 2006; Dowswell, Hewison & Millar, 1998) or conversely block access to it (Morgan, Cullinane & Pye, 2008). If managers have been involved in higher education themselves and approve of CPE, they are more likely to support staff with their academic pursuits (Tame, 2009; Bahn, 2007a). However, some managers are not perceived as supporters of continuing education (Cooley, 2008; Sheperd, 1995) and the barriers they erect to prevent CPE can cause resentment amongst staff (Hardwick & Jordan, 2002). Some senior management personnel have been described as having a 'schizophrenic attitude' towards professional development, as they espouse CPE but when finances are stretched choose to cut their training budget (Schuller, 2000b, p. 230). Others look more favourably upon staff who are in a position to self-fund their CPE, viewing this as an outward sign of their commitment to nursing (Barriball, 2002).

In an unpublished doctoral thesis, Tame (2009) carried out descriptive qualitative research within the operating department of a large teaching NHS acute trust. Semi-structured interviews were used to gather data from the 23 purposively selected participants and transcribed by the researcher along with field notes. Tame (2009) discovered that workplace culture and managers' attitudes determined the ease with which participants were able to study, including the degree of openness shared with other colleagues. Managers influenced the culture and acted as gatekeepers, deciding who would study, how many courses an individual could attend and what courses they could enrol on. The operating theatre environment appeared to foster an anti-intellectual culture, with participants believing that their managers would much prefer to support practical skills training as opposed to academic education (Tame, 2009). This led to 'secret study'; a concept identified by the reluctance of the peri-operative nurse in sharing with colleagues the fact that they are studying. A limitation of this research is that the researcher worked as a training advisor within the operating department as a colleague of the participants. This may have caused bias due to participants telling her what they thought she wanted to hear (Garton & Copland, 2010). Moreover, as Tame does not describe her duties and responsibilities within the organisation, the reader is left wondering whether there is a potential conflict of interest between her role and the research she has undertaken with work colleagues (Munro et al. 2002).

Driven by the need to provide economic health and social care services (Willis, 2006), modern healthcare is characterised by a fragmentation of health services resulting in specialised professional division of labour (Finn, 2008). Qualitative research undertaken with 25 UK GPs revealed they felt threatened by the prospect of specialist practitioner nurses undertaking activities previously carried out by a doctor (Wilson, Pearson & Hassey, 2002). These GPs expressed a lack of confidence in the ability of nurses to undertake a practitioner role, and voiced concerns about their lack of knowledge regarding CPE undertaken by nurse practitioners. Spencer (2006) discovered that some medical colleagues were ambivalent about nurses studying at Masters level, whereas others may be oblivious to nurses' post-qualifying qualifications (Tame, 2009). The medical culture that once

dominated healthcare is being undermined, with doctors coming under pressure to allow nurses to take some of their professional responsibilities (Arbuckle, 2013). Hence, the development of nursing has resulted in contested professional boundaries within medicine, which can be seen as a challenge to medical authority (Hall, 2005).

Organisational factors can therefore have a profound effect on the ability of qualified nurses to gain access to NHS funded higher education. Although policy has been put in place to facilitate nurse CPE (DH, 2000b), current financial constraints and efficiency cuts within the health service seem to have perpetuated the inequality of access to continuing education for qualified nurses. Consideration of geographical location will now be investigated, exploring whether access to CPE is affected by living on a small remote island.

Geographical Factors

In order to understand the issues around maintaining competency via CPE it is imperative to examine the context in which nurses live and work (Beatty, 2001).

Definition of a Small Island

It is estimated that 10% of the world's population live on islands (Baldacchino, 2008b), although Hay (2006) states that what constitutes an island is not irrefutably established. The basic dictionary definition of an island as 'a piece of land surrounded by water' (Thompson, 1995, p. 721) is critiqued by Royle (2001) as most simplistic, and he challenges the concept of 'island' by enquiring whether a rock is an island or whether an island has to be surrounded by sea at all times. Depraetere and Dahl (2007) concur, stating that defining an island is not a straightforward task but is essentially concerned with whether the land is isolated by water and separate from other lands. Nissology (the study of islands) is an emerging field of research, however the 'striking uniqueness of islands' (Fowles & Godwin, 1978, p. 12) and diversity of subject matter invokes a range of different geographical experiences resulting in an absence of coherent island theory (Hay, 2006).

Thus, to quote Holm (2000, p. 3), it would seem that 'an island is whatever we call an island'.

The definition of 'island' is further muddied by the lack of attention to scale, as there seems to be no apparent hard and fast rules when it comes to labelling an island by size (Royle, 2007). Baldacchino (2007) challenges us to contemplate when land becomes too large or small to be considered an island. Some consider the definition of 'island' to be the 'unit of land which fits within the retina of the approaching eye' (Hamilton-Paterson, 1993, p. 63), referring to the smallness of islands. Others consider that 'when a landmass surrounded by water becomes as large as Australia it loses this characteristic and must be thought of instead as a continent' (Edmond & Smith, 2003, p. 2). For the purpose of this project smaller islands are of particular interest to the researcher, especially islands where there is no resident university, as this emulates the geographical conditions of the research project. Whilst the definition of a small island remains contested, and in the view of Royle 'artificial and unhelpful' (2001, p. 42), it was necessary to identify suitable articles for this research. Therefore, Beller's (1986) definition of a small island as having an area of 10,000 Km^2 or less and a population of no more than 500,000 was adopted as the selection criteria for articles concerning the geographical context of nurse CPE.

Whilst the notion of what constitutes an island remains contested, terminology relating to islands is also an area of concern. One of the main critiques of island studies is the fact that many researchers in this area are non-islanders themselves (Baldacchino, 2004) and use the term *small island* in a deprecatory and demeaning manner (Nunn, 2004). Small islands are portrayed by these non-island researchers as irrelevant backwaters (Hay, 2006), their insularity a symbol of being 'out of touch' with the world (Lowenthal, 2007, p. 202). Lack of resources coupled with isolation from the outside world (Royle, 2001), increased transport costs and the small size of local markets result in economic disadvantage hampering small islands (King, 2009). Insufficient employment for young people often results in migration to the nearest large island or continent from which they seldom return (Hay, 2006). Due to diseconomies of scale, specialist medical care

may only be available off-island with tertiary education often exclusive to the mainland (Royle, 2001). Therefore as an indigenous islander and researcher, this project is a genuine attempt to discover whether the aforementioned geographical factors have an effect on the ability of Jersey-based community nurses to undertake relevant CPE.

The geographic locations of the research undertaken into nurse CPE on small islands comprise:

- Western Isles of Scotland
- Catanduanes in the Philippine Islands
- Crete
- French Polynesia
- Kosrae - a single-island state in the Federated States of Micronesia
- Malta
- Pacific Islands

In the UK pre-registration nurse education (NMC, 2010b) and formal CPE (NMC, 2008b; NMC, 2004) is delivered in Higher Education Institutes (HEIs), either on site or by distance learning packages. However this provision is not universal internationally and in some smaller Pacific Islands a lack of nurse CPE is cause for concern (UNSW, 2009). Of the seven articles analysed on this topic four islands had a university in situ, although this was not always where pre-registration nurse education or CPE was delivered.

The Western Isles of Scotland do not boast a local university, therefore qualified nurses undertake their CPE via distance learning offered by the University of Stirling situated in Inverness and Stornoway on the Scottish mainland (Boyd, 1998). Some Pacific Islands such as the Marshall Islands and the Federated States of Micronesia offer nurse education and CPE in conjunction with the University of the South Pacific (Buenconsejo-Lum, Maskarinec & Palafox, 2007). The University of Malta has provided nurse education and CPE since the late 1980s (Adami & Kiger, 2005). The University of Crete was established in 1973 but does not offer nurse training or CPE; instead this is delivered via the Technological Educational Institutes

or in one of the Greek mainland Universities necessitating off-island travel (Patelarou et al. 2009). Tahiti is home to the University of French Polynesia established in 1999, offering a Degree in Nursing Studies as well as CPE (Anon, 2012). In contrast Kosrae in the Federated States of Micronesia, has a Higher Education College with affiliation to various universities (Chen et al. 2007); whilst the Catanduanes State Colleges in the Phillipines delivers nurse training, but CPE has to be accessed by travelling to other universities in the region (Ogalesco, 2006). Thus, it would seem that the patchwork of varying access and availability to nurse CPE in smaller isolated islands is as colourful and at times as piecemeal as the islands themselves.

Initial nurse training was found to be insufficient for the extended roles undertaken by qualified nurses working on small isolated islands. The World Health Organisation (2001) recognise that qualified nurses in the Pacific island countries find themselves working in geographically isolated settings under difficult circumstances. Nurses living and working on the French Polynesian islands and atolls acknowledge that they are professionally unprepared for isolated nursing and lacked the necessary skills to provide the care required (Berteloot, 2004). Chen et al. (2007) concur, stating that the lack of an obstetrician on the island of Kosrae has led to a high level of responsibility for maternity cases being passed on to the midwives. On the island of Catanduanes in the Philippines, nurses have identified the need for more knowledge pertaining to the treatment of animal bites (Ogalesco, 2006). Conversely, nurses on the islands of Crete work within a very restricted task-orientated framework (Markaki et al. 2006) whilst Maltese nursing culture favours developing practical skills over nursing research and management roles (Adami & Kiger, 2005). Thus, whilst pre-registration nurse education gives the nurse a broad nursing knowledge, geographical location, local culture and isolation can lead to the need for specialised nursing knowledge and skills if the nurse is to competently cater for patient needs.

Nurses living and working on small tropical islands frequently do so under harsh conditions, living an isolated life often with poor working conditions (WHO, 2001). Personal isolation can be difficult to deal with and social life

can be limited due to being on call 24 hours a day (Berteloot, 2004). Landon (1981) confirms that life on a small island equates to being available to patients around the clock, however under these circumstances nurses run the risk of professional burnout due to the constant pressure (Berteloot, 2004). In a study of nurses working in remote areas of Pennsylvania in the United States of America, 40% indicated that their spouses/partners gave them no encouragement or were negative about their participation in CPE (Beatty, 2001). Penz et al. (2007) cite that rural and remote nurses with children or dependent relatives and those who were single, divorced or widowed perceived that their personal circumstances prevented them from undertaking CPE. Therefore, it would seem that geographical isolation and island life can have a detrimental effect on the ability of the nurse to access CPE.

Island life can make it difficult for nurses to access CPE as this often involves travelling some distance and maybe even going off-island (Boyd, 1998). Nurses working on the lesser-resourced Pacific islands are at a significant disadvantage when trying to undertake CPE due to the location of the regional educational institutes on the larger more populated islands (WHO, 2001). Beatty (2001) revealed that rural nurses often had to travel up to 60 miles to reach the nearest HEIs; claiming that respondents in her study who lived further away from the HEI were statistically less likely to participate in CPE (p=0.025). A more recent study into rural and remote nursing confirmed that the difficulty in having to travel a great distance to access a large library or HEI was a barrier in undertaking continuing education (Penz et al. 2007). Nurses in Catanduanes concur, stating that the distance of the CPE provider was a barrier to continuing education (Ogalesco, 2006) whilst Maltese nurses were unwilling to travel overseas to access formal education due to family and financial commitments (Adami & Kiger, 2005). Hence, the geographical location of nurses and the ease to which they can access an academic library or HEI is an important factor determining their ability to participate in CPE.

It has been identified by Beatty (2001) that the absence of a doctor in remote and rural areas has necessitated nurses working in these communities to

develop a broad knowledge base and undertake extended nursing practice. More recently, Penz et al. (2007) have confirmed Beatty's findings reinforcing that rural and remote nurses are required to work as generalists with extended nursing knowledge. As the only health care provider on a small island, Landon (1981) recorded having to deal with a wide range of health issues including dental problems, gynaecological issues and emotional problems; this included providing a midwifery service when the weather was too severe to allow transfer to the mainland. The shortage of doctors on Pacific island countries has led to the development of the nurse role to enable diagnosis and treatment of common health problems that would elsewhere be dealt with by medical practitioners (WHO, 2001). In French Polynesia nurses frequently face situations they are not trained for such as drowning, alcoholism, tornadoes and fires; with their extended role exposing them to social care problems, antenatal and childcare issues, circumcisions and even dealing with veterinary issues such as stitching up injuries in livestock (Berteloot, 2004). It is therefore apparent that pre-registration nurse education does not furnish these island-based nurses with all the necessary skills to deliver competent care and that CPE is vital in supporting their role as isolated nurses (Beatty, 2001).

A fundamental barrier to CPE with which small island nurses have to contend is professional isolation (WHO, 2001). Working in isolated geographical areas hampers networking with nurse and health colleagues (Beatty, 2001) and this coupled with the limited access to clinical supervision reinforces the feeling of professional abandonment (WHO, 2001). Nurses who work in remote areas are often the sole registered health professional within the healthcare setting and 66% cited this remote existence as the barrier to undertaking CPE (Penz et al. 2007). For instance, the vast distances between the islands and atolls of French Polynesia and Tahiti where the main HEI is located pose CPE issues, as passage is infrequent with a plane available only every two weeks and access by boat once every six weeks (Berteloot, 2004). Consequently, isolation from other health colleagues, distance from HEIs and limited travel opportunities impact negatively upon the ability of the nurse on a remote small island to undertake professional development and continuing education.

Island nurses are in a similar situation to their mainland counterparts in relation to staff shortages impinging on their ability to participate in CPE. In Malta a lack of qualified nurses in healthcare settings has resulted in an inability for CPE to be delivered during work hours (Adami & Kiger, 2005), corroborating the earlier findings of Beatty (2001). This problem is also reflected in Catanduanes where nurses are unable to access 'much-needed' CPE due to insufficient staffing levels within the hospitals (Ogalesco, 2006). Financial cutbacks in some remote areas has led to a high percentage of unlicensed healthcare workers, resulting in qualified nurses carrying large caseloads with enforced overtime, leaving them little time or energy to undertake CPE (Beatty, 2001). As indicated by Royle (2001), qualified workers will often migrate from small islands for better job opportunities causing significant issues for those left behind. This is the case in Kosrae, where migration has exacerbated severe staffing shortages, leaving nurses insufficient time to participate in CPE (Chen et al. 2007). Penz et al. (2007) highlights the plight of lone workers who have no one to stand in for them and so are unable to access professional education outside of their community. Staff shortages, whether due to financial constraints or migration, compound the difficulties faced by the island-based nurses in relation to accessing CPE in order to undertake professional development.

The financial issues and monetary constraints of healthcare providers appear to be a common problem that has a negative impact on the ability to provide CPE opportunities for nursing staff. Money available for nurse CPE can be adversely affected by the limited economy of small islands (Royle, 2001) resulting in Catanduane nurses having to totally self-fund their continuing education in order to comply with local criteria for renewal of their nursing licence (Ogalesco, 2006). In a study carried out by Adami and Kiger (2005), Maltese nurses were dubious about the value of nurse CPE as they work in a relatively unchanging environment where nursing innovation is not encouraged, however almost all respondents felt that the State should be fully responsible for funding professional education. Some Pacific islands that fall under the jurisdiction of the USA are fortunate to receive a grant to enable the development of sustainable continued medical education, which also includes CPE for qualified nurse specialists (Buenconsejo-Lum,

Maskarinec & Palafox, 2007). Beatty's (2001) research into rural and remote nursing heralded the lack of financial support as the main deterrent to nurses accessing continuing education; with 29% of isolated nurses claiming that economic constraints were deterring them from undertaking CPE (Penz et al. 2007). Thus, it would seem that the worldwide economic recession is perpetuating the already financially constrained island nurses, further limiting their ability to participate in formal CPE (Royle, 2001).

Educational and infrastructure issues in some remote islands also contribute to the problems surrounding the availability and accessibility of CPE. The World Health Organisation (2001) highlighted that nurse teachers in the Pacific islands are lacking up-to-date skills in clinical primary care. Difficulties around the reliability of video teleconferencing via satellite link coupled with lack of bandwidth, insufficient numbers of appropriately trained information technology support staff and an unreliable electricity supply are also problems that thwart distance education in the Pacific island countries (Buenconsejo-Lum, Maskarinec & Palafox, 2007). Likewise, major barriers to nurse CPE in Kosrae were a lack of appropriately qualified educators, a dearth of education materials and inadequate technological infrastructure to support audio or video teleconferencing (Chen et al. 2007). These aforementioned remote islands have been fortunate to receive financial support from the United States Health Resources and Services Administration (HRSA) creating the Pacific Association for Clinical Training (PACT) in 2007 to support the professional development of healthcare workers (Buenconsejo-Lum, Maskarinec & Palafox, 2007). Thus, in order to provide nurse CPE the infrastructure of some small remote islands needs improvement, necessary supplies of educational materials and leadership by educators who are current in professional practice.

Living and working on a small island can impact the nature of the nursing role as well as affecting opportunities to undertake CPE. The geographical context of small island nursing can result in some nurses working in an extended capacity (Penz et al. 2007; Berteloot, 2004; Beatty, 2001; WHO, 2001; Landon, 1981) whilst others are focused at a more practical level (Markaki et al. 2006; Adami & Kiger, 2005). Personal, professional and

academic isolation impinges on the ability of the nurse to undertake CPE (Berteloot, 2004; WHO, 2001), with the distance needed to travel to access a HEI or academic library further exacerbating the problem (Penz et al. 2007). The current economic crisis, resultant staff shortages, coupled with information technology and resource issues has also had an adverse effect on nurse CPE (Buenconsejo-Lum, Maskarinec & Palafox, 2007; Chen et al. 2007; Ogalesco, 2006). Thus, island nurses are challenged on many levels in their quest to develop pertinent professional and clinical skills to best care for their patients (DH, 2012a).

Outcome of CPE on Nurses

Glen (2003) argues that up until the late 1980s qualified nurses were lacking in critical thinking skills and incapable of adequate decision making in practice due to the apprenticeship-style model of nurse training undertaken at that time. This was reflected in the expectation of nurse CPE in the 1980s, which focused on a model of behaviour change (Cervero, 1985). The move of nurse education into Higher Education, combined with the development of the Diploma of Nursing, has resulted in qualified nurses with appropriate knowledge and skills to cope with the changing context of healthcare provision (Glen, 2003). Thus, contemporary nurse CPE needs to aid the development of skills such as critical reflection (Banning & Stafford, 2008; Bahn 2007a; Barriball, 2002) as well as supporting personal and professional growth and development (Cotterill-Walker, 2012).

A ten-year longitudinal study undertaken by Whyte, Lugton and Fawcett (2000) in Scotland followed up all graduates undertaking a Masters Degree programme from 1986 to 1996. One hundred and ninety questionnaires were posted out to former students with a response rate of 67%. 50% of respondents had teaching posts and had undertaken the Masters degree to safeguard their jobs as nurse education moved into HEIs. Following the period of study 50% of participants had been promoted, with the majority stating that the Masters degree played a significant factor in their promotion. The respondents' work was enhanced by core academic and research skills; such as their ability undertake critical analysis and their raised awareness of recent research relevant to their area of work. Respondents identified that

they now possessed a strategic approach to clinical practice and felt confident and able to assess complex situations. Gaining a Masters degree had improved their professional status and credibility with their colleagues. The acquisition of library skills and increased capability in their writing abilities enabled 58% of respondents to publish since completing their studies. However, this figure is probably skewed due to the high number of teachers included in the survey who are expected to be research active and publishing as part of their role in the HEI. Whyte, Lugton & Fawcett (2000) conclude that Masters level education provides the student with a broad range of transferable academic and professional skills to support a higher level of nursing practice. The drawback of this study was the constraint of collecting data via postal questionnaires that could restrict the depth of participants' response, with closed questions potentially limiting the factors important to respondents (Murphy-Black, 2006). Although the data was collected over a ten-year period, the ability to generalise the findings was affected by the focus on collecting data from only one institution.

A number of studies of nurse CPE have highlighted raised autonomy, increased critical thinking skills and research awareness as areas of personal and professional growth following formal academic study (Cotterill-Walker, 2012). In a DH funded longitudinal study into the careers of traditionally trained nurses, two-thirds of participants stated that the completion of a degree after qualifying enabled them to practise more autonomously (Davey & Robinson, 2002); whilst in the ten-year longitudinal study undertaken by Pelletier, Donoghue and Duffield (2003) 76% of respondents acknowledged an increase in their professional autonomy. Thinking takes on a critical focus as a result of competing post-registration learning (Bahn, 2007a); with community nurses claiming to think critically about specific practice issues following an episode of CPE (Banning & Stafford, 2008). The use of research-based practice is emphasised (Armstrong & Adam, 2002; Platzer, Blake & Ashford, 2000; Wildman et al. 1999) with a focus on the implementation of research findings (Hardwick & Jordan, 2002) and nurses making research-based care decisions (Pelletier, Donoghue & Duffield, 2003).

There is evidence to suggest that the rewards gained from increased status and earnings is a major factor influencing nurses when they embark upon CPE (Richards & Potgieter, 2010; Cooley, 2008; Calpin-Davies, 1996; Hogston, 1995). Research into the CPE experiences of Australian, German and UK nurses indicate that after a period of formal education, over half of participants reported promotion opportunities following their studies (Watkins, 2011; Pelletier, Donoghue & Duffield, 2003; Stanley, 2003; Davey & Robinson, 2002; Johnson & Copnall 2002). Nevertheless, just over a third of UK respondents were considering a career outside healthcare (Davey & Robinson, 2002). Some participants felt that they had achieved more control over their future career since undertaking further study due to the development of Specialist and Consultant Nurse roles in their area (Pelletier, Donoghue & Duffield, 2003). Consequently, nurses embarking on CPE do so for many reasons, amongst which is the advancement of their personal and professional status.

It is apparent that nurses need to continue to develop appropriate knowledge and practical skills to cope with the changing context of healthcare (RCN, 2012). A flexible workforce is necessary in order for the NHS to continue to deliver care that is responsive to patients needs, yet delivered by nurses who have kindness, compassion and respect for patients (DH, 2011c). The NHS has recognised that professional education is the vehicle by which promotion of evidence-based practice and innovation in healthcare will be delivered (DH, 2012a). Consequently, nurses undertaking CPE have shown an increase in critical thinking, research awareness and professional autonomy (Cotterill-Walker, 2012), the building blocks required for the delivery of an excellent healthcare service (DH, 2012a).

The body of knowledge surrounding nurse CPE has been developed by the findings of both quantitative and qualitative research. However, there are limitations and weaknesses to both research methods (Bryman, 2012) and these should be taken into consideration when using research findings to underpin the current investigation.

Methodological Considerations

The quantitative research articles explored within this chapter utilised survey research to measure phenomena (Bryman, 2012) in relation to nurse attitudes and experiences of CPE. Two self-completion questionnaires consisted of only closed questions (Markaki et al. 2006; Lee et al. 2005) making them quick to complete (Murphy-Black, 2006) but limiting the respondent to selecting answers identified by the researcher with the potential to bias the overall findings (Parahoo, 1997). Research undertaken on the island of Catanduanes was identified as descriptive-correlational, however whilst Ogalesco (2006) failed to identify the type of questions included on the survey, the use of statistical techniques helped to strengthen the evidence he gathered (Bowling, 2009). The majority of researchers have chosen to utilise a mixture of both closed and open questions in their surveys (Richards & Potgieter, 2010; Nalle, Wyatt & Myers, 2010; Drey, Gould & Allan, 2009; Evans et al. 2007; Gould, Drey & Berridge, 2007; Penz et al. 2007; Murphy, Cross & McGuire, 2006; Doyle, 2006; Nicholl & Timmins, 2005; Timmins & Nicholl, 2005; Aoki & Davies, 2002; Whyte, Lugton & Fawcett, 2000; Wildman et al. 1999) enabling rich data to be collected on nurses' attitudes, experiences and opinions (Parahoo, 1997). However, whilst surveys can be utilised as an economical way of collecting a large amount of data there is always the risk of non-response (Bryman, 2012).

Some surveys were undertaken using a random sample of nurses (Drey, Gould & Allan, 2009; Gould, Drey & Berridge, 2007; Penz et al. 2007; Doyle, 2006) yielding results that are more generalisable (Carr, 1994). The majority of quantitative surveys considered here were undertaken with purposive sampling (Richards & Potgieter, 2010; Evans et al. 2007; Murphy, Cross & McGuire, 2006; Nicholl & Timmins, 2005; Timmins & Nicholl, 2005; Lee et al. 2005; Aoki & Davies, 2002; Whyte, Lugton & Fawcett, 2000; Wildman et al. 1999); targeting their research on qualified nurses who had recently undertaken CPE in order to gather relevant data on CPE issues but risking a bias of results if the sample was not representative of the total population (Procter & Allan, 2006). For instance, it has proved difficult to capture the thoughts and attitudes of qualified nurses who choose not to participate in CPE (Tame, 2009; Aoki & Davies, 2002); the very nurses who should be

targeted as they are failing to keep themselves up to date and could potentially be missing opportunities to develop their practice in line with NMC requirements (2010a).

In quantitative research CPE needs to be reduced into component parts that are defined and measurable in order to undertake quantitative investigation; the researcher must then endeavour to explain the causal relationships between the variables (Topping, 2006). However, although CPE is considered to refer to formal education (Jeris, 2010; DeSilets, 2006; Parker, 1998; Jarvis, 1995; Eraut, 1994), the term 'CPE' lacks universal definition (Tame, 2009) and is therefore difficult to measure (Schweitzer & Krassa, 2010; Tame, 2009; Lawton & Wimpenny, 2003; Nolan et al. 2000; Wood, 1998; Fleck & Fyffe, 1997).

Qualitative researchers adopt an emic perspective, undertaking their research with the aim of understanding the individual's view or experience (Bowling, 2009). Studying people in their natural settings allows the researcher to make sense of the meanings that the participants' bring to the phenomena being investigated (Denzin & Lincoln, 2005). The adoption of this approach enables an in-depth understanding of the participants' social world (Snape & Spencer, 2003) and how this may affect nurses' participation in CPE. Therefore, by focusing on the nurse interpretations of CPE the researcher attempts to comprehend the participants' detailed experience of continuing education.

Qualitative researchers use an interpretative approach (Watkins, 2011; Kelly, Berridge & Gould, 2009; Tame, 2009; Banning & Stafford, 2008; Cooley, 2008; Berteloot, 2004; Gopee, 2003; Stanley, 2003; Jordan & Hughes, 1998; Hogston, 1995; Sheperd, 1995); resonating the research participants' experiences and viewpoints by utilising verbatim transcript quotations (Ely et al. 1997) thus increasing the trustworthiness and credibility of the research (Richards, 2009). Audit trails identifying decision-making within the research project as indicated in some studies (Watkins, 2011; Tame, 2009; Banning & Stafford, 2008; Stanley, 2003; Hardwick & Jordan, 2002; Platzer, Blake & Ashford, 2000a; Platzer, Blake & Ashford, 2000b), also boost the credibility

and trustworthiness of the research findings (Patton, 2002). However, the representational generalisation of qualitative study findings is limited due to the small numbers of research participants involved (Lewis & Ritchie, 2003). To overcome this problem several researchers have opted to undertake case studies using multiple data collection methods (Ellis & Nolan, 2005; Ellis, 2003; Hewitt-Taylor, 2002; Smith & Topping, 2001) in an effort to validate their findings (Bowling, 2009), and with attention to context make them more transferable to other settings (Guba & Lincoln, 1989).

In order to overcome methodological weaknesses, some nurse CPE researchers have chosen to use mixed methods research (MMR) (Mcveigh, 2009; Morgan, Cullinanne & Pye, 2008; Huges, 2005; Cook et al. 2004; Johnson & Copnall, 2002; Beatty, 2001; Nolan, Owens & Nolan, 1995; Sheperd, 1995). MMR incorporates quantitative and qualitative methods, which can be combined into nine different sequences for the purpose of achieving breadth and depth of understanding and corroboration (Bryman, 2012). However, this approach is not without its critics, with Bergman (2011) asserting that MMR is unable to answer a research question in all its complexity. Leahey (2007) draws our attention to the fact that this approach is limited to researchers who are involved in the original collection of survey data, highlighting that MMR is costly in terms of both money and time (Bryman, 2012). Consequently, although MMR is purported to cancel out bias, provide thicker rich data and increase confidence in results (Johnson, Onwuegbuzie & Turner, 2007), there are those who remain sceptical whether it is sufficiently rigorous as a methodology (Bergman, 2011).

Chapter Summary

It would appear that individual characteristics and educational ability, personal and work circumstances could either motivate or comprise barriers for nurse CPE. However, CPE does not occur in a vacuum and is influenced by the society in which we live (Merriam, 2010). The claim by Jarvis (1987a, p. 11) that 'learning is intimately related to that world and affected by it' is borne out by Caferella and Merriam (2000) who explain that learning is influenced by broad context and structural factors. From the limited amount of international research available on the CPE experience of island-based

nurses, it would seem that the geographical context of living on an isolated small island is worthy of further exploration in relation to registered nurses accessing post-qualifying formal education.

This literature review pertaining to nurse CPE and its influence on nurses and their practice has provided relevant evidence informing the basis of this research project. The only study pertaining to NMC registered nurses was located in the Highlands and Western Isles of Scotland and focused on the use of a modified student-centred/adult learning approach to distance learning (Boyd, 1998). The remaining literature exploring island-based nurses' CPE experiences and perceptions was global and based on the research findings from European, Pacific or tropical islands (Chen et al. 2007; Markaki et al. 2006; Ogalesco, 2006; Adami & Kiger, 2005; Berteloot, 2004; WHO, 2001). The transferability of these existing studies to nurses living and working on a British island may be limited due to the influence of local culture and nursing practices (Adami & Kiger, 2005). Therefore, there was a need to ascertain current experiences and perceptions of NMC registered island-based community nurses in regard to post-registration university education to address the gap in our current knowledge. The aim of this study, as identified in Chapter One of this thesis (p. 2), is to explore the following questions:

1. To establish the community nurses perceptions of CPE and its relevance to practice.
2. To investigate the types of CPE accessed by geographically isolated community nurses.
3. To explore the community nurses' personal experience of CPE.
4. To discover how each community nurse develops their professional knowledge and practice.

Chapters two and three have considered the literature pertaining to lifelong learning and CPE. Chapter two explored the importance of lifelong learning within modern society, highlighting that United Kingdom policies are supportive of the concept, believing that this will create beneficial opportunities for British society. Likewise, the National Health Service has

embraced lifelong learning, recognising the importance for healthcare workers to continually update their professional knowledge and skills. Chapter three has investigated CPE, focusing on the importance of formal education and considering the personal, organisational and geographical factors that influence the ability of nurses to participate. Finally, the impact that formal education has on nurses both personally and professionally was discussed, with consideration given to the impact this has on their practice. Gaps within the literature are noted, such as the dearth of research into community nursing, the lack of investigation into the CPE experiences of nurses employed within charities, and the limited amount of research concerning nurses on small remote developed islands. This confirms the need for research into these areas and warrants this doctoral research.

The following chapter outlines the research design which was used to explore the CPE experience of geographically isolated community nurses, allowing the thesis to contribute to the knowledge and understanding of the continuing formal education of nurses working on remote small islands.

CHAPTER 4: METHODOLOGY AND METHODS

This chapter will provide the rationale for using qualitative approaches within this doctoral research project, by exploring the philosophical and theoretical underpinning that led to the development of IPA. The use of IPA for researching nurse CPE and the rationale for using IPA in this project will be discussed. The methods of gathering data for this research will be explored, with the use of one-to-one interviews considered and compared to the use of focus group interviews and questionnaires as a means of data collection in IPA. Data management, transcription, coding, themes and analysis are considered and explained, prior to the discussion and presentation of ethical issues pertaining to this research project.

Framework for the Study

At the commencement of this doctoral research a framework was utilised to guide the progression of the inquiry, to contextualise it into the broader philosophical framework of research, and to ensure the most appropriate approach was undertaken to addressing the research questions. Crotty (1998) identified four main elements that need clarification in order to develop a research proposal: epistemology, theoretical perspective, methodology and methods of data collection, and each will be explored in this chapter, within the context of this research study.

This research project was concerned with community nurses' experience of CPE. It was the nurses' perception of CPE and how it affected their professional and personal life that determined this research. Therefore, undertaking a qualitative, or non-positivist approach enabled the investigator to adopt a naturalistic, interpretative stance focusing on the meanings by which these nurses understood their social world, including their CPE experiences (Ritichie & Lewis, 2003). In contrast, a quantitative, or positivist perspective concentrates on scientific knowledge, believing that the 'truth' is grounded in mathematical logic and can be unearthed utilising the statistical analysis of numerical data (Crotty, 1998). Researchers adopting this approach believe that phenomena do not occur in a haphazard way, but are linked to the participants experiencing it (Polit, Beck & Hungler, 2001).

Therefore, by conducting carefully controlled, objective, scientific investigation hypotheses can be tested to ascertain 'hard evidence' (Cutcliffe & Ward, 2007).

However, within contemporary nursing there is recognition that positivist research is unable to answer questions relating to personal experience (Topping, 2006). Important considerations within the research process are the type of knowledge one aims to produce, the assumptions made about the world and the role of the researcher in the research process (Willig, 2008a). As the research project required the collection of rich subjective data, a non-positivist approach was adopted, which supported the researcher's epistemological belief in constructivism. Epistemology refers to the philosophy underpinning the theory of knowledge, its nature, sources and limitations, and informed my belief as to the kind of knowledge that is in existence and how it was created (Craig, 2005).

Constructivism

Constructivism was the underlying epistemology of this project, where knowledge was defined as being developed by the social interactions between people in order to create their meaningful reality of the world (Crotty, 1998). The interpretation of personal experiences enabled individuals to construct a meaningful reality based on their perception of the world (Patton, 2002). This meaning-making ability of the individual mind leads to the construction of multiple versions of the 'truth' dependent upon past experiences and cultural socialisation (Turnbull, 2002; Crotty, 1998). The influence of culture on knowledge production will now be considered.

On the other hand constructionism, or the social construction of reality, refers to the influence that culture has on the ability of individuals to interpret the world (Crotty, 1998). Within this epistemological approach, the focus is on the collective creation of knowledge and meaning as opposed to the individual creation of knowledge. This perspective views knowledge as held within culture, organisational and interactional sites and therefore local in nature (Gubrium & Holstein, 1997). The purpose of this particular qualitative enquiry was to elicit the personal experience of the participants, therefore a

constructivist epistemology influenced the entire thesis, from the aims of the research questions, data collection methods and analytic techniques used to yield findings. IPA was both the theoretical perspective and methodology that underpinned the data collection and its subsequent analysis (Smith, 2004b).

Interpretative Phenomenological Analysis

IPA was developed in the mid-1990s by Jonathan Smith, as a qualitative approach for psychological research to complement the quantitative perspective favoured within psychology at that time (Hefferon & Gil-Rodrigues, 2011). IPA is concerned with how people understand and make sense of their personal and social world by exploring their lived experiences (Smith & Osborn, 2008). This is achieved through flexible data collection techniques enabling participants to give a vibrant picture of their experiences of the phenomena under investigation (Smith, 1995). Whilst health psychology was the original discipline to which IPA was appropriated, researchers from other disciplines such as sports science, music and educational enquiry have also adopted it (Smith, 2010).

The aim of IPA is to establish how individuals view and make sense of their life experiences (Smith, Flowers & Larkin, 2009). IPA offers a flexible data collection process, enabling the researcher to explore promising leads in order to capture rich information (Smith, Jarman & Osborn, 1999). The researcher endeavours to get an insider's perspective of the participant's world by capturing the quality and texture of the individual experience (Smith & Osborn, 2004). However, in reality this experience is not directly available to the researcher and is achieved through interpretation of what the research subject thinks and feels about the phenomenon under investigation (Willig, 2008b). This leads to the exploration of phenomenology, the underlying philosophical perspective of IPA.

Phenomenology

Phenomenology is the philosophical approach to the study of experience, which aims to clarify the lived experiences of people in their everyday life by being as accurate as possible to the phenomena and the context in which it

is experienced (Giorgi & Giorgi, 2008). In order to achieve new understanding from re-visiting an experience, it is necessary to put aside any preconceived ideas regarding the phenomena to enable the possibility of the emergence of unprejudiced meaning (Smith, Flowers & Larkin, 2009). Edmund Husserl, the founder of phenomenology, coined the term 'back to the things themselves' to describe the researcher's approach to bracketing their prior knowledge of the phenomena so that new meanings may emerge (Crotty, 1998, p. 78).

The phenomenological approach to the examination and comprehension of the individual lived experience represents the underlying philosophical principle of this thesis. The aim of this research was to uncover a detailed individual account of community nurses' experiences of CPE. The focus of this research was on the individual's recollection and reflection upon their experience and the meanings that they brought to it (Smith, Flowers & Larkin, 2009), creating a strong link with the constructivist epistemology of the research (Crotty, 1998). IPA focused on the importance of the individual's experience and the meaning making associated with reflecting on personal perceptions, which was achieved by the interpretation of both the participant and researcher. This leads us to consider hermeneutics, the second underlying influence of IPA.

Hermeneutics

The origin of hermeneutics is in the interpretations of religious texts, although it has subsequently been used for interpreting historical documents and unwritten events in order to try and make sense of what occurred (Crotty, 1998). Heidegger (1962/1927) explored the interpretative approach to phenomenology in *Being and Time,* investigating the interpretation of our being-in-the-world, arguing that each person perceives the same phenomenon in different ways through their own lived experience, understanding and historical context. This hermeneutic approach informs IPA, which is by definition an interpretative phenomenological approach to qualitative research (Smith, Flowers & Larkin, 2009). Moreover, the researcher undertaking IPA is involved in a double hermeneutic: where the participant is trying to understand and explain their experience, whilst the

researcher is trying to make sense of the story being told (Smith, 2004b). Therefore, the researcher is only ever able to produce an interpretation of the participant's experience (Willig, 2008b). This engagement at an individual level highlights the idiographic approach of IPA, which will now be discussed further.

Idiography

This doctoral research project seeks to explore the individual CPE experience of community nurses, with the researcher being committed to discovering the experience of these professionals within a remote small island setting. A qualitative approach was adopted to enable the collection of data for analysis. Qualitative research undertaken within the social sciences is primarily idiographic, seeking to discover what is concerned with the individual (Crotty, 1998). Idiography operates at two levels: the commitment given to the sense of detail and depth of analysis undertaken by the researcher and, the commitment to understanding how particular events have been understood from the perspective of particular people within a particular context (Smith, Flowers & Larkin, 2009). This is in contrast with quantitative research, which adopts a nomothetic approach in order to make general claims at large group or population level regarding the laws of human behaviour (Smith, 2008).

IPA adopts an idiographic approach beginning with a research question that focuses on the exploration of the participant's lived experience of the phenomena (Reid, Flowers & Larkin, 2005). Studies utilising IPA are conducted on small sample sizes, with 6 – 15 being the average number of participants, as the aim is to present an intimate portrayal of individual experience (Smith & Osborn, 2004). The researcher undertakes a detailed analysis of a case in order to produce insights into the phenomena being investigated (Willig, 2008a). Only then does the researcher move onto a detailed analysis of the next case, until all the cases have been reviewed, before finally subjecting the themes of each case to cross-case analysis (Smith, 2004b). The following section discusses these concepts in relation to the research project.

Justification of the Approach of the Study

In the context of the present research project several benefits of IPA emerge that have a key impact on this study. One of the main features of the research underpinned by the study's approach was to attract a number of different participants to contribute their experience. The phenomena of CPE remained central to the project but the variety of participants brought a wealth of experience allowing the analysis of differing viewpoints to bring to the fore several perspectives. This tied in with the idiographic nature of the study. The influence of idiography meant that CPE was viewed from the perspective of different grades of community nurses holding different hierarchical positions within the Charity. This is in contrast with the nomothetic view that results should be generalisable to a larger sample, and was considered a potential issue when assessing this unique category of island-based community nurses employed by a charity. The researcher was unable to locate a study concerning community nurses in a similar situation.

Another key approach of this research is hermeneutics as this played an important role in data analysis. Studies adopting a more empirical and objective epistemological starting point view the researcher as a separate entity overseeing the collection and analysis of data (Willig, 2001). However, throughout the process of the study the role of the researcher was acknowledged. The main reason for the development of the research project was my experience of undertaking CPE whilst employed as a nurse educator for the Charity responsible for the provision of community nursing services in Jersey. The decision to adopt a hermeneutical approach was based on previous research into this subject area (Banning & Stafford, 2008) and the decision to include my own experiences within this study. Throughout the research project a reflective diary was maintained, with reflections on my personal experiences of CPE as well as a research journal depicting my personal journey through the research process. This has meant the research findings include ethnographic analysis from my personal diary excerpts along with the data contained in the semi-structured interviews. Thus my role within the research is very apparent.

Evidence exists to support the advantages of using a qualitative approach to explore nurse continuing professional development (CPD). Banning & Stafford (2008) utilised semi-structured interviews to perform a qualitative study of CPD amongst community nurses employed within a National Health Service (NHS) Primary Care Trust (PCT) in England. By adopting a hermeneutic phenomenological approach Banning & Stafford (2008) were able to explore individual community practitioner's perceptions and experiences of CPD. Their research identified the main benefits of CPD as: professional development, career progression and practice development. Barriers to CPD were predominantly organisational in nature and the study concluded that in order to maximise staff development the PCTs needed to develop as 'learning organisations' (Banning & Stafford, 2008). Therefore, the adoption of a qualitative approach in this study is based on the premise that it is the most appropriate methodological approach to an exploration into the CPE experiences of island-based community nurses and through this will build on the body of knowledge in this area that has already been published.

Critique of Research using IPA

IPA has firmly established itself within psychological research since its development in the mid-1990s due to the ability to relate findings to the bio-psychosocial theories underpinning healthcare practice (Biggerstaff & Thompson, 2008). It is especially within the area of health psychology that IPA has had the greatest impact (Smith, Flowers & Larkin, 2009). The inductive stance of IPA, where a 'bottom up' approach is taken when exploring the meanings that participants give to their experiences, has been cited as the main reason for its popularity within psychology (Reid, Flowers & Larkin, 2005). Within healthcare, IPA has been suited to research investigating the personal experiences such as treatment and care issues. However, in recent years other disciplines have embraced IPA as a recognised method of qualitative research.

There is a long history of qualitative research within education (The Open University, 2001) nevertheless the use of IPA is still in its infancy as an approach to educational research (Smith, 2010). Creanor et al. (2006) used IPA as part of a mixed methods approach to explore the e-learning

experiences of 55 people over a wide age range. Their research included participants from community learning projects, Further Education Colleges and Higher Education. The study explored how learners felt about and coped with e-learning, with the researchers concluding that the IPA focus on the learner voice revealed new and unexpected issues (Creanor et al. 2006). IPA has been used to investigate continuing professional development among music teachers utilising semi-structured interviews and participant diaries to collect data (Bainger, 2011). This research enabled significant issues to come to the fore due to the climate of trust forged between the researcher and participants and the IPA of emerging data (Bainger, 2011). To date I have been unable to locate any research into nurse CPE or professional development using IPA, ensuring the uniqueness of this doctoral research. This study aims to address the gap in knowledge pertaining to community nurses working on a geographically remote small island and to use that evidence to enhance, improve or develop CPE for isolated healthcare workers.

Data Collection Method

The overall aim of qualitative research is to yield rich in-depth data about the lived experience of research participants (Richards, 2009). This is achieved through adopting an appropriate method that will enable participants to offer a first-person account of their experience of the phenomenon under investigation (Smith, Flowers & Larkin, 2009) whilst affording the researcher some control over the proceedings (Denscombe, 2010). Rich data is obtained by allowing participants to speak freely, explore and develop their ideas and concerns giving the researcher an insight into their interpretation of the phenomena (Warren, 2001). The data collection method recommended as best suited for IPA is the semi-structured interview (Smith & Osborn, 2008). This helped interviewees to take the interview in the direction that they wish to explore, thereby allowing significant issues to come to the foreground (Bryman, 2012). The flexibility of semi-structured interviewing allowed for sequence change when posing questions, enabling the interviewer to follow up to specific answers given by the interviewee (Kvale & Brinkmann, 2009). In the context of this study both the interviewer and the interviewee were able to actively participate in the ensuing 'conversation'

with the purpose of telling the participant's story (Smith, Flowers & Larkin, 2009, p. 57).

Semi-structured Interviews

By adopting a semi-structured approach the researcher was able to combine flexibility within the structure of the interview process (Legard, Keegan & Ward, 2003). This was useful when interviewing community nurses in order to explore the breadth and depth of CPE experiences they have encountered during their employment with the Charity. Semi-structured interviewing enabled the researcher to change the order of questions, probing and prompting where necessary, in order to allow the interviewee to recount their experience in full (Denscombe, 2010). Consideration was given to the use of unstructured interviews, whereby the interviewer conducts the interview without a question schedule instead relying upon a list of topics that need to be explored (Bowling, 2009). However, as the research aimed to explore community nurses' CPE experiences, the use of semi-structured interviews ensured that specific areas, such as investigating how these nurses developed their professional knowledge, were covered (Bryman, 2012).

A question schedule was generated by the researcher informed by academic literature, academic journal articles and personal experience of undertaking CPE in an island setting (Rapley, 2004), (Appendix 2). These questions served as a guide for the researcher who initially asked participants to 'tell their CPE story' and only used the question schedule with interviewees who needed prompting or had lost the thread of their narrative (Todd, 2006). Although questions were established prior to interview, Rapley (2004) highlights that these questions can change over the course of the project as the researcher becomes more knowledgeable and identifies other areas of interest in need of exploration. During this process the interviewer was instrumental, along with the interviewee, in the generation of new knowledge or thoughts concerning the topic under investigation (Legard, Keegan & Ward, 2003).

An important consideration for this research project was the fact that the researcher is a work colleague of the research participants. Garton (2010)

explored the issues surrounding the 'acquaintance interview' and identified that unforeseen problems can occur in this situation. The interviewer may often feel uncomfortable with the change in dynamics of the relationship, as they are required to take charge of the interview process. On the other hand, the interviewee is cast as the expert whose knowledge and opinion is sought. However, although this interview process may be unnatural for those with prior relationships, Garton (2010) concludes that the researcher is likely to have access to information that would not be disclosed to outsiders. This will be explored further in the reflexive section of Chapter 7.

One to one interviews

When adopting IPA it is recommended to undertake semi-structured interviewing on a one-to-one basis (Smith, Flowers & Larkin, 2009). The novice researcher is advised to adopt semi-structured interviewing over unstructured interviews enabling the use of prepared open-ended questions to probe the participant should they dry up during their interview, as opposed to a list of topics that the researcher would like to explore (Smith, 2010). By conducting interviews on an individual basis the researcher is able to accommodate the personal preferences of the interviewee with regard to arranging the venue and a suitable time to meet.

These interviews can be intense and it is best to ensure that disruptions are kept to a minimum to avoid disturbing the interviewee when they are in full flow (Smith & Osborn, 2008). By working with one informant at a time the researcher is able to develop a good rapport that aids in-depth personal discussion to ensue. One-to-one interviewing allows the researcher flexibility to guide the discussion and follow up on emergent issues thereby allowing the participant to clearly voice their experiences (Reid, Flowers & Larkin, 2005). IPA is an inductive approach with the emphasis on the participant as the expert. The researcher must endeavour to avoid prior assumptions about the topic under investigation thereby enabling emergent themes to arise from the data (Reid, Flowers & Larkin, 2005).

Comparison with other qualitative data collection methods

Focus groups are often used in qualitative research as an alternative to the semi-structured interview, where data is gathered in a group setting and the discussion is focused or structured (Redmond & Curtis, 2009). Within this informal interview setting, a group of people are encouraged to discuss topics in order that underlying matters might be uncovered (Parker & Tritter, 2006). However, Bryman (2012) identifies that the distinction between focus group and group interview is by no means clear-cut, with the researcher adopting a facilitator role in the former and an investigative role in the latter (Parker & Tritter, 2006). The recommended number of participants is between 6-10 (Macnaghten & Myers, 2007; Patton, 2002) as participants may be unable to discuss their experiences in a large group (Krueger & Casey, 2009). The researcher brings participants together to discuss a particular topic (Macnaghten & Myers, 2007), acting as facilitator to moderate the group discussion (Parker & Tritter, 2006). Focus groups may be used in an exploratory way especially in the first stage of developing the research project, as was the case with this research (Morgan, 1998).

The nature of the focus group enables participants to hear each other's comments, have exposure to the ideas and opinions of others, interact with them and respond whilst under the supervision of a moderator (Patton, 2002). Hence, focus groups are a useful forum for generating stimulating discussion (Redmond & Curtis, 2009). Focus groups allow the researcher to explore group characteristics and dynamics, as participants take over and own the interview space offering the potential to produce data seldom obtained through individual interviewing (Kamberelis & Dimitriadis, 2005). However, focus groups may intimidate the participant with the minority viewpoint to remain silent and not air their perspective in public, making this data collection method unsuitable for exploring highly personal issues or sensitive subjects (Patton, 2002). In the context of this research project nurses felt unable to speak publicly about lack of participation in CPE for fear of professional reprisals.

Within focus groups it is the group assertion that is analysed and not that of the individual (Morgan, 1997). Therefore, whilst not impossible to use this

method for data collection in IPA, the researcher needs to understand the problems inherent in undertaking experiential analyses with this data (Smith, Flowers & Larkin, 2009). The researcher would have to overcome theoretical and epistemological tensions, grappling with both individual data and group data whilst trying not to afford one more attention than the other (Tomkins & Eatough, 2010). Thus, the focus groups were undertaken first and the data gathered was used in the initial stages of research development as well as a means of triangulating findings from the semi-structured interviews.

The use of questionnaires is popular with researchers exploring the CPE and professional development of qualified nurses (Yfantis, Tiniakou & Yfanti, 2010; Drey, Gould & Allan, 2009; Morgan, Cullinane & Pye, 2008; Berridge, Kelly & Gould, 2007; Doyle, 2006; Ryan, 2003; Hardwick & Jordan, 2002). However, questionnaires were not considered suitable for this IPA research project due to limitations in their ability to allow participants to express their thoughts at length (Smith, Flowers & Larkin, 2009). Questionnaires are regularly used when targeting a large number of respondents and are often administered via the postal system, thereby avoiding any face-to-face contact between researcher and respondent (Denscombe, 2010). The format of the questionnaire involves the collection of data using questions that are developed by the researcher and therefore may be biased towards the researcher's viewpoint (Denscombe, 2010). The inductive nature of this enquiry required the data to be driven by the respondents rather than predetermined by the researcher. Although the researcher prepared the interview schedule, the nature of semi-structured interviewing allowed the respondent more freedom to express their views and experiences (Bryman, 2012).

Questionnaires often require the respondent to squeeze their response into a predetermined box (Robson, 2002) with the researcher left to assume that the data is accurate and honest, which may not be the case if answers are given in the most socially acceptable way (Cozby, 2005). Furthermore, unlike semi-structured interviews, the fixed nature of the questionnaire does not allow the researcher to follow up on points of interest that might occur. Questionnaires may also attend to issues and areas that the respondent

might find too sensitive to answer resulting in a non-response or low rate of return of between 30-60% (Gobo, 2007). As the main aim of the research project was to explore the nurses' CPE experience, collecting data via this method was considered inappropriate and therefore discounted.

Data Collection Process
It has been noted that there is no prescribed way to undertake IPA, that it is a personal process and is likely to be adapted by the researcher to suit their way of working and the topic they are researching (Smith & Osborn, 2008). However, it is imperative to identify a clear process as this enhances the rigour, transparency and coherence of the research project (Yardley, 2000).

Assessing the Quality of Qualitative Research
Qualitative research is quite distinct from quantitative research reflecting a different epistemology and commitment to different styles of research. It therefore follows that it would be inappropriate to evaluate qualitative research using reliability and validity, which are based on positivist assumptions (Ryan-Nicholls & Will, 2009). An alternative guide to the assessing the quality of qualitative research has been identified as follows: sensitivity to context, commitment and rigour, transparency and coherence, and finally impact and importance (Yardley, 2000) and are related to this study.

Sensitivity to context may be demonstrated in a number of ways. Sensitivity concerning the literature underpinning research methods and literature informing the topic being investigated enabled the researcher to develop a data collection tool that will yield rich data that can be related back to existing theoretical knowledge on the subject under scrutiny (Smith, Flowers & Larkin, 2009). This project demonstrates sensitivity to research methods identified in this Chapter. Chapters 2 and 3 explore previous research undertaken in this area with the development of a research question to explore an area of CPE that had not been addressed.

The researcher's appreciation of the interactional nature of data collection within the interview process is also an area where sensitivity to context

abounds (Smith & Osborn, 2008). The skills required to undertake an IPA interview to achieve a rich source of data included: self-awareness, listening skills and high levels of concentration. It is evident within the transcripts that participants were made to feel at ease by the researcher who exhibited empathy and understanding throughout the interview process. The analysis process also required sensitivity to context as the researcher tried to understand how the participant is making sense of their experience (Smith, Flowers & Larkin, 2009), with evidence of this found in Chapter 5. Finally, the resulting discussion (Chapter 6) and recommendations (Chapter 7) are the ultimate representation of the sensitivity to context undertaken by the researcher.

The commitment element of Yardley's (2000) framework refers to the degree of attentiveness the researcher is expected to show the participant during the data collection phase and the care given to the analysis of the resultant data (Smith, Flowers & Larkin, 2009). I went to great lengths to ensure that the participants were interviewed at a time and venue of their choice ensuring that time was spent prior to the interview to clarify any queries and make them feel at ease.

The rigour of the study commenced with the selection of the participant sample. Participants were carefully selected using selection criteria (Chapter 4, Table 4.1) to provide a homogenous sample best suited to explore the research question. The quality of the in-depth interviewing assisted the rigour of the research as does the analysis of the data, which was conducted thoroughly and systematically, one transcript at a time, and written up to include excerpts from participants' transcripts highlighting the idiographic nature of the study (Chapters 5 and 6). The process of drafting and re-drafting the writing up of findings enabled the researcher to undertake further analysis of the data, which are presented in Chapter 5. The use of NVivo8 facilitated a clear data trail, making my decisions with regard to coding and developing themes very transparent to outsiders (Hutchison, Johnston & Breckon, 2010) (Appendix 5).

One way of judging the impact of a piece of research lies in whether it tells the reader something interesting, important or useful (Smith, Flowers & Larkin, 2009). The direct practical implications of this research into community nurse CPE relates to patients, practitioners, the employer, and Jersey Health and Social Services policy makers (Yardley, 2000). Discourse, ideas and beliefs concerning CPE are an intrinsic part of the community nurse experience. This experience can be improved by research that contributes to challenging the way nurses and their employers think about CPE. For instance, money to support nurse CPE is very limited in these austere times and research has shown that some nurses over the age of 50 are not keen to participate in CPE (Aoki & Davies, 2002). However, raising the retirement age has resulted in nurses remaining in the workplace longer, requiring CPE to retain their competencies and embrace new working practices as healthcare technology improves.

Sampling

Within the qualitative approach the researcher is concerned with gathering a rich source of information (LoBiondo-Wood & Haber, 2006) and therefore subjects are recruited based on what is known about the population (Polit, Beck & Hungler, 2001) in order to identify key individuals to provide rich sources of data (Gerrish & Lacey, 2006). Potential participants were qualified nurses working for a charity providing nursing services (district nursing, health visiting and school nursing) to the population of Jersey. The Human Resource department of the Charity was approached to compile a list of qualified nurses employed thus identifying potential recruits. The research was advertised in the Charity newsletter as a forthcoming event that staff might wish to become involved with. Soon after, information letters (Appendix 3) were distributed to all qualified nurses detailing the purpose and duration of the study. Potential participants were given a month to express their interest in participating, and those who had not responded within that time frame were sent a reminder.

Potential participants for this research were selected using purposive sampling, a non-probability form of accessing a sample of prospective contributors (Bryman, 2012). Purposive sampling maximises the

representativeness of the participants within the research (Gobo, 2007), therefore the respondents had to be qualified nurses on the NMC Register and currently employed by the Charity. Those who had been in employment for less than 6 months were excluded, as it was unlikely that they would have undertaken CPE during their probationary period. Nurses about to leave the Charity's employment often returned to the UK and were consequently considered too difficult to access, and so were also excluded. Some nurses had two jobs and also worked at the General Hospital, able to access HSS funding for CPE, and for this reason were excluded from the research. Finally, it was important to interview nurses who had experienced CPE in Jersey during their employment at the Charity, as this was the main focus of the research. Therefore, purposive sampling provided a homogenous sample of participants (Smith, Flowers & Larkin, 2009) who were identified by utilising the selection criteria identified in Table 4.1 below. Participants were required to meet all six criteria.

Table 4.1 Selection Criteria

Selection Criteria
Qualified nurse
On part 1 or 3 of the NMC Register
Employed by the Charity for at least 6 months
Not working their notice period to leave the Charity
Working in the community
Experience of CPE whilst living in Jersey

These selection criteria were identified early in the research design aided by the aim of the study as it was perceived that the resultant participants would be able to offer rich insight into the community nurses' experience of CPE within the island (Smith, Flowers & Larkin, 2009). Ultimately, those who were prepared to come forward and participate in the research (Smith, 2008; Smith & Osborn, 2008) shaped the group of 16 participants. The small number of participants is not unusual in qualitative research, especially within IPA research that is best undertaken with only small sample sizes as it is the quality of data analysis that is important and not the volume of data gathered (Smith, 2008).

Interview Schedule Development

Several processes took place before the interview questions were decided upon. Firstly, a literature review was undertaken in order that interview questions could be informed by previous research into nurse CPE (Warren, 2001). Although it is acknowledged that IPA is an inductive process with the need to avoid prior assumptions (Smith, Flowers & Larkin, 2009), it was felt that a consultation of the literature would be useful at this stage to avoid unnecessary replication of previous research (Lacey, 2006). Secondly, I was a relative newcomer to the Charity and had only been in post for a year prior to commencing the data collection. My role as Education and Development Co-ordinator provided insight into the nature of the work, allowing the development of questions to explore interesting topics relating to community nurses CPE. Also, my position as a nurse undertaking CPE whilst employed on the island informed the development of the research questions.

Finally, pilot interviews were carried out with two colleagues to ensure the clarity of the questions and to assist in refining the questions ensuring that they were straightforward and easy to understand (Robson, 2002). Following feedback from participants who undertook the pilot interviews, I ascertained that no changes were required to the questions. The interview schedule used in the study can be found in Appendix 2.

Interview Process

Participants who agreed to be interviewed were re-issued with the research introduction and information letter in order that informed consent could be obtained immediately before the interview (Appendix 3). Ethical guidelines were discussed in relation to recording of the interview and the confidentiality of the information imparted to the researcher. Some participants had concerns that findings would be shared with management and were reassured that this would contravene research ethics and would not occur. Participants were informed of the anonymity of the interview transcript, its safe storage and the destruction of the audio file once transcription was complete. An outline was given as to how the findings would be presented in the thesis, including direct quotations from interviews. Prior to commencing the interview two consent forms (Appendix 4) were completed and signed by

the researcher and participant so that each could retain a copy for their records. The semi-structured nature of the interview was emphasised in order that the interviewee felt able to digress and discuss any experiences they felt might be pertinent to the research project.

Data Analysis

Computer software packages have been designed for use by researchers to assist in the storage and management of data to ensure transparency of the research process. The Computer Assisted Qualitative Data Analysis Software (CAQDAS) utilised in this project was NVivo8. It has been suggested that the utilisation of such software has the ability to turn qualitative research into an automated process devoid of human interpretation and reflection (Kelle, 1995). However, others have highlighted the ability of NVivo to provide proof of greater transparency (Hutchison, Johnston & Breckon, 2010) with the potential to facilitate the researcher in adopting a rigorous approach to data analysis (Richards, 2009).

Transcription

A transcription of the digital recording was undertaken after each interview had taken place. Interview participants were assigned a pseudonym at this point in order that the knowledge of their identity was exclusive to the researcher. This information was securely stored on a password-protected computer at the researcher's home. Interviews lasted between 45 minutes to just over one hour, yielding transcripts of varying length, from 7,000-10,000 words. The researcher was careful to ensure that data was transcribed verbatim, sensitively by removing any names and places that could identify the participants. Once the transcriptions were completed they were uploaded into the NVivo 8 qualitative data analysis programme in order that coding could proceed.

Coding

The coding process commenced by analysing one transcript at a time, only moving on to another transcript when the first was completely coded (Smith & Osborn, 2004). Each transcript was read several times in order to produce notes reflecting the researcher's initial thoughts and observations (Willig,

2008b). This process enabled the researcher to develop an intimate knowledge of the account and initiate key words to describe what was found in the text (Smith, Jarman & Osborn, 1999). This coding process assisted the researcher to reduce the data into a manageable format. The features available within NVivo enabled the codes to be stored, reassigned and merged as necessitated by the progress of the analysis. The coding process has been described as cyclical, following analysis and coding of the first text the researcher then scrutinised subsequent interviews looking for the emergence of new themes (Biggerstaff & Thompson, 2008). The codes were stored within NVivo8 on Free Nodes allowing the researcher to develop connections and establish themes (Appendix 5).

Themes

The creation of a framework of codes enabled the researcher to group similar data into themes. This was undertaken immediately following transcription, by reading through the transcripts, field notes and my research journal (Bryman, 2012). The claims, concerns and CPE experiences of each participant were analysed and codes assigned (Smith, Flowers & Larkin, 2009). The code categories that subsequently developed emerged from the transcripts and were able to condense and summarise the gathered data (Kelle, 2007). The codes were then reviewed to ascertain whether more than one code was being used to describe the same phenomenon, and where this occurred the data was relocated to one code (Bryman, 2012).

The phenomenological aspect of IPA maps out the concerns and cares of the research participants (Larkin, Watts & Clifton, 2006). In order to ascertain the participants' meaning of what occurred, the codes that were assigned following the systematic search of the interview transcripts were developed into emerging themes (Smith & Osborn, 2004). This was the first stage of the double hermeneutic process, establishing what sense the research subjects made of their CPE experience (Smith & Osborn, 2008). Re-reading the transcripts and listing the emergent themes facilitated the development of super-ordinate themes (Smith, Flowers & Larkin, 2009).

As themes and sub-themes emerged I continuously checked to ensure that these were evident in the text and accurately reflected participant opinion (Smith, Jarman & Osborn, 1999). This process was then repeated with all transcripts to ensure that these texts were treated individually (Smith, 2004b). Generic themes were created where similarities were found between transcripts (Willig, 2001). These shared experiences allowed me to draw comparisons across the participant population, but also highlighted how individuals can view the same thing differently (Reid, Flowers & Larkin, 2005). Once this stage of analysis was complete, the experiences, phenomena and themes identified during the thematic coding process were then analysed and interpreted using IPA (Appendix 5).

Role of the Researcher

The collaborative process between researcher and participant within IPA means that the researcher is an integrated part of the research process (Reid, Flowers & Larkin, 2005). The greatest influence exerted by the researcher was in the compilation of the question script. The questions indicated the topics that the researcher felt were of interest for the research project. Open-ended non-directive questions were developed (Willig, 2008b) to indicate to the respondent the area of interest without overly guiding them. These questions were piloted with colleagues in order to test for clarity and ensure that they would foster a good rapport with participants (Smith & Osborn, 2008). Therefore, the semi-structured interview allowed respondents to take control, changing direction of the interview with the bonus of revealing information not considered by the researcher (Smith, 1995).

The researcher is particularly prominent during the analytic phase as they bring meaning to the transcript of interviewees who are in turn recounting and reflecting upon their experience (Smith & Osborn, 2008). It is essential that the researcher is aware of the potential impact they can have on the outcome of the research project by keeping a research journal, documenting the process of the research and reflecting throughout the process of the project.

Writing up Findings

It is critical that the findings are written up clearly as it is the only way the researcher is able to give the reader access to the lived experience of the participants (Smith, Flowers & Larkin, 2009). The findings were organised and presented visually (Figure 5.3 & Table 5.2) to aid clarity and demonstrate the relationship between themes (Smith, 1995). This visual representation was used to provide the framework for the written account, with themes and sub-themes written up in a logical progression reflecting the findings (Smith & Osborn, 2008). The write-up of the findings consisted of extracts of participants' transcripts supported by analytic interpretation of these texts in order to make a case to illustrate the participants' experiences of CPE (Chapter 5). It was important that each participant was represented within this study and therefore quotations were selected from each transcript. These verbatim quotations were labelled with the participant's pseudonym and paragraph number from the transcript in order that the original data can be checked for context, procedural clarity and to increase validity (Smith, Flowers & Larkin, 2009) (Appendix 8).

Ethical Considerations

Ethical approval was sought from the Jersey Health and Social Services Ethics Committee in June 2010 (Appendix 6) and granted after a minor addition was made to the information letter that was to go out to potential participants. The University of Gloucestershire Research Ethics Committee was approached for ethical approval, which was granted in March 2011 (Appendix 7). It is vital for the researcher to have a commitment to moral issues (Bryman, 2012) therefore the research was subject to guidance offered by the DH (2005), NMC (2008) along with the recommendations of the RCN (2009a) and the University of Gloucestershire (2013). Due consideration was given to the following: research participation, informed consent, anonymity, confidentiality, data protection, beneficence and non-maleficence.

Research Participation

A lack of dedicated higher education institute on the island has resulted in a paucity of research being undertaken by nurses in the workplace and so it

was highly unlikely that potential participants had ever been asked to participate in doctoral research such as this. There is no mention of exposure to such a request within the job description and so the Chief Executive Officer (CEO) was approached to not only gain permission to undertake the research, but to allow employees who wished to participate the time away from work in order to do so. The research project was mentioned in a quarterly staff information letter and invitations were circulated to all qualified nurses employed within the community. The letter of invitation (Appendix 3) made it clear that there was no requirement to participate as suggested by Lobiondo-Wood & Haber (2006) and in subsequent contact with nurses it was made clear that refusal to participate in the research project would not have any detrimental effect as stipulated by Polit, Beck and Hungler (2001). Munro et al. (2004) explore the power relations in the workplace and research relationships, hence the information letter and consent form indicated to prospective participants their right to withdraw from the research at any time without personal penalty.

Informed Consent

It is good practice for prospective participants to be fully informed of the consequences of the research (Denzin & Lincoln, 2005). An individually personalised information letter (Appendix 3) was sent out to all nurses employed by the charity explaining the research project, what would be expected from those taking part, the promise of participant anonymity and the fact that permission would be gained prior to using quotes from interview transcripts.

Anonymity

Working within a small organisation posed operational challenges for the researcher in the ability to keep the participants' identity unknown (Seale 2007). However, participants were able to choose the location of their interview and the existence of satellite bases aided the process by providing the availability of secluded interview venues. This enabled participants to remain anonymous unless they chose to share with colleagues their participation in the research. All participants were issued with a pseudonym

known only to the researcher and this information was stored in a password-protected computer.

Confidentiality

In line with local Data Protection Act (SoJ, 2005) pseudonyms were added at the time of interview transcription and digital recordings deleted once transcription was complete to ensure privacy (Sapsford & Jupp, 2006). Details have been scrutinised to ensure that identity is protected and participant quotes carefully selected to ensure that confidentiality has not been breached.

Beneficence

Although it is difficult to predict the outcomes of qualitative research, the possible benefits of participating should be clarified to all concerned at the outset (Johnson & Long, 2006). Ideally the project should benefit the individuals participating (Gerrish & Lacey, 2006); in this instance the participants had the unique opportunity to discuss their personal experiences of CPE to someone in a position to improve their experience in the future. The research project also had the potential to increase the knowledge of how island based nurses access CPE and therefore may highlight issues to local health politicians. Participants were given the opportunity to de-brief immediately following the interview once the digital recorder was switched off, allowing questions to be asked 'off the record' and reassurance given regarding the confidentiality of information that had just been shared with the researcher (Polit, Beck & Hungler, 2001).

Non-maleficence

It is imperative that the researcher does no harm to the participants (Parahoo, 1997). However, the risk of harm is dependent on the nature of the research (Gerrish & Lacey, 2006) therefore it is possible to estimate the potential risk of harm to the participants (LoBiondo-Wood & Haber, 2006). In this instance it was possible that participants may regret their frankness and sensitive issues may leave the participant feeling upset (Ritichie & Lewis, 2003). Throughout the interviews the researcher was alert to any signs of emotional distress and arrangements were in place for an Occupational

Nurse to provide counselling should it be deemed necessary. Thankfully, this counselling service was not needed.

Reflexivity

Within qualitative research it is essential to identify the influence of the researcher on all aspects of the study through the process of reflexivity (Mason, 2002). Reflexivity refers to the researcher's reflections on the process of data making, acknowledging their part in the collaborative knowledge production process (Richards, 2009). This development of researcher self-awareness was undertaken using a reflective research journal throughout the whole of the research project enabling a continuous conversation to take place highlighting what shaped my perspective, as well as that of the participants (Patton, 2002). This reflexive approach aids the transparency and coherence of this qualitative research project, and is found in Chapter 7.

Chapter Summary

Crotty (1998) has been utilised to identify the four main elements required to develop this qualitative research project. Constructivism was identified as the epistemological underpinning of the research, whilst IPA informed the theoretic perspective and methodology and has been justified as a suitable approach for this study. Data collection methods have been explored, with one-to-one semi-structured interviews chosen as the best suited for the purpose of this research. The research process has been clearly identified and the application of quality criteria helped to guarantee the standard of this research. Ethical considerations have been explored to ensure that participants are afforded due care and consideration by the researcher. Finally, the role of the researcher and the importance of reflexivity have been discussed.

The next chapter will begin by exploring the demographic data pertaining to community nurses employed by the Charity, before presenting the findings of the research. The analysis of the data resulted in four superordinate themes that form the basis of Chapter 5, which are: the undercurrents affecting CPE,

getting underway with CPE, making headway with CPE and knowing the ropes following CPE.

CHAPTER 5: PRESENTATION OF FINDINGS

The purpose of this research was to explore the CPE experiences of community nurses working on a small remote developed island. This is an area that has been identified as under-researched in respect of nurses working outside the NHS (Aoki & Davies, 2002) as well as for nurses working on small islands (Patelarou et al. 2009; Buenconsejo-Lum, Maskarinec & Palafox, 2007; Chen et al. 2007; Ogalesco, 2006; Adami & Kiger, 2005; Berteloot, 2004). The aim was to discover what inspired the community nurses' decision making with regards to CPE and to explore the effect that living on a small island brought to that process.

Over the period of a year, from February 2011 until January 2012 data was collected from 16 research participants via two focus groups and semi-structured individual interviews. These data were transcribed verbatim and analysed one transcript at a time using IPA (Smith & Osborn, 2008) (Appendix 8). Themes were identified, with memos and journal entries adding to the data (Larkin, Watts & Clifton, 2006). The findings presented in this chapter are the result of coding and classifying the data until arriving at an interpretation of the perceived CPE experience of the community nurses who volunteered to participate in the research (Smith, Flowers & Larkin, 2009). Participants' quotes used within this chapter have been adapted for use in order to safeguard anonymity and maintain confidentiality (Appendix 9).

Demographic Data of Participants

Sixteen self-selecting participants were willing to share their unique experience of CPE with the researcher by undertaking individual interviews. At the time the research was undertaken the Charity employed 74 qualified nurses, therefore the sample comprised 21.6% of the nursing workforce. Demographic details were considered, as these may affect the participant's experience and the interpretation given to the data by the researcher (Ritchie, Spencer & O'Connor, 2003). The nurses who agreed to take part in the research represented all areas of adult nursing and child and family provision. Not all participants were female, however as the Charity only employs three male nurses it was not felt appropriate to identify the gender of

participants as this could compromise their anonymity (Lewis & Ritchie, 2003). The age of participants was also not recorded in the demographic data, as given the small nature of the workforce it could lead to participant identification (Johnson & Long, 2006). Thus the decision was made to omit data on gender and age in Table 5.1 as this may compromise the privacy of participants (Seale 2007). The demographic data and participants' characteristics are represented in Table 5.1.

Table 5.1 Study participants

Pseudo-nym	Where trained	How long qualified	Nurse Grade	Works Full or Part Time	Experience of CPE in UK	Experience of CPE in Jersey	Highest Qualification
Angela	UK	18yrs	6	P/T	Yes	Yes	Masters
Bella	UK	11yrs	6	F/T	Yes	Yes	Degree
Hannah	UK	23yrs	6	F/T	Yes	Yes	Degree
Kim	UK	18yrs	6	F/T	Yes	Yes	DipHE
Lisa	UK	13yrs	6	F/T	Yes	Yes	Level 7 modules
Mary	UK	26yrs	6	P/T	Yes	Yes	DipHE
Alice	UK	16yrs	5	P/T	Yes	Yes	Degree
Bridget	UK	28yrs	5	P/T	Yes	Yes	DipHE
Chris	UK	29yrs	5	F/T	Yes	Yes	DipHE
Lucy	UK	13yrs	5	F/T	Yes	Yes	Level 6 modules
Sam	UK	27yrs	5	F/T	Yes	Yes	Degree
Emily	UK	32yrs	4	F/T	Yes	Yes	Degree
Lily	Jersey	19yrs	4	F/T	No	Yes	Level 6 modules
Liz	Jersey	25yrs	4	F/T	No	Yes	DipHE
Margaret	Jersey	23yrs	4	F/T	No	Yes	DipHE
Nicola	Jersey	33yrs	4	F/T	No	Yes	Level 4 module

It is apparent from Table 5.1 that those participants who undertook their initial nurse training on the island failed to achieve a position in the Charity above Grade 4 (Staff Nurse). An enquiry to the Human Resources Department confirmed that of the 34 employees who held nursing Grade 5 (Junior Sister), Grade 6 (Senior Sister) or Grade 7 (Team Leader) posts, only 3 (8.8%) were locally born nurses who had trained in the UK. Of the 40 Grade 4

employees, 37.5% (n=15) were islanders. This lack of opportunity for career progression has not escaped the notice of the Grade 4 research participants:

> *I do sometimes think that the Charity should look at [training up] the good old home-grown down to earth reliable [nurses], don't forget your local blood really [Emily, Grade 4: 36].*

> *Quite a bit of me thinks, well I should have stayed [working] at the hospital.   I probably would have completed my degree by now and the opportunities [for promotion] would have been more open to me [Lily, Grade 4: 14].*

Junior Sisters, Alice and Sam (Grade 5) and a Senior Sister, Lisa (Grade 6) also identified a glass ceiling in relation to career progression:

> *I would only complete a Master's [degree] if I knew it was going somewhere and would facilitate my career pathway. But there's no promotion on the horizon. I would have to move back to the UK if I wanted to be a nurse consultant [Lisa, Grade 6: 40].*

> *There are no opportunities [within the Charity] for becoming a clinical nurse specialist [Alice, Grade 5: 84].*

> *How am I ever going to be allowed to progress in my chosen career, because outsiders [UK nurses] are going to be brought in and take the posts that I could do? If only I had that extra training and support [Sam, Grade 5: 78].*

This apparent inability of qualified nurses to attain career progression within the Charity is new evidence within island nursing studies, as previous research indicates that nurses on islands are frequently working in enhanced roles (Chen et al. 2007; Ogalesco, 2006; Berteloot, 2004; WHO, 2001).

The age of all qualified nurses employed by the Charity was obtained from the Human Resources Department and this was mapped against the age of the research participants and represented in Figure 5.1 below.

Figure 5.1 Age of qualified nurses employed by the Charity
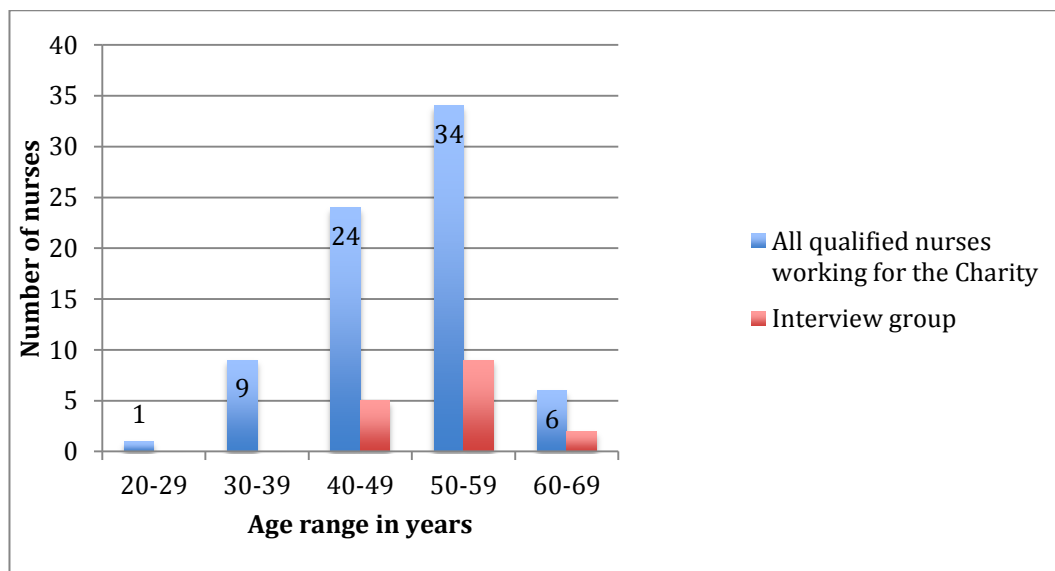
It was disappointing that age groups 20-29 and 30-39 were not represented, as this will not reflect the CPE experiences of community nurses who are under the age of forty. However this was beyond the researcher's control, as the participants were self-selecting (Ritchie, Lewis & Elam, 2003). The percentages of research participants representing the other age ranges were:

      40-49 years = 20.8% (n=5)
      50-59 years = 26.4% (n=9)
      60-69 years = 33.3% (n=2)

The age profile of all the nurses working for the Charity revealed an ageing workforce similar to that in the NHS (Watson, Andrews & Manthorpe, 2004), with just over half of the nurse employees being above the age of fifty (54%), represented in Figure 5.2 overleaf.

Figure 5.2 Age profiles of all qualified nurses working for the charity
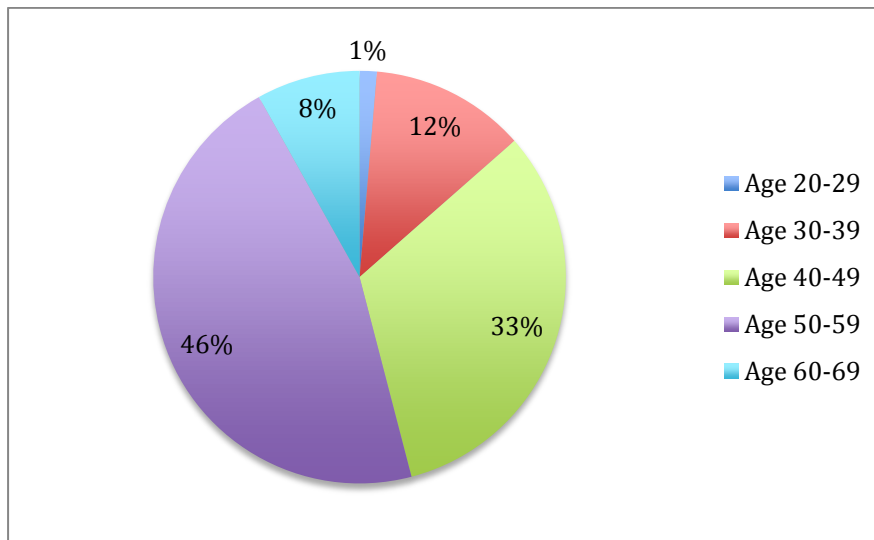
All demographic data was entered into NVivo8, along with memos and research journal extracts, to enable the researcher in building a visual concept of the research findings (Figure 5.3).

Conceptualising Island-based Community Nurses' CPE Experiences

With the assistance of NVivo 8 to organise the interview transcripts, descriptive nodes were created to classify the nascent new categories, resulting in the formation of tree nodes that connected the coded data (Richards, 2009) (Appendix 5). For a clearer understanding of the insider's perspective, the resulting information was then converted into a visual representation (Goodson, 2013) of the Jersey community nurses' experience of CPE. The analogy of CPE as a journey has been used in previous research (Tame, 2009; Stanley, 2003); therefore the researcher implemented this metaphor, because for some participants the journey was physical as well as metaphorical. Since being surrounded by water is pivotal to the definition of an island (Depraetere & Dahl, 2007), it felt appropriate to adopt a nautical theme. The four main themes of the data analysis are: undercurrents affecting CPE, getting underway with CPE, making headway with CPE and knowing the ropes following CPE.

Figure 5.3 Organisation of island-based community nurse CPE themes into abstract concepts
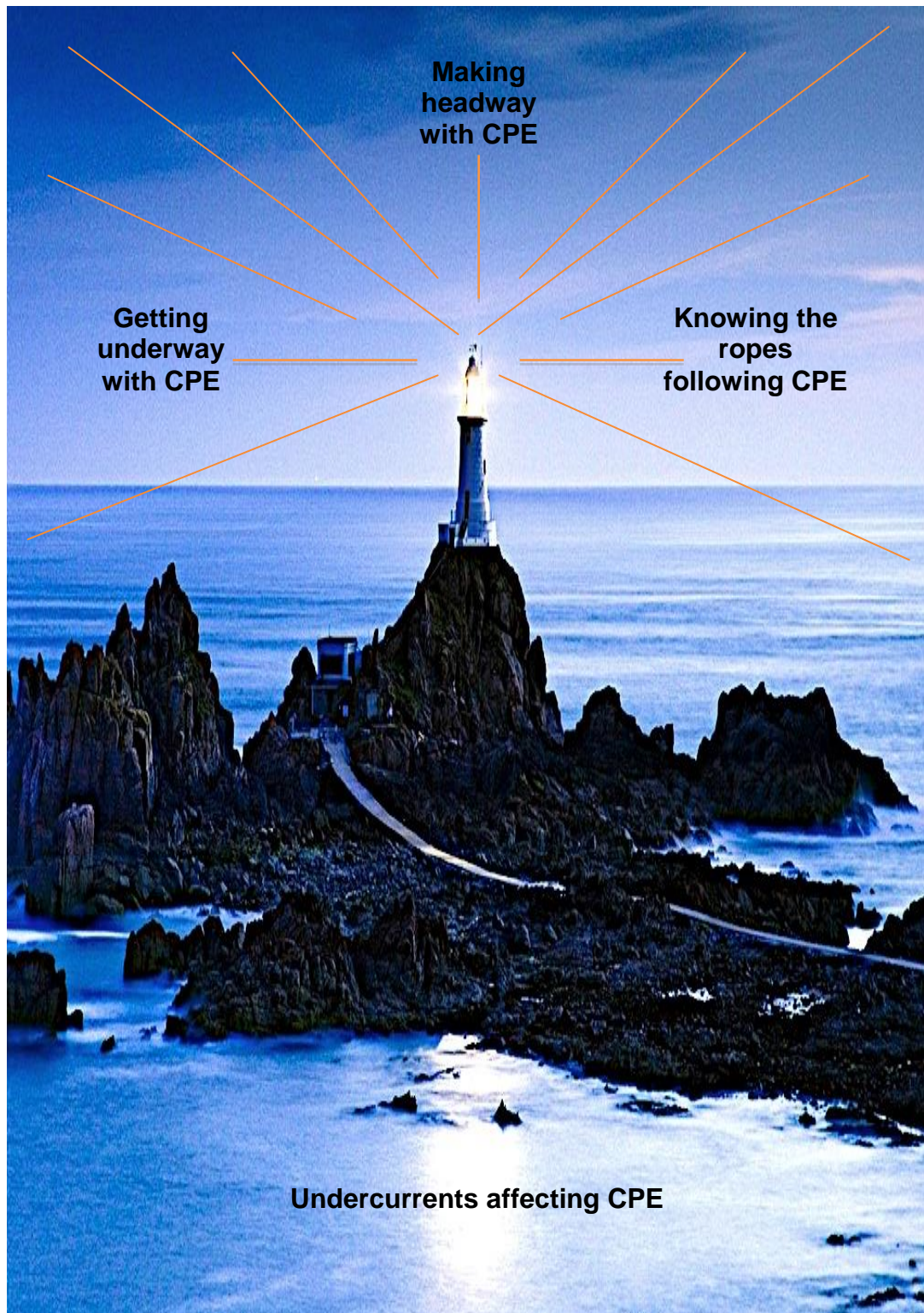
La Corbière Lighthouse, Jersey

The following table illustrates all themes identified within the data, which inform the remaining chapters of the thesis.

Table 5.2 Themes, sub-themes and sub-sub-themes identified in the data

Theme	Sub-theme	Sub-sub-theme
Undercurrents affecting CPE	Small Island	Geographical location
		Professional isolation
		Types of CPE accessed
		Travel issues
	Island Infrastructure	Island health service
		Professional rivalry
		Working for a charity
		Staff appraisals and PDPs
		Educational opportunities
	Healthcare Culture	Workplace culture
		Attitude towards CPE
Getting underway with CPE	Lack of academic study skills	
	Motivation	
Making headway with CPE	Family support	
	University support	
Knowing the ropes following CPE	Personal outcomes following CPE	
	Professional outcomes following CPE	Change own practice following CPE
		Change colleagues practice following CPE
		Improved patient care following CPE

Undercurrents Affecting CPE

As already stated, the interest in undertaking this research was fuelled by the dearth of available research exploring the effect that working on a remote small island might have on the ability of the nurse to participate in CPE. Studies have been found pertaining to small (Patelarou et al. 2009; Adami & Kiger, 2005; Boyd, 1998) and developing islands (Buenconsejo-Lum,

Maskarinec & Palafox, 2007; Chen et al. 2007; Ogalesco, 2006; Berteloot, 2004; WHO, 2001). However, they do not translate very well to this small economically viable 'entrepôt'[2] island, considered wealthy due its tax-free offshore investment finance services (King, 2009). One research article was found that explored the experience of nurses on a Scottish island as they undertook CPE via distance learning (Boyd, 1998). Nevertheless, it also does not translate well to the context of this research as it takes place within the NHS infrastructure, something that does not exist on the island. The following section explores the undercurrents affecting CPE from the perspective of Jersey community nurses, who work for a charity; and this is currently absent from the existing nursing literature.

Small Island

Jersey is the largest of the Channel Islands (Everard & Holt, 2004), however with its small land mass and population of less than 100,000 it is considered a small island in international terms (Beller, 1986). Whilst many islands globally have declining populations due to migration for better jobs and prospects (Connell, 2007), Jersey has become an immigrant society due to its status as a highly successful offshore finance centre (McElroy & Pearce, 2006). However, Royle (2001) highlights that island infrastructure is often found lacking in small islands, especially in relation to healthcare, where patients requiring specialist treatment may have to be evacuated to the mainland. Likewise whilst investment in tertiary education is essential for success in the knowledge economy and global market, it is often not provided locally due to the high costs involved (Martin & Bray, 2011). Therefore, qualified nurses working on Jersey find themselves isolated from the NHS, in a local health service that seems dated by UK standards, with less access to tertiary education than their mainland counterparts.

> *I think that when I arrived on Jersey my first*
> *impression was that the health service was 10 years*
> *behind the UK [Bella, Grade 6, 290].*

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[2] Entrepôt translates into English as a 'trading post'

I have to say that since I came to Jersey I've found it very hard to update, mainly because there are none of the facilities on the island that you would find in an NHS setting [Chris, Grade 5, 20].

I think here in Jersey we are fairly distant from the cutting edge of wound care technology and dressings. We just tend to the basics and that's it [Liz, Grade 4: 14].

Islanders are often portrayed as inward looking and out of touch with the world (Lowenthal, 2007). Due to geographical isolation, nurses working on small islands can run the risk of undertaking healthcare practices without the necessary skills or up to date knowledge (Berteloot, 2004; WHO, 2001).

Geographical Location

Jersey is located 23 km from the French coast and approximately 137 km from the South coast of England (States of Jersey Statistics Unit, 2011, p. iii). The main forms of travel to the United Kingdom (UK) are either airplane or commercial car ferry. This can lead to feelings of isolation from the outside world as commented on by two staff nurses:

I attended a conference in Birmingham recently. It was really good to see what everybody else was doing and hearing about all the latest developments in stoma care. There was loads of equipment that I'd never heard of, and probably wouldn't have if I hadn't got to the conference [Lily, Grade 4: 77].

We still come under the jurisdiction of the NMC even though we are in Jersey. But for some reason, and I find that with a lot of nursing staff here, it's like the NMC is some far distant body that has no relevance to them [Lisa, Grade 6: 112].

Research undertaken by the WHO (2001) found that nurses working on small remote islands may have difficulties in networking with other healthcare professionals, with similar findings amongst nurses practicing in remote rural parts of America (Beatty, 2001). Working as a nurse on a remote island can also limit access to clinical supervision (WHO, 2001).

Professional Isolation

In common with nurses working on small isolated developing islands (WHO, 2001), many research respondents spoke of their professional isolation. Specialist Nurses, who often only had one hospital-based nurse on-island with whom they could contact for professional support and advice, especially highlighted this. These Specialists felt disadvantaged by being on the island, with Angela declaring that it was hard work to beat the isolation of working on an island. Others found it difficult to keep up to date with current practices in their field of expertise:

> *The Specialist [Doctors] are on the mainland and I have to be able to go away to access that specialist training and keep updated, which I find very difficult to do being on an island [Lucy, Grade 5: 24].*

> *On a small island it's not like we can go to the training hospital up the road for six months and get the experience. We cannot, we're stuck. We don't have a resident university for nursing studies other than what the hospital has got [Sam, Grade 5: 78].*

Prior research undertaken in remote geographical areas reveals that rural nurses may have difficulties with professional isolation (Beatty, 2001). This research uncovered similar findings, as networking with Specialist Nurse colleagues proved difficult since professional meetings and forums often take place in the UK as related by Kim, Lucy and Nicola:

> *I was actually lucky enough to present [research] at an international conference. I was going to Florence, but there*

was no money from [the Charity] to send me, but they did give me three days [off work]. I felt the opportunity to network at a world conference was important, so I took holiday, otherwise what's the point? [Kim, Grade 6: 136]

I have been asked to go and be part of the committee for the Specialist Nurse Forum but you've got to go to [the UK for] five meetings a year and I just physically couldn't do it, which is a shame [Lucy, Grade 5: 64]

The problem is the centre is in Hampshire and I can't manage it from Jersey to go across to the meetings. So though I get the emails and I'm kept up to date, I'm not a functioning member of this group [Nicola, Grade 4: 72]

Lisa and Bella, two senior nurses, also felt isolated from their UK counterparts:

There are one or two colleagues that I liaise with in the UK just to see how things are developing there [Lisa, Grade 6: 16].

The benefit of attending the advanced care course in London was the networking opportunities. If I've got an issue with a client and would like advice, or someone else's opinion, I can ring up somebody I've met at the training [Bella, Grade 6: 56].

Whilst these research findings in relation to professional isolation are in keeping with nurses in other remote small islands (Berteloot, 2004; WHO, 2001; Landon, 1981), it is unique for community nurses to find themselves so cut-off from their NHS colleagues. Likewise, the distance from the UK, combined with the limited access to undergraduate modules, led to the community nurses accessing a variety of types of CPE.

<u>Types of CPE Accessed</u>

The majority of academic literature accessed for this research project was focused on university-based CPE (Tame, 2009; Bahn, 2007a; Evans et al. 2007; Dearnley, 2006; Spencer 2006; Ellis & Nolan, 2005; Gopee, 2003; Armstrong & Adam, 2002; Barriball, 2002; Dave & Robinson, 2002; Hardwick & Jordan, 2002; Johnson & Copnall 2002; Smith & Topping, 2001; Whyte, Lugton & Fawcett, 2000), compared with publications covering other means of attaining CPE, such as distance learning (Cook et al. 2004) or e-learning (Carroll et al. 2009; Maxwell, 2009). In contrast, this research revealed that the geographical location of the workplace dictates nurse CPE choices and is often dependent on local provision, which can be difficult on a small remote island with limited amenities (Berteloot, 2004; WHO, 2001). Due to the lack of university provision on the island, community nurses sought various means of accessing CPE.

Figure 5.4 Types of CPE undertaken by Jersey community nurses
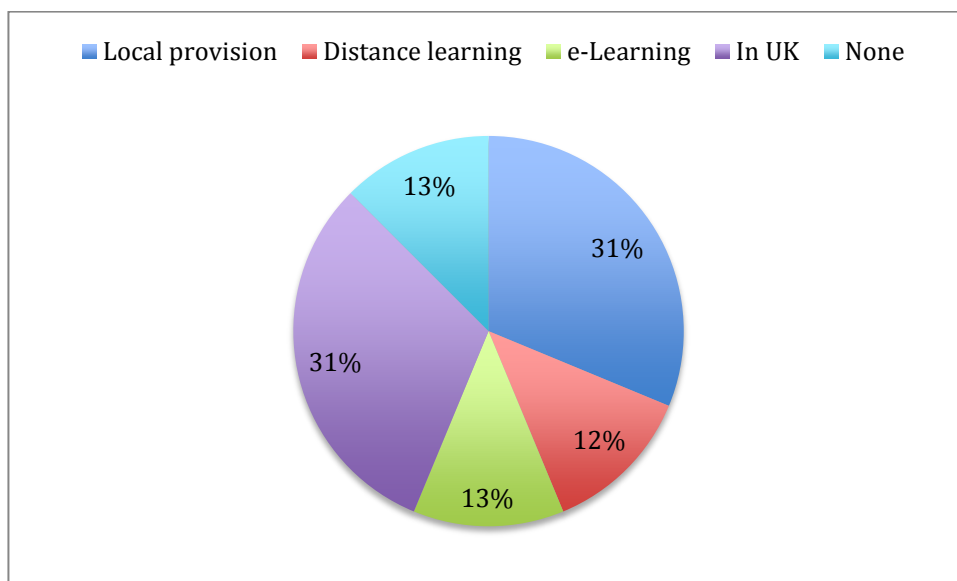
It can be seen from Figure 5.4 that almost a third of nurses (31%, n=5) accessed Level 6 modules offered by the Education Department at the local General Hospital, in order to achieve a Bachelor of Science Degree in Clinical Practice awarded via a university in the South of England:

> *The education centre here [at the General Hospital] was*
> *then starting to do courses. It was quite a revelation for the*

island and I was encouraged to do an additional specialist
course [Sam, Grade 5: 22].

In the last seven or eight years, due to a very proactive
education centre [at the general hospital], I got the chance
to do my Degree in Clinical Practice [Emily, Grade 4: 12].

As with other nurses from small islands (Berteloot, 2004), it was necessary for almost a third (31%, n=5) of respondents to travel to the mainland on a regular basis in order to attend a university offering them an appropriate academic course for their speciality or area of interest. Angela undertook a Masters Degree at a University in the South of England, whilst Mary attended a residential course in the UK. Distance learning is another viable option for nurses working on small isolated islands (Cook et al. 2004), with 12% (n=2) of the research group opting for this route. Likewise, with the advent of technological advances, some island-based nurses were able to access CPE via e-learning (Buenconsejo-Lum, Maskarinec & Palafox, 2007), and this was the case for 13% (n=2) of the respondents in this study:

The above findings have revealed how geographical location may influence the CPE choices made by community nurses who participated in this research. Several research participants had accessed CPE in the UK, as due to lack of infrastructure (Royle, 2001), the island was unable to offer any suitable tertiary education to facilitate their professional development. However, undertaking undergraduate or postgraduate studies in the UK commonly necessitates attendance at HEI, which results in associated travel issues when living on an island.

Travel Issues

Living on a small remote island does have its drawbacks; with nurses often having to travel off-island in order to access CPE (WHO, 2001). Previous research (Penz et al. 2007; Ogalesco, 2006; Adami & Kiger, 2005) has discovered that living a great distance from a university combined with limited access to an academic library is perceived by nurses as a barrier to undertaking CPE. Both Mary and Bridget found the logistics of getting away

from the island too tricky to contemplate, especially when trying to accommodate the needs of their family members. Family commitments can make nurses unwilling to travel to the mainland to access CPE, especially if they lack extended family on the island to help care for dependents in their absence (Adami & Kiger, 2005). These circumstances resulted in Lucy and Nicola questioning whether or not to participate in CPE in the UK:

But leaving them [family] is difficult and you have to plan ahead and you have to sort things out before you go and when you're going to be back. And you can guarantee something always happens when you're off island [Lucy, Grade 5: 36].

You have your family to care for. Through my working life I've had children at home and I've also had a dependent relative. My life was pretty much taken up by my family [Nicola, Grade 4: 20].

As identified by previous research (Feinstein, Vorhaus & Sabates, 2008), Sam found that family life commitments took precedence over CPE:

It became increasingly difficult [to continue with studies] because I was working, I had young children, I went through a divorce and I was moving house. So all those things really made it difficult. So although I did three out of the six modules for the degree pathway, I had to shelve it [Sam, Grade 5: 18].

In her study of nurses working on the Scottish islands Boyd (1998) found travelling off-island a deterrent to CPE; likewise, nurses in the present study claimed the expense of travelling to England discouraged them from attending formal education in the UK:

That piece of water and the fact that it's [the cost of] an airfare, sometimes people just throw their hands up in horror. [Kim, Grade 6: 128].

It's the cost of getting off [the island]. It's the cost of leaving family. Financial commitments [Lucy, Grade 5: 24].

Jersey nurses are faced with the same situation of other island-based nurses, whereby the expense and inconvenience of travelling to the mainland to participate in CPE, family commitments and the uncertainty of the elements can all add up to make accessing continuing education a stressful activity (Ogalesco, 2006; Adami & Kiger, 2005; Boyd, 1998). Jersey lacks a comprehensive tertiary education infrastructure and this will be considered in relation to the delivery of continuing education for nurses.

Island Infrastructure

The island does not have a dedicated Higher Education Institute (HEI) and to address this shortfall the local Further Education College runs a University Centre with some undergraduate and postgraduate degree provision in financial services and social sciences (Highlands College, 2013). The local General Hospital is affiliated to a university in the South of England offering a limited number of modules at Level 6, enabling nurses who qualified before nurse education entered higher education the opportunity to gain a BSc in Clinical Practice (Health and Social Services (HHS), 2013a). More recently, nurse prescribing is being taught at both Level 6 and 7 (HSS, 2013b). However, the limited access to nurse CPE and high price of modules has had a detrimental effect on the community nurses:

I think the whole 'islandness' of being small, limited money [for CPE], just feeds into the downward spiral [Bella, Grade 6: 346].

I think we need to accept that we have an educationally depleted workforce, that standards are not wonderful

because they don't have the education, development and training [Chris, Grade 5: 28].

But the fact that [the Charity] isn't part of HSS, [means] that if you do want to access those same courses that are available at the hospital, it's at a really high cost [Emily, Grade 4: 14].

The above findings highlight the CPE experience of nurses who are employed by a charity and seem to lack the opportunities to undertake formal education compared to their healthcare colleagues employed by local government. A recent review of healthcare in Jersey revealed poorly integrated services (KPMG, 2011), which the local government is in the process of updating (SoJ, 2012b).

<u>Island Health Service</u>

On the island General Practitioners (GPs) provide primary care, the hospital delivers secondary care, and all other healthcare provision is by charities (the Charity, Jersey Hospice, specialist residential homes) or the private sector (nursing agencies, care homes, nursing homes) (SoJ, 2011). The recent Jersey HSS White Paper '*Caring for Each Other, Caring for Ourselves*' claims that the healthcare offered by these services is not considered to be seamless (SoJ, 2012a), as illustrated by comments from all grades of Community Nurses:

Clients don't automatically have a dietician until there's a need to have a dietician. They don't automatically have a social worker unless there's any social concerns picked up and a referral made. You don't have so much of a team around the [complex care client] as you do in the UK [Hannah, Grade 6: 40].

I find it quite frustrating that [professionals] on this small island can't get together: primary care, secondary care and the GPs [general practitioners] and do some joined-

up thinking, to be able to identify the processes we need to consider [for complex care management] [Sam, Grade 5: 30].

It's an island-wide problem because there isn't a CAMH [Child and Adolescent Mental Health] unit or APU [Adolescent Psychiatric Unit] over here to facilitate mental health services for young people … so I do feel that we don't give [young people] a good service at all [Emily, Grade 4: 72].

The unique configuration of the Jersey healthcare system has resulted in a lack of a seamless service due to the combination of government provision, private sector agencies and charities (KPMG, 2011). The participants perceived that this distinctive island health provision prohibits interprofessional working, fosters professional rivalry and could ultimately impinge on client care.

Professional Rivalry

Professional rivalry (Nolan et al. 2000) exists in the Charity with community nurses making contemptuous remarks about their Specialist Nurse colleagues, whilst the lack of inter-professional working is also highlighted as an issue:

I look around and I think 'they've got it good' [referring to Specialist Nurses]. They don't really do anything; they spend their days doing whatever they want to. There are one or two people in relatively senior Specialist Nurse posts who I feel sure probably do a quarter of a days work in a day. That's very scathing, I know it is, but I think it's grossly unfair that everybody in the Charity seems to be aware of this but nobody does anything about it [Chris, Grade 5: 162].

One of the problems I had though, once I managed to get that course, is that when I came back I was kind of rebuffed by the [specialist] centre over here because they hadn't had the funding or the time to be able to send their own employees off to go on this course. I wasn't received very warmly, or welcomed, and that made things very difficult because there was no other ways to be able to get this experience [Sam, Grade 5: 20].

The participants within this research shared their views with regard to the professional rivalry between various healthcare workers both within the Charity and between their hospital counterparts, however there was also a perceived rivalry among local GPs and the community nurses.

The White Paper '*Caring for Each Other, Caring for Ourselves*' reveals that local GPs are undertaking duties that could be performed by nurses, with the Jersey Health and Social Services Department encouraging GPs to employ practice nurses so their time can be released for more appropriate medical tasks (SoJ, 2012a). Alongside this, community nurse team leaders working for the Charity felt their relationship with GPs on the island was limited:

I feel from our service point of view, whereas we work quite closely with GPs in the UK, here we don't. We very rarely have any liaison unless there's particular concerns or information that we need to know about. But GPs certainly don't contact us about anything at all, even though we are the people who are going in and seeing that family, several times a week in some cases [Hannah, Grade 6: 42].

That's a real big barrier here. I find the GPs are very separate and there is no way you could recommend a course of action because they would say "hang on … I'm the doctor". So it is a constraint, yeah. And sadly there are some GPs that I really can't talk with easily because

they're just not interested. They don't see what we do as
part of their remit [Lisa, Grade 6: 18].

This research has therefore discovered that unlike the experience of island nurses recorded in the extant literature (Dean, 2012; WHO, 2001) these participants perceived that they had very limited working relationships with local GPs. Therefore, the unique configuration of the Jersey health service would seem to hinder good working relationships between some local GPs and the community nurses who are employed by the Charity.

Working for a Charity

The community nurses were employed by a local charity that had been providing care on behalf of the island community for over a hundred years (McNeela, 2007). The Charity did ring-fence money for use in succession planning and training. However, since I commenced employment with the Charity in 2009, the education budget had been reduced by £12,000 per annum. The current allowance for education and staff development is £100 per employee, which includes mandatory training purchased from outside agencies such as: first aid, basic life support and safe moving and handling. Accordingly, nurses felt that funding was a particular issue and voiced their concerns:

It's our responsibility as nurses to keep updated, but if
there's no money available in the education budget then
we end up self-funding [Kim, Grade 6: 132].

The problem with funding for part-time staff, is to actually
take time out of their caseload [to attend CPE] is almost
impossible [Alice, Grade5: 26].

I do think a lot of the problem is funding. To do a degree
costs £9,000. If you have children and they want to do a
degree, you're more likely to invest your money on your
children [Nicola, Grade 4: 86].

This knowledge of limited funding for educational purposes encouraged the community nurses to find alternative means of funding to meet their CPE needs as illustrated in Figure 5.5 below.

Figure 5.5 Jersey community nurse CPE funding
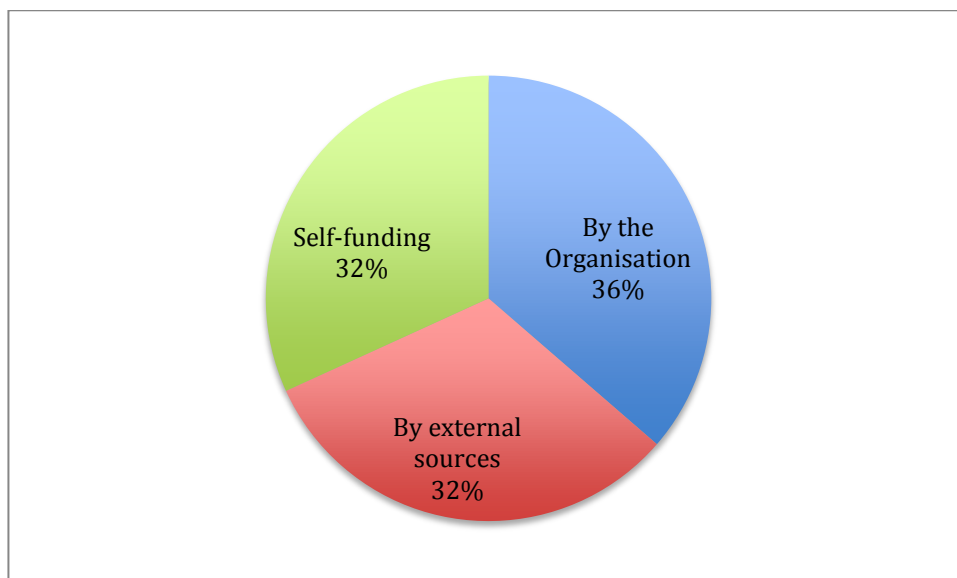
What is distinctive about Figure 5.5 is that almost a third of the nurses (32%) secured funding for their CPE by approaching agencies outside the Charity. This practice was revealed to me for the first time during the interviews, until this point I had no idea that community nurses were approaching private companies for CPE funding. The securing of private funding for lifelong learning had been a longstanding custom within the Specialist Practitioners, who regularly approached local charities and Trust Funds, as well as UK companies, for sums of money to finance their CPE.

> *And to get there [CPE in the UK] I had to get funding from the [named] companies. All I did was to write to every one of them and got different bits of money [Kim, Grade 6: 52].*

> *Funding has come mainly from myself and from charities. It's come from drug companies in the UK, not here in Jersey. I've had some from companies here [in Jersey] some of the law firms and the banks have actually funded courses for me as well [Lucy, Grade 5: 26].*

Similarly, another point of significance was that an equal number of community nurses (32%) resigned themselves to the fact that they would have to fund their own CPE; which is what nurses on the island of Catanduane are required to do to retain their licence to practise (Ogalesco, 2006):

> *The clinical supervisor came over [to the island], but that was an added cost because I had to pay for their flight, time and hotel – huge costs. I never allow myself to think how much it cost me, because it was vast [Angela, Grade 6: 62].*

> *[Speaking of a work colleague] she actually paid for herself, which I thought was quite sad, one degree module was £500, the other was £700 [Bella, Grade 6: 460].*

> *The self-funding cost probably in excess of about £4,000, as the actual module was based in Oxford [Bridget, Grade 5: 18].*

Despite the limited financial capital available, the Charity funded just over a third (36%) of community nurse CPE undertaken by the research participants:

> *It was identified that I needed further education to get to degree level. Since then the Charity has funded the modules towards this [undergraduate] degree [Hannah, Grade 6: 12].*

> *One [particular] training I attended was very unique and it cost the Charity £2,000 to get me on the residential course in the UK [Mary, Grade 6: 22].*

One of the pivotal messages that came from the research participants was the strong feeling voiced around their inability to access CPE via the Charity:

> *Personally I feel that I give one hundred per cent and more, and I feel that I do deserve training and I do feel that I don't receive it [Chris, Grade 5: 56].*

> *It feel demotivated because there isn't enough [CPE], my morale goes down … and I'm very angry that I've had to do all that [fund raising for CPE] myself [Lucy, Grade 5: 30].*

> *I feel like I am going down the [promotion] ladder rather than up … I feel I am being penalised for not having a [specialist] degree [Emily, Grade 4: 102].*

Moreover, the lack of employer investment in these employees had led to feelings of lack of self-worth:

> *I was upset, but I felt definitely undervalued [by the Charity] as if everything I had done didn't count [Kim, Grade 6: 82].*

> *I actually felt very, very, negative and very undervalued … for nobody to see my potential [Bridget, Grade 5: 46].*

> *Very disappointed [at being told that funding for CPE was being withdrawn]. I feel very let down … now I'm just stagnant and not worth anything [Lily, Grade 4: 14].*

Researchers have previously identified other organisational barriers to CPE, such as heavy workload (Spencer, 2006), staff shortages (Sheperd, 1995), lack of protected study time (Davey & Robinson, 2002; Hardwick & Jordan, 2002; Dowswell, Bradshaw & Hewison, 2000), and discrimination of part-time staff (Kelly, Berridge & Gould, 2009; Levett-Jones, 2005; Nolan et al.

2000). These were also reported as factors either preventing Jersey nurses undertaking CPE or making it very difficult:

> *There is so much [CPE] I would like to do and I can't do,*
> *and I think that is to do with being a part-timer [Angela,*
> *Grade 6: 82].*

> *I've found getting the time off [to attend CPE] difficult …*
> *eventually I was allowed three days but the rest I had to*
> *take as holiday [Kim, Grade 6: 80].*

> *It's quite stressful going away [to attend CPE] … knowing*
> *that your work is building up 'cause there's nobody else to*
> *do it for you [Lucy, Grade 5: 24].*

Within the UK NHS, funding for community nurse CPE is provided locally by Local Education and Training Boards (LETBs) (DH, 2012b), with decisions to fund an episode of formal education informed by a PDP following staff appraisal.

<u>Staff Appraisals and Personal Development Plans</u>
Similar to the NHS, personal appraisals were carried out on an annual basis (DH, 2004b). However, due to staff shortages and the emphasis on client care, this has now been revised down to every three years unless requested earlier by the staff member. Personal Development Plans (PDPs) were written in conjunction with the line manager and sent to the Education and Development Co-ordinator for progression. Nurses commented that their experience of annual appraisal was far from positive:

> *I think that's why the nurses lost heart with the PDPs,*
> *because they were never looked at [Bella, Grade 6:268].*

> *It feels as though we get offered what's available rather*
> *than what we have identified we require in our PDP*
> *[Mary, Grade 6: 22].*

On my first appraisal, when I was 42, I was told that at my age they couldn't see me doing anything else other than working part-time on twilight, and so there was no need for me to do any further CPE because they couldn't see me doing any other job [Bridget, Grade 5: 18].

Research undertaken in private care homes in a large city in the North of England identified that nurses working outside the NHS had similar difficulties accessing appraisals (Aoki & Davies, 2002). Following appraisal staff nurse Nicola recounted having an item recorded on her PDP for several consecutive years that was never accomplished:

Undertaking risk assessment training was identified during my appraisal, but it never materialised. So though I have a professional interest in it, I've never developed it academically [Nicola, Grade 4: 14].

Some nurses working in the private sector identified a general lack of information about CPE provision in their local geographical area (Aoki & Davies, 2002), making it difficult to ensure that opportunities for professional development are undertaken (Crisp, 2005).

Educational Opportunities

In his seminal work *'Continuing Learning in the Professions'*, Houle (1980) discovered that 15% of a professional workforce is made up of laggards, who show a high resistance to learning with resultant skill deterioration. Two (13%) of the nurses in this study revealed that although they had undertaken CPE since qualifying, they felt there had been no opportunity to access CPE whilst in the employment of the Charity and were very keen to share their experience:

As far as [the Charity] goes I can honestly say … apart from mandatory training, I've done virtually nothing [referring to CPE] since I've been here [Chris, Grade 5: 20].

I wish we were offered more [CPE]. I mean I'm not quite sure in what, but I just wish I had the opportunity to develop myself a bit more [Liz, Grade 4: 66].

Prior research into the experiences of other nurses has identified a number of situations that resulted in a lack of opportunity to undertake CPE such as: attitudes of colleagues and managers (Gopee, 2003), work commitments (Richards & Potgieter, 2010) and time constraints (Spencer, 2006). Chris gave several reasons for a lack of involvement in CPE:

When I came to the Charity initially I wanted to do a degree in palliation, but I have found it very difficult to access it. I did speak with the CEO [Chief Executive Officer] about it and was assured that it would be no problem whatsoever. It appears it was just empty promises [Chris, Grade 5: 22].

Roles like mine are very hard to get back-filled. Nobody wants to act across, nobody wants to fill your shoes and you tend to sort of think that doing CPE is too much trouble [Chris, Grade 5: 36].

Managers have been identified as gatekeepers to accessing CPE (Tame, 2009; Gould, Drey & Berridge, 2007) but also have the ability to block a member of their staff from undertaking work related CPE:

And the worse thing about it is that nobody cares. The management in the Charity, they really don't care if I do CPE or not [Chris, Grade 5: 40].

I've got to say that my manager did not want me to do [the certificated training course], but I did it in my own time anyway [Alice, Grade 6: 14].

Having nearly completed 4 years [of Level 6 modules] it didn't take that much for me to stop my studies. It was purely because there was no encouragement from my manager [Bridget, Grade 5: 22].

Nurses employed in the private sector had previously identified a lack of information with regard to CPE opportunities (Aoki & Davies, 2002) and was reflected in this research. Many nurses working for the Charity were unaware of the undergraduate modules available via the Education Department at the General Hospital, even though these modules were advertised within the HSS nurse development prospectus available online (HSS, 2013a). This web page was only available to staff whilst at work as it is located on the Jersey HSS intranet and was therefore unavailable from a home computer:

The way of accessing good quality training is the first thing that comes to mind, because good quality training isn't generally available on the island in my perception [Mary, Grade 6: 20].

I've worked at the hospital and I didn't know that they offered degree modules; I've only just found out because you told me [Chris, Grade 5: 126].

The Charity offered a yearly timetable of both mandatory training and other developmental education. Initially, there was no prospectus indicating what training might be accessible on island, however I instigated this during the course of the research. The Charity focused on the delivery of continuing professional development (CPD) as this could be delivered on-island by in-house trainers or Specialist Nurses, keeping the cost of education to a minimum:

It's hard when you're doing an appraisal on a member of staff and you've got nothing to offer them apart from mandatory training [Bella, Grade 6: 96].

I think we need a more stringent and effective appraisal system. We look at the needs of the staff, we write them down on paper and then that's it. It's a paper exercise [Chris, Grade 5: 102].

In fairness the only training I've had from [the Charity] is CPD. I've asked for money to go off island for CPE and I have been turned down on several occasions [Lucy, Grade 5: 24].

The formation of LETBs in the UK reflects the need to facilitate the uptake of new healthcare technology in the NHS by bringing health, education and research sectors together (DH, 2012a). Alongside these technological advances, the DH has charged HEE to improve the quality of healthcare by ensuring that the workforce has appropriate values and behaviours (DH, 2013b).

Healthcare Culture

The island has recently undertaken a public consultation to propose a new model for health and social care in Jersey in order to cope with the increasingly ageing population (SoJ, 2011). Any level of cultural change in health care takes a long time to become embedded, as people feel strongly about local provision for their well-being and consider changes with suspicion (Arbuckle, 2013). Therefore the actions of the islanders as well as that of health care workers shall be considered.

Jersey HSS Department is currently advocating a change in the delivery of health care, with the recommendation that more patient care takes place within the community (SoJ, 2012a). The White Paper '*Caring for Each Other, Caring for Ourselves*' identifies a surfeit of GPs for the island population and is proposing to introduce health service delivery by a wider multi-professional team, including nurses (SoJ, 2011). Despite the best efforts of local government to update Jersey healthcare services, there is resistance to the changes:

126

We had the idea of introducing early discharges from the acute ward into the community. Took that idea to [the acute ward], presented the whole project to them … and vocally they seemed very supportive. When it came down to [implementing] it the complete thing was a disaster [Hannah, Grade 6: 32].

Needless to say, GPs are also resisting the implementation of the White Paper (SoJ, 2012a) as they feel that their role within the healthcare service is being eroded (Arbuckle, 2013). The Charity's Senior Management Team agreed that developing Nurse Practitioners in the near future was highly unlikely, as it would pose a financial challenge to the local GPs [Manager's Focus Group: 80]:

I found it very difficult when I came here to work. We didn't take bloods and we don't take blood pressures – we were restricted by the GPs [Bella, Grade 6: 151].

The way the doctors lead and manage the care over here, it's a very medical model. What they say goes. The nurses are expected to be handmaidens to the doctors. [Hannah, Grade 6: 56].

Some of the aspects of the job are really frustrating, such as the GPs doing the [childhood] vaccinations, when there's nurses that could be doing it so much cheaper [Alice, Grade 5: 90].

In small developing islands, nurses often report working beyond the remit of their initial nurse education, undertaking tasks for which they have not been sufficiently trained (Berteloot, 2004; WHO, 2001; Landon, 1981). In comparison, Jersey community nurses participating in this research reported de-skilling and under-utilisation of their nursing expertise:

There are a lot of skills that I have lost: phlebotomy, flushing chemotherapy lines – so there is an element of de-skilling that has occurred, which is a bit scary. Similarly with some of the symptom control around End of Life Care, I used to remember the drugs and their side effects but now I can't recall them [Lisa, Grade 6: 142].

It was just so disappointing because I was so excited about doing this training course. I haven't been able to cascade this training to colleagues due to the lack of a co-trainer, which is a necessary part of the course [Mary, Grade 6: 54].

I felt I had a lot of skills and knowledge; especially for how to put research into practice, which nobody here wanted to know about. I had an awful lot of skills in bed management, but nobody wanted to know what I had. It was almost seen as a threat [Bridget, Grade 5: 46].

Patients and their families within one specialist area of healthcare were also unsure about the changes to service provision, choosing to circumvent the system to suit their needs:

The clients ring us up, ask us to go out and do a visit and tell us what their concerns are. But they almost want the reassurance of a doctor anyway. Then they go to the [hospital] ward directly [Hannah, Grade 6: 36].

Over here clients go directly to their [Specialist Doctors]. They have their personal mobile numbers. They have their personal secretary's number. They really do have a much more direct route and a direct access to them [Hannah, Grade 6: 40].

Correspondingly, the managers' focus group came to a concensus about the uniqueness of island culture, identifying that when islanders feel poorly they expect to be seen by a doctor or a consultant [Managers' Focus Group: 294]. Moreover, the findings demonstrate that these Jersey nurses perceive they are losing their nursing skills and are under-utilised, in comparison to healthcare workers in remote islands who reported working beyond their professional remit (Chen, 2007; Ogalesco, 2006; Berteloot, 2004). Also, the private nature of the healthcare service in Jersey allowed for patients to have personal contact numbers for their hospital doctors, a situation not normally found within the NHS.

Workplace Culture

Despite being bound by the NMC post registration and education for practice (PREP) requirements (NMC, 2010a), not all nurses embraced the concept of undertaking CPE for professional development. As previously identified in figure 5.1, the workforce can be described as 'ageing' with 54% of qualified nurses working for the Charity aged over 50 years. During the focus group discussions, senior managers agreed that they would not be happy to spend the education budget on CPE for nurses over the age of 50 since this would not be considered 'value for money' [Managers' Focus Group: 45]. This overt ageism is not widely reported in the existing nursing literature and is reflected in comments made by the research participants:

I felt very negative and very undervalued, … especially the comments about being too old at 42 [Bridget, Grade 5: 46].

I think age is a very definite disadvantage. I do think when you are older you don't receive as much training because it's seen as a waste of resources [Chris, Grade 5: 54].

Well at my age … I don't think I'll get the chance to do it [CPE]. I would have liked to [Nicola, Grade 4: 26].

Senior nurses could identify fellow workers who were just coasting to retirement:

> *Within our organisation there are a lot of people who are exhausted, burnt out, disappointed with life [Angela, Grade 6: 82].*

> *We've got people here who've been in the same job for twenty-five or thirty years and they're so stale, set in their ways and so antiquated, just waiting for retirement [Chris, Grade 5: 162].*

Many nurses employed by the Charity completed their initial nurse training when it was the State Registered Nurse qualification and expressed negative thoughts about the obligation to continually keep updated:

> *The way I'm feeling at the moment, there's no way I'd want to pick up a book or start writing an essay [Lisa, Grade 6: 24].*

> *You feel like you're constantly on a treadmill … and you can't get off [Lucy, Grade 4: 38].*

> *I haven't progressed since my certification as a State Registered Nurse [Nicola, Grade 4: 22].*

The managers' focus group discussed their concerns that in the quest for new knowledge nurses might forget the basics of their profession [Managers' Focus Group: 13]. One respondent reflected these thoughts:

> *I find some colleagues very negative, and in a conversation this morning two other nurses were saying there was no need for Specialist Nurses to have a degree [Bridget, Grade 5: 48].*

A perceived lack of team working within the Charity was identified by respondents who referred to working in silos, whereby barriers between teams resulted in nurses working against each other (Lencioni, 2006) to the detriment of client care. This was identified by all grades of staff, representing all divisions of the Charity:

> *We're working in silos … just blinkered. This is my little bit [of nursing practice] and your bit doesn't matter. Whereas the whole picture is it all matters, because we all have an impact on everyone [clients and colleagues] in what we do [Lisa, Grade 6: 54].*

> *One of the main things that gave me enormous frustration is the lack of communication between the hospital and primary care nurses that are actually delivering the care [Sam, Grade 5: 28].*

> *The communication side of things is an absolute minefield. There is no system within [the Charity] where everybody can tap in and know who is involved [in client care], so we know who to direct information to [Margaret, Grade 4: 145].*

A small body of international nursing literature revealed that nurses working on islands are being developed in order to undertake enhanced healthcare roles (Dean, 2012; Buenconsejo-Lum, 2007; Usher et al. 2004; WHO, 2001), whereas this research found a lack of investment in the professional development of Jersey community nurses, which informed the extant knowledge of island-based nurse CPE. Furthermore, due to the limited number of qualified nurses living on the island and the small number of student nurses being educated locally, the Charity advertises nurse vacancies in the nursing journals and regularly recruits nurses from the UK. Nurse participants viewed this in both positive and negative terms. Alice, Chris and Emily were positive about the possibility of new knowledge changing practice:

We've had quite a few staff in from England and it's implied that they're quite dynamic. And it's wonderful 'cause they're up to date. It's really difficult if you've been here a long time, because the only reason we're not dynamic is we haven't been invested in [Alice, Grade 5: 20].

We've got a very new person at the moment, which is a breath of fresh air. Just yesterday at our staff meeting she made a suggestion that made everyone sit up, and we sat there thinking, "wow let's look at that" [Chris, Grade 5: 150].

There is a new person coming [from the UK to work for the Charity] who has the Community Degree and the opportunity to learn from them will be great [Emily, Grade 5: 56].

However, for Jersey born Lily, these UK nurses represent the lost opportunity to undertake District Nurse training and develop her nursing career:

They'd rather be getting District Nurses from outside [the island] instead of [training up] locals [Lily, Grade 4: 92].

Unlike some small islands that are concentrating on developing their existing nurses by encouraging CPE (WHO, 2001), the Charity adopted the practice of trying to employ nurses from the UK who already have the community nursing skills required. This lack of opportunity to develop professionally could have an adverse effect on the nurses' attitude towards CPE.

<u>Attitude Towards CPE</u>

The decision to undertake CPE is influenced by colleagues, managers and other professionals working in the local health service (Tame, 2009; Gopee, 2003; Alejandro, 2001):

> *I must admit it's been better since the current Grade 6
> joined the team. They're more conscious of the need for
> education and supportive of CPE [Chris, Grade 5: 70].*

> *You have to go through your line manager [to access CPE]
> and you think, "oh, forget it, just carry on and do your job"
> [Emily, Grade 4: 98].*

Employees when newly appointed to the Charity could not understand the attitude of some qualified nurses, but subsequently appreciated how the heavy workload, (Munro, 2008; Bahn, 2007b) staff shortages (Sheperd, 1995) and limited funding for CPE (Nalle, Wyatt & Myers, 2010; Richards & Potgieter, 2010) can have a detrimental effect:

> *Old style nursing – you just get on with it, don't make a
> fuss. I never had the feeling of satisfaction with a job well
> done. I just had a level of anxiety all the time [Angela,
> Grade 6: 30].*

> *I do think it does grind you down. When I first came here
> I looked at some of these people and thought "how can
> you be like that?" Three years down the line I know
> [Chris, Grade 5: 132].*

> *That's the problem of an island isn't it? We're so small,
> limited resources in terms of staff. I've been told several
> times I can't be released [to attend CPE] because the
> service can't run without me [Lucy, Grade 5: 24].*

Those participants attending the managers' focus group did concede that within the Charity access to CPE lacked parity [Managers Focus Group: 54], a theme declared by a significant number of participants and a distinctive finding within this research:

So it's one rule for one, and one rule for another. Sometimes one person is on a course and a few months down the line they're off on another [Kim, Grade 6: 110].

I do think that the availability of some of the training isn't distributed fairly. I sometimes think that there is favouritism in place when some of the courses are offered [Alice, Grade Grade 5: 20].

I just feel that when it comes to education certain people within the Charity seem to get lots of courses. Others don't seem to get any education; they're just left to get on with it [Lucy, Grade 5: 72].

Notwithstanding the seemingly negative attitude towards CPE from some colleagues and managers, the majority of community nurses who took part in this research were committed to participating in CPE, as sanctioned by the NMC (2010a).

Getting Underway with CPE

The motivation to undertake CPE, personal skills required, and barriers that prevent formal study from taking place have been widely reported (Schweitzer & Krassa, 2010; Yfantis, Tiniakou & Yfanti, 2010; Tame, 2009; Gould, Drey & Berridge, 2007; Chiu, 2005; Gopee, 2003; Ryan, 2003; Stanley, 2003; Davey & Robinson, 2002; Hardwick & Jordan, 2002; Friedman, Davis & Phillips, 2001; Nolan et al. 2000; Dowswell, Hewison & Hinds, 1998). The following section investigates this from the perspective of geographically isolated island-based community nurses employed by a charity, something that could not be located in the literature.

Lack of skills for academic study

It is reported that nurses are largely unprepared with the necessary study skills required to enter CPE (Ellis & Nolan, 2005). The lack of academic ability of the community nursing workforce was acknowledged during the

managers' focus group [Managers' Focus Group: 103] and is borne out by the research participants:

> *We need more Level 4 courses for staff like myself that have been qualified a long time [Alice, Grade 5: 14].*

> *You're embarrassed … to admit that you need certain skills … it is frightening [Margaret, Grade 4: 56].*

> *I did the module … at Level 4 because not having any recent academic development I could not have accessed it at Level 5 [Nicola, Grade 4: 28].*

Having already admitted to possessing an ageing workforce, it is apparent to management that their employees lack computer skills [Managers' Focus Group: 111], which was also acknowledged within these research findings and an important element of island-based CPE where distance learning or e-learning courses are accessed:

> *My husband's computer skills were better then mine so he did a lot of tidying up of my paragraphs and things like that [Angela, Grade 6: 66].*

> *I've taught myself how to use the computer, because my computer skills were minimal when I joined [the Charity] [Liz, Grade 4: 14].*

> *I didn't have a computer at home, so unless I could access [one] at work I felt helpless [Nicola, Grade 4: 16].*

Previous research identified a lack of proficiency in computer skills as detrimental when participating in formal education (Doyle, 2006), nonetheless this did not curb the community nurses' motivation to undertake CPE.

Motivation

The research participants gave both personal and professional motivations for undertaking CPE, illustrated in Figure 5.6 below.

Figure 5.6 Motivators for CPE
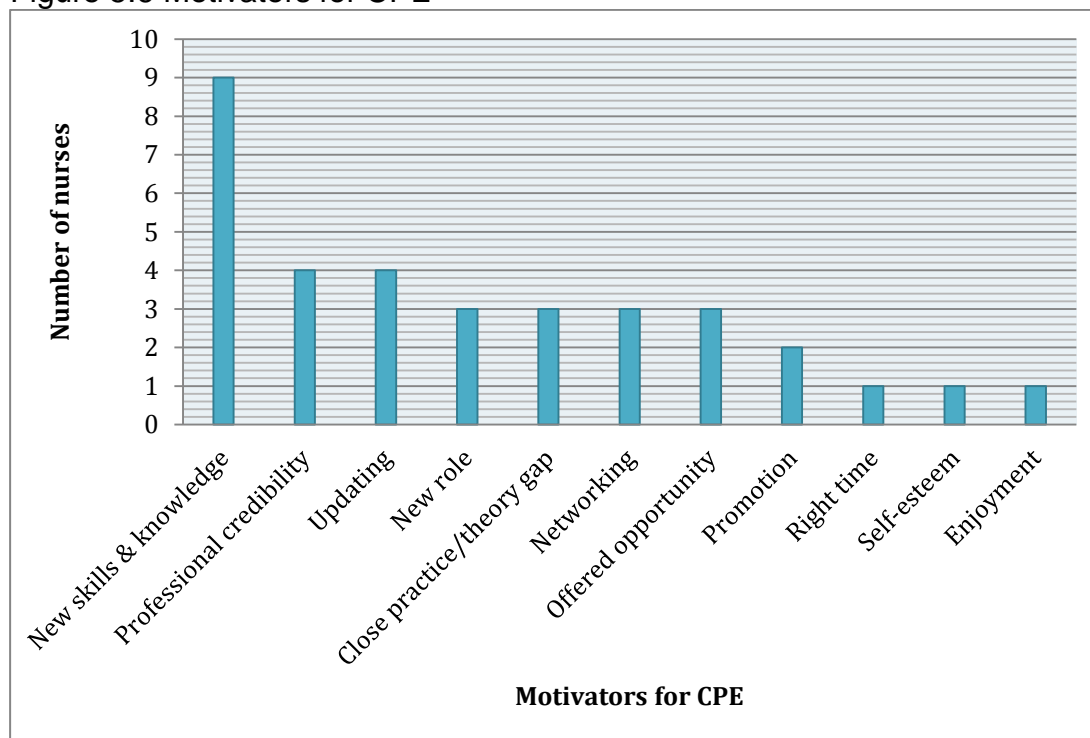
Personal motivation for embarking on CPE (Spencer, 2006) was indicated by just two community nurses who self-funded their studies:

> *It would be a huge boost to one's self-esteem to end up*
> *with a MSc [Angela, Grade 6: 34].*

> *I do enjoy it … and I do enjoy the challenge of the course*
> *as well [Margaret, Grade 4: 42].*

As identified in previous community nurse research into lifelong learning (Banning & Stafford, 2008) the majority of respondents cited that gaining new skills and knowledge motivated them to undertake CPE:

> *When I finished my district [nurse training] I wanted to*
> *then go on and do further qualifications [Kim, Grade 6:*
> *32].*

For training related to my actual [community nursing] I would say that most of it has been self-motivated. I did a drug and alcohol course, which comes in handy when dealing with clients in our job [Alice, Grade 5: 14].

I have tried to change my own practice by ensuring that I do go away [off island] to do a course [Lucy, Grade 5: 46].

As reported elsewhere within nursing (Tame, 2009; Ellis & Nolan, 2005; Gopee, 2003; Stanley, 2003; Hardwick & Jordan, 2002), several of the nurses identified that their motivation for participating in CPE was the professional need to keep up to date with developments in their area of expertise:

[Going away to the UK] really opens your eyes to what is actually going on and the changes in [specialist area] that we're not privy to over here [Lucy, Grade 5: 48].

To me [CPE] is probably the most important way of keeping up to date and being aware of current research [Emily, Grade 4: 10].

During the years I accumulated quite a lot of short [ENB] courses in relation to my nursing needs [Nicola, Grade 4: 14].

Two nurses were single parents and highlighted the importance of having a secure career as reported previously (Tame, 2009; Gopee, 2003; Hardwick & Jordan, 2002), and took every opportunity to put themselves in the position for promotion:

I set myself on the road of getting some extra qualifications to make myself more marketable [Sam, Grade 5: 18].

> *I would like to do a module at Master's level because
> ultimately I would like to further my career [Emily, Grade
> 4: 16].*

Closing the practice / theory gap (Bahn 2007a; Dowswell, Hewison & Millar, 1998) was the driving force to undertake CPE for two respondents, who qualified as nurses before nursing entered higher education:

> *I wanted to then go on and do further qualifications and
> hence the reason I did the conversion [course] [Kim,
> Grade 6: 32].*

> *I was able to pursue the … [modules] and finish my
> degree. [Bridget, Grade 5: 26].*

The opportunity of CPE sponsorship by the Charity was the necessary motivation for two research participants:

> *I managed to get on [a management course] because two
> of the other Grade 6s didn't want it [Bella, Grade 6: 26].*

> *I was awarded a higher [job] grade … and I needed
> further training to degree level to work within that role
> [Hannah, Grade 6: 12].*

Driven by the rapid changes in healthcare and the White Paper '*Caring for Each Other, Caring for Ourselves*' (SoJ, 2011), some community nurses relished the opportunity of enhancing their job prospects by undertaking CPE (Richards & Potgieter, 2010). However, family support was deemed necessary to facilitate success.

Making Headway with CPE

The majority of research participants had undertaken some form of CPE and relished any support that facilitated the passage of their journey. Previous research, indicated below, highlights the importance of both family support

and academic support from the higher education institute. However, workplace support was not mentioned by any of the respondents, a distinctive finding on CPE for nurses employed in the charity sector. Conversely, nurses in the UK employed by the NHS did experience some level of help from work colleagues (Tame, 2009; Gopee, 2003).

Family support

As reported in previous studies (Tame, 2009; Stanley, 2003; Alejandro, 2001), the nurses welcomed family support whilst undergoing their CPE journey, as without it they would find studying difficult:

> *My husband was very supportive in all sorts of ways …*
> *with his computer skills … and putting [our son] to bed*
> *[Angela, Grade 6: 66].*

> *My husband was very understanding. He would look after*
> *my son when I was away and my parents did as well. So,*
> *actually, it was a big family event [Bridget, Grade 5: 38].*

> *I do have a very supportive family, my husband's quite*
> *keen for me to study, bettering myself as it were [Lily,*
> *Grade 4: 24].*

However, even with family support, modern day living is fraught by disruptions and uncertainty (McNair, 2009), with community nurses requiring university support if they are to succeed in the unfamiliar world of academia.

University support

The respondents in this research found that academic support from the university was mixed; with distance learners finding the lack of assistance particularly challenging, a significant finding in relation to island-based nurses who are more likely to undertake their CPE via this mode of delivery:

Doing my dissertation [distance learning] with [university in the South of England] was not a good experience; I didn't get good support at all [Angela, Grade 6: 16].

I felt as though there isn't much support … but I suppose that is because it's distance learning. It's quite difficult when you do find yourself getting stuck and wanting more information [Hannah, Grade 6:18].

The [university] tutors were so supportive. In fact, money was built in so that my personal tutor could come and visit me on the island [Bridget, Grade 5: 30].

Not all nurses consider themselves as 'academic' (Tame, 2009) and deem family support as vital for success in their CPE studies. Research undertaken in the UK revealed that the pressure of family commitments has the potential to cause nurses to abandon their formal studies (Bahn, 2007a). Nonetheless, following a successful episode of CPE there is the assumption (RCN, 2002; Audit Commission, 2001) that nurses have gained knowledge enabling enhanced patient care (Dh 2012a; Willis, 2012).

Knowing the Ropes Following CPE

As stated within *The NMC Code of Conduct* (2008c) it is the duty of nurses to keep their knowledge and skills up to date throughout their working life. This ensures the nursing workforce remains flexible, coping with new and pioneering techniques necessary for improving patient care (DH, 2012a). Indeed, research undertaken within community nursing revealed the importance of CPE for accepting new innovations in healthcare and maintaining job motivation (Banning & Stafford, 2008). It is generally acknowledged that nurses consider they are more knowledgeable following a period of formal education (Tame, 2009; Bahn, 2007a; Adriaansen, van Achterberg & Borm, 2005; Considine, Botti & Thomas, 2005; Smith & Topping, 2001; Wildman et al. 1999), and the research participants echoed this.

Personal outcomes following CPE

Previous research (Cotterill-Walker, 2012; Tame, 2009; Stanley, 2003; Johnson & Copnell, 2002) has observed that participants believe they are more self-assured following CPE, with Angela (Grade 6) and Staff Nurses Emily and Lily stating that they felt more confident. CPE also had the ability to improve the general mood and professional outlook:

> *The whole thing [CPE] impacts on you in a positive way, makes you feel happy in what you're doing, especially when you feel valued [Alice, Grade 5: 24].*

The findings above indicate that these research participants had developed personally following an episode of formal education, with this increase in confidence and self-esteem influencing their professional growth (Cotterill-Walker, 2012).

Professional outcomes following CPE

Earlier research has commented on the importance of sharing new knowledge with work colleagues (Hogston, 1995). However, as reported by Gopee (2002), and more recently by Tame (2009), the perceived attitudes of management and co-workers can be forbidding and is not mentioned in current island-based nurse CPE research:

> *It didn't really change anything with management. You can go to them with your ideas and they used to keep telling me 'you've got to walk before you can run' [Bella, Grade 6: 74].*

> *It's very hard sometimes, although you've got the evidence and you can prove that it's the best way forward, changing people's attitudes and actual practice is quite difficult [Kim, Grade 6: 102].*

> *I think with certain colleagues you won't change their mindset, they just won't change [Margaret, Grade 4: 56].*

Some participants just preferred to be used as an information source by their colleagues, perhaps not wanting to 'show off their knowledge' (Schuller, 2000b, p. 231):

> *I don't like to consider myself an expert, but I certainly get used as a reference point. I get 'phoned at home [for advice] [Bridget, Grade 5: 54].*

> *When people know you've been on a course they approach you for advice and support [Alice, Grade 5: 48].*

> *We have patients who have problems with their stomas. Generally the colleagues in my team are quite good and so I feel able to suggest that they try [various] things [to alleviate the problem] [Lily, Grade 4: 50].*

The existence of a theory / practice gap is well documented within nursing literature and may thwart the transfer of newly acquired knowledge regarding healthcare research into practice (Maben, Latter & Clark, 2006; Gallagher 2004).

Change own practice following CPE

Although the remit of CPE is to increase one's knowledge, this does not always translate into a change in nursing practice (Lee, 2011; Tame, 2009; Griscti & Jacono, 2006; Spencer, 2006; Hardwick & Jordan, 2002), with some nurses unable to use their CPE. Both Alice (Grade, 5) and Emily (Grade, 4) identified that pressures of work prevented them from using the new skills obtained during formal education for the benefit of their patients. However, some respondents felt they were able to use their newfound knowledge within their area of practice:

> *I use the knowledge from the course to inform my time management, budgeting and getting the best out of my team. I found it does make me a better team leader [Bella, Grade 6: 86].*

> *What I've done so far in my course has enabled me to develop local policies in relation to my specialist area of practice [Hannah, Grade 6: 26].*

> *I have been able to use my interview techniques when doing patient consultations and getting information from patients [Sam, Grade 5: 38].*

Whilst the philosophy behind CPE is the development of personal and professional skills (DH, 2012b; NMC 2010a), there is an expectation that qualified nurses will share their knowledge with colleagues (NMC, 2008b; Pelletier, Donoghue & Duffield, 2003) and act as mentors to pre-registration nursing students (NMC 2010b).

Change colleagues practice following CPE

Whilst earlier research indicates that line managers can have a detrimental effect on positive changes in nursing practice (Lee, 2011; Cooley, 2008; Hardwick & Jordan, 2002; Jordan, 1998), this was not the experience of some of the nurses in this research:

> *I've been able to bring ideas … to present to the team, and we consider how could we make this work over here [in Jersey] [Hannah, Grade 6: 32].*

> *I would say that CPE has influenced our practice quite a lot, because we've now introduced a care pathway [Bridget, Grade 5: 52].*

> *It becomes easier to change others' practice when you are in a senior role. You are the immediate line manager of people and can actually challenge practice [Sam, Grade 5: 50].*

However, it was acknowledged that the process of change management was not something that could be rushed:

I introduced [change] gently. You can't just go storming in with all these ideas from the course and say 'we'll work this way'. So with my team I was able to introduce change gradually without them noticing it [Bella, Grade 6: 73].

If you just drip feed [the information], … gradually they'll come around [Lucy, Grade 5: 54].

The information is filtered down, drip, drip. But I think change is like that sometimes. But I think now we're moving forward. But it's slow. A very, very slow process [Nicola, Grade 4: 78].

As highlighted in earlier studies (Tame, 2009; Ellis & Nolan, 2005) some senior practitioners within this research were frustrated by their inability to bring about practice changes following an episode of CPE:

I do try [to influence my colleagues] and occasionally I stop trying, because it's like hitting your head against a brick wall [Angela, Grade 6: 88].

What has been very, very, frustrating is the inability to implement basic kind of initiatives where I can see things going wrong [Sam, Grade 5: 38].

It has been recognised that the practice environment can be influential as a determinant of change (Tame, 2009; Ellis & Nolan, 2005; Gopee, 2003; Stanley, 2003). In some instances the respondents were frustrated by their inability to instigate changes due to influences within their work setting:

I think it's very difficult [to change colleagues' practice], because nobody listens to each other. Everybody is desperate to get their views heard; they want to be understood [Angela, Grade 6: 88].

It is fairly easy to encourage change within your own team. Bit harder with other teams because you're not always in daily contact with them [Lisa, Grade 6: 44].

Not a great deal of change has happened because we're just too small a team. There are not enough nurses on the ground and the work has to be done [Emily, Grade 4: 54].

Some studies have asserted that resistance to change in nursing practice may be due to professional jealousy between colleagues (Tame, 2009; Davey & Robinson, 2002; Hardwick & Jordan, 2002; Nolan et al. 2000), and referred to by some respondents in this study:

I think that changing the practice of other nurses is difficult. I've been around for a few years and nursing has always been an area where there is non-stop change. It's a continual thing but there are still some people who find it very difficult [Kim, Grade 6: 148].

It's trying to create an environment where nurses share the same values or have the same vision and are working towards the same aims. That's quite difficult … because we're integrating new staff that have different practice experience. It's trying to change practice from that point of view. It's a challenge, but an enjoyable challenge because it was on our territory [Sam, Grade 5: 54].

Sometimes it can bring up negativity, because you tread on other people's toes and in other people's areas. Sometimes it's a bit difficult to manage how you approach things with colleagues. They get very protective of their own areas. And yeah, some of it's been positive and some of it's been negative. But I think now we're moving

forward. But it's slow. Very, very slow process [Nicola,
Grade 4: 78].

Notwithstanding the various obstructions within the workplace, such as the practice environment or professional jealousy that can be construed to impede the application of formal education to practice, the main aim of CPE is to improve patient care (DH, 2013b).

Improved patient care following CPE
The difficultly in proving that CPE directly affects patient care has already been stated (Chapter 2), with only three research studies located that reveal tangible results (Considine, Botti & Thomas, 2005; Aiken et al. 2003; Considine, Ung & Thomas, 2001). Nevertheless, nurses claim that nursing practice improves following CPE (Lee, 2011; Aitken et al. 2008; Davey & Robinson, 2002), perceiving an improvement in patient care (Griscti & Jacono, 2006). Similarly, community nurses within this study felt that they were able to deliver a higher standard of care after participating in an episode of formal education:

> *I've done some discharge planning and have managed to*
> *get together a funded package of care for a client [with*
> *complex care needs] to be discharged into the community*
> *[after spending two years in hospital] [Hannah, Grade 6:*
> *36].*

> *It actually helps tremendously in how you view families*
> *that have got these difficulties. To be less judgemental,*
> *and it's not so shocking if you've done training and*
> *understand a little bit more about how people get to the*
> *stage in their lives where they're using substances [Alice,*
> *Grade 5: 40].*

> *One lady is enjoying life again. She was housebound and*
> *couldn't go out, as her leg was weeping and malodorous.*
> *Now she is going back to church and out for meals with*

her family. Her leg is practically healed and she's not in
pain [Nicola, Grade 4: 58].

This positive impact on client outcomes following CPE would seem to indicate that continuing education was improving healthcare practice within community nursing.

Chapter Summary

This chapter offers a synopsis of island-based community nurses' experiences of accessing and attending formal education, including subsequent exploration of post-education outcomes. The descriptions presented by research participants reveal similarities within the existing CPE literature. Nevertheless, some narratives have extended the knowledge relating to the experience of community nurses based on a geographically isolated small island, revealing information that could not be located in the current nursing journals.

These Jersey-based community nurses identified 'undercurrents' obstructing their ability to participate in formal education. Nurses stated that working on a remote small island caused professional isolation, creating difficulties in keeping up to date with the most current nursing practice and an inability to network with colleagues on the mainland. Although these findings are similar to those faced by nurses working in developing small islands (WHO, 2001), the nursing literature lacks reference to this in relation to community nursing on small, developed islands.

The lack of university, coupled with limited local access to undergraduate modules meant one third of respondents travelled to England to take degree courses, incurring resultant travel and accommodation costs, as well as causing family disruption. Current literature on the plight of other island-based community nurses is lacking, although there is reference to similar findings for nurses in rural and remote areas (Penz et al. 2007), therefore the findings of this research are significant. Furthermore, the healthcare infrastructure is unique to the island, with the hospital functioning similar to one in the National Health Service. However, the general practitioner service

is not free, with patients incurring a charge each time they visit their doctor. District nursing, health visiting, school nursing and the community paediatric service is provided by the Charity*;* part-funded by the local government and supplemented by charitable donations. Respondents felt that the charitable status of their employer restricted the finances available to them for CPE. Therefore, these findings are relevant to other nurses who are employed by charities.

The healthcare culture revolves around an island with a surfeit of general practitioners, who are not allocated by geographical area but are the patients' choice (SoJ, 2011). The Jersey Health and Social Services Department is currently changing the delivery of health services, proposing to provide more nurse-led community care (SoJ, 2012a). However, according to the respondents, the medical profession is proving resistant and continue to undertake what are considered as 'nursing tasks' (SoJ, 2011). Therefore, unlike their colleagues in small developing islands who are working beyond their professional remit (Berteloot, 2004; WHO, 2001; Landon, 1981), the research participants feel de-skilled and under-utilised. This role erosion in Jersey community nursing is a unique finding within island-based nurse research and potentially de-motivating, giving little incentive to participate in continuing education.

The small developing islands are training local nurses to provide healthcare services (WHO, 2001) to the indigenous population. However, due to the lack of trained nurses available on the island, the Charity often employs nurses from the UK; this tends to trigger mixed feelings from Jersey nurses who feel side-lined. Incoming nurses are hailed by management as 'innovative' and 'dynamic', and this may result in a workforce of demotivated local nurses who feel 'under-valued' and 'second-rate'. Table 5.1 clearly indicates that Jersey trained nurses are restricted by a 'glass ceiling' with very few achieving promotion beyond staff nurse (Grade 4), resulting in strained relationships between local nurses and UK nurses. Professional rivalry was manifest between the Specialist Nurses and District Nurses, with nursing teams reporting that they are working in silos (Lencioni, 2006).

Whilst highlighted in perioperative nursing by Tame (2009), these findings have not been reported previously in island-based community nursing.

The ageing community nurse workforce is apparent in Jersey (Figure 5.1), as it is elsewhere (Watson, Andrews & Manthorpe, 2004). However, the ageist attitude of the Charity evident in not funding CPE for nurses over the age of 50 was illuminating; leading to almost a third of respondents self-funding their CPE or else securing sponsorship from outside agencies. Whilst self-funding CPE is not unusual, having to secure outside funding to undertake formal education has not previously been reported in the community nursing literature. Within the Charity access to education was not seen as equitable, with respondents claiming favouritism and managers conceding that the process lacked parity. As reported elsewhere, ageing nurses posses limited academic skills, having trained before nursing entered higher education (Ellis & Nolan, 2005), and lack adequate computer skills, both necessary for successful academic study.

As revealed in prior research (Tame, 2009; Spencer, 2006; Gopee, 2003; Stanley, 2003; Hardwick & Jordan, 2002), the respondents were motivated to engage in formal education for personal, professional and practice related reasons. Nevertheless, a strong narrative developed surrounding the perceived lack of CPE on offer by the Charity, with 10 of the 16 participants relating the negative feelings this evoked. Other barriers to accessing continuing education relating to heavy workload, staff shortages, lack of protected time and discrimination against part-time employees is recorded elsewhere (Kelly, Berridge & Gould, 2009; Spencer, 2006; Levett-Jones, 2005; Davey & Robinson, 2002; Hardwick & Jordan, 2002; Dowswell, Bradshaw & Hewison, 2000).

As demonstrated in earlier studies (Tame, 2009; Stanley, 2003; Alejandro, 2001), respondents welcomed support offered by family whilst participating in formal education. There were mixed reports from participants in relation to assistance offered by the university, with those participating in distance learning least satisfied. A noteworthy revelation of this research was the lack of support from colleagues or the Charity in relation to nurse CPE adding to

149

the extant knowledge on nurse CPE. Nurses reported that they felt more confident following successful completion of education, able to share their new-found knowledge with colleagues and alter their practice in light of what they had learnt; and these findings compare to the current nursing literature. As previously demonstrated (Tame, 2009; Davey & Robinson, 2002; Hardwick & Jordan, 2002; Nolan et al. 2000), and reiterated in this study, professional jealousy between colleagues can impede the dissemination of good nursing practice.

The following chapter will expand upon key findings in more depth, exploring the significance for community nurses on the island. In particular, the 'undercurrents' affecting the ability to access CPE will be the main focus of the discussion.

CHAPTER 6: DISCUSSION OF RESEARCH FINDINGS

IPA involves a double hermeneutic process; whereby the participant attempts to assimilate an insider's account of events (Larkin, Watts & Clifton, 2006), whilst the researcher's reflection upon fieldwork observations and research journal entries assist in the interpretation of the findings during the writing up stage, leading to a deep analysis of the data (Bainger, 2011). Thus, the final analysis is the joint product between the participants and the researcher (Smith, Flowers & Larkin, 2009). The analysis of findings was informed by the following conceptual theories: lifelong learning, human capital and social capital. What follows is a discussion of the research findings in accordance with my research questions as identified on page 2 and with reference to themes, sub-themes and sub-sub-themes identified in Table 5.2 and discussed in Chapter 5:

1) To establish the community nurses perceptions of CPE and its relevance to practice.
2) To investigate the types of CPE accessed by geographically isolated community nurses.
3) To explore the community nurses' personal experience of CPE.
4) To discover how each community nurse develops their professional knowledge and practice.

Undercurrents Affecting CPE

Small Island

Small islands are limited by physical size, economic ability and restricted population (Royle, 2001), which all enhances the effect of 'islandness' (Baldacchino, 2004, p. 272). The definition of a small island has already been explored in Chapter 3. However, further to this, Bray (2011, p. 40) indicates an island with a population of less than 100,000 is classed as the 'smallest of the small'. The 2011 census revealed the current population of Jersey to be 97,857 (States of Jersey Statistics Unit, 2012, p. 5), thus indicating potential difficulties in island administration (Raadschelders, 1992) when trying to establish and sustain a health service comparable to the UK NHS. Healthcare provision for small populations is not cost effective (Royle, 2001) with the 2011 review of Jersey's Health and Social Services confirming

that it costs more to provide health and social care services to the island compared to similar service provision in England (KPMG, 2011). One of the major challenges for the island is lack of economies of scale (Bray, 2011), whereby the local general hospital exists to service a population half the size of a similar district hospital in the UK (SoJ, 2011). This has the resultant effect of employing more healthcare staff relative to the population size in order to provide out of hours cover, thereby raising the cost of service provision (Gould & Moon, 2000). The Jersey Government is currently redesigning health provision with a view to increasing the care delivered in community and primary care settings necessitating nursing staff to work in enhanced roles (SoJ, 2012a). Community nurse CPE is implicit in achieving this goal.

Geographical Isolation

Lily commented on feeling 'cut off' from the mainland, whilst Margaret asserted the notion of getting off the island as being a 'big thing'. Both of these nurses are islanders who undertook their nurse training on Jersey, and have only accessed CPE via distance learning or by e-learning. Islands can be identified as 'unique' due to their geographical location, whereby remoteness, isolation and peripheral location in relation to the mainland present constraints for islanders (Dodds & Royle, 2003; Royle, 2001). Consequently, nurses on some islands are deemed to be at significant disadvantage in terms of ongoing professional development due to their geographical separation from regional universities (New Zealand Nurses Organisation, 2010). Nevertheless, not all island nurses are isolated from mainland higher education institutes, with strong links identified between the Western Scottish Isles and the main university campus sites in Scotland (Boyd, 1998). Jersey community nurses have no higher education connections, although the General Hospital Education Centre plans to commence a Degree in Nursing in collaboration with a UK university in the autumn of 2013 (Mesny, 2013, personal communication).

Nevertheless, the major obstacle highlighted in this research was geographical in nature due to the increased cost of course fees (SoJ, 2013b); limited CPE funding by the Charity; cost of travel (Royle, 2001); and

disruption to family life due to travelling off-island (Adami & Kiger, 2005). Figure 5.5 highlighted funding issues in relation to community nurses obtaining financial support for CPE, with just under a third of community nurses self-funding. Bridget spent in excess of £4,000 towards completing her degree and Kim paid over £3,000 for CPE in one year. This is a similar situation to nurses who work in UK private care homes where the manager or owner is reluctant to spend money on formal education (Aoki & Davies, 2002). Nonetheless, this does cause inequality within the Charity with those having to self-fund likely to participate in professional education choosing topics that personally appeal with little or no regard as to whether it would be of benefit to their employer (Tame, 2009). This could have implications for the proposed implementation of the White Paper (SoJ, 2012a), whereby community nurses may not have the skills and knowledge necessary to develop the service appropriately.

Professional isolation

It has been acknowledged that the limited number of local specialists hinders the development of expertise on small islands (Chittoo, 2011); with Sam voicing concerns regarding lack of access to colleagues in training hospitals and Angela finding it difficult to escape the feeling of professional isolation. Nurses working in isolation on the Orkney Islands concur, stating that the main challenge is to maintain professional skills, which they achieve via teleconferencing colleagues to discuss problematic cases (Dean, 2012). Research undertaken by the World Health Organisation (WHO) considers the extended roles undertaken by nurse practitioners on Pacific islands, concluding that it is difficult to arrange CPE but essential if remote health workers are to keep their skills updated (WHO, 2001). The improvement in human capital that occurs as a result of continuing education is more readily achieved when linked to social capital (Schuller, 2000a). Attendance at conferences and Specialist Nurse forums builds the bonding social capital that exists within homogenous groups (Field, 2005), aiding the transfer of informal knowledge and practice (Royal, 2012).

The remoteness of Jersey nurses from UK colleagues and universities appeared to hinder their ability to participate in lifelong learning and

subsequently enhance their professional development. Kim had difficulties getting time off work to present at an international conference, whilst both Lucy and Nicola were unable to attend their Specialist Nurse regional forum meetings, which were held in the UK. The isolation of nurses from expert support has been cited as a barrier to the application of research in clinical practice (Birks et al. 2009), with consequent lack of practice development. Research into rural nursing revealed that professional isolation prevents networking with colleagues to discuss new treatments and evaluate its effectiveness (Beatty, 2001). More recent research discovered that 85.7% of rural nurses cited geographical remoteness as the biggest barrier to CPE (Curran, Fleet & Kirby, 2006), with innovative solutions required to reduce professional isolation (Richards, Farmer & Selvaraj, 2005), in order to ensure that nurses who work in extended roles maintain patient safety (Penz et al. 2007). Whilst Jersey residents have stated the need for more primary care nursing (SoJ, 2012a), community nurses may be unable to retain their competencies due to a lack of access to the latest research and practice innovations. Challenges are highlighted in the Jersey Government's plan for an improved and efficient health service (SoJ, 2012a). Moreover, ensuring the professional development of community nurses is not mentioned, yet this could have a great impact on its success or failure.

Types of CPE Accessed by Community Nurses

Local CPE

Whilst most of the literature on nurse CPE focuses on university-based education (Tame, 2009; Bahn, 2007; Evans et al. 2007; Dearnley, 2006; Spencer, 2006; Ellis & Nolan, 2005; Gopee, 2003; Armstrong & Adam, 2002; Barriball, 2002; Davey & Robinson, 2002; Hardwick & Jordan, 2002; Smith & Topping, 2001; Whyte, Lugton & Fawcett, 2000), only Sam and Emily spoke of their experience in undertaking local studies. The Education Department at the General Hospital is spoken of in favourable terms, with access to continuing nurse education on the island considered as quite a revelation. The chance to enrol locally on to a Degree in Clinical Practice appealed to community staff, as similar to other island nurses, not all are prepared to travel off island to further their professional knowledge (Adami & Kiger, 2005). This reluctance to leave the island for CPE may be due to family

commitments as identified by Nicola, or due to the financial constraints of course fees and associated travel and accommodation costs highlighted by Kim and Lucy. Only a third of participants accessed CPE locally.

CPE in the UK

Unlike their Maltese counterparts (Adami & Kiger, 2005) almost a third of Jersey nurses were prepared to travel to the mainland for formal education, with both Mary and Angela accessing CPE this way. Angela received no financial support from the Charity and experienced such limited academic assistance from university tutors that it was necessary to employ a clinical supervisor at great personal expense in order to achieve the Master's degree. Whilst Mary was financially supported by the Charity, the experience of participating in an intense residential course was described as unpleasant due to a recent bereavement that was not acknowledged by the Charity.

Research participants related that travelling to England to access CPE involved added transport and accommodation expense (Curran, Fleet & Kirby, 2006). Also, as Baldacchino (2005) asserted and confirmed by Kim and Bridget, journeys that involve crossing water can be affected by airport or ferry disruptions, having a negative impact to accessing CPE on the mainland. One must also consider that not all nurses are good travellers, with Bridget confessing to a fear of flying. Thus, geographical location is an important factor in accessing CPE with nurses in remote locations penalised by the added costs of degree modules, transportation and accommodation (Gumm, 2007).

Distance learning

The lack of infrastructure on some small Pacific Islands leads to the adoption of distance learning as a preferred method of accumulating academic credit post-registration (Buenconsejo-Lum, Maskarinec & Palafox, 2007). Likewise, since 2004 Jersey has been delivering the Diploma in Nursing using distance learning methods with placements provided locally (Tickle, 2010). Both Hannah and Margaret had enrolled onto distance learning courses as a means of fulfilling their professional development, with Hannah requiring a degree to lead and develop a specialist community nursing team. This

approach to CPE is seen as a solution to distance, time and the ability to attend classes (Richards, Farmer & Selvaraj, 2005). However, the remoteness from tutors and lack of classroom support can leave students feeling isolated and demotivated (Black & Bonner, 2011); as identified by Hannah, and also Angela who wrote her dissertation whilst living in Jersey. Nurses in the Scottish Isles have adopted a supported distance-learning package with a local tutor offering one-to-one guidance and support (Boyd, 1998). If distance learning continues as a chosen means of accessing CPE in Jersey, then the adoption of a similar support mechanism would be beneficial. Moreover, the development of web conferencing, and the potential it brings to facilitate face-to-face contact with university lecturers, may serve to ensure that distance learning becomes a more supportive method of accessing CPE on the island.

e-learning

For isolated island-based or rural nurses information technology (IT) may seem the perfect answer to accessing CPE (Carroll et al. 2009; Maxwell, 2009). Whilst this offers the flexibility of access to higher education there is an expectation by the HEI that students would possess prior knowledge of IT use and ease of access (McVeigh, 2009). Both Lily and Liz undertook learning online and did not report any difficulties in successfully completing the e-learning module. However, whilst e-learning is seen to support lifelong learning and develop employees' knowledge, not all nurses have the necessary computer skills. Hylton (2005) reveals that nurses are reluctant to develop their IT skills with as many as 53% of nurses lacking computer proficiency. Having identified that 54% of Jersey community nurses are over 50 years of age, this method of CPE may require the enhancement of their technological expertise if it is to be a viable option for the future. Nevertheless, nursing is a 'hands-on' occupation, with NMC requirements for 50% academic and 50% practical experience to qualify as a Specialist Community Public Health Nurse (SCPHN) (NMC, 2004), rendering e-learning as an unsuitable means of delivery. Supernumerary status is also a requirement and may pose difficulties for a small workforce that is already working at full capacity.

Chris and Liz wished to share their experiences of a lack of provision and access to CPE. Unlike the 'laggards' referred to by Houle (1980), these participants were keen to undertake CPE but due to family constraints (Liz), heavy work commitments and lack of staff to back-fill the role (Chris), opportunities to participate were not forthcoming. Whilst one may regard family commitments outside of the Charity and time management as personal issues, the participants were clear that perceived staff shortages impeded their CPE opportunities. CPD in the form of mandatory training was accessed, so Chris and Liz were able to keep some aspects of their practice up to date, but felt unable to develop professionally. This perceived lack of investment in human capital by the Charity had led to a 'them and us' culture, with newly appointed UK trained nurses viewed in a negative light by some nurses who have worked on-island for some time.

Travel Issues

Islands are viewed as penalised due to their small size and separation by water (Gould & Moon, 2000), with the presence of the sea intensifying the sensation of being cut-off from the rest of the world (Péron, 2004). The difficulty with leaving Jersey is compounded by the inconvenient water crossing, which is expensive and impacts on accessibility to services (Royle, 2001), such as higher education institutes. For some islanders travel is impeded by the infrequency of the airplane or ferry (Berteloot, 2004), whilst for others the weather is identified as a force to be reckoned with, as wild and unpredictable seas particularly prevalent within the winter months leave travellers exhausted (Landon, 1981). Nonetheless, we are challenged by Hay (2006) to consider if islands are vulnerable or resilient, and to contemplate whether islanders are uniquely creative when faced with the aforementioned problems of island living.

Due to lack of tertiary education provision on Jersey (Royle, 2001) just under one third of participants (31%, n=5) accessed Level 6 and Level 7 Degree modules in the UK. The geographical situation of the island requires participants to fly to the mainland in order to attend university for the taught element of their course (Gould & Moon, 2000). Kim highlights that time spent

travelling is not comparable to a student in the UK, as flights often do not arrive in time for a morning lecture, resulting in having to fly over to England the night before and pay for overnight accommodation. Similarly, Bridget's taught sessions often did not finish in time to travel back to Jersey the same day, leading to an overnight stay before catching the early morning flight back to the island and going straight into work. Thus, the distance and cost of travel coupled with the cost of accommodation economically disadvantages Jersey nurses who endeavour to participate in CPE in the UK.

Island Infrastructure

As is common with other small islands the diseconomy of scale has a knock-on effect to the development of local services such as higher education. Jersey lacks a resident university, and since the island does not contribute to UK tax, islanders are charged a higher 'island student' rate for degree studies, with annual fees up to £19,292 (SoJ, 2013b). Within the island there is limited attention to the development of tertiary education, with the local Further Education College offering foundation, undergraduate and postgraduate degrees aimed at the finance industry, building sector, and childcare providers (Highlands College, 2013). However, this does not meet the CPE needs of qualified nurses who need to undertake 35 hours of *Post Registration Education for Practice* (PREP) every three years to remain on the NMC register (NMC, 2010a). Whilst these 35 hours of PREP can be achieved through formal and informal learning, many Jersey community nurses wished to commit to higher education undergraduate degree modules to bring their professional qualification in line with that of their peers. Therefore, the lack of tertiary education on the island impedes the ability of local nurses to extent their professional knowledge and skills, which may in turn hinder the development of community nursing practice.

The Education Centre at the General Hospital offers a limited number of undergraduate degree level modules to qualified nurses in conjunction with a university in the South of England. However, a new alliance has been forged with a university from the North of England with experience of delivering the pre-registration Degree in Nursing to the Isle of Man. It is envisaged that this will offer a greater access to CPE for Jersey nurses. Availability of an

academic library is limited to the resources held within the General Hospital, with associate membership to the Further Education College allowing access to some relevant literature. On-line access to a university library was available, however this was associated with being enrolled on a degree pathway and therefore only accessible to nurses who were undergraduate students. Investment in tertiary education is essential for successful participation in the knowledge economy (Crossley, 2011) and failure to do so could impede the professional development of qualified healthcare employees.

Island Health Service

In the UK the Coalition Government published *Liberating the NHS: Developing the Healthcare Workforce* (DH, 2012a), focusing on the need to produce a flexible healthcare workforce. The proposed investment by the NHS in its human capital was aimed at improving the health of the nation. This was formalised by the development of HEE and local LETBs (DH, 2012b) to ensure that investment in healthcare education and ongoing CPD remained clearly focused on an adaptable workforce, which would be responsive to innovation and new technologies (DH, 2012a). The Jersey health service, whilst identified as 'relatively comprehensive' (KPMG, 2011, p.3), lacks a similar all-inclusive island-wide healthcare workforce planning policy. Therefore, within Jersey healthcare provision there could be the possibility of a lack of 'joined up thinking' in relation to the CPE/CPD of nurses required to fulfil the requirements of the White Paper, *Caring for Each Other: Caring for Ourselves,* with its focus on community care (SoJ, 2012a).

As highlighted in Chapter 1, the health service in Jersey is shaped by the UK National Health Service model (SoJ, 2011) but with some major differences. Secondary care is delivered free of charge at the Jersey General Hospital, with all other provision delivered by the private sector or charities (KPMG, 2011). The Jersey Health and Social Services White Paper (SoJ, 2012a) revealed a lack of seamless provision on the island and this was backed up with the experience of five research participants. Hannah, Lisa and Sam, all senior nurses involved in the co-ordination and delivery of complex care, confirmed the lack of cohesion in relation to service delivery for their clients.

Emily acknowledged a shortfall in service to one particular client group, with Bridget developing a new service to alleviate the inequality in provision for 'End of Life' patients. In the fight to ensure an equitable service for their clients, community nurses may be neglecting their own professional development, which may ultimately affect the quality of community nursing delivered in the future.

Due to the previous lack of nurse training on Jersey and the lack of appeal of nursing as a career (Davey & Robinson, 2002) the island has relied heavily upon UK trained nurses to make up the majority of the healthcare workforce (Tickle, 2010), as their high quality training makes them sought after internationally (Royal, 2012). However, in a response to the recent economic downturn, government-led pay freezes in Jersey has caused discontent amongst nurses, many of whom were no longer able to afford to live on the island (Sprinks, 2012). One factor is the prohibitive cost of housing, with the average value of a one bedroomed flat estimated at £224,00 and a three bedroomed house costing on average £477,000 (States of Jersey Statistics Unit, 2013, p. 4). The Jersey General Hospital has experienced difficulties in recruitment and retention, resulting in the re-introduction of pre-registration nurse training via distance learning in 2004 (Tickle, 2010). The training of District Nurses and Specialist Community Public Health Nurses was also possible on-island via a Scottish University distance learning degree. However, a reduction in human capital and subsequent loss of knowledge and expertise had occurred due to the recent retirement of a District Nurse Practice Teacher (Covell, 2008), which may hinder the development of community nurses locally.

Professional Rivalry

Fragmentation of health services has resulted in specialised divisions of labour within modern healthcare (Finn, 2008), challenging the bridging social capital (Field, 2005) that existed between health workers. Activities previously undertaken by UK GPs are now the responsibility of Specialist Nurse Practitioners, which in some instances has led to professional rivalry (Wilson, Pearson & Hassey, 2002). Compared to the UK, which has on average 68 General Practitioners (GPs) per 100,000 people, Jersey has 90

GPs (SoJ, 2011) servicing a population of 97,857 (States of Jersey Statistics Unit, 2012). In an attempt to modernise Jersey healthcare and move away from medicalised and institutionalied models of provision (SoJ, 2011), the service is being developed focusing on care delivery in community settings (SoJ, 2012a). However, for this to take place GPs are tasked with relinquishing some of their services such as health promotion and chronic disease management to nurses (Laurant et al. 2009). Whilst this has taken place within isolated British islands such as the Scilly Isles and the Orkney Islands in Scotland (Dean, 2012), this research suggests that local doctors are currently feeling professionally undermined (Arbuckle, 2013). Limited bridging social capital between the professions was expressed as uncooperative behaviour, as illustrated by some GPs refusing to collaborate with Hannah and Lisa.

Working for a charity

Jersey is unique in that community nursing is provided by a local charity that was established over one hundred years ago (McNeela, 2007). The Charity receives a large sum of Jersey government money annually to deliver all aspects of community care such as: health visiting, paediatric community nursing, school nursing, district nursing and specialist nursing services for long-term and complex conditions (The Charity, 2011). These services are agreed with the States of Jersey HSS under a service level agreement (SLA), but within this the funds for professional development and CPE are not identified or indeed linked to workforce development as they are in the UK (Health Education South West, 2013).

The Charity has a governance department where the education and development team was located. However, monies made available for nurse CPE have been diminishing annually in response to the recent economic financial crisis (O'Connor, 2010). Kim, Alice, Lucy, Lily and Nicola expressed concerns regarding the reduction in the Charity's education budget, viewing it as problematic and necessitating self-funding should they wish to participate in CPE. Prior research into the private sector has revealed a lack of access to funding making it difficult for nurses to participate in CPE (Aoki & Davies, 2002). Munro (2008, p. 958) explores the 'charity paradigm', investigating

nurses' negative perceptions about lack of employer support for CPE. In particular, 29% of rural nurses expressed a concern about the lack of finance for professional development (Penz et al. 2007). This short-sightedness in the development of human capital could risk a lower-skilled workforce, making the forthcoming changes to the Jersey health service harder to instigate. This adoption of the 'charity paradigm' (Munro, 2008, p. 958) by the Charity has tested community nurses' resourcefulness in obtaining funding to pursue professional development.

With the Charity only funding 36% of formal education undertaken by community nurses, ten research participants expressed very strong feelings about their perceived inability to access CPE through the Charity. Lily and a staff nurse on Bella's team were disappointed at the lack of professional development opportunities available within the workplace, with an apparent lack of managerial commitment to nurse CPE causing resentment amongst nursing staff and confirming previous findings (Hardwick & Jordan, 2002). Three other staff nurses expressed negative feelings with Margaret disillusioned by the lack of CPE availability, Emily feeling that she was going down the promotional ladder, and Nicola wishing she had been offered more developmental opportunities during her career. Lack of CPE opportunities resulting in a demoralised nursing workforce has been identified in previous research (Drey, Gould & Allan, 2009; Barriball, While & Norman, 1992) and may be responsible for nurses leaving the profession (Sheward et al. 2005; Barriball, While & Norman, 1992). Table 5.1 indicates that Jersey trained nurses rarely attain above Grade 4 (staff nurse) within the Charity and this failure to invest in local nurses may be causing professional rivalry within the nursing teams, potentially impacting on the delivery of community nursing services.

Nurses with Grade 5 and 6 posts were equally upset at the paucity of formal education on offer, causing Kim (Grade 6) to consider holding back all the extra input she gives to the Charity as she is feeling so undervalued at the lack of funding for CPE (Royal, 2012). Likewise, Bridget does not feel valued due to the short-sightedness of the Charity in its failure to support degree studies and not utilise the skills and knowledge already attained (Cotterill-

Walker, 2012). Chris, who has not received any CPE since commencing employment in the community, expressed that professional commitment should be rewarded with sponsorship on formal courses. Finally Lucy, one of the Specialist Nurses who procured funds by writing to outside agencies, expressed anger at this being the only way to fund CPE. The Charity's perceived lack of investment in nurse CPE was causing very strong feelings amongst qualified employees, and may be fuelling the silo mentality that already exists within the Charity (Lencioni, 2006).

Previous researchers have revealed other organisational barriers to CPE, such as heavy workload (Yfantis, Tiniakou & Yfanti, 2010; Banning & Stafford, 2008; Spencer, 2006) with Specialist Nurses Kim and Lucy both acknowledging that due to the specific nature of their work others would not take on their caseloads resulting in a build-up of work whilst they were absent (Halcomb, Meadley & Streeter, 2009). Staff shortages have also been exposed as another barrier to formal education (Watkins, 2011; Schweitzer & Krassa, 2010; Banning & Stafford, 2008; Sheperd, 1995) with Lisa describing a diminished workforce due to employees leaving the Charity for employment elsewhere. Part-time nurses were discriminated against in relation to accessing CPE (Kelly, Berridge & Gould, 2009; Levett-Jones, 2005; Nolan et al. 2000) with Alice and Angela denied the opportunity of undertaking CPE due to the nature of their work contract. Thus, organisational factors can have a profound effect on the ability of qualified nurses gaining access to formal education (Gopee, 2003), a situation exacerbated by the recent financial constraints and efficiency cuts within the health service (O'Connor, 2010).

Within the Philippine Islands qualified nurses are required to self-fund in order to fulfil their annual professional requirements (Ogalesco, 2006), whilst Maltese nurses assert that the state should be responsible for funding nurse development (Adami & Kiger, 2005). Likewise rural nurses identify a lack of economic investment in their professional development (McCoy 2009). Due to the limited funding available, only 36% of nurse participants employed by the Charity received funding for CPE, and in the Hannah's case this was directly related to service provision. Kim acknowledges that keeping updated

is a professional responsibility, however Lucy indicated the need for the employer to make more financial capital available for CPE. Nicola mentioned the excessive cost of trying to study for a degree whilst living on the island and Lily had the unfortunate experience of having the promise of financial backing rescinded by the Charity. The sparse funding available for community nurse CPE and the lack of investment in workforce development has the potential of restricting the progression of primary care services, which in turn may well serve to impede the States of Jersey's vision and plans for future healthcare delivery (SoJ, 2012a).

Some Jersey nurses were in the fortunate economic position to afford self-funding their CPE. However, Angela was obliged to fund the cost of employing a clinical supervisor due to lack of support whilst undertaking a Master's degree on the mainland. The cost of Bridget's undergraduate studies amounted to over £4,000. This self-funding indicates the high motivation of these nurses towards their personal and professional lifelong learning. However, those without such personal finances had not forsaken the possibility of CPE and had written to local charities and businesses asking for sponsorship

Staff appraisals and personal development plans
The Charity had adopted the NHS annual appraisal system (DH, 2004a), but a three yearly model now superseded this. Justification for this change in staff monitoring had been the lack of time available to senior staff due to other work commitments. Effective appraisals are considered good employment practice as they evaluate the nursing contribution to the organisation and encourage a clear understanding of the role played by nurses (RCN, 2009b). The NHS relies upon nurse employees 'possessing and applying the knowledge and skills required for effective performance' to deliver excellent patient care (The NHS Staff Council, 2010, p. 2). This monitoring of the nursing workforce against the *Knowledge and Skills Framework* six core dimensions facilitates the production of personal development plans to ensure CPD improves patient outcomes (DH, 2004c). Therefore, by opting to undertake nurse appraisals less frequently, the Charity may be unable to monitor the human capital of its employees against

the required standard of knowledge and skills necessary for improved client care.

Within the private sector the number of appraisals completed was 50%, but some employees work for many years without ever having the opportunity for their role to be evaluated (Aoki & Davies, 2002). It is also unclear as to whether appraisals and subsequent personal development plans (PDPs) are designed to meet the needs of the practitioner or the service (Berridge, Kelly & Gould, 2007). Hence, the Charity's decision to change the appraisal system to once every three years may indicate a lack of employer commitment to investment in human capital and subsequent workforce development, underpinned by lack of financial support. This may have a knock on effect, such that CPE needs are not readily identified thereby restricting the professional development of community nurses.

Eductional opportunities

Some nurses working within the private sector (Aoki & Davies, 2002) and those employed in rural communities (Curran, Fleet & Kirby, 2006) lacked information about CPE opportunities. Within the Charity posters were circulated to the nursing teams at the beginning of each year to inform nurses about forthcoming mandatory and in-house training. As previously reported in Chapter 5, a Grade 5 nurse in charge of a District Nurse team was unaware of the degree modules on offer at the General Hospital and so was unable to cascade this CPE information to staff nurses. These modules were advertised on the local government website (HSS, 2013a). However, this was a secure website only accessible via a workplace computer and cannot be accessed from home. Therefore, whilst CPD was openly advertised within the Charity, participants experienced limited access to information regarding CPE due to constraints in their working day restricting the time available to search the Jersey Health and Social Services webpage.

As identified in Chapter 2, neither CPE nor CPD are considered as a more effective means of improving knowledge and skills (Houle, 1980). However, a graduate nurse workforce is considered to facilitate the management of complex skilled care within a rapidly evolving healthcare system (DH, 2012a;

Willis, 2012).   Nevertheless, employers tend to favour CPD as a means of developing nurses, as it is often delivered in-house and is less costly than formal education (Cooley, 2008; Bahn, 2007a, Adami & Kiger, 2005; Gopee, 2003; Audit Commission, 2001).   The compilation of an annual timetable of mandatory training offered by the Charity consisted of topics delivered in-house by Specialist Nurses, along with basic life support and first aid training delivered by outside agencies.   This is similar to the Maltese experience, where nurses are offered CPD such as infection prevention & control or intravenous drug therapy training (Adami & Kiger, 2005).   Such CPD does develop human capital, enhancing nurses' roles and extending nursing practice in the community (DH, 2012a), thus fulfilling some aims of the White Paper (SoJ, 2012a).   This approach to nurse development is considered more economically viable for a small organisation with limited finances (Lawton & Wimpenny, 2003), such as the Charity, however it may not deliver the advanced practice and critical thinking skills required by community nurses to provide complex care (Cotterill-Walker, 2012).

Healthcare Culture

With its Norman history, French influence and British loyalty the island of Jersey has a diverse mixture of cultural heritage (Johnson, 2010).   Jersey's distinctive individuality is important, with the Jersey Government stating *'that we need to preserve, enhance and promote our unique cultural identity'* (SoJ, 2009, p. 31).   Due to its small size and insularity, Jersey society exhibits a relatively robust social cohesion (Hampton & Christensen, 2002), with inhabitants strongly integrated into island living (Spinaze, 2008).   Moreover, islanders celebrate their unique sense of islandness and identity within the British Isles via artwork and imagery (Johnson, 2010), with local structural symbolism such the General Hospital (Arbuckle, 2013), an outward sign to the world of the care provided to the islanders from the local government.

As a result of the diseconomies of scale many island health services struggle to deliver the appropriate level of healthcare in the insular setting, with patients requiring specialist and emergency treatment evacuated to the mainland for appropriate care (Royle, 2001; Gould & Moon, 2000).   A review of Jersey's health system revealed poorly integrated services, with privately

delivered primary care and low intensity support in the community (KPMG, 2011). In response to this review, Jersey's Health and Social Services Department has set out initiatives to improve and update local healthcare provision (SoJ, 2012a). In spite of this, Hannah comments that her clients are circumventing the system in ways to suit their needs. Moreover, government initiatives are often difficult to implement when set against a back-drop of 'cultural chaos', resulting in a strong and sustained resistance to changes (Arbuckle, 2013, p. 64). As Hannah reports, whilst medical personnel within the hospital support implementation of an early discharge scheme from acute care, they have appeared so far to resist implementing this change. This suggests that medical personnel as well as the general public are fearful and anxious about the changes in healthcare resulting in failure to comply with new procedures (Arbuckle, 2013).

Current models of healthcare within the island are more medicalised and institutionalised compared with other jurisdictions (SoJ, 2012a). Similar to rural doctors, Jersey GPs are highly involved in the health and social needs of their patients (Richards, Farmer & Selvaraj, 2005). However, as indicated by Bella and Hannah, Jersey GPs undertake tasks that could be considered nursing duties, such as administering childhood vaccinations and routine blood pressure monitoring. Traditionally the medical profession has undertaken an undisputed leadership role in patient care, although this is considered inappropriate in today's complex healthcare system (Cowie, 2005). Thus, it may be asserted that changing the model of healthcare provision failed to impact on the power and status of doctors (Baxter & Brumfitt, 2008), something that this research seems to confirm.

Bridging social capital within Jersey healthcare professionals appears compromised as rapport between community nurses and primary care doctors on the island was called into question, with Hannah relating that contact between some GPs and the Specialist Nursing Team was minimal. This was also reflected in recent research exploring interprofessional relations in healthcare, which revealed that clinical decision making remained firmly under medical control (Churchman & Doherty, 2010). Lisa, a Senior Sister in charge of a community nurse team, was unable to engage with

some GPs to collaborate over client issues, since they do not consider liaising with community nurses as part of their remit. This devaluation of nursing knowledge and the nurse role would seem to verify medical hegemony of the decision-making process in healthcare (Coombs & Ersser, 2004), confirming doctors' social and cultural dominance of other health service professionals (Allsop, 2006). Despite evidence that nurses can deliver as high quality care as primary care doctors and achieve good health outcomes for patients (Goodman et al. 2010; Laurent et al. 2009; QNI, 2009), current medical barriers appear to hinder the professional development of Jersey community nurses.

Nurses in small developing islands report working beyond the remit of their initial nurse education, undertaking tasks for which they have been insufficiently trained (Berteloot, 2004; Usher et al. 2004; Beatty, 2001), whilst nurses in the Scottish Isles adopted advanced practitioner roles (Dean, 2012; Richards, Farmer & Selvaraj, 2005). However, in complete contrast to this situation, Jersey community nurses report de-skilling and under-utilisation of their nursing expertise. Senior nursing sister Lisa comments on loosing phlebotomy skills and an inability to competently flush chemotherapy lines, whilst Bridget voices the frustration of not putting her research knowledge into practice. The surfeit of primary care doctors along with strong medical dominance of the island healthcare system combines to sustain the community nurse in a subservient role (Bourgeault & Mulvale, 2006; Willis, 2006), functioning within a restricted and more task-orientated framework (Markaki et al. 2006). Unless this culture is challenged locally, primary care nurses may be demotivated with regards to undertaking CPE, thereby sustaining the medical model of healthcare currently in place in Jersey and failing to bring about the proposed changes in service delivery (SoJ, 2012a).

Workplace culture

The average small island dependency, such as Jersey, is an immigrant society reliant upon an imported labour force (McElroy & Pearce, 2006). This is confirmed in the 2011 Island census indicating that only 46% of the resident population were Jersey born, 33% identifying themselves as British, 8% considered themselves to be Portuguese or Madeiran, 3% from Poland

and the remaining 10% are 'Asian', 'Black' or classify themselves as 'mixed race' (States of Jersey Statistics Unit, 2012, p. 13). Micro-territories such as small islands with populations of less than one million often suffer from a lack of available skilled workforce (Baldacchino, 2002). This is certainly the case in relation to the shortage of qualified nurses available for employment in Jersey, exacerbated by the lack of pre-registration nurse training on the island prior to 2004 (Tickle, 2010). Nevertheless, there is difficulty in attracting UK nurses working within secondary care to relocate to Jersey (Nursing Times, 2011), although primary care has been more successful in attracting District Nurses, Health Visitors and School Nurses to come and work on the island (see Table 5.1).

Islanders often perceive that nurses from the mainland possess high quality training, knowledge and skills (Royal, 2012), and are considered very employable by the Charity, especially as it is more economically viable than training local employees. However, the resultant lack of professional development opportunities for local staff nurses such as Emily and Lily, coupled with the influx of UK trained nurses taking up Grade 5 and 6 vacancies within the Charity, appears to be attributing to dysfunctional teamwork within the community nursing workforce with minimal bonding social capital apparent. Lisa and Alice remarked that teams within the Charity were all working in their 'little silos', referring to 'turf wars' leading to the waste of resources as employees fight unwinnable battles with people who should be their colleagues (Lencioni, 2006). This was described by Lisa referring to the struggle in eliciting change in nursing practice due to fragmentation within the service.

Bella, Alice, Sam, Emily and Margaret identify communication difficulties with outside agencies due to the lack of integration between Jersey Health and Social Services and the Charity (SoJ, 2011), having a negative impact on the bridging social capital (Field, 2005). The struggle of Jersey healthcare professionals to define their boundaries has led to each health worker operating within silos ensuring members have experiences and values in common (Hall, 2005). However, Finn (2008) warns us that teamwork is often fraught with conflict and struggles between competing sets of interest within

a group work situation, exacerbated by infrequent formal education limiting promotion opportunities (Chittoo, 2011). This current lack of integration and silo working will need addressing across primary care, secondary care, the various charities and private organisations if the proposed Jersey health service is to provide a seamless healthcare service in the future (SoJ, 2012a).

Attitude towards CPE

Demographic structures of resident island populations tend to be dominated by older age groups (Gould & Moon, 2000). However, Jersey is the exception to this with only 17.7% (n=17,291) of people over retirement age and two thirds (n=64,365) of working age (States of Jersey Statistics Unit, 2012, p. 8). The NHS has an ageing workforce, with a growing proportion of nurses over 50 years and a declining population of nurses under the age of 30 years (Joseph Rowntree Foundation, 2003). The demographics of the UK nursing workforce indicate that 65.4% of Registered Nurses are over the age of 40 years (NMC, 2008c). It has been recognised that community nurses tend to be, on average, older than their counterparts in acute services (Watson, Andrews & Manthorpe, 2004) and Jersey was no exception to this with Figure 5.2 showing that 87% of the Charity's workforce was over the age of 40 years. A further breakdown of UK figures reveals that 25% of District Nurses, 29% of Health Visitors and 24% of Community Staff Nurses were aged over 50 years (Watson, Andrews & Manthorpe, 2004). In comparison the Charity's workforce consisted of 81% District Nurses, 47% of Health Visitors and 48% Community Staff Nurses aged over 50 years. The ageing workforce of the Charity can potentially create problems for the future development of community healthcare services (SoJ, 2012), due to the retirement of the majority of primary care nurses in the next fifteen years.

Research undertaken by Wray (2009) reported that older nurses had less access to CPE than their younger counterparts, borne out by this research where the managers voiced an ageist attitude towards funding nurses over the age of 50 years. In essence, the ageist attitude within the Charity starts even earlier, with Bridget being discouraged against completing her degree studies when she was 42 years of age, as her line manager considered her

too old. Further research into ageism and nurse professional development opportunities shows that the CPE needs of older healthcare workers is not being met (Lammintakanen & Kivinen, 2012). More recent findings indicate that lack of training opportunities coupled with limited employer support and lack of encouragement from co-workers results in a lower participation rate in professional development of older nurses (Pool, Poell & Ten Cate, 2013). These research findings concur, with Chris and Nicola voicing that age has been an issue in accessing CPE. With such a high percentage of the community nurse workforce potentially excluded from CPE (Figure 5.2), it would seem that the proposed change in healthcare delivery (SoJ, 2012a) is at risk of failure.

Getting Underway with CPE

Lack of academic study skills

The identification of the charity's ageing workforce was indicative of nurses who have undertaken their training when it was taught along the lines of an apprenticeship model, as opposed to contemporary nurse training which is now delivered within higher education at degree level (NMC, 2010b). The old style pre-registration nurse course was taught using traditional pedagogic teacher-centred methods characterised by a rigidly prescribed nursing curriculum (Glen, 2003), and failed to produce qualified nurses capable of patient-focused critical thinking skills (Heliker, 1994).   Margaret voiced embarrassment at her paucity of academic study skills, causing her to be frightened to participate in CPE. Lack of academic confidence due to negative education experiences and lack of independent learning skills has been reported as barriers to participating in lifelong learning (Gopee, 2001; Sparling, 2001). Accordingly, a more recent investigation has indicated 'academic naivety' in relation to qualified nurses undertaking degree level study (Evans et al. 2007, p. 736). Both Alice and Nicola admit to feeling more comfortable accessing undergraduate degree modules at Level 4, and these findings are similar to previous research findings whereby nurses question their ability to write academically and successfully complete their studies (Ellis & Nolan, 2005; Timmins & Nicholl, 2005).

E-learning has been acknowledged as combatting geographical isolation (Carroll et al. 2009), with nurses working in remote and rural areas favouring distance learning delivered using information technology (IT) as this provides the opportunity to overcome the inherent barriers of distance, time and cost when accessing CPE (Sheppard & MacKintosh, 1998). Likewise, nurses on the isolated Pacific Islands also preferred distance learning, although required additional basic computer proficiency and Internet skills training to maximise the benefits (Buenconsejo-Lum, Maskarinec & Palafox, 2007). Similarly, the lack of university provision on Jersey resulted in the nurses undertaking both distance learning (12%) and e-learning (13%) as a means of accessing formal post-registration education (Figure 5.4). The Island's White Paper regards enhancing the IT infrastructure and developing the use of technology as one of the enablers for the delivery of the proposed programme of service change (SoJ, 2012a), indicating that community nurses may need to be proficient with the use of these technologies.

Notwithstanding the progress of nurse CPE in relation to IT (Haigh, 2004), we are cautioned that computer literacy and the ability to use information technology is essential to the distance learning method of delivery (McVeigh, 2009). Research undertaken by Maxwell (2009) determined that inadequate computer skills, limited experience and lack of confidence in nurses over 50 years old contributed to a reluctance in participating in online learning. Whilst more recent findings revealed that the 'more mature' students lack IT skills (Moule, Ward & Lockyer, 2011), which adversely effected their engagement in e-learning (Moule, Ward & Lockyer, 2010). Almost a third (n=5) of respondents declared themselves to be lacking in computer skills, in contrast to the 50% of nurses unable to use an electronic library catalogue in Cole and Kelsey's (2004) study. Furthermore, 80% of UK primary care nurses possessed limited skills in relation to obtaining educational information from the Internet, leaving them disadvantaged in their studies (Docherty & Sandhu, 2006). There is no room for complacency as students with limited IT skills perceive distance learning post-qualifying courses more difficult due to their lack of computer experience (Cook et al. 2004). Therefore, it may be beneficial for nurses to ensure that the pre-requisite

information technology knowledge and skills are acquired before embarking on formal studies (Laurillard, 1993)

Motivation

The motivation to participate in lifelong learning can be influenced by personal factors such as age; alongside those associated with the individual's profession, illustrated as: the setting in which the professional works, their autonomy, responsibility, quality of their formal and informal work life, and career opportunities (Houle, 1980). More recently, indications reveal that those most likely to participate in adult learning are white professionals over the age of 40 and most likely working in education or healthcare (Ginsberg & Wlodkowski, 2010). Six of the research participants recounted their involvement with CPE for purely personal reasons (Figure 5.6). Both Angela and Bridget indicated the boost to their self-esteem in achieving post-qualifying study, vis-à-vis previous under-achievement and wanting to prove their capability (Watkins, 2011). Four of the participants reported that it was the 'right time for them', denoting freedom from childcare responsibilities, as recounted by Lisa. However, a lack of employer funding for CPE, coupled with over reliance on nurses' personal motivation and goodwill gives the impression that learning is not valued by the Charity, as discussed earlier by Munro (2008).

As identified in previous community nursing research (Banning & Stafford, 2008), and in order to fulfill their NMC PREP requirements (NMC, 2010a), the majority of respondents that participated in CPE (n=9) cited that gaining new skills and knowledge motivated them to undertake formal education. This is in keeping with other studies into the CPE experiences of qualified nurses (Watkins, 2011; Cooley, 2008). Four of the community nurses wanted to keep up to date with their practice, especially given the forthcoming proposed changes to local healthcare services (SoJ, 2012a). The Specialist Nurses were aware of the disparaging remarks colleagues made about them, and felt pressurised into CPE as a method of maintaining their professional credibility within the Charity (Dowswell, Hewison & Hinds, 1998), and as a means of increasing levels of respect (Murphy, Cross & McGuire, 2006).

Kim and Bridget both qualified as nurses before nursing entered higher education, and for them undertaking CPE closes the practice / theory gap, ensuring that they are not feeling left behind their colleagues who may hold Diplomas in Nursing (Bahn, 2007a; Dowswell, Hewison & Hinds, 1998). Similarly, these experienced practitioners were also nurse mentors supporting student pre-registration degree nurses, and need to feel adequately educated to cope with probing questions that might be asked regarding their practice (Gopee, 2011). Nurses who were previously involved in formal education are more likely to study (Alejandro, 2001), which was the case for Kim who felt inspired to undertake CPE following successful completion of the District Nurse training, along with her personal motivation to continue learning more.

Hannah's line manager identified insufficient professional qualifications for the role to which she was employed at her appraisal. A personal development plan was drawn up and implemented, whereby the Charity funded Hannah to complete an Undergraduate Degree in Professional Practice via distance learning as a necessary pre-requisite for the job role. Mary was also financially sponsored by the Charity to undertake a short formal course in the UK, but although the training, accommodation and travel were all fully funded the experience was marred by personal tragedy and therefore was not a positive one. Both Sam and Lisa participated in CPE as part of a new role, whereby annual appraisal revealed a deficit in their knowledge necessitating a further period of study (Brown et al. 2010; Berridge, Kelly & Gould, 2007). This underlines the importance of the appraisal system in ensuring that employees have the necessary knowledge and skills to undertake their roles safely (The NHS Staff Council, 2010).

Some nurses highlighted the importance of having a secure career as reported previously (Tame, 2009; Gopee, 2003; Hardwick & Jordan, 2002), with two participants identified as single parents and taking every opportunity to participate in formal education to enhance their chances of promotion (Cooley, 2008; Gould & Fontenla, 2006; Spencer, 2006). Indeed, since participating in this research both Sam and Emily have achieved the promotion they sought. The Specialist Practice Nurses voiced their concerns

around professional isolation, with only one other nurse in their specialist area based at the General Hospital. They chose to enroll on CPE courses based on the mainland in order to facilitate networking with UK colleagues, as this was a way of keeping abreast of developments in their area as well as seeking out peer supervision (Royal, 2012; McCoy, 2009).

The participants within this research were motivated to engage in CPE for a variety of different reasons, personal motives included fulfilling individual ambitions and goals and some for professional reasons. However, being motivated to participate in formal education is only one aspect of their experience, as personal, organisational and socio-political factors can influence progress (Gopee, 2003).

Making Headway with CPE

Family support

Support from family members was both forthcoming and greatly welcomed by five participants, and was in keeping with previous research (Tame, 2009; Stanley, 2003; Alejandro, 2001). Angela's husband supplied the necessary computer skills to aid her studies, compensating for her lack of technological ability. Hannah commented that her husband was very supportive and attentive to her personal needs whilst she studied and Lily's husband was keen for her to better herself through formal education. For Bridget, the support for studying included the whole family as both her husband and parents provided childcare whilst she was in England attending university. This was in complete contrast to Sam, who suspended her studies due to divorce, instead concentrating efforts on bringing up a young family. Thus, family support would appear to be crucial to the success of nurse CPE, especially when there are dependents within the household (Tame, 2009; Steele et al. 2005; Stanley, 2003; Alejandro, 2001).

University support

University support proved to be a mixed experience for the participants. Emily who attended the Jersey General Hospital Education Department, undertaking an Undergraduate Degree in Clinical Practice, felt actively supported in her CPE studies. Bridget, who commenced undergraduate

studies in the UK, had the added bonus of a personal tutor who visited her on the island to provide extra encouragement due to her distance from the university. However, Hannah and Angela both felt that studying via distance learning was quite a solitary affair, with minimal support provided by the university, something which has also been identified by rural nurses in Australia (Gumm, 2007). However, whilst the literature advocates the use of distance education as an efficient means of delivering CPE to remote and rural nurses (Richards, Farmer & Selvaraj, 2005), it is recommended that universities and employers work in conjunction to provide the student with academic support (Black & Bonner, 2011).

Lack of colleague support

Lifelong learning, with its associated increase in knowledge and skills, is more readily achieveable when linked to social capital (Schuller, 2000a). Belonging to a social group with a strong educational ethos is a good predictor of favourable educational achievements (Feinstein, Vorhaus & Sabates, 2008), however the opposite is true when the group foster low aspirations that discourage educational success (Schuller, 2007). Since the nature of network resources is context dependent it is imperative to consider the specific environment in which the group exists (Field, 2005). Baldacchino (2005) reports that small island territories are good sites for observing the effects or absence of social networks. Jersey's unique healthcare service provision has been identified as having integration and communication problems (KPMG, 2011), with research participants reporting a lack of cohesive working between various nursing disciplines within the Charity. Practices such as this can lead to the hoarding of information within close networks in a bid to gain advantage (Schuller & Field, 1998).

Indeed, for many people social connections are closely bound up within their workplace (Field, 2005). However, in this research low levels of both bonding and bridging social capital were apparent, and therefore the Charity did not seem conducive to support lifelong learning or the sharing of knowledge (Schuller, 2007). None of the participants mentioned support from colleagues within the Charity in relation to their CPE, with this lack of bonding social capital similar to prior research into the experience of rural

176

nurses (Beatty, 2001). Lack of employer support could be encountered as lack of study time (Davey & Robinson, 2002; Hardwick & Jordan, 2002; Dowswell, Bradshaw & Hewison, 2000) or no financial sponsorship (Bahn, 2007a; Huges, 2005; Aoki & Davies, 2002), with those nurses working outside the UK experiencing far greater difficulties in securing funding for CPE (Nalle, Wyatt & Myers, 2010; Richards & Potgieter, 2010; Schweitzer & Krassa, 2010). Previous studies highlight the benefit that distance learning brings to isolated nurses, enabling them to access CPE from remote locations (Buenconsejo-Lum, Maskarinec & Palafox, 2007; Curran, Fleet & Kirby, 2006; Richards, Farmer & Selvaraj, 2005; Cook et al. 2004). However, the requirement for independent learning, studying in seclusion, coupled with little face-to-face support could hinder motivation (Cook et al. 2004), hence the modified distance learning method adopted within the Western Isles of Scotland (Boyd, 1998).

Knowing the Ropes Following CPE

UK registered nurses are instructed by the NMC to keep their knowledge and skills up to date throughout their working career (NMC, 2008a), thus ensuring the nursing workforce remains flexible and able to contend with new and pioneering techniques necessary for improving patient care (DH, 2012a). There is a lack of exploration into the formal educational experiences of primary care nurses, with an Irish study confirming that there is a dearth of high quality research to underpin community practice (McKenna, Ashton & Keeney, 2004). However, a UK study confirms the importance of CPE for assisting community nurses in accepting new innovations in healthcare practices (Banning & Stafford, 2008).

Personal outcomes following CPE

Both Lily and Emily remarked that they felt more confident following their episode of CPE, a finding that is consistent with previous research (Pelletier, Donoghue & Duffield, 2003; Stanley, 2003; Davey & Johnson, 2002; Hardwick & Jordan, 2002; Johnson & Copnall 2002; Whyte, Lugton & Fawcett, 2000). This new-found conviction in their professional ability can be attributed to an increase in knowledge (Bahn, 2007a; Griscti & Jacono, 2006; Adriaansen, van Achterberg & Borm, 2005; Pelletier, Donoghue & Duffield,

2003; Hardwick & Jordan, 2002; Smith & Topping, 2001), leading to greater assertiveness (Bahn, 2007a; Pelletier, Donoghue & Duffield, 2003). Bella highlighted an improved morale following formal education whilst Alice expressed feeling positive and valued. This may be credited to an increase in interpersonal skills enabling them to enter professional discussions with colleagues in a more confident manner than previously (Pelletier, Donoghue & Duffield, 2003). Angela's anxiety towards her professional role decreased following a Master's degree, with the higher level of knowledge enabling the assessment of complex situations and the adoption of a more strategic approach (Whyte, Lugton & Fawcett, 2000).

Professional outcomes following CPE

Professional outcomes following a period of formal education are explored within the nursing literature with several themes emerging: the ability to change one's own practice, the capacity to change the practice of others and improvement in patient care. These will now be discussed in relation to the findings of this research.

Change own practice following CPE

Although the recognised remit of formal education is to increase one's knowledge (Jeris, 2010; Queeny, 2000) and self-development (Barriball, 2002) this does not always translate into a change in nursing practice (Lee, 2011; Tame, 2009; Griscti & Jacono, 2006; Spencer, 2006; Hardwick & Jordan, 2002). Alice highlighted a lack of time to use the knowledge gained from successful completion of the Diploma in Asthma in practice, and this has been indicated in previous research (Hallin & Danielson, 2008). Furthermore, staff nurse Emily was unable to make any changes to personal work practice on completion of a Degree in Clinical Practice, suggestive of a personal lack of power within practice area (Spencer, 2006). This failure to make full use of trained nurses (Hallin & Danielson, 2008) can result in frustration (Ellis & Nolan, 2005; Stanley, 2003) leading to nurses leaving the profession for employment elsewhere (Tame, 2009).

It is reported that nurse managers view change to practice following formal education as an individual practitioner responsibility (Lee, 2011). Senior

nurse Bella recounted using knowledge from CPE to inform team administration, with an improvement in leadership and management revealed as a positive outcome of post-graduate study (Whyte, Lugton & Fawcett, 2000). Hannah's degree studies have enabled development of local policies to elicit change in working practices in the area of specialist practice. Hannah's position within the hierarchy of the Charity, along with increased knowledge and self-confidence (Pelletier, Donoghue & Duffield, 2003) has enabled the adoption of such a strategic approach to improve client care (Whyte, Lugton & Fawcett, 2000). Mary's specialist training had a major impact on her working practice with personal development and self-confidence allowing a view of the 'bigger picture' of healthcare services (Griscti & Jacono, 2006). Finally, Sam divulged improvement in client consultations and information gathering due to the use of newly learnt interview techniques, revealing increased self-confidence and assertiveness within practice (Bahn, 2007a). Thus, following CPE each of these nurses has instigated changes within their own practice aiming for improvement in client care.

Change colleagues practice following CPE

The significance nurses place on sharing information with colleagues following an episode of CPE has been established (Hogston, 1995). However, as Gopee (2002) noted not all participants found sharing information easy due to the perceived attitudes of their co-workers. Bella, a Grade 6 nurse, approached senior managers following an episode of CPE in order to share new knowledge and suggest the instigation of a new approach to working within the team. However, the response was not positive and management were unsupportive of the proposal. This result is highlighted in the nursing literature, with previous research revealing lack of managerial support influencing the ability to introduce new change into the workplace (Lee, 2011; Ellis & Nolan, 2005). Kim's frustration was with her work colleagues, encountering difficulties in changing their attitudes and practice even though they were presented with research-based evidence. This emulates the findings of prior research, whereby the content of CPE was found ineffective in bringing about change in practice if the work processes were not altered, leading to well-trained but frustrated nurses (Buenconsejo-

Lum, Maskarinec & Palafox, 2007). Staff nurse Margaret found that some colleagues' attitudes were so fixed that it was impossible to influence them and they resisted any change in nursing practice. This is reminiscent of the 'laggards' first exposed by Houle (1980), who exhibited high resistance to learning, resulting in skill deterioration and a failure to adopt new practices. Thus, employees participating in CPE may not always translate this into an improvement in services, as established by research undertaken in Malta (Adami & Kiger, 2005).

Some nurses were quite reticent following CPE and did not want to be perceived by others as 'showing off their knowledge' (Schuller, 2000b, p. 231). Bridget was very modest in regards to her extensive knowledge of palliative care, but was happy to be utilised as a resource (Tame, 2009), even to the point of being contacted for advice when she was off-duty. Likewise both Alice and Lucy acknowledged that when nursing colleagues were aware that they had undertaken advanced studies they would approach for advice and support. Lily, a Grade 4 staff nurse, indicated that her expertise in stoma care was kept within the confines of the team. This could be as a result of the limited bonding social capital (Field, 2005) attributing to the 'silo mentality' (Lencioni, 2006) within the Charity whereby it felt comfortable to share knowledge with close colleagues and frightening to do so with the whole organisation. Nevertheless, the aforementioned participants who are Specialist Nurses cascade their knowledge to other healthcare staff within the Charity via regular taught updates throughout the year, although attendance at these session is dependent upon work pressures.

As the senior nurse in charge of a specialist area of healthcare, Hannah presented ideas acquired during CPE to the team for consideration, with a view to implementing a change in service delivery to their client group. Research by Ellis and Nolan (2005) confirmed that this type of managerial support is influential and a key factor as to whether change could be introduced into the workplace. Sam conceded that it is far easier to make changes to nursing practice when you are in a senior role, such as the immediate line manager, whereby others' practice can be challenged and

brought up to standard. Likewise, with support of the Charity's Senior Management Team, Bridget was able to utilise her knowledge in palliative care and introduce an 'End of Life' care pathway, alleviating inequity for those on the island dying from non-cancerous illness who are not embraced by the local hospice. Hence, the experience of practitioners within this thesis builds upon that found within Harwick and Jordan's (2002) research, whereby practitioners valued their manager's support in transferring CPE knowledge into practice.

The process of social transformation is not easily achieved, with culture change at any level of healthcare a gradual process culminating in indeterminate outcomes (Arbuckle, 2013). Those participants who attempted to instigate change in primary healthcare practice acknowledged that it was best introduced gently, as Bella described, change was introduced gradually to the team 'without them noticing it'. Likewise, Nicola explained that her approach to change management was to slowly filter the information down to work colleagues in order to move practice forward. However, Nicola cautions patience, as the process moved at a relaxed pace, but gradually nurses embraced the changes with a resulting improvement in patient care. Similarly, Lucy advanced modification in practice with colleagues by also adopting a slow pace of change to ensure that the nurses came around to her way of thinking. Change has a destabilising effect on teams, can be emotionally disruptive when imposed from 'outside' leaving people feeling insecure and under-valued (Ballatt & Campling, 2011), hence the gentle approach adopted by these practitioners.

Nevertheless, not all practitioners were successful in bringing about change to their colleagues practice, with Angela admitting that she stopped trying to influence her fellow nurses due to their resistance to change. Likewise, Sam declares utter frustration with the inability to implement basic initiatives when things are identified as going wrong. Similarly, recent research revealed difficulties in engaging and enthusing nurses to develop their practice (Lee, 2011). Nurses are attached to their job and particular way of working, investing themselves and taking pride in what they offer, therefore a service redesign can leave strong feelings of loss (Ballatt & Campling, 2011). Thus,

we are cautioned to be patient with colleagues as they face the uncertain process of change, and allow time for their acceptance that change is essential in healthcare practice (Arbuckle, 2013).

The practice environment can be influential as a determinant of change (Tame, 2009; Ellis & Nolan, 2005; Gopee, 2003; Stanley, 2003). The transfer of theoretical learning into practical application is often thwarted by the practice milieu (Stanley, 2003), with Angela's colleagues desperate to get their views heard and not listening to each other, making it impossible to share the knowledge gained during CPE. When back in practice following formal education some nurses find their 'wings are clipped' (Armstrong & Adam, 2002, p. 173), as Lisa discovered when unable to elicit changes in the wider district nursing team. The practice environment dictates the ultimate success of CPE (Ellis & Nolan, 2005), with Emily's efforts at change hindered by the heavy workload of a small team. Likewise, Sam failed to bring about much needed changes to a specialist area where practice needed improvement. Some studies have uncovered that resistance to change in nursing practice may be due to professional rivalry between colleagues (Tame, 2009; Davey & Robinson, 2002; Hardwick & Jordan, 2002; Nolan et al. 2000). Indeed, some research has revealed a level of interpersonal conflict (Hunt & Marini, 2012; Lim, Cortina & Magley, 2008; Hardwick & Jordan, 2002) leading to poor working relationships within teams (Finn, 2008; Hall, 2005; Davey & Robinson, 2002).

Nicola found instigating change within nursing brought up negative feelings and the perception that colleagues felt affronted that the credibility of their traditional nurse training was being undermined, as already documented by Davey (2002). Healthcare is characterised by an increasingly fragmented and specialised workforce, whereby different professional interests are leading to conflict (Finn, 2008). Sam found it a challenge to try and create an environment where nurses shared the same vision and are working towards the same aims, and like other new graduates experienced resistance from colleagues (McKenna et al. 2003). Minor instances of disrespect, such as the disparaging remarks made by Chris, can have an adverse impact on the workforce (Lim, Cortina & Magley, 2008), with the Specialist Practitioners

aware of the lack of collegiality (Thomas, 2003) within the Charity. Poor colleague relationships (Farrell, 2001) can result in conflict and strain between professionals leading to the disruption of relationships and poor co-operation (Hunt & Marini, 2012) creating workplace difficulties in instigating change.

<u>Improved patient care following CPE</u>

There is great difficulty in providing tangible results that formal education directly affects patient care, with only three research studies located and critiqued within Chapter two (Considine, Botti & Thomas, 2005; Aiken et al. 2003; Considine, Ung & Thomas, 2001). Nonetheless, the nurses within this research gave anecdotal accounts of how they perceived an improvement in clients' conditions after they participated in an episode of CPE. Angela discussed practicing with a 'lighter touch' since undertaking the Masters degree, whilst Alice indicated a less judgemental approach to clients with substance misuse. Likewise, Lucy considers herself far more knowledgeable following an episode of formal education, bringing back information on new treatments for clients within the specialist area of practice. This demonstrated that whilst participants felt that their practice had changed they were unable or unwilling to give examples to illustrate this, consistent with the findings of Hardwick and Jordan (2002).

Conversely, following the completion of a degree, Hannah organised a multi-disciplinary discharge plan for a client with complex care needs who has spent the past two years in hospital. Similarly, Bridget worked with various teams within the Charity to develop and launch an 'End of Life' pathway, ensuring standardisation of care and symptom control for those patients requiring palliation at the end of their lives. This corroborates the conclusions of Davey and Robinson (2002) who assert that following CPE nurses are able to contribute more effectively to discussions regarding client treatment. Those nurses involved with patients who have leg ulcers were able to practice their Doppler and bandaging skills with tangible results. Lisa relates how following treatment with compression bandaging a client's leg has now healed, whilst Nicola focuses on the vast improvement to a female patient's social life since her malodorous, weeping leg ulcers have almost

subsided. The ability to give examples of the capability to apply new knowledge to practice following an episode of CPE is consistent with the previous research findings (Lee, 2011; Smith & Topping, 2001).

Chapter Summary

This doctoral research project has yielded a substantial rich data set and enabled the researcher to undertake IPA in an attempt to reveal the experiences of sixteen voluntary participants with regard to participating in CPE to enhance their professional development. Many of the findings confirm previous information about nurse CPE; however, this research has uncovered some unique revelations. For instance, the funding that some nurses are securing from outside agencies to pay for their CPE has not previously been mentioned in the literature. Likewise, the professional rivalry and limited binding social capital between community nurses and GPs within an island setting has not been documented before. Furthermore, the limited bonding social capital within the Charity and resultant lack of colleague support for community nurse CPE is also unprecedented. The main issues all participants felt strongly about were the undercurrents, which lurked beneath the fabric of everyday working life, and posed a real threat to potentially scupper their chances of participating in formal education. There now follows a brief summary of the context of this research.

A major factor in relation to professional development was living on a remote island with no immediate access to a university or academic library. This geographical isolation from academia left community nurses at a significant disadvantage in relation to undertaking formal studies, as England is a four-hour ferry trip from Jersey, or a one-hour airplane journey. Notwithstanding the economic factor of such travel, the unpredictable weather can have an adverse affect on travel plans resulting in missed lectures. Specialist nurses complained of professional isolation with often only one other nurse on the island with a similar interest. Whilst they were members of regional specialist nurse forum groups, the location of these meetings in the South West of England led to their non-attendance due to lack of time and money. Therefore, the issues surrounding geographical isolation discovered by this

research adds to the information already in the nursing literature on island-based nurses.

Jersey boasts a unique healthcare system, modelled on the National Health Service, and yet challenged by dis-economies of scale. Secondary care is offered free of charge, but the hospital serves a population of less than 100,000 compared to 250,000 serviced by a district general hospital in England. The result is an expensive health service, which the Jersey Government is currently addressing following a service review. Primary healthcare is private, with patients having to pay to see a general practitioner. The primary care nursing services are delivered by a charity partly funded by the States of Jersey under a service level agreement (SLA). However, these monies are earmarked for healthcare provision with no ring-fenced money for workforce development. This unique health service with its private primary healthcare adds new knowledge to the provision and development of healthcare on small remote islands.

The Jersey health service is poorly integrated and has been identified as following a more medicalised and institutionalised model of care than other jurisdictions. There is a surfeit of general practitioners per capita, undertaking some roles that are considered the domain of nurses. This has resulted in de-skilling and under-utilisation of community nurses. The minimal liaison between primary care doctors and community nurses is indicative of clinical decision-making remaining firmly under medical control. This apparent devaluation of nursing knowledge and the nurses' role within primary care seems to verify medical hegemony and confirming doctors' dominance over other healthcare professionals. The States of Jersey wish to address the low intensity support within the community by focusing on more care delivery within patient's homes. To achieve the Jersey Government's goal there will need to be better integration and liaison between primary and secondary care. Also, whilst not mentioned within the White Paper, the professional development of community nursing staff is implicit to achieve success. The excess number of GPs within the Jersey health service and the perceived effect on community nurses is an original contribution to the extant knowledge on island nurse CPE.

The Charity receives almost seven million pounds under the SLA for the provision of community nursing services to the population of Jersey. This is insufficient to fulfil the financial cost of such provision, and therefore fundraising is necessary to meet the shortfall. The annual budget for development and training amounts to £100 per employee and therefore the Charity only managed to fund 36% of community nurse CPE. The workforce is considered 'ageing' with 87% of nurses over 40 years old and 54% due to retire in the next fifteen years. A further breakdown of these figures highlights a looming crisis within district nursing, with 81% over the age of fifty. However, there appears to be no active workforce planning in place as the management culture subscribes to recruiting qualified nurses from England to cover any shortfall. The resultant lack of career progression seems responsible for developing a dysfunctional workforce, working in silos, with minimal bonding social capital apparent between staff.

The findings from this research revealed an ageing community nurse workforce with limited academic skills and computer expertise prior to embarking on formal studies. Despite the apparent lack of promotion opportunities within the charity, participants remained highly motivated to partake in CPE for both personal and professional reasons. The main personal barrier to professional development was securing funding; as islanders are charged more to study at university therefore fees are higher. This finding is unique to island nurses who are not considered resident UK students. For those choosing to travel to England there was the added financial burden for travel and accommodation, coupled with the inconvenience to family whilst they were absent from home.

Organisational barriers to accessing CPE were similar to that found in previous research, with the exception of lack of sufficient funding. The Specialist Nurses found it particularly difficult to be away from work, as lack of backfill on their caseloads meant their clients were not attended in their absence. The recent economic crisis has resulted in nurses not being replaced on retirement or when leaving the Charity, with this reduction in staff numbers causing a heavy workload for those left behind, leaving no spare time to study. Research findings reveal that part-time participants perceive

that they are being discriminated against by the Charity by not sponsoring their CPE, instead favouring the full-time workers.

When enrolled onto a formal education module the nurses appreciated the support offered by family and friends. Those who travelled to the mainland for CPE relied upon their partners and extended family to provide childcare in their absence, especially if this resulted in an overnight stay. The local support for continued studies was spoken of very favourably, with easy access to the General Hospital Education Department and library. However, the nurses who undertook distance learning felt very isolated from their peers, and did not consider themselves well supported by the university. Not one participant spoke of support from colleagues or the Charity whilst enrolled in CPE. Lack of employer support could relate to lack of study time or absence of financial sponsorship, whilst lack of bonding social capital amongst staff could explain the reticence of those undergoing formal studies in asking for colleagues' assistance.

Following successful completion of a period of formal education, community nurses noted an increase in their personal skills. The improvement in nursing knowledge aids the development in confidence resulting in an increase in assertiveness. Several nurses also described an improved sense of morale and feeling valued. The participants were keen to share their new knowledge with colleagues, especially if it involved an improvement in client care. However, some nurses exhibited resistance to such information, feeling challenged by prospective changes to their practice. Lack of time and shortage of staff inhibited the transfer of knowledge into the workplace, although most participants were able to inform and enhance their own practice following CPE. Senior grade nurses were best placed for instigating a change in nursing practice, procedure or policy following formal education. Whilst no tangible evidence was offered, most nurses reported an improvement in client care following an episode of CPE.

The unique situation of nursing on a small remote island, with a lack of tertiary education infrastructure has led to undercurrents that impinge on the community nurses' ability to access and participate on CPE. Moreover,

being employed by a charity is another distinctive feature revealed in this research, with the associated apparent lack of funding for professional development adversely impacting on the community nurses' access to continuing education. The following chapter concludes this thesis, exploring the findings in relation to both the nursing literature and island studies, and will explore the methodological issues of this research before identifying the new contributions to CPE knowledge.

CHAPTER 7: CONCLUSION AND RECOMMENDATIONS

This chapter draws together the findings of earlier chapters and considers how they relate back to the initial aims (Chapter 1), the existing literature on lifelong learning (Chapter 2) and nurse CPE (Chapter 3). The findings are considered in the context of existing evidence in both nursing literature and island studies, with recommendations for practice proposed. Methodological issues in this research and suggestions for future research are contemplated before presenting a reflection on the researcher's personal development throughout the research process. Firstly, consideration will be given to the originality of the research.

Originality

The Quality Assurance Agency (QAA) defines doctoral level study as that which 'creates, constructs or interprets knowledge and by doing so extends the forefront of a discipline, usually through original research' (QAA, 2008, p.24). In order to achieve doctoral status the thesis needs to show originality, which according to Phillips and Pugh (1994) could be achieved in fifteen different ways, one of which is undertaking something in this country that has previously only been done in other countries and was achieved by this research. Murray (2011) suggested a refined list of thirteen approaches to originality and this research achieves one of these suggestions by discovering that some Jersey-based community nurses approached external agencies to fund their CPE. Moreover, research originality can be categorised within three main areas: the topic, the process and the outcomes (Tinkler & Jackson, 2004), and these are now explored.

Whilst lifelong learning within nursing has been explored both in the UK and internationally, this research focused on the CPE experiences of community nurses employed by a charity and working on a small developed island, an area of continuing education previously undocumented. Although qualitative research is well recognised within nurse education literature, IPA methodology was adopted (Smith, Flowers & Larkin, 2009). The application of IPA has not been established in the exploration of nurse education, therefore in that respect this research is original. Conceptually the thesis is grounded in human capital and social capital, which are inextricably linked to

lifelong learning (Field, 2005). The research revealed limited bonding and bridging social capital both within the community nurse teams and between the Charity and other local healthcare service workers. Whilst social capital had been explored before in relation to nurse education (Royal, 2012; Covell, 2008; Gopee, 2003; Gopee, 2002), these research findings are unprecedented (Tinkler & Jackson, 2004). Consideration is now given to the CPE experience of community nurses working on the island of Jersey.

Addressing the Aims of the research

As Education and Development Co-ordinator for the Charity, my interest concerned the access to university courses for CPE as the island lacks a resident university. Aware of the limited budget available for professional development, I was keen to discover how qualified nurses working outside Jersey Health and Social Services Department funded and attended to their formal educational needs. The overall aim of this research was to explore the CPE experiences of qualified community nurses working on the island of Jersey. My research proposal was divided into four aims indicated below:

1. To establish the community nurses' perceptions of CPE and its relevance to practice.
2. To investigate the types of CPE accessed by geographically isolated community nurses.
3. To explore the community nurses' personal experience of CPE.
4. To discover how each community nurse develops their professional knowledge and practice.

The main themes of the research findings will now be addressed in relation to these four aims.

Community nurses perceptions of CPE and its relevance to practice

Geographical isolation from their peer group (Chittoo, 2011), and lack of tertiary education (Royle, 2001), placed island-based community nurses at a significant disadvantage in terms of CPE due to their inability to access a regional university. Despite this, Jersey community nurses remained motivated to participate in formal education as a means of professional

190

development. These island-based primary care nurses valued CPE, identifying that knowledge gained is pertinent to practice improvement. Due to staff shortages, the annual appraisal system had been altered by the Charity to a three yearly cycle, and may be indicative of lack of employer commitment to investment in human capital and workforce development. Moreover, limited employer funding for CPE, coupled with an over reliance on nurses' personal motivation and goodwill gave the impression that learning was not equally valued by the Charity (Munro, 2008).

Types of CPE accessed by geographically isolated community nurses
Geographical isolation can pose a barrier to nurses wishing to undertake CPE (Penz et al. 2007; Ogalesco, 2006; Adami & Kiger, 2005; Beatty, 2001; WHO, 2001), especially when living on an island involves travelling to the mainland to access a university (Berteloot, 2004; Royle, 2001; Boyd, 1998; Landon, 1981). Thus location is an important factor in accessing CPE with island-based nurses penalised by the added costs of degree modules, transportation and accommodation (Gumm, 2007). However, in the face of such adversity, Jersey community nurses have shown resilience and inventiveness in the various types of formal education accessed. Almost a third of respondents participated in formal studies at the Education Deparment located within the Jersey General Hospital (Figure 5.4), undertaking undergraduate modules in order to achieve a degree in clinical practice.

Postgraduate studies on the island are currently limited to the Nurse Independent and Supplementary Prescribing course, resulting in just under a third of nurses travelling to England (Figure 5.4) to participate in both undergraduate and postgraduate studies. The Specialist Nurses prefer this method of accessing CPE, as it is also a means of combatting professional isolation and seeking out peer support (Richards, Farmer & Selvaraj, 2005). Travelling to the mainland to attend university involves added transport and accommodation expense (Curran, Fleet & Kirby, 2006). These costs, along with the enhanced 'island student' higher education fees, serve to financially penalise (Gumm, 2007) Jersey nurses.

Thirteen per cent of community nurses chose to participate in e-learning as a viable method of undertaking formal education without leaving the island (Figure 5.4). The use of information technology (IT) seems an appropriate method of accessing CPE for isolated island-based nurses (Carroll et al. 2009; Maxwell, 2009) offering flexible access to higher education (McVeigh, 2009). Nevertheless, we must be mindful that 54% of the community nurse workforce are over the age of fifty (Figure 5.2) and may not be competent in the use of computers. The Jersey Health and Social Services White Paper regards enhancing the IT infrastructure and developing the use of technology as one of the enablers for the delivery of the proposed healthcare service (SoJ, 2012a), therefore community nurses will need to be competent with the use of these technologies. Thus, it would be wise to ensure that pre-requisite information technology knowledge and skills are acquired before embarking on formal studies (Laurillard, 1993).

The limitations of the island higher education infrastructure have led to the adoption of distance learning as a method of obtaining post-registration education (Buenconsejo-Lum, Maskarinec & Palafox, 2007) for 12% of Jersey's community nurses (Figure 5.4). This approach to CPE is seen as a solution to distance, time and the ability to attend classes (Richards, Farmer & Selvaraj, 2005). However, some respndents reported a lack of support from the university, and this has the potential to leave students feeling isolated and demotivated due to insufficient contact with tutors and fellow students (Black & Bonner, 2011). A supported distance-learning package has been developed in the Scottish Isles, with a local tutor providing one-to-one guidance (Boyd, 1998). If distance learning continues as a chosen means of accessing CPE in Jersey, then the adoption of a similar support mechanism would be beneficial. Nursing literature advocates the use of distance education as an efficient means of delivering CPE to remote and rural nurses (Richards, Farmer & Selvaraj, 2005), however universities and employers are encouraged to work in conjunction to provide the student with academic support (Black & Bonner, 2011).

Community nurses experience of CPE

A pivotal finding of this research is the revelation that Jersey community nurses are becoming de-skilled and under-utilised due to the surfeit of general practitioners on the island undertaking nursing tasks as part of their remit (SoJ, 2012a). Evidence from the research suggests that the strong medical dominance of the Jersey healthcare system, along with the excess of primary care doctors, is resulting in community nurses practicing within a task-orientated framework (Markaki et al. 2006). Unless this culture is challenged locally, primary care nurses may be demotivated with regards to undertaking CPE, thereby sustaining the medical model of healthcare currently in place in Jersey and failing to bring about the proposed changes in service delivery (SoJ, 2012a).

The delivery of community nursing services on Jersey is unique, provided by a charity under a Service Level Agreement from the Jersey Health and Social Services Department (The Charity, 2011). Due to the majority of its finances targeted at the provision of client care; the budget for education and development was very restricted. Notwithstanding this, the managerial culture towards workforce development was focused on the employment of nurses from the United Kingdom, as the Charity perceived this was more financially effective than developing local nurses (Royle, 2001). However, the community nurses were resourceful in funding their professional development with 32% approaching local businesses and charities in a bid to secure financial sponsorship for CPE. This is unprecedented. The resultant lack of promotion opportunities for local nurses had not gone unnoticed within the Charity, with Jersey staff nurses frustrated due to the lack of career prospects within the workplace.

The Charity has an ageing workforce with 87% of qualified nurses over the age of forty years old, and 54% due for retirement in the next fifteen years (Figure 5.2). A crisis is anticipated in the coming years as 81% of District Nurses are over the age of fifty. However, there is no apparent workforce development plan to address these potential shortfalls, with the option to employ qualified nurses from the mainland considered the most economical way for continued service delivery. With regard to funding CPE, senior

managers confessed to having an ageist attitude (Lammintakanen & Kivinen, 2012), and would be reluctant to fund any nurse over the age of fifty years. This ageist attitude coupled with the lack of career progression could have contributed to the dysfunctional workforce, where professional rivalry and a lack of bonding social capital were apparent.

The nurses working within the Charity are split into teams, servicing different areas of the population, such as Child and Family Services, Adult Nursing Care and Adult Social Care. This increasingly specialised workforce is leading to different professional interests, culminating in internal conflict and 'silo working' (Lencioni, 2006). Research participants describe how teams within the charity fail to communicate, leading to a fragmentation of care delivery. A lack of support for lifelong learning is apparent between nurse teams and from their managers, with the most common complaints being restricted funding for CPE and lack of protected time to undertake professional development. Favouritism exists within the Charity especially in the application for CPE funding, with managers conceding that the system lacks parity. This current lack of integration and silo working will need addressing across primary care, secondary care, the various charities, and private organisations if the proposed changes within the health service are to provide a seamless healthcare service in the future (SoJ, 2012a). Whatever the cause, the lack of collegiality needs to be tackled to prevent retention issues in an already overworked workforce, with restorative group supervision suggested as a means of resolution (Thomas, 2003).

Discovery of how community nurses develop professional practice
Following an episode of formal education, nurses are keen to cascade their knowledge to colleagues in an attempt to enhance patient care (Hogston, 1995). However, within such an ageing workforce, there was resistance to change, and not all participants find information sharing easy due to the perceived attitudes of their co-workers (Gopee, 2002). Some participants were unable to use their knowledge gained from CPE due to pressure of work as indicated by previous research (Hallin & Danielson, 2008). Personal lack of power within the work area (Spencer, 2006) is also a deterrent to instigating theory into practice. This inability to make full use of trained

nurses can result in frustration (Ellis & Nolan, 2005) and may result in nurses leaving the profession (Tame, 2009).

The nurse's position within the hierarchy of the Charity was an important factor as to whether influence may be exerted over colleagues, with senior nurses more successful at introducing change into the workplace (Pelletier, Donoghue & Duffield, 2003). The process of cultural change within healthcare services is a gradual process (Arbuckle, 2013), with participants describing the introduction of new practice as 'slow' and 'gentle'. However, not all practitioners were successful in bringing about change to their colleagues' practice, due to lack of engagement and enthusiasm (Lee, 2011). The practice milieu can also affect the transfer of theoretical knowledge into practice (Stanley, 2003), with some nurses finding the application of theoretical knowledge in to practice limited following academic study (Armstrong & Adam, 2002). Nonetheless, community nurses were able to give anecdotal accounts of improved patient care following an episode of CPE.

Methodological Issues

This research was subject to limitations, which may have affected the resultant findings, despite careful planning and a reflexive approach to data collection and analysis (Seale, 1999). In acknowledging these limitations it is important to describe the sensitivity to context, rigour, transparency, and coherence adhered to within this qualitative study (Yardley, 2000).

Role of the researcher

My role as Education and Development Co-ordinator within the Charity afforded a privileged situation with regards to data collection and analysis (Kvale & Brinkmann, 2009). This 'insider' position may have caused bias and assumptions, which could result in important data being overlooked (Colbourne & Sque, 2004). However, the Charity had a robust process in place for distributing CPE funding, allocating this responsibility to a panel. My role involved delivering or arranging education and training in response to personal development plans of the Charity's employees, which included: managers, qualified nurses, nursery nurses, health care assistants and

administrative staff. This included sitting on the aforementioned panel, along with a Human Resources Officer and a Governance Manager, to ensure the allocation of funding for staff CPE was transparent and appropriate to meet the core business of the Charity. This was informed by the Charity's education policy and followed a robust, documented process and therefore helped to mitigate any personal conflict of interest between this research and allocation of CPE funds.

Methodological approach

Adopting a qualitative approach allows the collection of rich subjective data, enabling the researcher to draw meaning from the opinions and experiences articulated by participants (Willig, 2001), taking into consideration contextual factors (Yardley, 2000). Establishing the context behind individual community nurse narratives provides the researcher with information to assist with interpretation of data (Patton, 2002). Moreover, this provides context within the findings, helping the reader to understand the data and the researcher's interpretation of what has been divulged (Yardley, 2008). By undertaking this research using IPA the data was subjected to a double hermeneutic, whereby the researcher is making sense of participants' understandings of their own world (Smith & Osborn, 2004). However, the reader's interpretation could be construed as a third interaction with the data, suggesting that the participant's own perspective can never be completely identified (Smith, 2004b).

Semi-structured interviews

The use of a semi-structured interview approach allows flexibility within the interview process (Legard, Keegan & Ward, 2003). This enabled the researcher to change the order of questions, probing and prompting the interviewee in order to elicit a full account of the experience (Denscombe, 2010). The process of rich data collection is reliant upon the personal and professional qualities of the interviewer and their interviewing technique (Kvale & Brinkmann, 2009), with the likelihood of researcher inexperience affecting the quality of data collected in earlier interviews. There are a number of limitations associated with using interviewing as a means of data collection. The respondent may find it difficult to discuss personal

experiences, instead choosing to give socially acceptable responses they think the researcher wishes to hear (Parahoo, 1997). Secondly, whilst every opportunity was taken to ensure that interviews took place in a private room to avoid disruptions, interruptions (such as a mobile phone or bleep) occurred, which could potentially affect the information flow (Legard, Keegan & Ward, 2003). Thirdly, some participants were fearful about issues that might be personally or professionally damaging, only discussing those particular experiences 'off the record' once the digital recorder was switched off (Warren, 2001). In some instances, the participants were then happy to repeat these conversations with the digital recorder switched on, and this data has been analysed and included within this research. However, some information remained 'off the record' and has therefore not been included in this thesis.

Use of Computer Assisted Qualitative Data Analysis Software (CAQDAS)

A file was created for this study within NVivo8, where transcripts of the sixteen participants were uploaded. Although the focus of this research was on the individual's experience of CPE, each interview was coded using themes generated from the data, as the CAQDAS package was capable of separating out each individual experience. Free nodes were created to enable data sorting, with second and third level nodes enabling the development of a hierarchy of themes and super-ordinate themes. Thus, the use of NVivo8 enabled the researcher to provide proof of greater transparency (Hutchison, Johnston & Breckon, 2010), with the potential to assist in the adoption of a rigorous approach to data analysis (Richards, 2009).

Real-world research

The key point within IPA is the significance of the findings from the perspective of a particular group of people, in a particular context; not the generalisability of these findings or whether they can be replicated (Smith, Flowers & Larkin, 2009). As this research took place within the context of island-based nursing it may be transferable to nurses in similar geographical situations (Smith, Flowers & Larkin, 2009).

<u>Reflextivity</u>

Within qualitative research methodology reflexivity is used to analyse the role played by the researcher within the research process (Dowling, 2006). The acknowledgment that pre-conceptions, biases and the researcher's belief system may impact on data collection, interpretation of findings and construction of meaning aids the transparency of the research (Bainger, 2011). Moreover, keeping a research journal to record personal emotions, opinions and responses is imperative when studying members of a group to which the researcher has a professional relationship (Arber, 2006). Furthermore, such reflective accounts also enable the researcher to explore emotional issues related to the research process, thereby aiding the readers to recognise the impact of those experiences on findings (Biggerstaff & Thompson, 2008), as well as increasing research validity.

Semi-structured interviews are the preferred method of data collection for IPA (Smith, Flowers & Larkin, 2009). The interview questions were informed by data gathered via two focus groups, the knowledge of the literature (Chapter 2) and familiarisation of the research context (Chapters 1 and 3). The questions were flexible, with participants encouraged to 'tell their story' and the question schedule was only used with interviewees who needed prompting or had lost the thread of their narrative (Todd, 2006). During this process I was aware that my role was instrumental, along with the interviewee, in the generation of new knowledge or thoughts concerning the topic under investigation (Legard, Keegan & Ward, 2003).

As a fellow employee of the Charity, I was considered an 'insider' and was aware of the influence that this could potentially bring to the interview process, analysis and dissemination of findings (Allen, 2004). I purposefully chose to interview the participants at a satellite base, in a neutral location to both parties. This afforded the participants with some anonymity, which could enable them to disclose their experiences more freely. By this stage of the research process I had been working in the capacity of Education and Development Co-ordinator for approximately a year and had built up a relationship with some of the participants. At times this made the interview process a little difficult, as we negotiated our new roles, with the interviewee

as the expert whose opinion I was seeking (Garton & Copland, 2010). During the interviews I often struggled to keep my emotions at bay as participants recounted some of their experiences. Thankfully, my many years of experience as a nurse enabled me to remain professional, and I avoided making comments on perceived injustices. Some of the participants viewed my researcher role with suspicion, asking for the digital recorder to be switched off so they could be reassured that what they were about to tell me would remain confidential. A few experiences were only recounted 'off the record' as participants could not bear to think of a recorded copy of what they had disclosed.

It is in the analysis phase of the research that the researcher can have the most influence on findings, deciding what to focus on and how to present the findings. The use of a research journal in which to document decisions and thoughts, aided me in developing themes and concepts, ultimately leading to the visual representation of my findings. Revisiting recordings of the interviews and re-reading transcripts enabled me to transport myself back to the interview, evoking memories and some of the raw emotions of the participants. My own experience as a self-funded student, who had been refused study leave, has to be acknowledged. I was also exposed to the same lack of tertiary island infrastructure and working within the same organisation as my participants. Whilst I have recorded the decisions I have made and the process I undertook in my research journal, it is not possible to verify how much of my assumptions, values and experiences have sub-consciously affected the process.

Future research

This study has confirmed the transferability of prior CPE research to community nurses in relation to motivations and barriers to formal study and its outcomes for patient care. Moreover, new insights into the experience of island nurses employed outside the National Health Service (NHS) have been discovered, specifically in relation to geographical isolation, lack of island infrastructure to support professional development, and employment by a charity. Few studies have explored the professional development of nurses working on a remote small developed island, with those in the nursing

literature based in the Scottish Isles and located within the NHS (Dean, 2012; Boyd, 1998).

It would be essential to interview the senior management team at the Charity to enquire about the strategies and policies that are in place to guide the decision-making process regarding the amount of money that is set aside for professional development and workforce planning. Additional research is also required to explore the CPE experience of those nurses employed by the Charity aged less than thirty years. This group was not represented within the current study and it would be illuminating to discover their commitment to CPE, as they are likely to remain employed within community care for the next thirty-five years or more. It would also be enlightening to access those nurses within the Charity who have not participated in CPE and endeavour to discover the barriers preventing them from undertaking formal education. Likewise, it is important to explore the formal education experience of nurses employed by the Jersey Health and Social Services Department in secondary care, to ascertain their experience of CPE. In order to ensure comprehensive workforce planning it is essential that employers and policy makers are aware of the professional development of Jersey nurses, whose role is pivotal in relation to successful implementation of the proposed enhanced healthcare system (SoJ, 2012a).

Recommendations

This section considers the recommendations that emerged from the findings of this research. They include policy and practice recommendations directed at practitioners, the Charity and the Jersey Health and Social Services Department.

Recommendations for community nurses

The community nurses employed by the Charity need encouragement to be more proactive in relation to their professional development. For instance, although the appraisal system has been moved to every three years any member of staff can request an appraisal if they perceive a learning need that is not being met. I recommend that qualified nurses request an annual appraisal with their line manager in order to ensure that they remain

competent to practice. Below is a list of suggestions aimed at the qualified nurses to assist in their CPE based on the findings of this study:

1. Use the appraisal system to highlight professional training needs.
2. Utilise the charity*'s* prospectus as a resource to professional education available on the island.
3. Explore the Jersey Health and Social Services Webpage to discover undergraduate and postgraduate nursing courses available via the Education Centre at the Jersey General Hospital.
4. Access a study skills course via the Education Centre at the Jersey General Hospital if you feel inadequately prepared to undertake academic study.
5. Access computer training via the local Further Education College if not proficient in computer and information technology skills.
6. Petition the Charity to increase the education and development budget.
7. Utilise teleconferencing as a means of maintaining professional development.
8. Specialist nurses to undertake peer supervision regularly with their UK counterparts via teleconferencing.
9. Secure local academic support if undertaking CPE via distance learning.
10. Use restorative peer supervision within the charity as a means of tackling the lack of collegiality.

The above list is by no means exhaustive, and community nurses are urged to speak with the Education and Development Co-ordinator to discuss any perceived learning needs and to seek advice and support in accessing CPE.

Local policy

In order to ensure comprehensive workforce planning the Charity needs to identify a commitment to the professional development of its qualified nurses, its most important asset. I recommend that money needs to be secured from the States of Jersey via the Service Level Agreement, which could be ring-

fenced and used in the professional development of the workforce in order to meet the forthcoming changes in healthcare service on the island.

The Charity
1. Incorporate funding for nurse professional development as a necessary element of the Service Level Agreement with the States of Jersey Health and Social Services Department.
2. Provide practical advice and guidance on nurse professional development.
3. Invest in the professional development of local nurses through the provision of a career structure.
4. Develop an equitable process for qualified nurses to access funding for CPE.
5. Make the European Computer Driving Licence (ECDL) mandatory training for all qualified nurses.
6. Ensure the technological infrastructure is in place to support teleconferencing.
7. Work in conjunction with university providers to ensure adequate support for distance learners.

This list could be extended, with the Charity working closely with its qualified nurse employees to ascertain what could be put in place to meet their CPE requirements. Furthermore, the States of Jersey Health and Social Services Department need to be aware of the investment required in the community nurses if the recommendations in the White Paper are to be successfully delivered.

Jersey Health and Social Services Department
1. Invest in the professional development of community nursing staff.
2. Work more closely with charities and private agencies to ensure that nurses continue their professional development.
3. Encourage inter-professional working within the Jersey healthcare service.
4. Challenge the medical dominance of Jersey healthcare service to ensure community nurses are working to their full potential.

The recommendations above may go some way in addressing the current shortfalls in community nurse CPE. However, a more collegial approach to healthcare planning and development is needed on the island, including addressing the CPE needs of community nurses. Failure to do so could jeopardise the proposed changes in the Jersey health service.

Contribution to knowledge

The expectation of doctoral research is that the findings will make a distinctive contribution to the development of discipline knowledge (Dunleavy, 2003). In particular, with practice-based doctorates, such as this Doctorate in Education, there is an expectation that the research will take the topic into new areas (Winter, Griffiths & Green, 2000). My findings have revealed several original contributions to nurse CPE as identified below:

- Community nurses applying to external agencies for money to fund their CPE
- Professional rivalry and limited bridging social capital between community nurses and some GPs may be hindering the professional development of Jersey community nurses
- Professional rivalry and limited bridging social capital between community nurses and other healthcare workers in primary and secondary care could be having an adverse effect on seamless healthcare provision
- Professional rivalry and limited bonding social capital between the community nurses working for the Charity resulting in lack of colleague support for CPE

My research has focused on the experience of island-based nurses who are working for a charity, with the findings contributing to the body of knowledge already known on the subject

Island nursing

Prior research into island nursing has been dominated by the study of geographically isolated small developing islands, whereas this research has focused on the experiences of nurses on a small remote developed island.

Geographical location has been identified as an issue in relation to island nurses accessing CPE causing financial and travel issues with regard to attending university in England, with seasonal adverse weather conditions adding further difficulties. Lack of an island tertiary education infrastructure was also found to influence CPE choices, although this was impacted upon by lack of investment in professional development in favour of employing nurses from the UK; leading to thwarted career prospects of local nurses and the perception of 'silo' working' preventing the transfer of nursing knowledge. Jersey's healthcare provision is not part of the NHS, therefore the research participants felt professionally isolated from their UK counterparts and unable to attend to their professional development. The fragmentation of the healthcare system coupled with its medical dominance led to a limited working relationship with island general practitioners leaving community nurses feeling de-skilled and under-utilised. The island nurses are considered an ageing workforce with limited study skills and information technology ability, which is a significant finding when almost a quarter of the participants access CPE via distance learning and e-learning. The above findings are a new contribution to island nursing studies, as current research relates to nurses in the Scottish Isles, which are part of the NHS and therefore governed by health service policy such as Agenda for Change. Within the context of island nursing, these findings are transferable to other remote islands, contributing to the body of knowledge on island nurse professional development.

Employment by a charity

The provision of community nursing by a charity is unique and this research revealed that the nurses appeared to lack CPE opportunities compared to nurses employed by the local government. The limited funding available for nurse continuing education lead to nurses approaching outside agencies and businesses for financial sponsorship, a finding unprecedented in the current nursing literature. An apparent lack of employer commitment to workforce development through the absence of annual nurse appraisals and lack of parity to access CPE has culminated in professional rivalry, as nurses perceive their inability to access formal education and lack of social capital if

enrolled into studies. These findings contribute to the body of knowledge regarding the CPE experiences of nurses employed by a charity.

Chapter Summary

Living on a small geographically isolated island with limited tertiary education provision impacts on the CPE experiences of community nurses. Working for a charity with restricted finances available for professional development challenged primary care nurses' creativity in applying for and securing financial sponsorship for formal education. A variety of methods to access post-registration education include; local undergraduate study, attending university in the UK, e-learning and distance learning. The study participants remain motivated with regards to their professional development although strong feelings were expressed at the perceived lack of employer support for local workforce development.

In 2011 the Jersey Government undertook a review of healthcare provision, which identified a medicalised and institutionalised service in comparison with other jurisdictions. The proposed change to the delivery of Jersey healthcare adopts a patient-centred approach, with more care delivered within the community and clients' homes. The professional development of community nurses is implicit within this proposal and vital for its success. By highlighting the post-registration education experiences of the Charity's qualified nurses, this research adds weight to the argument for sufficient funding to support workforce development. The present research represents an original contribution to nursing education, in its methodological approach and in-depth nature of findings obtained from geographically isolated community nurses working on a small island, which is currently under-represented in the field.

General Conclusion

This research was designed to explore the experiences of Jersey-based community nurses on their ability to fund and access post-registration professional education. The findings have reflected the initial aims and highlight issues relevant to the Jersey Government, Jersey Health and Social Services Department policy makers, the Charity and community nurses. The

qualitative approach allowed for an in-depth exploration, adding new insights, making a unique contribution to existing nurse CPE knowledge and emphasises professional developmental issues surrounding the access to tertiary education when living on a small geographically remote island. In particular, these findings inform the current proposal for future healthcare delivery on Jersey.

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Appendix 1: Search Strategy

Databases	Bookfind online	<u>Search Terms</u>
	Cinahl	1. Continuing Professional Development
	Cochrane Library	2. CPD
	EBSCO Academic Search Elite	3. Continuing Professional Education
	Effective Practice and Organisation of Care Group	4. CPE
	Elsevier Science Direct	5. Post-registration Education and Practice
	Index to Theses	6. PREP
	Ingentaconnect	7. #1 and nurses
	Internurse	8. #2 and nurses
	JSTOR	9. #3 and nurses
	National Research Register	10. #4 and nurses
	Networked Digital Library of Theses and	11. #5 and nurses
	Dissertations	12. #6 and nurses
	Proquest	13. #1 and benefits
	Proquest Digital Dissertations	14. #2 and benefits
	REGARD	15. #3 and benefits
	ReFeR research findings register	16. #4 and benefits
	Sage	17. #5 and benefits
	SIGLE	18. #6 and benefits
	Swetswise	19. #1 and values
	Taylor Francis	20. #2 and values
	Zetoc	21. #3 and values
		22. #4 and values
		23. #5 and values
Web Sites,	Audit Commission	24. #6 and values
Search	Centre for Reviews and Dissemination (CRD)	25. #1 and patient care
Engines	Community Practitioner and Health Visitor	26. #2 and patient care
and	Association (CPHVA)	27. #3 and patient care
Subject	Department of Health (DH)	28. #4 and patient care
Gateways	Google Scholar	29. #5 and patient care
	Department for Education and Skills Learning and	30. #6 and patient care
	Skills Gateway	31. #1 and barriers
	Joseph Rowntree Foundation	32. #2 and barriers
	National electronic Library for Health (NeLH)	33. #3 and barriers
	National Institute for the Advancement of Continuing	34. #4 and barriers
	Education (NIACE)	35. #5 and barriers
	Nursing and Midwifery Council (NMC)	36. #6 and barriers
	NMAP gateway	37. #1 and obstacles
	Professional Associations Research Network	38. #2 and obstacles
	(PARN)	39. #3 and obstacles
	Royal College of Nursing (RCN)	40. #4 and obstacles
	ScHARR	41. #5 and obstacles
	SCIRI network	42. #6 and obstacles
	SHIMA	43. #1 and nurses and perceptions
	SOSIG	44. #2 and nurses and perceptions
	States of Jersey Government	45. #3 and nurses and perceptions
	The Charity's Web site	46. #4 and nurses and perceptions
	The King's Fund	47. #5 and nurses and perceptions
	The Stationery Office Bookshop	48. #6 and nurses and perceptions
Journals –	Community Practitioner	49. Community nursing
hand	Health Service Journal	50. #1 and community nursing
searched	Journal of Advanced Nursing	51. #2 and community nursing
	Journal of Community Nursing	52. #3 and community nursing
	Nurse Education in Practice	53. #4 and community nursing
	Nurse Education Today	54. #5 and community nursing
	Nursing Standard	55. #6 and community nursing
	Nursing Times	56. Island nurses
		57. #1 and island nurses
		58. #2 and island nurses
		59. #3 and island nurses
		60. #5 and island nurses
		62. #6 and island nurses
		63. Rural nurses
		64. #1 and rural nurses
		65. #2 and rural nurses
		66. #3 and rural nurses
		67. #4 and rural nurses
		68. #5 and rural nurses
		69. #6 and rural nurses
		70. Remote nurses
		71. #1 and remote nurses
		72. #2 and remote nurses
		73. #3 and remote nurses
		74. #4 and remote nurses
		75. #5 and remote nurses
		76. #6 and remote nurses

Appendix 2

Interview Schedules

Interview questions for semi-structured one-to-one interviews with community nurse participants.

1. How long have you been qualified as a community nurse/health visitor?
2. Where did you undertake your initial nurse training?
3. Do you have more than one qualification?
   - If yes, what are they?
4. How long have you been working for the charity?
5. Have you worked off-island at all?
   - If yes, where?
   - For how long?
   - Did you undertake any continuing professional education?
6. Can you describe to me your personal experience of continuing professional education? The idea is for the participant to recount their narrative with minimal interruptions from the interviewer. The following bullet points are prompts only to be used if the participant dries up:
   - What sort of continuing professional education did you undertake?
   - What was positive about the experience?
   - What was negative about the experience?
   - What impact did it have upon your personal life?
   - What impact did it have upon your professional life?
   - Did you have to overcome any difficulties?
   - How easy was it to change your practice following this episode of continuing professional education?
   - To what extent was it possible to bring about changes in your colleagues practice following this episode of continuing professional education?
   - How do you think clients have benefitted as a direct result of your continuing professional education?
7. Do you have any other suggestions that would be of interest to this study?

Interview questions for the focus group consisting of nurse managers.

1. What is your perception of continuing professional education?
2. How keen are you in participating in continuing professional education?
3. What do you think influences you to undertake continuing professional education?
4. To what extent do you choose to participate in continuing professional education?
5. What factors may cause you to fail to engage in continuing professional education?
6. What is the relevance of continuing professional education to your area of practice?
7. How do you develop your professional practice on the island?
8. What factors can influence the development of nursing/health visitor practice?
9. Is there anything further that you think would be of interest?

Interview questions for the focus group consisting of community nurses and health visitors.

1. What is your perception of continuing professional education?
2. How keen are you in participating in continuing professional education?
3. What do you think influences you to undertake continuing professional education?
4. To what extent do you choose to participate in continuing professional education?
   - What justifies your decision?
   - Describe occasions when you have signed up to training and then not turned up?
   - Can you relate any occasion when you felt that education was a waste of time?
   - Have you ever left a training session early? If so, why?
5. What personal/professional factors may cause you to fail to engage in continuing professional education?
6. What is the relevance of continuing professional education to your area of practice?
7. How do you develop your professional practice on the island?
8. What personal/professional factors can influence the development of nursing/health visitor practice?
9. Is there anything further that you think would be of interest?

Appendix 3

Information Letter

UNIVERSITY OF GLOUCESTERSHIRE

January 2011

Dear Colleague,

You are invited to take part in a research project exploring the continuing professional education experiences of qualified nurses working for Family Nursing and Home Care (Jersey) Inc. This project is being carried out by Julie Lemprière who is a student at the University of Gloucestershire and is undertaking the research as part of her doctorate in education. The project is being supervised by Dr Diane Crone from the University of Gloucestershire, who has been involved in NHS research for over fifteen years.

This information sheet is designed to inform you about the project because it is important to understand why the study will be done before you decide whether or not to take part. Please take time to read the following information carefully and discuss it with friends, relatives or colleagues if you wish. Please ask Julie or Di Crone if there is anything that is not clear or if you would like more information. Feel free to take your time before coming to a decision.

What is the purpose of the study?
The purpose of the study is to explore the experiences, perceptions and attitudes of community nurses and health visitors with regard to their continuing professional education.

Do I have to take part?
Taking part is voluntary. It is up to you whether or not to take part. Even if you decide to participate you are free to withdraw from the study at any time without stating the reason.

What will I be asked to do if I decide to take part?
Consenting participants will be asked to take part in a focus group and/or one-to-one interview, during work time, at a workplace venue with the researcher. The focus group will last no longer than 60 minutes and will involve questions related only to your experiences, attitudes and opinions of continuing professional education. You will be asked to answer only the questions that you want and there are no right or wrong answers; it is only your experiences, opinions and attitudes of continuing professional education that are of interest to the researcher. The topics of conversation will include questions about your previous experiences of continuing professional education, what you thought/think about it and what role it plays in developing your professional knowledge and practice. Participants will also be invited to attend an interview lasting no longer than 60 minutes where their personal continuing professional education experiences can be further explored in depth. The researcher may want to anonymously quote some of what you say in her thesis. If you are in agreement, you will be asked to check that your words have been quoted appropriately and that you have not been misrepresented. However, if you do not feel comfortable about being quoted in the thesis, it is within your rights to refuse without stating the reason.

What are the possible benefits to taking part?
The information derived from the study will help to evaluate your experience of continuing professional education. Finding out and understanding participants' experiences will help make necessary changes to improve the education and training offered to you.

Who has reviewed the study?
The Gloucestershire University Ethics Committee and the States of Jersey Health and Social Services Ethics Committee have both reviewed this study.

If you wish to take part or you need further information on this study, please contact Julie Lemprière or her Supervisor:
Julie Lemprière Tel: 445077   E-mail: j.lempriere@the charity*.org.je (*pseudonym)

or

Diane Crone, Faculty of Sport Health and Social Care, University of Gloucestershire, Oxstalls Campus, Oxstalls Lane, Gloucester, GL2 9HW, Tel: 01242 715161 Fax: 01242 715222
Email: dcrone@glos.ac.uk

Version 5 – 23/01/11

Vice Chancellor Dr Paul Hartley
Registered Charity No 900478

Appendix 4: <u>Consent Form</u>

UNIVERSITY OF GLOUCESTERSHIRE

13th January 2011

CONSENT FORM

Title of Project: 'Continuing Professional Education: Exploring the Experience of Community Nurses Working on a Small Remote Island.'

Name of Researcher: Julie Lemprière

Please initial box

1. I confirm that I have read and understand the information sheet dated January 2011 (version 5) for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐

3. I agree to be digitally voice recorded and understand that the recording will be destroyed on completion of the study.

    ☐

4. I agree to take part in the above study. ☐

_____   _____   _____
Name of Participant   Date   Signature

_____   _____   _____
Julie Lemprière, Researcher   Date   Signature
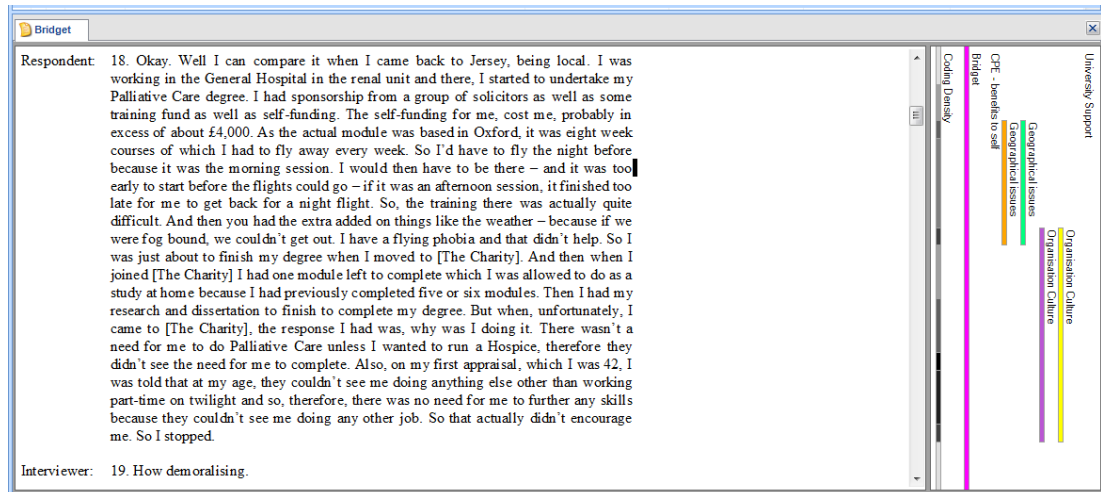
1 copy for participant; 1 copy for researcher.

Version 1

Appendix 5

<u>Development of Themes</u>

This diagram shows a segment of transcript coded using NVivo, with the coding bar to the right showing the themes that emerged from that segment of text.

Following this, links/connections were made between codes in order to develop themes and sub-themes. The example below shows these relationships in an earlier draft.
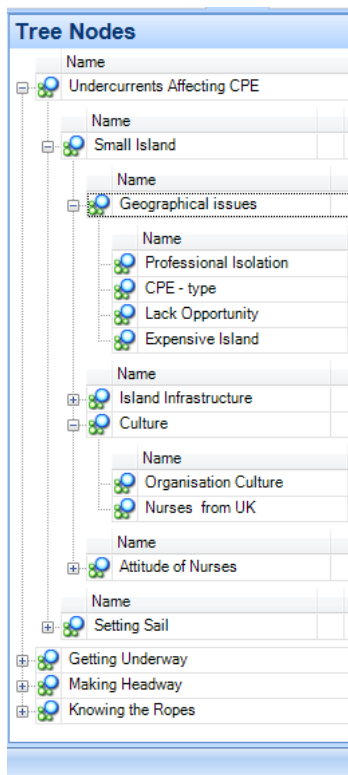

In this draft 'geographical issues' was the key theme, with a number of sub themes emerging. As analysis progressed these themes and sub themes developed.

273

Appendix 6

Approval from the States of Jersey Health and Social Services Ethics Committee

Health and Social Services Department
Pharmacy
General Hospital, Gloucester Street
St Helier, Jersey, JE1 3QS
Tel: +44 (0)1534 442000
Fax: +44 (0)1534 442886

States
of Jersey
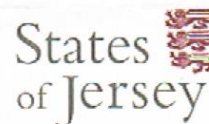
14 October 2010

Our ref: PMcC/EG

Julie Lempriere

Dear Julie

Project exploring Continuing Professional Education experiences of a Community Nursing Team working on Jersey

Thank you for your application and for attending the recent meeting of the Ethics Committee to present your research proposal.

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research based on the information provided in the application and your presentation to the Committee.

I would also like to convey the Committee's best wishes for the success of this project.

Yours sincerely

Paul McCabe
Chief Pharmacist

direct dial: +44 (0)1534 442314
email: p.mccabe@health.gov.je
www.gov.je

Appendix 7

<u>University of Gloucestershire Approval for Research</u>

UNIVERSITY OF GLOUCESTERSHIRE
at Cheltenham and Gloucester

23rd March 2011

Julie Lempriere

Postgraduate Research Centre
HC305
Francis Close Hall
Cheltenham GL50 4AZ
Tel: +44(0) 1242 715367
sbrookshaw@glos.ac.uk

Dear Julie,

Application for registration for research degree
I am pleased to inform you that the University Research Degrees Committee has now approved your registration as follows:

Faculty: Applied Sciences   **Degree:** EdD

Title of programme of research
A case study exploring the continuing professional education experiences of a community nursing team working on Jersey

Supervisory arrangements
First supervisor: Dr Diane Crone
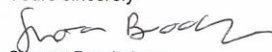Second supervisor(s): Mr Harry Cowen

Date and period of registration
The period of registration will be: a maximum of 7 years of part-time study
Start date: 1/1/2006
The *maximum* period of registration expires on: **1/1/2013**

For fee purposes, you are to be regarded as a home student. A full list of tuition fees is available at http://resources.glos.ac.uk/departments/financeplanning/tuitionfees/index.cfm and any queries concerning your account should be addressed to Finance and Planning on 01242 714231. If you are in receipt of a University Studentship, please forward your fees invoice to me. If you are in receipt of a Department Bursary, you should forward the invoice to your Head of Department or Research Unit.

With best wishes for your research.

Yours sincerely

Sharon Brookshaw
Research Administrator

Copies: Supervisors

Annotated interview transcript

Continuous paragraph numbering allows easy reference back to original transcript

Square brackets are used to indicate when information had been replaced/re-worded to preserve anonymity

Speakers:
I = interviewer
H = Hannah (pseudonym)

11	I: So can you describe to me your personal experience of professional education whilst working as a nurse in Jersey?
12	H: Okay, When I started at [the Charity] within about six months, I recognised that in my post, I was working beyond the grade that I'd come over here on. And delving deeper into that, found out that there hasn't been a post-holder in that post when it had been awarded that grade. So I asked for a review of my post. And that took place and I was awarded a higher grade. And then in my IPR we identified that I needed further training to get to degree level, to work within that role. So that was identified within the first six to eight months of me arriving in [the Charity]. And since then because I've only been here for three years that is what my studying has been. It's the modules working towards the degree.
13	I: And how have you undertaken those modules?
14	H: I've undertaken them distance learning through the … university. I would have liked to have done the Specialist Practitioner Community Degree but that wasn't available as a distance learner. And because I wasn't already at degree level, I couldn't do it within a nine-month time span, which I believe one or two of the universities do. If you already have a degree, you can then go and do that as a full-time nine-month course. So it would have meant, well going off island basically. You just can't do it as a distance learner and actually stay here in Jersey. So I looked at other courses and read up about this one which the [name of professional organisation] brought about in partnership with the … university, which was about nursing practice with child pathway and decided that that was best fitted the direction I was going really.

Appendix 9

Annotated quotation

Quotations were italicised and indented to distinguish them from the rest of the text

Three full stops indicate a break in text e.g. where words have been removed. This was deemed necessary for brevity.

As far as [the Charity] goes I can honestly say … apart from mandatory training I've done virtually nothing [referring to CPE] since I've been here [Chris, Grade 5: 20]

Square brackets denote a change from the original text. E.g. above words have been added to provide the reader with context as some has been lost when removing the quote from the original transcript. Below Angela stated her son's name, but for anonymity it was removed

…at the time [my son] was about three and [a colleague] had a baby, and the only way we managed going over to [the South of England] was if we went straight to [a toy shop] and bought them something [Angela, Grade 6: 56]

The participants' pseudonym and paragraph numbers from the original transcript have been provided. This allows the reader to see the original context of the quote if desired.