New Zealand Nurses Organisation

Education Survey Report: implications for practice

Authored by:
Anne Brinkman, Ruth Wilson-Salt & Leonie Walker

Enquiries:
Anne Brinkman, Professional Nursing Advisor
PO Box 2128
Wellington
Tel: 04 499 9533
anneb@nzno.org.nz

November 2008

November 20, 2008

Dear Colleague

Professional development is an ongoing requirement of nurses as a result of the Health Practitioners Competence Assurance Act (HPCAA). The Act's principal purpose is to protect the health and safety of the public by ensuring health practitioners are fit and competent to practise.

The HPCAA's legislative mandate for assuring nurses are fit and competent to practise, belongs to the regulatory authority, the Nursing Council of New Zealand (NCNZ). Competence requirements are met through practice hours, professional development hours, and meeting the Council's competencies for the nurse's scope of practice, as relevant to the nurse's area/context of practice. Therefore, in meeting these NCNZ requirements, nurses can choose from a range of professional development opportunities (see http://www.nursingcouncil.org.nz/contcomp.html) that are relevant for their safe and ongoing competent practice.

The Nursing Council supports the Professional Development Recognition Programmes (PDRP), available through district health boards to ensure individual nurses' competence. The Council has developed standards for programme approval to ensure the relevant competencies are met.

NZNO is very interested in this process of setting competence standards, meeting the competencies, and the many options that are open (but not necessarily accessible) to nurses in maintaining relevant professional development.

Patient safety is the baseline for competent practice. The process of meeting competence requirements embraces actual practice hours, learning and refreshing one's knowledge and skills. Having the time and resources to achieve these ends is vital to this process.

This survey was designed to explore the avenues nurses have taken, and would prefer to take, for their professional development. It is important that the issues nurses face in trying to meet their professional development requirements are understood.

NZNO is keen to secure 'competent systems' that assess and maintain nurses' competence, too. The current drive for safe staffing across/in concert with the 21 district health boards embraces seven elements (http://www.nzno.org.nz/Site/Campaigns/safestaffing.aspx). One of these seven elements recognises the need for a skilled and knowledgeable workforce:

> *All NZNO members must have support to acquire and use the knowledge and skills they need to do their jobs safely and well. This requires dedicated time and resources for study and encouragement from management to acquire skills and knowledge. Competencies and qualifications must be established for all health workers to extend and improve their skills and patient care.*

Patient safety goes hand-in-hand with competent nursing practice. NZNO hopes this survey report will contribute to the ongoing discussions and planning for nurses' professional development.

Regards

Anne Brinkman, Professional Nursing Advisor

Table of Contents

Tables

Figures

NZNO Education Survey
November 2008

Abstract

Professional Development issues for regulated nurses in the New Zealand setting

Background: The issues surrounding professional development for nurses require exploration in order to bring about national, effective system(s) that address nursing competence. Understanding competence for nurses and its assessment, while identifying and delivering on learning needs, will meet the requirements set out by the Health Practitioners Competence Assurance Act 2003.

Aims and objectives: To explore the issues around professional development from the nurses' point(s) of view so that an informed position for lobbying for improved systems can be put to effect.

Method: An anonymous survey with both quantitative and qualitative analysis.

Findings: Nurses overwhelmingly favour professional development in the workplace. More than half the respondents reported a conflict with other time commitments, while a number of respondents wrote to their desire for work-life balance, reflecting the other 'components' of their lives. The cost of fees, the ability to take time off work, and time and travelling distance were all hurdles to professional development.
Nurses cited information technology, conflict resolution, managing challenging behaviour, and dealing with rostered & rotating shifts as aspects of their current work for which their nursing education (pre and post) had not adequately prepared them. Nurses also indicated that their pre-registration education in health systems and political processes was inadequate for their current work. As nurses aged, their interest in professional development increased, though many still preferred workplace options.

Conclusions: In order for professional development opportunities to be accessible and relevant, resources and time must be made available. This is vital to achieve ongoing education of nurses and improved patient outcomes. Management support, combined with effective assessment of learning needs guiding professional development opportunities, are fundamental to ensuring nurse competence.

Introduction

There is increasing evidence of the influence nurses have on patient safety, healthcare outcomes, and the professional work environment (Aiken, Clarke, Sloane, Sochalski and Silber, 2002; Tourangeau, Doran, & McGillis Hall, 2007). It is vital to patient safety that nurses meet the requirements and challenges of today's health environment and be able to attain, develop and maintain their competencies throughout their career. Being able to meet those requirements involves motivation, ability and sufficient resourcing through mechanisms that recognise time, costs and other supportive factors.

The professional nursing advisors are often asked about meeting the competency requirements required by the new legislation, the Health Practitioners Competence Assurance Act 2003 (HPCAA), and then determined by the Nursing Council of New Zealand. It was decided a survey of NZNO membership would help describe and quantify the significant issues facing nurses were facing in trying to demonstrate, achieve and maintain their competence.

The objectives for the study were:

- To understand the educational needs of nurses in meeting the Nursing Council of New Zealand (NCNZ)/Health Practitioners Competence Assurance Act 2003 (HPCAA) competency requirements
- To provide information that would enhance the ability of NZNO to lobby for effective educational frameworks, funding and opportunities for nurse
- To examine nurses planned future options

The questionnaire was piloted in the Hutt Valley District Health Board in the following areas: the nursing development unit; nurses in a surgical ward across two shifts; and in consultation with a senior nursing educator at a university.

Application was made to the Central Regional Ethics Committee for ethics approval for the study. NZNO was then notified that the Chair of this regional committee, Trevor James, had judged that ethical approval for this research was not required. NZNO was referred to Operational Standard for Ethics Committees 2006, 4.0, 138 in support of this decision (Letter, 4 July 2007). *See Appendix 1*

The questionnaire was sent to a random sample of NZNO's registered and enrolled nurse members (33,000 at the time of the survey). This meant 1650 questionnaires were sent to members, with a response rate of 720 (representing 43.6%). The questionnaire was voluntary and respondents could not be identified.

The Nursing Council's demographic questions were used, with some minor alterations/additions. An equal number of questions within the survey asked about education. The survey focused on: the educational options nurses use to complete the professional development requirements for their practising certificates; issues nurses face in completing their professional development; where nurses seek advice for their professional development; and the options for learning opportunities nurses would be interested in, in the future.

In two diagrams (Figures 1 & 2) the respondents have been compared for demographic variables with the New Zealand Health Workforce Statistics 2004 (www.nzhis.govt.nz/stats/nursestats.html). The workforce statistics do not differentiate between active registered nurses and midwives, and the figures for these are used as a proxy for registered nurses. This approach therefore assumes that the midwives' demographics are similar to those of registered nurses (see Figure 2 re type of work/area of practice for fairly comparative rates). For some demographic variables the statistics are

presented separately for registered nurses and enrolled nurses and this division has been maintained.

Table 1 Demographics – age, gender, ethnicity, qualifications *(Q1, 2, 3, 8b)*

	n	**%**
Gender		
female	681	94.5
Male	39	5.5
Age		
20-29	48	6.6
30-39	129	17.9
40-49	232	32.1
50-59	240	33.2
60+	71	9.2
Ethnicity		
NZ European	540	75
NN Maori	34	4.13
Other European	60	8.4
Pacific Island	11	1.5
SE Asian	9	1.2
Chinese	11	1.5
Indian	15	2
Other Asian	11	1.5
Other	29	4
Highest Qualification		
Pre Tertiary	326	45.3
Tertiary	347	48.2
Post Graduate	47	6.5

Respondents to the questionnaire are older than the workforce for both the registered and enrolled Nurse groupings. They were representative of the nursing workforce's gender mix, but not its ethnicity, with Maori, other European nationals and Pacific Islanders under-represented. They were representative of Indian and South East Asian ethnic groups.

Table 2 Length of time working as a nurse *(Q 9)*

Length	**Number**
< 12 months	19
1-5 years	72
6-10 years	83
11-15 years	85
16 – 20 years	84
21-30	191
> 30 years	181
Blanks	5
Total	720

Correlation between length of time working as nurse vs age, using Pearson Coefficient: 0.68 (i.e. moderate positive correlation)

There is the possibility in answering this question that different people will have calculated their time as a nurse differently. For example, some may have taken years from qualification

or years actually in practice, discounting (or not) time child rearing, and/or the effects of part-time work on cumulative totals. It would appear evident that the vast majority of the respondents will have had at least ten years' experience working as a nurse.

Annual Practicing certificate

700 of the 720 respondents needed an annual practicing certificate (APC).
Of those 20 not requiring an APC, seven were in employment other than nursing, one was parenting, and the others did not specify. All had three to seven years' nursing experience, and all but one was NZ trained.

Table 3 Workplace and average working hours per week – eliminate hours possibly

Employment setting	number	Average hours
Public Hospital	378	34.5
Private hospital	54	30.0
DHB PHC	28	33.6
Primary Health care	116	30.25
Intermediary service*	38	32
Hospice	13	30.5
Self-employed	5	34.2
Maori HSP	7	38
Educational institution	5	39.4
Government agency	3	23.1
Pacific HSP	0	-
Nursing agency	4	21
Rest home / res. Care	30	37.3
Other	19	37

*Intermediary service mainly comprises District nursing.

Well more than half the respondents work in hospitals, be they public or private. It appears the average number of hours they work per week equates to approximately four eight hour shifts. Anecdotal reports since the 2004-2006 NZNO/district health board multi-employer collective agreement (MECA) have informed NZNO that after the pay increase a significant number of nurses reduced their EFTS to either a 0.9 or 0.8 level. These hospital work hours would support that position.

Working rostered and rotating shifts places a demand on the nurses that goes over and above regular 9-5, Monday to Friday positions (Brinkman, 2000). In order to meet these demands, as well as trying to achieve a work-life balance, nurses are choosing to reduce their hours from full-time positions.

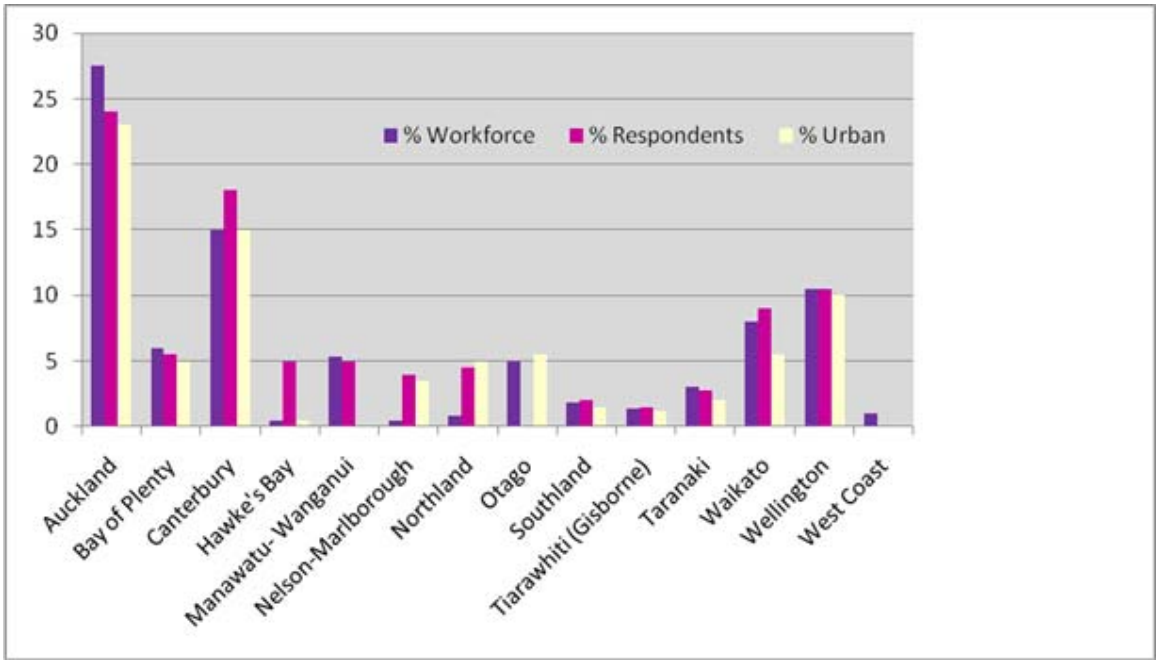
It is interesting that even in settings where the opportunities for more regular hours exist, eg primary health care and intermediary service, nurses are electing to reduce their hours to a similar average. Again, this could reflect the multi-dimensional aspects of their lives, and the demands placed on them.

Table 4 Overseas trained nurses *(Q7a)*

Country	Number	country	Number
Africa (except SA)	8	Germany	1
Australia	15	India	7
Canada	1	Malaysia	1
China	1	Philippines	15
Denmark	1	South Africa	6
England + UK	59	Sweden	1

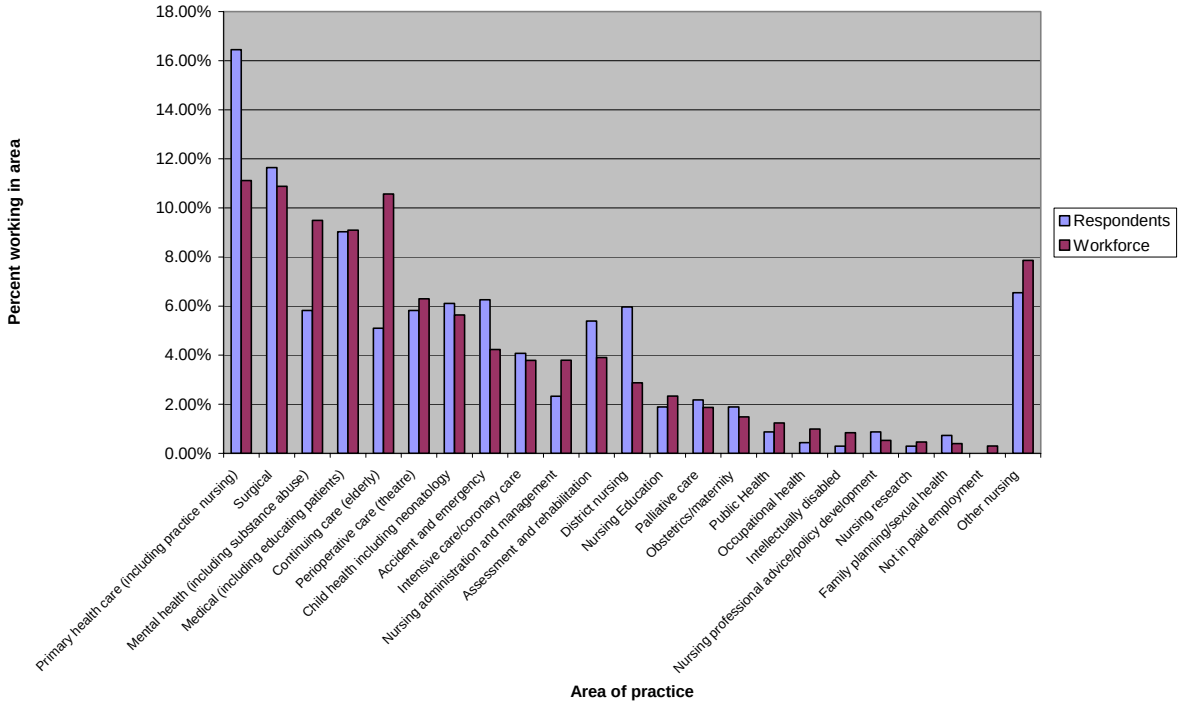
Geographic spread (Q4)
Respondents were not representative geographically. The major urban areas - Auckland, Waikato and Canterbury - were over-represented, while the West Coast, Manawatu-Wanganui and the Bay of Plenty were under-represented, based on the comparative workforce statistics.

Figure 1 Geographic spread of respondents compared with workforce



The respondents were representative by scope of practice (the four scopes are registered, nurse practitioner, enrolled nurse and nurse assistant). When type of work was considered, the respondents were over-represented in primary health care (PHC) and district nursing, and under-represented in mental health and continuing care (elderly).

Figure 2. Type of work/area of practice *(Q12)*

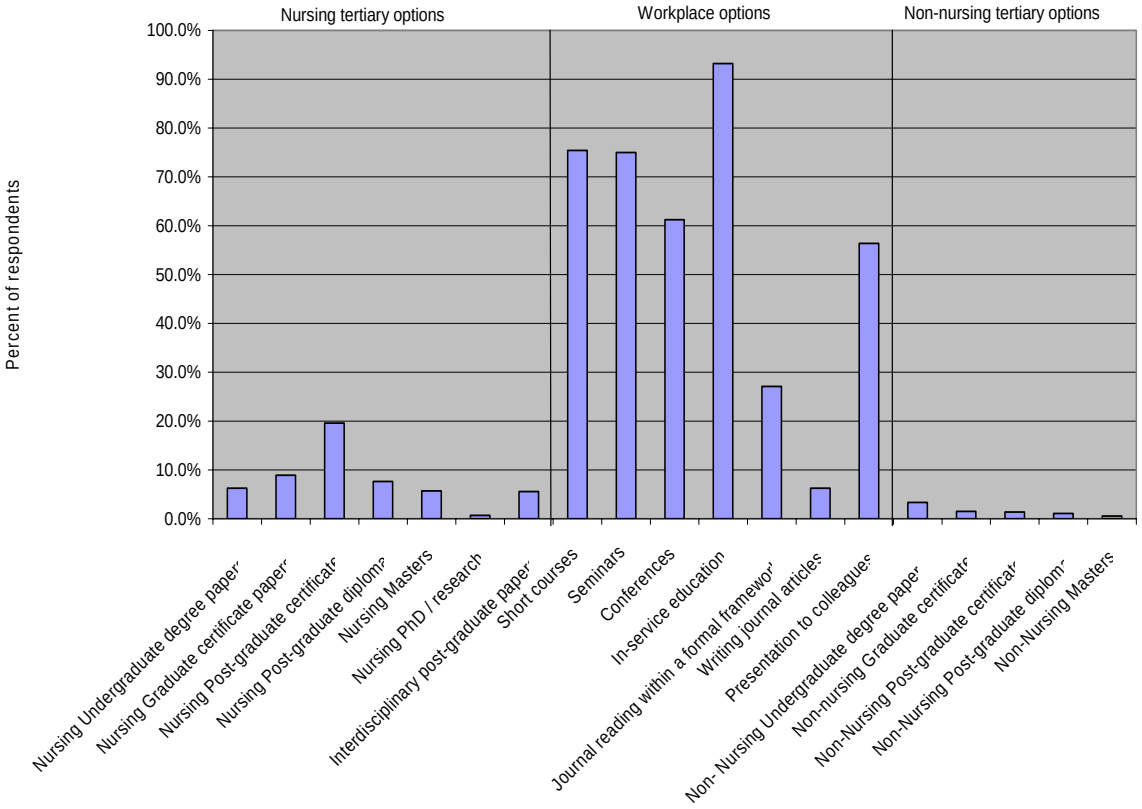


There were comparatively fewer nurses working in continuing care, but more in assessment and rehabilitation. The response in mental health was also smaller (could be related to the fact many mental health nurses are members of other unions, eg the Public Service Association). There were more nurses in PHC and district nursing, which could be a reflection of the age groupings of the participants, with older nurses appearing more motivated to respond to the survey and express themselves.

Survey findings

In answer to how they completed their professional development, the respondents primarily took up workplace-based educational options, eg in-service education, seminars, short courses and presentations to colleagues.

Educational opportunities taken up for professional development
Figure 3*(Q18)*



Respondents chose workplace options, despite the fact the respondents were over-represented in terms of where they live, ie in large urban areas close to tertiary educational institutions. Was this because workplace options overcome some of the barriers to professional development or because these in-house options are more relevant, or because they represent the most time and cost-effective ways of meeting competency requirements?

Issues completing 60 hours (over 3 years) of professional development (Q19)

Table 5

Issue	**%**
Other time commitments	54
Costs in fees	49
Able to take time off work	40
Time and distance to travel	37
Able to attend in work time	35
Time not paid for	35
Concern about ability to do assignment work	33

Hours of work a factor	28
Information technology skills	22
Lack of support/encouragement from employer	19
Access to computer based resources	18
Own motivation to complete	16

More than half (54%) the respondents reported a conflict with other time commitments, perhaps reflecting the (frequent?) necessity to complete the professional development in their own time. A number of respondents wrote of their desire for work-life balance, reflecting the other 'components' of their lives. The cost of fees was the next rated barrier identified (49 %), followed by the ability to take time off work (40%), and time and distance to travel (37%).

The ability to take time off work can be complicated by a number of issues: staff availability to cover the nurse's absence (35% identifying that being able to attend in work time was an issue for them); does the nurse have Clinical Training Agency (CTA) funding for backfill payments should this be the pathway to level 800 studies; even with CTA funding available, do staff exist to provide the backfill?; are workloads such that nurses feel obliged to complete their professional development during annual leave or; on their days off? Funding, workloads, backfill, and professional development opportunities being available are all part of the equation towards achievement.

It is interesting that having 'other time commitments' has the highest ranking of the responses received. Work-life balance received significant qualitative comment as well, and is an ongoing issue associated with combining living, family responsibilities and nursing jobs for many nurses. These issues cumulate, affecting nurses' motivation for continuing education – are they propelled by regulatory requirements, learning needs for safe practice, or career development? Or, of course, a combination of all these factors is possible.

Part-time workers in the survey did not report any more barriers to attending professional development. The group with the greatest numbers of barriers, by hours worked, was the group employed for between 30 and 40 hours per week. Given the higher proportional cost of professional development for part-time workers, no affect was apparent for that reason. The allocation of financial resources to part-time workers varies across the country. There were only 42 respondents out of the 720 who indicated working 40 or more hours per week.

Qualitative comments from Q19

The comments (wholly voluntary) were divided into two main categories:
External/Organisational (n=219) and Internal/Personal (n=350).

Table 6 Framework analysis of 258 free text comments *(related to Q 19, as above)*

Description	Number	**%**	**Additional comments**
External / Organisational			
Staffing – no cover to allow educational activity	67	31	Often leads to permission being withdrawn at last minute
Workload – too busy with own work to attend	32	15	Especially in service training (IST)
Cost – organisation budget constraints	21	10	Work waiting lists, private practice
Management supportive	21	10	Some reporting no problems at all
IT – no or inadequate access at work	20	9	Database searching often mentioned

Lack of relevant courses	19	9	Related to scope of practice
Management unsupportive	17	8	
Time commitments for particular courses	6	3	Preference for very short Inservice Training
Courses cancelled	6	3	Especially Inservice,
Innovation	4	2	More use of IT (2), Less reliance on IT (2)
Difficulties attending due to work setting (primary care)	2	1	Sole nurse, private practice
Information / Booking / process difficulties	2	1	
Academic issues	2	1	Fairness / consistency of marking X2
Internal / Personal			
Responsibilities: child care, dependents	65	30	Time, cost, energy, priority
Work life balance	48	22	All WLB except where family/ childcare mentioned specifically.
Cost of fees / travel personal	40	19	
Own time: not willing to use own time for study	37	17	Where resented necessity to do so
Travel: time / distance	36	17	Rural, night driving, over-night stays a problem
Part time / casual: less management support for study	22	10	Fairness of access to education for PT
Motivation	21	10	Older, experience not valued, no financial gain from study, burn out
Shift work: not available due to working shifts	20	9	(5 specifically mentioned nights, rest shifts)
Stress / tiredness	17	8	too tired / stressed due to work to study
Own time: willing to use own time for study	15	7	Where saw this as a professional necessity
Timing: inconvenient, notice required, length away from work	14	6.5	
Lack of confidence / study skills	12	5.5	Especially use of IT, many mentioning age, preference for practical rather than assignments
Other commitments (not family)	3	1	Voluntary / political work
Other: Fitting 60 hours in after breaks for maternity, sick leave, EN access to study reduced, staff having to share access to training in work time			

Within the external/organisational category, 46% of the participants commented on either not having staff to provide cover/backfill for their absence, or their own workload preventing them attending. Despite having CTA funding (for level 800 courses) available to cover the need for backfill, anecdote has confirmed that nurses, in some instances, are still unable to get leave from work unless taken as annual leave. These barriers could have synergies, with the two elements involving costs (10%), and unsupportive management (8%), though the latter is counter-balanced with supportive management (9%) being recognised.

Another hurdle that drew comment (9%) was the absence of, or limited access to, information technology (IT) at work. This IT barrier could significantly hamper nurses' ability

to search databases, surf the net for credible information, or seek support through peer networks. This is similar to enrolling in a course but only having access to the texts on a haphazard basis, which affects outcomes and satisfaction with progress. Comments around IT innovation were made (n=2), though the same number wanted less reliance on IT. Again, the spectrum of interest in, and motivation of nurses in the pursuit of professional development, is apparent. It begs the question of how are learning needs assessed (and by whom) and met? Who, then, decides the relevant learning outcomes, in order to promote professional development and enhance patient safety? Does professional development become a jumble of learning opportunities in some instances that ostensibly meet the Nursing Council requirements, and, hopefully, the nurse's learning requirements?

Do these barriers affect all nurses equally? (Q15, 19)

Issues accessing training vs qualification

There was some difference in the barriers reported by enrolled nurses compared with registered nurses in the NZNO survey results. Enrolled nurses were more likely to report difficulty with taking time off work, being able to attend in-service opportunities in work time, their hours of work, and IT skills and access to computer-based resources (Table 6). Nurse assistants and nurse practitioners were not included in the analysis of barriers due to their small numbers.

Table 7 Difference in issues reported by RNs compared with ENs *(Q7, 19)*

Top six issues re access top training: RN vs EN (other titles certainly too small)

Issue	**RN n=663**		**EN n=43**	
	Number	**%**	**Number**	**%**
Other time commitments	366	55	20	46.5
Cost in fees	323	49	23	53.5
Able to take time off work	264	40	21	49
Time and distance of travel	256	39	12	28
Can attend in work time	229	34.5	21	49
Lack of support	124	19	9	21

2 tailed T Test paired sample: 0.94 (i.e. no significant differences between Registered and Enrolled nurses, though yes/no scale and small numbers make this an imprecise exercise).

Table 8 Issues accessing training vs title *(lower score means fewer issues)*

Title	**number**	**Mean score**	**Title**	**number**	**Mean score**
Staff nurse	379	4.2	Nurse practitioner	0	-
Nurse manager	10	1.4	Clinical nurse specialist	21	4.2
Clinical nurse manager	15	2.8	Duty Nurse manager	4	4
Charge Nurse manager	11	2	Clinical resource nurse	1	2
Assist. clinical nurse manager	7	3.1	Specialty clinical nurse	7	4

Assist. charge nurse manager	4	4.2	Family Planning nurse	3	4
Clinical nurse coordinator	7	3.1	Practice nurse	91	3.6
Nurse coordinator	11	4.2	Public health nurse	8	2.3
Nurse educator clinical	8	2.75	Enrolled nurse	39	4
Nurse educator academic	3	3.4	Nurse assistant	2	5
Nurse researcher	1	1	Other	66	3.8
Nurse consultant	0	-			

Table 9 Access to professional development vs Job Title

Highest access	Researcher	Nurse Manager	Charge Nurse Manager	Clinical Resource Nurse	Public Health Nurse
Lowest access	Nurse Assistant	Staff Nurse	Nurse Coordinator	Clinical Nurse Specialist	Assistant Charge Nurse

Caution is required with interpretation due to small numbers and the yes/no scale proxy measure.

Issues accessing training vs area of nursing

Nurse researchers and occupational health nurses had fewest issues related to accessing training, while those with the most issues related to accessing training were nurses working in assessment and rehabilitation, medical and family planning. Non-nursing related options were excluded from the analysis.

Rural nurses

Table 10 Difference in issues reported by rural nurses compared with urban nurses (Q5, 19)

Caution with interpretation as above

Issue	**Rural %**	**Urban %**
Able to take time off work	40	41
Able to attend in work time	35	35
Lack of support/encouragement from employer	22	18
Hours of work a factor	34	26
Own motivation to complete	14	17
Time not paid for	32	35
Costs in fees	52	48
Other time commitments	55	54
Time and distance to travel	62	33
Information technology skills	24	21
Access to computer-based resources	23	17
Concern about ability to do assignment work	34	32
Other reasons	8	8

Rural nurses are more likely to report issues with time and distance to travel for professional development (62% compared with 33%) and hours of work as barriers to professional development (34% compared with 26%). The mean hours of work in this group was not

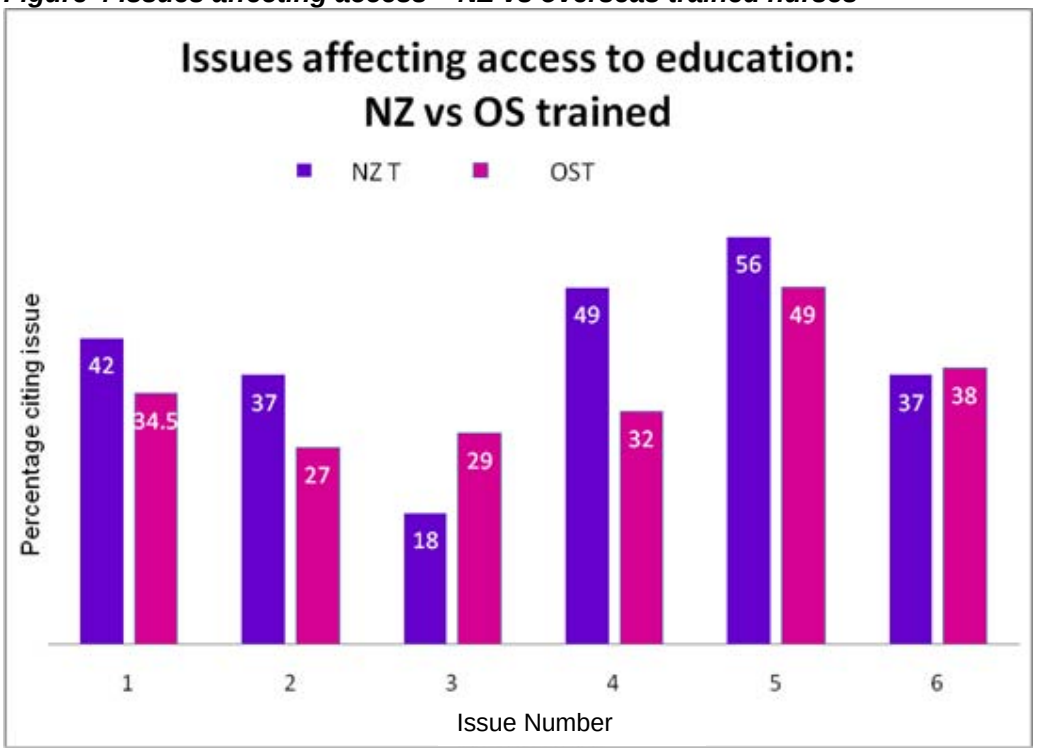
significantly different between urban and rural nurses (urban n=592, $\bar{x}$ =33.68, sd=10.47; rural n=103, $\bar{x}$ =32.01, sd=12.202) - nor was the number or type of professional development opportunities used different between the two groups, urban and rural.

Table 11 Top six issues re access to training: NZ vs OS trained

Issue	NZ trained		Overseas trained	
	Number	%	Number	%
1 Other time commitments	320	56	68	49
2 Cost in fees	284	49	45	32
3 Able to take time off work	240	42	48	34.5
4 Can attend in work time	212	37	37	27
5 Time and distance of travel	212	37	54	38
6 Lack of support	104	18	28	20

2 tailed T Test paired sample: 0.57 (i.e. no significant differences between home and overseas trained nurses, though yes/no scale and small numbers make this an imprecise exercise).

Figure 4 Issues affecting access – NZ vs overseas trained nurses



Where 1-6 are the issues taken from Table 11. From this it would appear that NZ nurses perceive more issues hinder their access to training (proportionately) – except support from their managers. Time and distance to travel for training is perceived as affecting both groups, almost equally.

Table 12 Access to further training opportunities: pair-wise comparisons

Category	n	Sum issues	mean
English speakers	675	2676	3.96
Non-English speakers	45	11	3.13
Public HC	116	456	3.93
Residential care	31	123	3.96
Total	720	2852	9.96

Small numbers, 1/0 options make a statistical difference undetectable, however, there may be a perception from the non-native English speakers that access to further training is less problematic than for English speakers. This may reflect lower expectations, or that access in NZ is better than their home countries, leading to less dissatisfaction with access.

Education background(s) (Q7, 8b, 16)
Only 10 nurses responded that they were 'not at all prepared' for over five subjects, with all having qualified before the 90's, and seven of the ten nurses had hospital-based training certificates, with six out of ten being general and obstetric nurses.

Table 13 Preparedness vs title *(Q15, 17)*
Analysis was performed *excluding all the Not Applicable scores*. Crudely, with a score of 1=completely prepared, 2= somewhat prepared and 3=Not at all prepared, the higher the score across all elements of the pre-registration subjects, the less prepared the respondents considered themselves for their current nursing work.

Title	number	Mean score	Title	number	Mean score
Staff nurse	379	1.58	Clinical nurse specialist	13	1.78
Nurse manager	10	1.78	Specialty clinical nurse	4	2.01
Clinical nurse manager	8	1.72	Family Planning nurse	2	1.1
Charge Nurse manager	7	1.6	Practice nurse	62	1.68
Assist. clinical nurse manager	5	1.6	Public health nurse	6	1.4
Assist. charge nurse manager	3	2.03	Enrolled nurse	15	1.6
Clinical nurse coordinator	3	1.74	Nurse assistant	1	1.8
Nurse coordinator	7	1.86	Other	39	1.7
Nurse educator clinical	7	1.75			
Nurse educator academic	1	2.27			

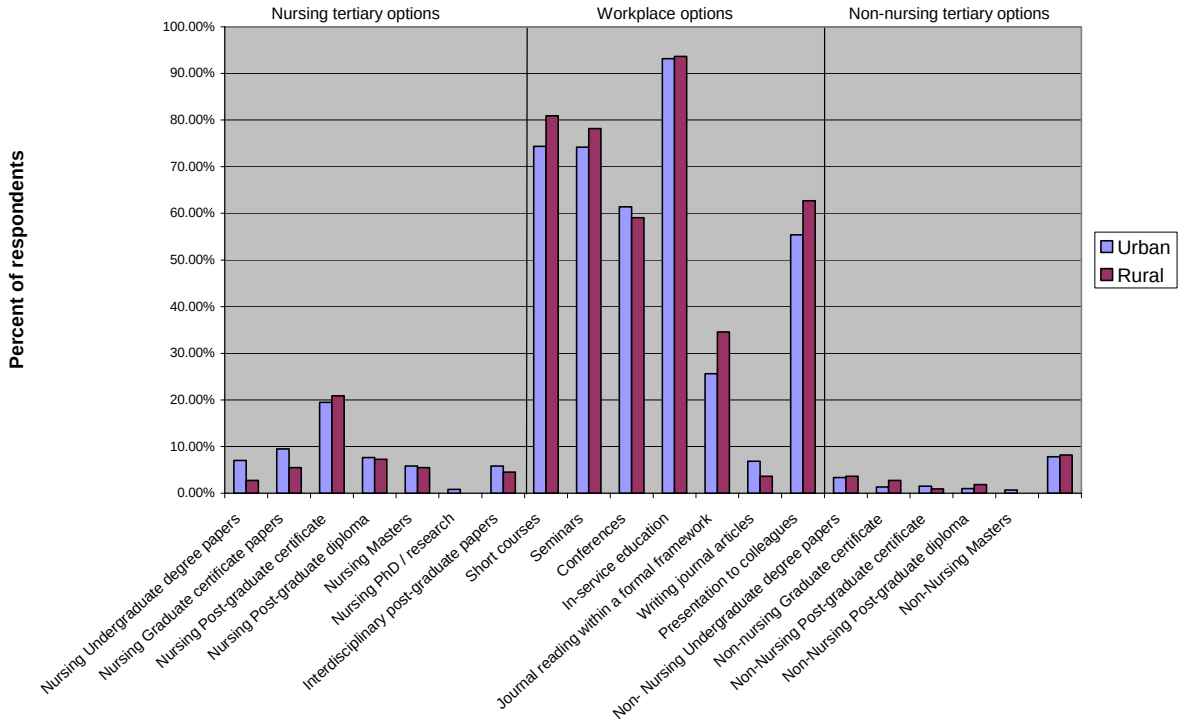
Interpretation of this question (Q17) is hampered by small numbers, and the small subjective scale provided, allowing for the three options described here. There are possibilities such as: seniority implying a longer time since training (tested below); seniority may also confer greater awareness of deficits of training; or greater specialisation meaning that pre- and post- registration training did not equip the nurse for their current role (differently interpreted question); or age and recall bias might have affected their response.

Table 14 Preparedness vs length of time worked as a nurse
(analysis excludes those not replying to these questions N/A and blanks)

Length Service	number	Preparedness score
<12 months	2	1.65
1-5 years	2	1.62
6-10 years	2	1.57
11 – 15 years	85	1.73
16-20 years	85	1.65
21-30 years	191	1.84
>30 years	183	1.98

Pearson correlation r = 0.8, (i.e. length of service positively correlated with unpreparedness at initial training). However, given the small numbers and the limited subjective scale (proxy measure) these results must be used with caution in contrasting with those nurses with less than ten years' experience.

Professional development preferences for chosen area of practice
Figure 5 *(Q24)*



In effect, employers could well be the ones to make the "preference" through the choices made about topics, speakers, etc. Assessing learning needs should be an intrinsic component of any formulae determining what might be placed on offer. For example, professional development might require technological skills for competent practice, meaning any deficiencies/new learning in the nurse's skill set should be addressed. Despite the origin and range of the choices on offer, the respondents identify being confident in choosing relevant professional development (Q21).

Comparing urban nurses with rural nurses shows that the latter prefer short courses, seminars, journal reading within a formal framework, and presenting to colleagues. These choices potentially reflect the issues of distance, and time to travel for the rural nurse.

Preference vs qualification
Table 15 *(Q7, 18)*

Qualification	n	Work-based options %	Nursing tertiary %	Non-nursing tertiary %
Enrolled nurses and nurse assistants	52	90	5	4
Registered nurses hospital certificate	309	89	10	1
Registered nurse with diploma	143	89	10	1
Registered nurse bachelor degree	195	81.5	17.5	1
Post-graduate nursing qualifications	7	88	10	1.5
missing	14			

Respondents were separated into five categories. Enrolled nurses and nurse assistants form one category, nurse practitioners another, and registered nurses are split into three categories, based on their qualification for registration: either a hospital certificate, diploma, or degree.

Registered nurses with a degree qualification are the most likely of the three registered nurse qualification groups (hospital certificate, diploma or degree qualifications) to have used nursing tertiary education options for their professional development (17.5%) in the previous three years. In contrast, 10% of registered nurses with a diploma or hospital certificate sought tertiary education opportunities. Nine percent of enrolled nurses and nurse assistants have used nursing tertiary education options, while four percent have taken non-nursing tertiary education options.

A reasonable explanation for the disparity in education choices between the different registered nurse groups might be that those with an initial degree are more likely to have confidence to continue with post-graduate study as they are already familiar with tertiary education systems. In contrast, those nurses with a certificate or diploma qualification, historically had to first seek 'recognition for prior learning', and then complete a bachelors degree to continue on with post-graduate study. This process presented a greater hurdle to pursuing opportunities for post-graduate education.

This is not the case in New Zealand now. There have been historic differences among educational institutes and their entry criteria for postgraduate study. Nurses can now pursue masters level education in some tertiary education institutions without having completed an undergraduate degree. However, with that entry comes the recognition by the nurse of having to 'catch up' with their peers in the academic processes.

Additionally, there could be confounding factors around the effects of age or time post-registration, affecting the outcomes of whether or not to study at a higher level of education.

It is interesting to note that nurses with post-graduate qualifications report similar preferences to those nurses with a diploma or hospital training certificate for work-based

options, perhaps reflecting that, having a post-graduate qualification they then use alternative options for professional development (Figure 4).

Enrolled nurses, on the other hand, place the cost in fees (53.5%), ability to attend in work time (49%) and ability to take time off work (49%) as their three greatest barriers, with proportionately more enrolled nurses reporting those barriers than for the group in general. Of course, their salary is less than that of the RN so it follows that costs in fees are proportionately more of a burden for them.

Academic barriers aside, for survey respondents, the average age of nurses with a degree is 39, while for nurses with a diploma it is 43, and for nurses with a hospital training certificate it is 55. The benefits to be gained from post-graduate education, which has real costs in fees and time, may be less for the older age group, decreasing the likelihood that post-graduate options will be favoured. Given the variable nature of employer support, are there any indicators linking access to funding, and places for postgraduate study to age? This could be a topic for further research.

Adequacy of pre-registration education - Q16 f and 16p compared with low/high scoring aspects

(total count shown is of 1+2+3 e<u>xcluding</u> 4 not applicable, i.e. the higher the score, the less prepared people felt. Nursing theory, the subject most confident in is included for completeness)

Table 16 *(Q16)*

16a	Nursing theory	= 31
16f	Health systems / political processes	= 198
16p	Deteriorating patient / early warning systems	= 100
16r	Information technology	= 202

The interplay between being au fait with IT and health systems/politics is real in order to stay current, and to be able to take an active part in the health arena. Facility to contribute to the wider environment by making submissions, for example, or keeping abreast of new developments in the health sector, implies using computers and the internet adeptly. Also, given recent findings from the Health & Disability Commissioner's Office, it is imperative that nurses are well versed in on-line data exchange and deterioration/early warning systems for safe patient monitoring (HDC Office, 2008).

There are a substantial number of respondents indicating that their pre-registration education in health systems and political processes was inadequate. This gap in education has significant implications for nurses' ability to lobby for themselves, let alone patients.

Possible content for professional development (Q17)
The respondents were asked "Thinking about your current nursing work, how well has your nursing education (pre and post registration) prepared you for the following aspects of your job?"

Table 17 *(Q17)*

Aspect - ordered by completely prepared (col1)	completely prepared %	somewhat prepared %	not at all prepared %
Communication with other nurses	62	36	2
Teamwork with other health professionals	58	39	3
Communication with other health professionals	54	41	5
Own role organization on day-to-day basis	51	44	5
Delegation and direction of other health workers	44	46	10
Shiftwork / Rostered & rotating	44	41	15
Self-management on day-to-day basis	42	47	11
Conflict resolution	27	53	20
Managing challenging behaviour	26	54	20
Information technology	25	49	26

Aspect - ordered by not at all prepared (col3)			
Information technology	25	49	26
Conflict resolution	27	53	20
Managing challenging behaviour	26	54	20
Shiftwork / Rostered & rotating	44	41	15
Self-management on day-to-day basis	42	47	11
Delegation and direction of other health workers	44	46	10
Communication with other health professionals	54	41	5
Own role organization on day-to-day basis	51	44	5
Teamwork with other health professionals	58	39	3
Communication with other nurses	62	36	2

The last five items in the tables demonstrate that more than 50% of the respondents stated they were somewhat or not all prepared by their nursing education for working within the following areas:

- Information technology
- Managing challenging behavior
- Conflict resolution
- Self-management of day-to-day basis
- Shiftwork/ rostered & rotating.

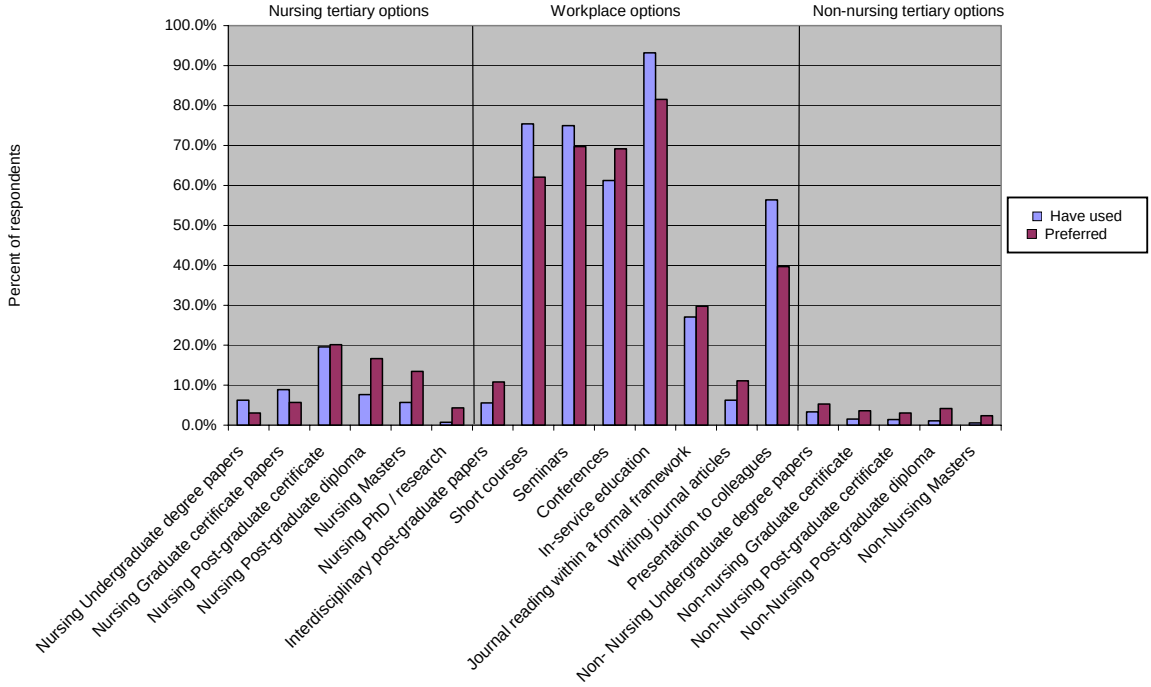
These identified issues have implications for what might be covered within professional development to upskill the staff and augment their confidence and competence.

Having only the three sections of differentiation for response was probably a weakness in the survey in that those choosing the middle section can actually represent between 34 – 66% in their level of feeling prepared – a substantial spectrum to consider! Closer definition of parameters might have helped provide better information. For example, depending on how you look at it, IT could be a problem for 75% of people (on the basis that their response was directed at the lower end of the 'somewhat prepared' scale) in contrast to 74% being prepared (answering at the higher end of the middle spectrum). This would be an area for further research to tease out the details of preference out more accurately.

Professional development preferences (Q 2, 24)

When asked for their preferences in developing their specialty skills and clinical knowledge, respondents indicated that workplace options were still the most preferred, with the only major change being a notable interest (~70%) in attending conferences. Nurses were interested in attending conferences, but hadn't (substantially) used that option to complete their professional development in the previous three years. Of course, attending a conference means time away from the workplace and substantial costs for conference registration, travel and accommodation, all of which were reported as barriers to professional development.

Figure 6 *(Q18, 24)*
Which have you taken up versus How would you prefer to develop specialty skills and clinical knowledge for your chosen area of practice?



Respondents indicated that the workplace options were still the most preferred (Figure 5), although there was some change from workplace options to both nursing and non-nursing tertiary options, with a larger move towards nursing postgraduate diploma and masters options.

Age, Postgraduate training, overseas training background vs. plans

Table 18 Age vs plans for further study

Age	number	Weighted score
20-24	18	39
25-29	30	37
30-34	51	43
35-39	78	41
40-44	115	42
45-49	117	43
50-54	149	42
55-59	91	48

60-64	51	51
Over 65	19	55

Pearson correlation coefficient r = -0.89 (i.e., inclination for further study increases with age – looking at the figures, this starts after age 55). Newly qualified nurses also appear to want a break from further study. Caution needs to be exercised in the interpretation, though, given the small numbers, and the proxy scale.

A weighted score was generated by summing the answers given for interest in future choice options, divided by the number of respondents of the relevant age group. These were inverted for clarity, and are shown graphically in figure 6

Figure 7 Age versus interest in further study

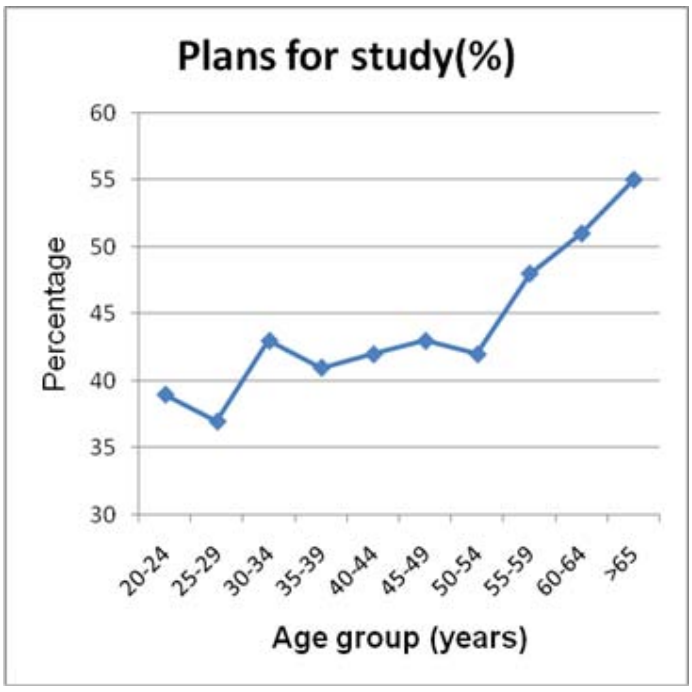


Figure 6 demonstrates that with increasing age, comes increasing interest in further study. This probably reflects changing demands placed on nurses, across their lives, in achieving work/life balance. Hence, their interest and motivation to study will vary according to their lifestyle and choices available to them.

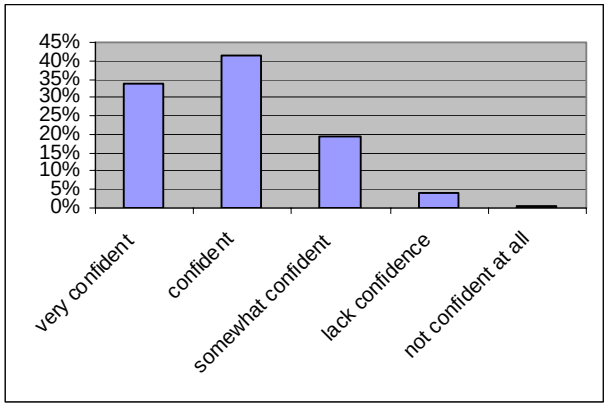
Postgraduate training vs plans for further study, and overseas training vs plans for further study

Using the analysis as above, no differences could be determined between either the highest level of qualifications and having plans for further study, nor between the plans of overseas-trained or New Zealand-trained nurses. However, the interested / possibly interested / not interested proxy scores and the large number of items, 14, (even once non-nursing options were excluded) makes significance difficult to demonstrate.

Confidence in choosing Professional Development

Figure 8 *(Q21)*

How confident are you about choosing relevant professional development that will help you to meet the competencies



Despite issues around completing professional development, 75% of respondents were confident or very confident choosing relevant professional development.

Seeking advice

Table 19 *(Q22)*

Who/Where do you seek advice from regarding meeting the professional development requirements for your scope of practice?

Organisation or person	%	Organisation or person	%
Nurse educator	29	Peer - other nurse	11
PDRP coordinator	17	Education institution/staff	7
Senior nurse	14	NZNO	5
Nursing council	13	Others	3

The three major sources for nurses wanting advice on how to complete professional development are found within the respondents' workplace(s) – nurse educator, professional development recognition programme (PDRP) coordinator and senior nurse proved to be the first points of reference for nurses. The Nursing Council follows next and does have relevant information available on its website. It is the Council's mandate to ensure competence through professional development.

If the first three sources, and peers (ranked fifth) are grouped together, then 71% of advice is sought from the workplace, with only small numbers seeking advice from education institutions or NZNO.

The type of advice sought by nurses is not differentiated in the question. This could be an area for further research so that websites could be enhanced to provide relevant information, not only to the nurses but to those providing the advice as well.

There were very mixed qualitative answers to question 23a about clarification or support that might help the nurse in assessing her/himself against the competencies. This is a potential area for further research.

Performance appraisals (Q20)
Performance appraisals may be a time where educational plans are discussed, and management support is negotiated. For these respondents, 21% had had a performance appraisal (PA) for each of the last three years. Sixteen percent had two PA in three years, 49% had had one PA in three years, and 14% had not had a PA in 3 years. Respondents who had indicated that a PA was not applicable were excluded from these percentages and they represent 3% (n=24) of the 720 respondents.

The Nursing Council does not make a formal recommendation that PAs be regularly carried out. Instead, PAs are one of three options for competency self-assessment processes, with only two of these options being compulsory for any one round. It would be over to the employer to make that call for regular PAs.

Future plans
Table 20 *(Q25)*

Future intention	**%**
satisfied, no plans to leave	55
unsatisfied, no plans to leave	4
satisfied, plan to change	14
unsatisfied, plan to change	4
plan to practice overseas	4
plan to retire	4
leave nursing within 6 months	1
leave nursing within 2 years	3
unsure of plans	10

Fifty-five percent of respondents reported they were satisfied with their job and had no plans to leave, and 14% reported that they were satisfied but planned to change.

Eight percent of nurses reported they were unsatisfied with their jobs, and 4% planned to leave nursing. Retirement and practising overseas were the different options chosen by another 8% of respondents. Therefore, the cumulative total of 26% of nurses potentially exiting the nursing workforce within two years is significant and warrants exploration from a workforce planning perspective.

Table 21 Future plans vs age vs aged care staff

Plans	% aged over 55	% under 35	% Aged care staff
No plans to change	50	44	39
Change role but remain in nursing	21	14	29
Leave nursing in NZ in next 6 months	22	27	32

The numbers of respondents in Table 19 are too small for significance, but are interesting in that they demonstrate similar results for those nurses not planning to change or to leave nursing within the next six months across varying groupings. The biggest difference lies with those nurses in aged care who indicate a greater desire to change their role within nursing.

Discussion, with relevant literature

Nurses must complete 60 hours of professional development every three years to maintain their practising certificate. An audit process is carried out by the Nursing Council as a compliance measure to monitor whether nurses have met the requirements for their practising certificate. How do nurses respond to this requirement? We found this set of respondents is confident about choosing appropriate professional development and assessing themselves against the competencies, but barriers do hinder or prevent their initiation and/or completion of professional development. The professional development options they choose may be an attempt to reduce those barriers and/or are seen as more relevant to their clinical practice. There is also the possibility that the choices taken represent the paths of least resistance for the nurses: - least effort, least cost, least time needing to be invested, – as opposed to relevance to their clinical work.

Learning needs (Q18, 24)

Nurses seek support for their learning through different avenues, depending on their personality, access to resources (time, costs, energy, learning needs), and motivation (Hughes, 2005; Joyce & Cowman, 2007). Is there an over-emphasis on taught-type courses at the expense of reflective practice, self-directed learning and peer-led learning here in New Zealand? The Ministry of Health's CTA funding streams promote formal education opportunities only (CTA, 2006). Funding through the district health board (DHB) pool of money available to nurses (via each director of nursing; nursing development unit(s)) is variable around the country, which must affect the other possibilities open to nurses.

The practicalities of acquiring support, resources and opportunities depend on a number of factors in pursuing learning. To encourage ongoing participation and completion requires appropriate, relevant options able to meet nurses' learning needs.

Therefore, enhancing learning opportunities, - and their uptake, - are important to the maintenance of professional development. In parallel, recognising and reducing/removing the barriers to learning is important. Aside from concerns about access to learning resources for the nurses themselves, there is the possibility of placing particular population groups at risk, if some nurses face more barriers to professional development than other nurses. This risk should be an essential driver for professional development to positively affect patient care and patient outcomes (Washburn & Hornberger, 2008; Guardini, Talamini, Fiorillo, Lirutti & Palese 2008).

An example of the learning requirements of nurses in meeting patient needs was illustrated in a study exploring the provision by nurses of smoking cessation interventions. The study showed that over half of the respondents (nurses) had not received training for this patient support, with three quarters expressing interest in learning more about how to help people stop smoking (ASH-KAN Aotearoa, 2007).

Understanding the processes of learning and teaching is essential to provide professional development opportunities. Along with assessing learning needs that complement and augment the nurse's practice, differing styles of teaching are very relevant to successful learning. Facilitating learning requires flexibility to adapt to the capabilities and styles of the nurses involved. Time and reflection are often necessary components, too, for the learner to formulate new ways of thinking and functioning (DeSilets & Dickerson, 2008) with the fact outcomes have been met not necessarily apparent, in the first instance.

On the other hand, time can also work against the nurse's learning. A study of nurses' knowledge of pain management showed that "knowledge progressively decreases, if refresher courses are not held regularly (Guardini, Talamini, Fiorillo, Lirutti & Palese, 2008,

p. 285)". As well, it was found that "inadequate methods of learning and professional traditions continue to affect the quality of acute pain management (ibid)". These are disturbing findings, though they underline the importance of continuing education to update nurses' practice in pain management, as an example of the value of professional development.

Nurses, like all health professionals, need professional development to ensure their continuing competence. Both formal and informal options are acceptable according to the Nursing Council requirements. The profession needs to study the gap between pre-registration systems and formal post-graduate studies in New Zealand to determine appropriate and relevant educational possibilities. This education gap between our layers of formal education represents fertile ground for learning for many nurses, as was demonstrated in our findings. National policies around accessibility, quality and the fiscal responsibility for continuing education are vital to nursing competence (Yoder-Wise, 2008; Sevean, Dampier, Spadoni, Strickland & Pilatzke, 2008).

Workplace as choice issues (Q18, 24)
A survey of nurses in the United Kingdom by Gould, Drey and Berridge (2007) found that "work-based learning was regarded by many nurses as at least as important as classroom-based opportunities (p. 606)". Another study by Gibson (1998) had respondents who expressed "acceptance that nursing needs to move away from a course-dominated culture to one in which learning and development are an intrinsic part of everyday professional practice" (p. 457). The survey (Figure 3) showed that more than 80% of the respondents choose to complete their professional development requirements through inservice education options.

Preferences, motivations (Q24)
A possible explanation for the disparity between the different registered nurse groupings (Table 15) might be that those with an initial degree are more likely to have confidence in tertiary education requirements for continuing with post-graduate study. The age of the registered nurse at the time of planning further study, as well as the time elapsed since registration, will influence the choices taken.

With post-graduate studies, historically, nurses had to seek 'recognition for prior learning' for their hospital certificate or diploma to be credited towards completion of a bachelors degree, as a pre-requisite for post-graduate study. Since then, requirements have changed. The National Framework for Nursing Professional Development and Recognition Programmes and Designated Role Titles report (2005) states that, "Registered Nurses no longer have to complete an undergraduate degree to gain access to Masters level study and can gain provisional entry and continue in a [post-graduate] degree (p. 15)."

This criteria makes entry to post-graduate studies easier for some, but it does place extra pressure on the student who could well have to 'catch up' with their peers in terms of learning pathways to ease the demands of study. For example, familiarity with library systems and databases; basic essay construction and correct referencing; bringing 'life' to their assignments and understandings by being able to think beyond the fundamental requirements. This leap-frog entry to tertiary studies can also have ramifications for the teaching staff, as more academic and pastoral support can be required by the student. Therefore, the student must understand this is not necessarily the easier option to take – as opposed to completing some tertiary study before setting out on postgraduate courses.

Barrier issues (Q19)

The literature cites a number of issues surrounding the pursuit of professional development. Motivational factors, combined with appropriately pitched and supported professional development, promote the education options being pursued. This is, particularly when the options are designed in response to need, and with learning outcomes being appropriately evaluated (Furze, G. & Pearcey, P. (1999). However, factors that deter participation in professional development are also cited, such as time, costs to the nurse, limited access to adequate child care, workplace budget constraints including staff shortages, lack of employer support, scheduling difficulties, family responsibilities and the desire for work/life balance. (Bahn (2006); Aoki & Davies (2002)).

Respondents in the study by Gould et al (2007, p607) reported that "the demands of undertaking [professional development] conflicted with home and domestic commitments and were perceived as a barrier to achieving desirable work-life balance….They complained that managers expected they would invest personal time in [professional development] intended to primarily improve service delivery". These expectations must sit alongside the entitlements negotiated for professional development.

The MECA 2007 – 2010 states that (27.3, p. 49),

- "the employer shall grant professional development leave of 32 hours per calendar year from 31 March, 2008, for full time employees (pro rataed to no less than 8 hours per calendar year for part time employees) who are registered/enrolled nurses and/or midwives. This leave is to enable employees to complete qualifications, to attend courses and to undertake research or projects that are relevant to the employer and which facilitate the employee's growth and development."
- "Paid leave to meet organizational and service requirements, and those HPCA requirements not otherwise addressed in this clause, shall be granted in addition to the above provisions. The employer will meet any associated costs."

The second clause provides for organizational, service and HPCA Act requirements to be met with paid leave. However, given the working environment where skeletal staffing numbers translate to nurses being unable to take time off work (for study) or to attend in-service education during work time, the opportunities for release are reduced. Anecdotally, even with guaranteed CTA-funding to meet the costs of backfilling, nurses have had study leave requests refused, due to staffing issues (Rae, 2008). The end result is that they are forced to use their days off or annual leave to meet study requirements. This, in turn, cuts into the quality of their time off work for rest and relaxation, i.e., work/life balance.

Work/life balance (Q19)

Child care issues were not detailed within the survey questions themselves but were raised by respondents in their qualitative responses (Table 6). Literature points to child care being one of the major challenges and dilemmas identified by workers. Quality, availability, hours and cost of child care are the central issues that bear down on the workers in trying to seek solutions to their needs (Doiron et al, p. 198). As well, if a child/dependent is ill, then it can mean the nurse is having to use annual leave entitlements in order to meet these family needs – this in turn is an added pressure for the nurse as stated above.

Anecdotal evidence refers to mothers (and other carers) trying to meet their many family needs, while trying to maintain/update their professional knowledge, skills and competencies. It is not surprising that the problems around work/life balance and childcare emerged as significant points of response.

With nursing a female dominated profession, it is important to bear in mind that three quarters of most forms of unpaid care is done by women (Doiron, Hall & Jones, 2008, p. 189). It is noted that in Australia:

> Under the current Work/Care regime, the intersection between non-market care and paid work is *sore*. The two collide. In many places the articulation of the two kinds of work is primitive and awkward. Many carers contort themselves around jobs and workplaces – or give up on jobs. Forty per cent of primary carers for people with a disability or older people who are unemployed or not in the labour force would like to work but many have given up looking for suitable jobs (ABS Cat No 4436.0).

Workplace culture must be noted as impacting on work/life balance (Table 5). Expectations of workmates, colleagues and managers make finding the balance harder to achieve, according to New Zealand research (Department of Labour, 2006). Key measures have been put forward for improving the Australian work environment that do, or could, make traction in New Zealand workplaces, including: flexible approaches to hours of paid work; improving rights for part-time work; workplace initiatives in response to need; leave provisions; extension of quality, affordable universal child care (and recompense for the child care workers); higher value placed on care, carers and dependents across society; revitalizing 'community'; and rethinking consumption (ibid, pp 253 – 257).

However, it's all very well to have flexible working hours but the demands of the 24/7 health environment cast a different light on/ mean flexible hours can be hard to attain for some nurses dealing with the unpredictable 'rostered and rotating' shift systems.

The Code of Ethics for Nurses (American Nurses Association, 2001) recognises the value of nurses taking care of themselves. The code states, "the nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth (p. 4)." A presentation at NZNO's 2008 conference on the need for nurses to consider their own dignity, in order to deliver safe and competent care, reflected these themes (Lawless, 2008).

Nurses in this survey, particularly in their qualitative comments (Table 6), made it clear that seeking and maintaining work/life balance is a significant issue for them.

Ageing workforce (Q2, 19, 25)
The transfer of knowledge includes clinical and role expertise, which may be enriched by education and experience, including longevity in the profession. Formal education opportunities are more easily and tangibly measured, in comparison with experience. This difference (in ease of measurement) is sometimes regarded as an affront to experienced nurses, but is entrenched due to the numbers of nurses and the difficulties in consistently assessing professional development on a national basis.

A number of the respondents (in the 'higher' age groups) indicated they were not interested in (further) formal study (Table 18). The literature does acknowledge the need for customising education for the older worker and creating adaptations that focus on the skills needed for their role expansion or refocus (Hatcher, 2004). Yoder-Wise (2008) speaks to the under-development of older nurses that is common in many areas of practice. So, how do we ensure their needs are met within the learning resources provided in the workplace? How do we also encourage them to share their knowledge and experience in appropriate learning forums?

The costs of lost knowledge are difficult to quantify, yet this needs to be considered as the "baby boomers" retire. DeLong (2004) speaks to it being worth retaining experienced nurses for their "efficiency-knowledge – knowledge of how to get a job done faster and better." It is

possible, as experienced nurses retire and patient care is provided by novice nurses, less experienced nurses, and for some immigrant nurses unfamiliar with organisational procedures and cultural expectations, that hospital safety and effectiveness could well be compromised. This could have a negative impact on the quality of care, patient satisfaction and safety, productivity, and organisational performance.

Similarly, concern about the general lack of preparedness by employers in responding to the aging workforce is a real issue (Hatcher, 2006). Here in New Zealand, it is only in the few months before the 2008 general election that the (then) government signaled that the responsibility for health workforce planning is to be revisited by the Ministry of Health. Health workforce planning ceased in the mid-eighties (Salmond, 2003).

Do we need to assess and monitor nurses' intention to retire? Could we develop a low-cost, readily available, easy-to-interpret Web-based survey instrument to regularly assess work environment issues affecting nurses' intent to stay on the job? Could we foster research on the effects of the employment of older nurses on patient care and nursing practice? Are these questions that will be more easily answered once the Ministry of Health has collated the relevant workforce data? In the meantime, given the chosen preference for workplace based options, it is apparent that professional development needs to be in the workplace to best support the older nurse.

Rural nurses (Q5)

For the rural nurse, further barriers to professional development can include the distance to learning forums, travel, a lack of opportunities and/or lack of information about the options, and lack of resources available (Penz, Stewart, Kosteniuk, Morgan & Smith, 2007; Beatty, 2001; Rosenthal, 2005). In this study, rural nurses report that time and distance to travel (62%), other time commitments (55%) and costs in fees (52%) are their greatest barriers (Table 10), confirming Beatty's (2001) findings for rural nurses in Pennsylvania.

There was virtually no difference in the options preferred for professional development between rural and urban nurses (Figure 5). Whether this represents a choice based on learning styles and interest, as opposed to availability, is unclear. The literature attests to rural nurses indicating a need for "continuous learning with opportunities that are accessible, flexible, efficient, and relevant (Pearson & Care, 2002, p. 178)." Those are education principles that can be applied across the nursing spectrum.

Scopes of practice (Q7)

In the literature, two United Kingdom studies demonstrated enrolled nurses were less likely to be given the opportunity to attend professional development (Aoki and Davies, 2002; Barriball and White 1996). Issues around seniority, backfill, expression of need, supportive management and personal drive can all influence this equation.

In this NZ study, being able to take time off work, and attending professional development in work time, were more of a problem for the ENs than for the RNs (Table 7). These issues could be related to the amount of discretion and/or control the ENs have over their practice.

Workplace stress theories attest to discretion (control and essential job skill) and demands (workload and other stressors) having an interactive effect on outcomes. The more discretion and/or autonomy you have, the less pressure (stress) you are likely to exhibit (Karasek & Theorell, 1990). Logically, it is reasonable to extrapolate from these principles of demand-control theory to the EN's position, within the team, when trying to bargain for time to attend professional development.

Education background(s) (Q7, 8b, 16, 17)

The study did flush out some learning needs not met through either pre- or post-registration education (Table 17). Information technology, conflict resolution, managing challenging behavior, shiftwork, and self-management on a day-to-day basis, were cited as areas of learning need. Three of these five topics encompass communication and emotional health issues.

Flores (2008) writes about many nurses not feeling able to manage the verbal and physical abuse they encounter from patients and families. Twedell (2008) identifies some communication challenges with patients who are "anxious, manipulative, or threatening; those with a dementia illness; and those with a traumatic brain injury". These represent just some of the myriad exchanges nurses can face on a daily basis and reflect areas of learning that can be explored and better handled through continuing education. For comparison, in a study of self-reported competence of home nursing staff (our district nursing equivalent), it was found that in meeting clients' spiritual needs, 38% of the respondents classified themselves as good or very good, with 62% feeling able to meet mental health and cognitive needs (Gronroos & Perala, 2008). Those nurses, of course, are likely to be more autonomous and experienced in that role.

Nurses working in mental health were under-represented (by about 30%) in the NZNO survey (Figure 2). However, the results could therefore point more strongly to nurses working outside mental health not being adequately prepared for dealing with challenging behaviours – be it with patients, their peers or even themselves - given the expressed need for improved self-management techniques, and being able to deal with conflict and manage challenging behavior.

Weak IT skills were identified by the NZNO respondents (Table 17), affecting their ability to meet current nursing work demands. The Gronross & Perala study (2008) found that about half of their respondents reported deficiencies in their ability to use IT devices (except mobile phones). Supporting IT skills will help nurses to use professional and scientific literature databases necessary for competence and evidence-based practice development, while raising their levels of confidence in dealing with today's technologies and with technologically competent generations.

To illustrate a possible professional development option here, e-mentoring could overcome the barriers of distance, isolation and busy schedules, with the advantage of meeting some parts of the Nursing Council's competency assessment. E-mentoring could also be a viable strategy in connecting nurses to a shared learning environment (Miller, Devaney, Kelly & Kuehn, (2008)). Lobbying and resourcing will determine the promotion and availability of these options to nurses. This is very relevant, as many nurses have no or limited access to information technologies, let alone the skills to drive them.

NZNO is aware that the Chief Nurse is currently involved in trying to increase access to the electronic database of the Joanna Briggs Institute, while also assessing access to IT systems across the health settings. There are continuing reports of the variability of quality and outcomes across the 21 DHBs on many levels, including IT.

From an even broader perspective, there are several electronic teaching resources being developed by nurses around the country now - across both the DHB and the PHC sectors - that could be used by nurses for professional development. It seems a natural extension of these local processes to lobby the Ministry of Health to provide an electronic 'learning repository', where such resources could be placed for national access by nurses. This viable and cost-effective method of learning, dissemination of information and networking could prove to be a significant source of learning materials for absorption and application by the individual/group to their practice.

Sevean et al (2008) speak of the satisfaction derived from e-learning whereby nurses didn't have to leave their community to seek information and exchange. Thus, e-learning could be an adjunct to learning in the workplace, without the nurse having to use their personal time and incur personal expense (computer, printer, etc.) to complete professional development requirements. This could reduce a number of barriers to continuing education.

Regulatory requirements (Q6, 7)

Gibson (1998) suggests that it is more important for study activity to be relevant to practice and transferable to the working environment, than that it comes from an official source. She comments that "approaches such as networking, job exchanges and practice development projects may have greater validity and relevance than some formal approaches to professional updating" (p457). These approaches need to be investigated and researched for relevance and validity, in order to be accepted as meeting the mandatory professional development requirements.

Other research has found that length and variety of work experience are the most important factors relating to the development of nursing competence, such as in learning and developing psychomotor, interaction, communication and decision-making skills (Arbon, 2004; Tabari Khomeiran et al, 2006).

Mentoring, too, can be an effective vehicle to enhance learning through professional support, and can be an option within the professional development paradigm. Zachery (2002) describes mentoring as targeting another's learning and being concerned with the "acquisition of knowledge, the application in practice, and critical reflection" (p. 27). The benefits of mentoring include: collaboration and reciprocity, with each party incorporating new perspectives into their practice and a richer engagement with their work. Mentoring is also possible beyond face-to-face interaction and can be effectively employed via combinations including: face-to-face, telephone or email contact.

The NCNZ (2005) describes professional development for the nurse:
"You need to choose activities to meet your needs in the context of your practice. These activities may be within your work environment or within an educational context. Your professional development must be relevant to your practice as a nurse (p. 7)." This does leave wide enough scope for the articulate and/or supported nurse to justify how learning in the work environment will positively affect her/his practice.

There is an increasing awareness of the issues surrounding emotional intelligence (Wilson & Carryer, 2008). A nurse's job is the source of a variety of emotion-related processes and outcomes. Nurses work in very close proximity with patients and their emotional and psychological realities. Zammuner, Lotto and Galli (2002) discuss emotional labour as being "emotional regulation as it occurs within work contexts (p. 219)." The authors (ibid) found that "emotional labour is a very important aspect regarding the psycho-physical well-being of hospital employees whose job demands interactions with patients" (p. 228).

Staff well-being is a baseline starting point for competent patient care. The NZNO respondents' comments reflected this real need for work-life balance that they were seeking to attain and/or maintain. Reducing the number of hours worked was one mechanism to achieving balance, though there is a price from the professional development point of view of pro-rata funding to the part-time worker.

Nurses need to manage their feelings and emotional expression, to be congruent with their professional standards and organisational expectations. Emotional competence is needed for nurses' professional and therapeutic relationships to work. From a regulatory point of view, it is timely for NZNO to lobby for emotional competence being designated as one of the nursing competencies by the Nursing Council.

Fronroos & Perala (2008) cite aspects of emotional competence as flowing through: interaction and co-operation, teamwork, supervision and handling emotional conflicts in the workplace. In undergraduate nursing curriculums in New Zealand, it appears that mental health (as opposed to illness) is given varying amounts of emphasis (and therefore, understanding) in pre-registration education, despite its transfer to the tertiary sector, where wider academic discipline input is available. Ironically, given the current tertiary education funding systems (NZNO, 2008), some nursing programmes have or are reducing/removing input from other disciplines due to the commensurate decrease in funding.

Emotional competence is not currently recognised as integral to comprehensive nursing care. Emotional competence needs to be a part of the Nursing Council competencies, and its inclusion should improve the understandings of emotional intelligence, and its application to life and to nursing, across the settings, including education and health. A very positive spin-off of this focus could well be the reduction in the oft-reported workplace violence between nurses. With awareness, comes understanding, and a better chance of positive thinking and mature action (Akerjordet & Severinsson (2007).

Performance appraisal (Q20)
Performance appraisals can serve as useful planning tools that lead to better understandings between the nurse and the senior nurse involved. The PA centres on a designated time for both parties to share in order to: clarify their expectations (the contributions made by the nurse to the work environment, and planning for the year ahead with an understanding of the resources required) while promoting collegiality through increased understandings (Pearce, 2007).

Used well, PAs can enhance the maintenance of competent nursing practice. The Nursing Council (2005) states that, should a nurse be selected for (random) audit that s/he needs to assess their practice against the competencies for their scope of practice. Three methods of assessing these competencies are offered by the Nursing Council as viable alternatives, with one being, "senior nurse assessment or performance appraisal (p. 8)."

The Nursing Council (2005) also writes to the relationship of performance appraisals to the Professional Development Review Programmes (PDRP) in stating that, "competence is assessed at least three-yearly. This could be part of the performance appraisal/review process depending on the programme assessment procedure (p. 4)." The PDRP programmes have not been standardised across the country so do not necessarily encompass PAs as part of their assessment processes. NZNO is aware of some DHBs where more than 50% have not had a PA in the past three years. This could be due, in part, to senior nurses not having the time and/or propensity to provide this (Beck & Kos, 2007). This is concerning, as the benefits of this good management tool will not be experienced by the affected nurses.

Self assessment (Q22)
The Nursing Council (2005) also states that self assessment is one of three acceptable methods for measuring the nurse's practice against the competencies. An attached proviso to these three methods is that, "All evidence needs to be verified by someone appropriate who can attest to the accuracy of the assessment or information (p. 8)." Therefore, to the extent that a nurse can self-assess against the competencies, there is the requirement that this process be overseen and verified. It cannot be done in isolation.

Self-assessment can pose a problem for some nurses who do not work with a senior nurse. Some practice nurses work with a general practitioner, say, so theoretically anyway, their nursing practice cannot be verified apart from what might be related to a colleague/peer by the nurse herself. The realities of the working environment, for example in aged care, mean nurses may be able to participate in professional development at their workplace. The possibility of meeting these needs through information technologies warrants exploration, and further development, through effective lobbying of the Ministry of Health and District Health Boards of New Zealand (DHBNZ) for adequate resourcing.

Seeking advice (Q23)
71% of advice regarding meeting professional development requirements is sought from the workplace (Table 19). The end result of seeking advice is highly dependent on the quality of the advice given. Yet, a study (Carryer, Russell & Budge, 2007) concluded that there remains "significant areas of concern and resistance" amongst the nurses surveyed regarding the professional development recognition programmes (PDRP). These areas of concern could well, in turn, affect the advice offered to those seeking information.

Future plans (Q25, 26, 27)

The global shortage of registered nurses is well documented (Buchan & Calman, 2004). It is due to changes in both supply and demand, with fewer nurses staying in nursing, and the need for health services is increasing as the population ages (Hatcher, 2006). Why are a significant number of registered nurses choosing to work on a casual basis, with reduced hours, or in other careers? How are these factors contributing to nursing shortages?

A significant number of the respondents indicated their intention to leave nursing within two years (Table 20). This is worrying. The education and training of nurses, and the opportunities for continuing professional development and career development have consistently been shown as crucial to nurse recruitment and retention (Simon, 2004). As well, these education factors are positively correlated with improved job satisfaction, with some studies specifically rating the issue highly among the factors related to nursing turnover (Jackson, Mannix & Daly, 2001; Coomber & Barriball (2007); and Yin J-C, Yang K-P (2002)).

The barriers to, and systems of, assessing professional competence are crucial to the myriad factors affecting safe patient outcomes. Nurses must be compelled towards systems analysis. A nationally congruent and effective professional development process need be put in place, embracing relevant, timely, accessible and adequately resourced learning opportunities available to nurses across the settings.

Limitations

The questions relating to 'educational opportunities' that referred to short-term courses may have been ambiguous when thinking of the short courses offered by some tertiary institutions, although there were survey options specifying such tertiary courses. Post-registration courses at level 700 could be an example of this ambiguity, although there are very limited offerings of these courses nationally. The paucity of available courses

hampered the use of this descriptor in the 'educational opportunities' questions because of concern it would cause confusion, with nurses not differentiating between post-registration and post-graduate courses. In future studies, it would be worth making this distinction as the intent, resourcing and outcomes of these courses are different and need to be evaluated separately.

Christchurch Polytechnic Institute of Technology runs successful short courses at the 700 level for RNs (and ENs/NAs) that cover a range of topics and have had over 900 enrolments for the 2008 academic year. The success of these courses appears to be that they are a practice-driven, academically linked approach to professional development, responsive and relevant to nurses' learning needs.

At the time of writing, the Nursing Council is currently updating its standards for post-registration education (November 2008).

Another point is that professional development and career development needs might be usefully differentiated in the nurse's mind, but not in terms of meeting Nursing Council requirements. There may be very different issues in the pursuit of one-off qualification-related study like a Masters, compared with ongoing updating of skills, but those differences have not been distinguished within this study.

Some questions could well have had a variety of interpretations, eg "How long have you worked as a nurse?". Some people consider working as a health care assistant before undertaking their formal education should count as experience. Or, the amount of hours worked over the years might be variably assessed.

Also, the limited 'Likert' scales, with only three options to encompass responses for some questions, could have been confusing for some: being either too limiting in interpretation; or too broad in scale. Participants could have had difficulty pinpointing their responses only having the three choices.

Questions to be asked/Implications for future research:

- What are the most effective methods for verifying a nurse's competence?
- How do the other NZ regulatory authorities assess the practitioner's competency? What are the areas of best practice that nurses could adapt/adopt for this process?
- Do pre-registration programmes prepare nurses adequately for their current nursing work?
- What type of information about professional development, via accessible information sources, is/would be of most use to nurses?
- What support do nurses need in order to assess themselves against the competencies?
- What support systems need to be in place for nurses to practise in a competent, safe, and ethically sound manner?
- What do nurse managers require in order to be supportive to nurses in meeting competence requirements?
- Is there an over-emphasis on taught-type courses, at the expense of reflective practice, self-directed learning and peer-led learning?
- How can sharing knowledge and experience be encouraged in appropriate and accessible learning forums?
- What are the educational needs of isolated and/or rural nurses, as their scope of practice increases within the context of today's health environment?
- What additional assessment and planning skills are required of nurses within their rural/isolated workplace settings?

Recommended areas for professional development

- Recognition of the parameters and standards of safe and competent nursing practice.
- Assessment of the learning needs of nurses in the respective health settings.
- Assessment skills in early warning systems, emotional intelligence, conflict resolution, performance management.
- Recognition of the barriers to professional development, with relevant options of delivery, process and content being explored.

Concluding remarks

Nurses who responded to this survey overwhelmingly chose workplace options for professional development. This may be due to the barriers they face attending and funding professional development but, even when asked their preferred options, this group chose workplace options. Seeking advice about professional development occurs in the workplace. In turn, PAs are being carried out but not on an annual basis for all nurses, and 18% of respondents had not had a PA in the past three years. Sixty nine percent of these respondents were satisfied with their jobs.

The usefulness of these results will best be found in identifying learning needs and nurses' preferences. In today's environment where synergies are encouraged between tertiary education institutions and stakeholders (TEC, 2007), this study should add to those discussions.

Nurses in New Zealand are legislatively mandated to meet professional development requirements in order to gain their annual practising certification through the Nursing Council. Given the diversity of workplaces, educational backgrounds and the uptake of education opportunities identified in this study, the need for flexible, supported development opportunities is apparent. Resources such as time and money figure largely as the main barriers to professional development, resulting in a preference for opportunities in the workplace.

It is therefore important that more questions are raised, possibilities discussed, and further studies done on supporting nurses to meet their competency requirements. Identifying, assessing, and focusing professional development needs is important so the best options are made available to nurses with the ultimate aim of improving patient outcomes and reducing health disparities. An ongoing supply of better informed and competent nurses is integral to safe care and good nursing practice (Levett-Jones, 2005; Kramer and Schmalenberg, 2004; Aitken & Patrician, 2000).

Improved job satisfaction through professional development and career development is crucial to nurse recruitment and retention. Patients, of course, deserve a safe environment, which includes a health workforce able to effectively meet their needs. Nurses can only meet those needs if they are adequately resourced and supported to do so. They should not be expected to meet competency requirements in their own time and at their own cost, as to do so potentially affects other aspects of their lives, both inside and outside of work. As was stated in the Department of Labour's research (2006):

> Teachers, nurses, police and other trained service workers are significantly more likely to report that the timing of meetings and training, the type of work they do, the number of hours or overtime they need to work, expectations and attitudes of colleagues and workmates, and having to take work home make it harder to achieve work/life balance. As a result, respondents in these occupations are more likely to report that work often

> makes it difficult to spend time with family, take care of personal business, keep healthy and fit or play sports, or engage in other leisure activities (p. 25)."

Providing the necessary time and resources to ensure accessible professional development opportunities is vital for our professional realities and responsibilities, contributes to the lifeblood of our profession and ultimately enhances patient safety.

References

ABS (1998). *Caring in the community,* Australia, Cat No 4435.0, Canberra, ABS.

Aiken, L.H., Clarke, S.P., Sloane, D.M., Sochalski, J. & Silber, J.H. (2002). Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *JAMA,* 288(16), 1987-1993.

Aitken, L. & Patrician, P. (2000). Measuring organizational traits of hospitals: The Revised Nursing Work Index. *Nursing Research*, 49(3), 146 – 153.

Akerjordet, K. & Severinsson, E. (2007). Emotional intelligence: a review of the literature with specific focus on empirical and epistemological perspectives. *Journal of Clinical Nursing,* 16(8):1405-16.

American Nurses Association (2001). *Code of ethics for nurses with interpretive statements.* Maryland: Author.

Aoki Y & Davies S (2002) Survey of continuing professional education within nursing homes *British Journal of Nursing,* 11(13) 902-912.

Arbon, P. (2004). Understanding experience in nursing. *Journal of Clinical Nursing,* 13(2), 150-7.

ASH-KAN Aotearoa (2007). *Smoking and Nurses in New Zealand*. Wellington: ASH New Zealand 2007.

Bahn D (2007) Reasons for post-registration learning: Impact of the learning experience. *Nurse Education Today,* 27, 715-722.

Barriball and White, 1996, Participation in continuing professional education in nursing: findings of an interview study. *Journal of Advanced Nursing,* 23, 999-1007.

Beatty R M (2001) Continuing Professional Education, Organizational Support, and Professional Competence: Dilemmas of Rural Nurses. *The Journal of Continuing Education in nursing,* 32(5), 203-209.

Beck, V. & Kos, K. (2007). Julia makes her move: first steps into leadership. *Employment today.* 5, 30-33.

Brinkman, S.A. (2000). *A study into the causes and effects of occupational stress in a regional women's service.* Unpublished thesis for Victoria University of Wellington.

Buchan, J. & Calman, L. (2004). *The global shortage of Registered Nurses: an overview of issues and actions.* Switzerland: International Council of Nurses.

Carryer, J., Russell, A., & Budge, C. (2007). Nurses' understandings of the professional development recognition programme. *Nursing Praxis in New Zealand,* 23(2), 5-13.

Clinical Training Agency (2006). *CTA Postgraduate Nursing Training Specification.* Retrieved November 4, 2008, from http://www.moh.govt.nz/moh.nsf/pagesmh/4581/$File/1B48-cta-postgrad-nursing-mar07.pdf

Coomber, B. & Barriball, K.L. (2007). Impact of job satisfaction components on intent to leave and trurnover for hospital-based nurses: a review of the research literature. *International Journal of Nursing Studies,* 44, 297-314.

Davey, B. & Robinson, S. (2002). Taking a degree after qualifying as a registered general nurse: constraints and effects. *Nurse Education Today,* 22, 624-631.

Department of Labour (2006). *Work-Life balance in New Zealand: a snapshot of employee and employer attitudes and experiences.* Wellington: Author.

Doiron, D., Hall, J. & Jones, G. (2008). Is there a crisis in nursing retention in New South Wales? *Australia and New Zealand Health Policy*, 5,19.

Flores, N. (2008). Dealing with an angry patient. *Nursing 2008,* 38(5), 30–31.

Furze, G. & Pearcey, P. (1999). Continuing education in nursing: a review of the literature. *Journal of Advanced Nursing*. 29(2), 355-63.

Gibson, J.M.E. (1998). Using the Delphi technique to identify the content and context of nurses' continuing professional development needs. *Journal of Clinical Nursing,* 7, 451-459.

Gould, D., Drey, N. & Berridge, E. (1996). Nurses experiences of continuing professional development. *Nurse Education Today,* 27, 602-609.

Gronroos, E., & Perala, M-L., (2008). Self-reported competence of home nursing staff in Finland. *Journal of Advanced Nursing,* 64(1), 27- 37.

Guardini, I., Talamini, R., Fiorillo, F., Lirutti, M. & Palese, A. (2008). The effectiveness of continuing education in postoperative pain management: results from a follow-up study. *The Journal of Continuing Education in Nursing,* 39(6), 281-288.

Hatcher, B. (Ed). (2006). *Wisdom at work: The importance of the older and experienced nurse in the workplace.* Princeton, NJ: Robert Wood Johnson Foundation.

Health & Disability Commissioner (2008). *Safety of Patients in New Zealand Hospitals: A Progress Report*
Retrieved 4 November, 2008, from
http://www.hdc.org.nz/publications/ccdhb-inquiry/index

Hughes, E. (2005). Nurses' perceptions of continuing professional development. *Nursing Standard,* 19(43), 41-49.

Jackson J, Mannix, J. & Daly, J. (2001). Retaining a viable workforce: a critical challenge for nursing. *Contemporary Nurse*, 11, 163-172.

Joyce, P. & Cowman, S. (2007). Continuing professional development: investment or expectation? *Journal of Nursing Management,* 15, 626-633.

Kramer, M. & Schmalenberg, C. (2004). Development and evaluation of essentials of magnetism tool. *Journal of Nursing Administration,* 34, 365–378.

Lawless, Jane. (2008). *An Exploration of Dignity in the work lives of Nurses.* Paper presented at the 2008 NZNO National Annual Conference: The Heart of Health Care, Wellington, NZ.

Retrieved November 05, 2008, from
http://www.nzno.org.nz/Site/Members/Members_Only/conference.aspx

Levett-Jones, T.L. (2005). Continuing education for nurses: a necessity or a nicety? *The Journal of Continuing Education in Nursing*, 36:5, 229–223.

Meadows, S., Levenson, R., & Baeza, J. (2001). *The last straw: Explaining the NHS nursing shortage*. London: Kings Fund.

Miller, L.C., Devaney, S., Kelly, G.L., & Kuehn, A.F. (2008). E-mentoring in public health nursing practice. *The Journal of continuing education.* 39(9), 394 – 399.

Nursing Council of New Zealand (2005). Framework for the approval of professional development and recognition programmes to meet the continuing competence requirements for nurses.
Retrieved October 22, 2008, from
http://www.nursingcouncil.org.nz/contcomp.html#ProfDev

National Professional Development and Recognition Programmes Working Party (2005). *National Framework for Nursing Professional Development and Recognition Programmes and Designated Role Titles: A report to the National Nursing Organisations*.
Retrieved 5 November, 2008, from
http://www.nzno.org.nz/Site/Professional/Other/PDRP/PDRP.aspx

Pearce, C. (2007). Ten steps to conducting appraisals. *Nursing Management*, 14(6), 21.

Pearson, C.L., & Care, W.D. (2002). Meeting the continuing education needs of rural nurses in role transition. *Journal of Continuing Education in Nursing,* 33(4), 174-179.

Penz, K., D'Arcy, C., Stewart, N., Kosteniuk, J., Morgan, D., & Smith, B. (2007). Barriers to participation in continuing education activities among rural and remote nurses. *The Journal of Continuing Education in Nursing.* 38(2), 58–68.

Rae, J. (2008). Personal communication.

Rosenthal, K. (2005). What rural nursing stories are you living? *Online Journal of Rural Nursing and Health Care*, 5(1), 37-47.
Retrieved October 3, 2008, from
http://www.rno.org/journal/index.php/online-journal/article/viewFile/55/147

Salmond, G. (2003). *Paradigm shifts, making connections and managing change: A personal perspective.*
Retrieved November 11, 2008, from
http://www.hwac.govt.nz/events/summit/paradigm-shifts.doc

Sevean, P., Dampier, S., Spadone, M., Strickland, S. & Pilatzke, S. (2008). Bridging the distance: education nurses for telehealth practice, *Journal of Continuing Education in Nursing,* 39(9), 413-8.

Simon, V. (2004). A snapshot of Maori nurses' health and safety issues. *Kai Tiaki Nursing New Zealand*, 11, 14-15.

Tabari Khomeiran, R., Yekta, Z.P., Kiger, A.M. & Ahmadi, F. (2006). Professional competence: factors described by nurses as influencing their development. *International Nursing Review,* 53, 66-72.

Tertiary Education Commission (2007). *Investment Guidance 2008-2010.* Retrieved November 5, 2008, from http://www.tec.govt.nz/upload/downloads/investment-guidance.pdf

Tourangeau, A.E., Doran, D.M., McGillis Hall, L. et al. (2007). Impact of hospital nursing care on 30-day mortality for acute medical patients. *Journal of Advanced Nursing, 57, 32-44.*

Twedell, D. Managing Challenging Patient Behaviours. *The Journal of Continuing Education in Nursing.* 39(9), 391-2.

Washburn, S.C., & Hornberger, C.A. (2008). Nurse educator guidelines for the management of heart failure. *The Journal of Continuing Education in Nursing,* 39(6), 263 – 267.

Wilson, S.C. & Carryer, J. (2008). Emotional competence and nursing education: a New Zealand study. *Nursing Praxis, 24(1), 36-47.*

Yin J-C, Yang K-P (2002). Nursing turnover in Taiwan: a meta-analysis of related factors. *International Journal of Nursing Studies,* 39:573-58.

Yoder-Wise, P.S. (2008). Transferring knowledge: the goal of continuing education/continuing competence. 39(9), 387.

Zachery, L.J. (2002). The role of teacher as mentor. *New directions for adult and continuing education,* 93, 27-38.

Zammuner, V.L., Lotto, L. & Galli, C. (2002). Regulation of emotions in the helping professions: nature, antecedents and consequences, 217-231. In: Morrow, L., Verins, I., & Willis, E. (Ed.), *Mental health and work: issues and perspectives,* Adelaide: Ausinet:The Australian Network for Promotion, Prevention and Early Intervention for Mental Health.

Appendix 1

Health and Disability Ethics Committees

Central Regional Ethics Committee
Ministry of Health
Level 2, 1-3 The Terrace
PO Box 5013
Wellington
Phone (04) 496 2405
Fax (04) 496 2191

04 July 2007

Anne Brinkman
Professional Nurse Advisor
NZNO
P.O. Box 2128
Wellington

Dear Anne

NZNO Education Survey

The Chair of the Central Regional Ethics Committee considered the above education survey that you intend to use on your members over current nursing education issues. The Chair decided that ethical approval for this research was not required (please refer Operational Standard for Ethics Committees 2006, 4.0, 138).

Thank you for seeking the advice of the Central Regional Ethics Committee on this matter. I wish you well with your research.

Yours sincerely

Claire Yendoll
Administrator Central Regional Ethics Committee

Appendix 2

NEW ZEALAND NURSES ORGANISATION

Part 1: Demographic Questions

So that we can determine whether or not the respondents to this survey are typical of the wider nursing workforce could you please answer the following questions about yourself.

1. Are you:

Female	…1
Male	…2

1. Please write code in box below

2. What age are you?

Between 20 and 24 ……1	Between 45 and 49 ……6
Between 25 and 29 ……2	Between 50 and 54……7
Between 30 and 34 ……3	Between 55 and 59……8
Between 35 and 39 ……4	Between 60 and 64……9
Between 40 and 44 ……5	65 and above……10

2. Please write code in box below

3. Which ethnic group do you most closely identify with?

NZ European …1	Tongan …6	South East Asian …11
NZ Maori …2	Niuean …7	Chinese …12
Other European …3	Tokelauan …8	Indian …13
Samoan …4	Fijian …9	Other Asian …14
Cook Island Maori …5	Other Pacific …10	Other (please specify) …15

3. Please write code in box below

4. What geographical code best describes the location where you practice?

If you practice in two locations please enter the code for the geographical area where you spend most of your time.

Northland……1	Hawkes Bay……6	West Coast……11
Auckland ……2	Taranaki……7	Canterbury……12
Waikato……3	Manawatu – Wanganui……8	Otago……13
Bay of Plenty……4	Wellington……9	Southland……14
Tairawhiti (Gisborne)……5	Nelson-Marlborough……10	Other (please specify below)……15

4. Please write code in box below

5. Do you consider the location where you practice to be urban or rural?

Urban	…1
Rural	…2

5. Please write code in box below

6. What is your scope of practice?

Registered Nurse	……..1	Enrolled Nurse	……..3
Nurse Practitioner ™	……..2	Nurse Assistant	……..4

6. Please write code in box below

7. What qualification(s) led to your registration in your current scope(s)? Please also indicate the year you completed the qualification(s) (note question 8 re further completed qualifications)

Scope of practice qualification only							
Registered Nurse		**Nurse Practitioner ™**		**Enrolled Nurse**		**Nurse Assistant**	
BN	…1	PhD	…..6	Cert HSc (EN)	……11	Cert HSc (EN)	…15
BHSc	…2	MN	…..7	Cert EN	……12	Cert EN	…16
DipN	…3	MA	…..8	Hospital based training certificate	……13	Other (EN)	…17
Hospital based Training Certificate (see below)		MN Applied	…..9	Other (EN)	……14		
General and obstetric	…4a	Other (NP)	…10				
Psychiatric	…4b						
Psychopaedic	…4c						
Obstetric Nurse	…4d						
Maternity Nurse	…4e						
Other (RN)	…5						

7. Please write code & year completed in boxes	Code	Year Completed	Code	Year Completed

7a. Did you complete your nursing qualification(s) overseas?

Yes	…1
No	…2

7a. Please write code in box below

If yes, please state country in which you completed your qualification:

8a. Do you have any OTHER completed tertiary qualifications?

Yes	…1
No	…2

8a. Please write code in box below

8b. If YES

PhD……..1	Med……5	BSc……9	Grad Cert……13
MN……..2	BN……..6	PG Dip……10	SANS……..14
MA……..3	BHSc……7	PG Cert……11	Plunket Cert……15
MA (Applied)……4	BA……8	Grad Dip……12	Dip AdvNursStud……..16
			Other qualifications……17

8b. Please write code & year completed in boxes below

Code	Year Completed
Code	Year Completed

9. How long have you worked as a nurse?

Less than 12 months	……1	16-20 year	……5
1-5 years	……2	21-30 years	……6
6-10 years	……3	Over 30 years	……7
11-15 years	……4		

9. Please write code in box below

10. Does your current position require you to have an Annual Practicing Certificate? Please note: the Nursing Council's definition (2006): "*Nursing practice is using nursing knowledge in a direct relationship with clients or working in nursing management, nursing administration, nursing education, nursing research, nursing professional advice or nursing policy development roles, which impact on public safety.*"

Yes	…1
No	…2

10. Please write code in box below

If your answer is YES, please GO TO Question 12

If your answer is NO, please GO TO Question 11

11. Could you please tell us about what you are doing?

Other non-nursing paid employment	……..1
Other non-nursing unpaid employment (e.g. voluntary work)	…..2
Not in paid employment (e.g. parenting)	……..3
Retired	……..4
Other (please specify below)	……..5

11. Please write code in box below

Code	Code

Other (Question 11)

For those who answered NO to Question 10, we thank you for your time taken with this survey form. The remaining questions relate to current nursing employment so you have completed all the questions required. Please forward the survey form in the return envelope to NZNO, along with your 'Draw Card' to enter the draw if you would like to do so.

12. What code or codes best describes your current employment settings?

Please select up to two codes from the selection below, to show your main employment settings.

Public hospital ...1	Hospice ...6	Pacific health service provider ...11
Private or non-public hospital ...2	Self-employed ...7	Nursing agency ...12
DHB – Primary health care employment (e.g. PHC Nursing consultant; Public Health Nursing) ...3	Maori health service provider ...8	Rest home / residential care ...13
Primary health care/community service (e.g. Practice Nurse, NGO service) ...4	Educational institution ...9	14 Other - please specify 14
Intermediary service (e.g. District Nursing) ...5	Government agency (MOH, ACC, prisons, Defense force) ...10	

Main employment setting | 12a. Code | Next main employment setting | 12b. Code | Other current employment setting | 12c. Code

13. How many hours do you work in a typical week?

At main employment _____

At other employment _____

Total hours _____

14. Which code or codes best describes your current nursing practice?

Please select up to two codes from the selection below, to show your main employment settings.

Emergency and trauma	...1	Mental health (including substance abuse)	...9	Palliative care	...17
Assessment and rehabilitation	...2	Medical (including education patient)	...10	Perioperative care (theatre)	...18
Child health including neonatology	...3	Nursing administration and management	...11	Primary health care (including practice nursing)	...19
Continuing care	...4	Nursing education	...12	Public health	...20
District nursing	...5	Nursing professional advice/policy development	...13	Surgical (including education patient)	...21
Family planning/sexual health	...6	Nursing research	...14	Assessment and rehabilitation	...22
Intellectually disabled	...7	Obstetrics/maternity	...15	Other nursing practice (please specify below)	...23
Intensive care/coronary care	...8	Occupational health	...16		

14a. Main nursing practice code | | 14b. Next main practice code | |

Other nursing practice:

15. What is/are your current job title(s)?

Staff Nurse	….1	Nurse Practitioner ™	…13
Nurse Manager	….2	Clinical Nurse Specialist	…14
Clinical Nurse Manager	….3	Specialty Clinical Nurse	...15
Charge Nurse Manager	….4	Duty Nurse Manager	…16
Associate Clinical Nurse Manager	….5	Clinical Resource Nurse	…17
Associate Charge Nurse Manager	….6	Family Planning Nurse	…18
Clinical Nurse Coordinator	….7	Practice Nurse	…19
Nurse Coordinator	….8	Public Health Nurse	…20
Nurse Educator (Clinical)	….9	Enrolled nurse	…21
Nurse Educator (Academic)	…10	Nurse Assistant	…22
Nurse Researcher	…11	Other (please specify below)	…23
Nurse Consultant	…12		

Please write code(s) in boxes, as appropriate:	15a. Main title Code	15b. Second title code

Other job title:

Part 2: Nursing is a demanding job. We would like to know if you feel your nursing education (pre-registration and post-registration) prepared you to do your current job.

16. How adequate was your pre-registration education in the following subject areas?

Please circle the answer which applies, for each of the following (Q 16 continues on next page).

	Pre-registration Education subjects	Adequate	Somewhat adequate	Not at all adequate	Not applicable
16a	Nursing theory……..	1	2	3	4
16b	Nursing Process……..	1	2	3	4
16c	Nursing Diagnosis……	1	2	3	4
16d	Nursing Care Plans……	1	2	3	4
16e	Ethics/Law……	1	2	3	4
16f	Health systems and political processes…	1	2	3	4
16g	Maori Health ……	1	2	3	4
16h	Cultural Safety ……	1	2	3	4

16i	Biological sciences……..	1	2	3	4
16j	Pharmacology……..	1	2	3	4
16k	Psychology……..	1	2	3	4
16l	Social sciences……..	1	2	3	4
16m	Mental health……..	1	2	3	4
16n	Primary health care……..	1	2	3	4
16o	Acute care ……..	1	2	3	4
16p	Deteriorating patient / early warning systems……..	1	2	3	4
16q	Chronic care……..	1	2	3	4
16r	Information technology……..	1	2	3	4

Comments (Q 16):

17. Thinking about your current nursing work, how well has your nursing education (pre and post-registration) prepared you for the following aspects of your job?

Please circle the answer which applies, for each of the following:

	Aspects of nursing work now	Completely prepared	Somewhat prepared	Not at all prepared	Not applicable
17a	Self-management on day-to-day basis (stress/emotional balance, i.e. your own)	1	2	3	4
17b	Own role organization on day-to-day basis	1	2	3	4
17c	Communication with other nurses	1	2	3	4
17d	Communication with other health professionals	1	2	3	4
17e	Teamwork with other health professionals	1	2	3	4
17f	Delegation and direction of other health workers	1	2	3	4
17g	Conflict resolution (with nurses, other health professional, patients, etc)	1	2	3	4
17h	Managing challenging behaviour (e.g. aggression)	1	2	3	4
17i	Information technology	1	2	3	4
17j	Shiftwork / Rostered & rotating	1	2	3	4

Comments (Q 17):

Part 3: How do you typically complete your 60 hours of professional development every 3 years?

When you apply for your annual practising certificate, you are required to have undertaken 60 hours professional development over the previous three years. This requirement arose from the enactment of the Health Practitioners Competency Assurance Act 2003. We would like to know how you typically meet that requirement and what education opportunities are useful to you for meeting that requirement.

18. Which of the following educational opportunities have you taken up in the past three years to meet the professional development requirement(s) of the Nursing Council of New Zealand?

Please circle yes or no, as applicable

	Educational opportunities		
18a	Nursing Undergraduate degree papers……	Yes	No
18b	Nursing Graduate certificate papers ……..	Yes	No
18c	Nursing Post-graduate certificate……	Yes	No
18d	Nursing Post-graduate diploma……	Yes	No
18e	Nursing Masters……..	Yes	No
18f	Nursing PhD / research……..	Yes	No
18g	Interdisciplinary post-graduate papers / qualifications……	Yes	No
18h	Short courses……..	Yes	No
18i	Seminars……..	Yes	No
18j	Conferences……	Yes	No
18k	In-service education……	Yes	No
18l	Journal reading within a formal framework e.g. a journal club……..	Yes	No
18m	Writing journal articles……	Yes	No
18n	Presentation to colleagues……..	Yes	No
18o	Non- Nursing Undergraduate degree papers…..	Yes	No
18p	Non-nursing Graduate certificate ……	Yes	No
18q	Non-Nursing Post-graduate certificate……	Yes	No
18r	Non-Nursing Post-graduate diploma……	Yes	No
18s	Non-Nursing Masters……..	Yes	No
18t	Other (please specify) ……..	Yes	No

Comments (Q 18):

19. Does completing 60 hours of professional development present any issues for you, for example in time or costs? Please circle 'Is an issue' or 'Not a problem' for each option, as applicable.

	Possible reasons around professional development completion	**Is an issue**	**Not a problem**	**Comments**
19a	Able to take time off work……	Is an issue	Not a problem	
19b	Able to attend 'in-service education' in work time……	Is an issue	Not a problem	
19c	Lack of support/encouragement from employer……	Is an issue	Not a problem	
19d	Hours of work a factor (e.g. part-time entitlements)……	Is an issue	Not a problem	
19e	Own motivation to complete ……	Is an issue	Not a problem	
19f	Time not paid for……	Is an issue	Not a problem	
19g	Costs in fees ……..	Is an issue	Not a problem	
19h	Other time commitments……....	Is an issue	Not a problem	
19i	Time and distance to travel ……	Is an issue	Not a problem	
19j	Information technology skills……..	Is an issue	Not a problem	
19k	Access to computer based resources……	Is an issue	Not a problem	
19l	Concern about ability to do assignment work…	Is an issue	Not a problem	
19m	Other reasons (please specify below) …….	Is an issue	Not a problem	

Comments (Q 19):

20. Have you had a performance appraisal done by a senior nurse (evidence of assessment of competence) in one, or more, of the following time frames: Please tick, if yes.

2006 – 2007	**2005 – 2006**	**2004 – 2005**	**Not applicable**
☐	☐	☐	☐

21. How confident are you about choosing relevant professional development that will help you to meet the competencies required for your scope of practice? (circle)
(Nursing Council website re competencies – www.nursingcouncil.org.nz/competenciesrn.pdf)

I am:

1	2	3	4	5
Very Confident	Confident	Somewhat confident	Lack confidence	Not confident at all

22. Who/Where do you seek advice from regarding meeting the professional development requirements for your scope of practice?

Nursing Council	1	NZNO	5
PDRP co-ordinator	2	Senior nurse	6
Nurse educator	3	Peer – other nurse	7
Education institution/staff	4	Others	8

22. Please write code in box below

Comments (Q 22):

23. How confident are you about assessing yourself (self-assessment) against all of the Nursing Council competencies for your scope of practice, when you answer Question 8 in your application for a practising certificate.
(Nursing Council's Question 8 reads: Do you meet the Council's competencies for your scope of practice?
The list of competencies is provided in the guide to completing your application for your practising certificate.)

I am:

1	2	3	4	5
Very Confident	Confident	Somewhat confident	Lack confidence	Not confident at all

23a. If you lack confidence / are not at all confident, what sort of clarification or support might help you with assessing yourself against the competencies?

Please write comments here:

Comments (Q23a):

Part 4: What are your future plans?

24. How would you prefer to develop specialty skills and clinical knowledge for your chosen area of practice? Please circle your level of interest for the following choices, as applicable.

	Future choices	interested	Possibly interested	not interested
24a	Nursing Undergraduate degree papers……..	1	2	3
24b	Nursing Graduate certificate ……	1	2	3
24c	Nursing Post-graduate certificate……	1	2	3
24d	Nursing Post-graduate diploma……	1	2	3
24e	Nursing Masters……	1	2	3
24f	Nursing PhD / Research……	1	2	3
24g	Interdisciplinary post-grad papers / qualifications……	1	2	3
24h	Short courses such as……	1	2	3
24i	Seminars……	1	2	3
24j	Conferences……	1	2	3
24k	In-service education……	1	2	3
24l	Journal reading within a formal framework e.g. a journal club……	1	2	3
24m	Writing journal articles	1	2	3
24n	Presentation to colleagues……	1	2	3
24o	Non- Nursing Undergraduate degree papers……	1	2	3
24p	Non-nursing Graduate certificate ……	1	2	3
24q	Non-Nursing Post-graduate certificate……	1	2	3
24r	Non-Nursing Post-graduate diploma……	1	2	3
24s	Non-Nursing Masters……	1	2	3
24t	Other (please specify) ……	1	2	3

Comments (Q 24):

25. What are your future intentions (for the next 2 years) regarding your nursing employment?

Future Intentions	
Satisfied with job, no plans to leave	1
Unsatisfied with job, no plans to leave	2
Satisfied with job, but plan to change to another area / specialty skill of nursing	3
Unsatisfied with job, and plan to change to another area / specialty skill of nursing	4
Plan to practice overseas (please give reason below)	5
Plan to retire	6
Leave nursing employment within six months (please give reason below)	7
Leave nursing employment within two years (please give reason below)	8
Unsure of plans	9

25. Please write code in box below:

Comments Box (Q 25):

26. If you plan to practice overseas could you please give us your ONE main reason as far as your nursing work is concerned

Comments (Q 26):

27. If you plan to leave nursing altogether within the next six months to two years could you please give us your ONE main reason.

Comments (Q 27):

Thank you for taking the time to complete this questionnaire. Please place in the return envelope to NZNO. Do include your card for the draw, if you would like to enter!