

INCREASING COMPETENCE ASSESSMENT IN NURSING:
FACILITATING A PORTFOLIO APPROACH

A THESIS

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ABSTRACT

Pressure is increasing on nurses' regulatory bodies to demonstrate to the public and government that they are meeting their mandate to ensure the continuing competence of their members. This study explores the process I used to introduce the use of portfolios to nurses to enable them to demonstrate continuing competence. I initiated, designed, and facilitated an educational intervention, comprised of a workshop in three 3-hour sessions over a 2-month period, in which I introduced 10 nurses to a model of portfolios. I focused on the learning portfolio and its two components; a professional self-assessment derived from nursing regulatory bodies' codes of ethics, standards of practice, and competencies documents; and a self-directed learning plan based on the areas identified from the professional self-assessment. I used questionnaires, pre- and post-intervention, to survey nurses' attitudes and practices surrounding continuing professional development. Results from the study indicate that a flexible approach to planning and implementing an educational workshop is effective. Nurses found professional self-assessments useful for diagnosing learning needs, and self-directed learning plans straightforward for the learning process. They also found portfolios to be a useful method for planning, evaluating, and monitoring their learning and continuing professional development to demonstrate continuing competence. In this thesis, I describe my educational method and approach to addressing this issue. I also discuss the implications for providers of adult education, nurse educators, employers, and nursing regulatory bodies.

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CHAPTER 1

INTRODUCTION

Many nursing jurisdictions have implemented, or are considering implementing, quality assurance programs designed to ensure the continuing competence of their members. These programs often take the form of organized and recognized courses or workshops that follow the nurses' successful completion of registration exams set by their regulatory body. Nurses prove initial competence by graduating from an approved school of nursing and passing the registration exams. These exams are updated continually to keep abreast of change in technology and procedures. Continuing competence, however, is another issue. For some time, the nursing profession has questioned whether it should simply assume the same (updated) level of competence in the nurse who has been practicing for 3, 5, or 10 or more years. Alternatively, a nurse could leave professional nursing practice to raise a family, and return to nursing many years later, without any requirement to take a refresher course, be re-tested, or in any way demonstrate competence (and safety) to practice. One approach to ensuring competence is the use of portfolios which are a useful mechanism for nurses to plan, evaluate, and document their continuing professional development activities and consequent learning, and help nurses plan for their participation in monitoring and maintaining their continuing competence. Although other professionals use portfolios to ensure competence, nurses in Saskatchewan do not use them.

In this thesis, I describe and analyze a study in which I examined nurses' attitudes toward and factors surrounding continuing competence and participation in continuing professional development. I also facilitated the implementation of portfolios as a way for

nurses to demonstrate continuing competence. This study explores whether an educational intervention can influence nurses' beliefs and practices about the usefulness of portfolios. Specifically, this thesis is about my use of a portfolio model that combines the career and learning portfolio to demonstrate continuing competence.

Background Information

Nurses' regulatory bodies must concern themselves with ensuring that nurses are competent and safe practitioners. There is increasing pressure on regulatory bodies to demonstrate accountability to government and the public that they are fulfilling their mandate. Canadian nursing jurisdictions approach this challenge in a variety of ways and have used criteria such as a minimum number of hours of practice per year, testing, and continuing professional education, to name a few. Portfolios are relatively new to nursing, although many professions use them or are exploring their use to demonstrate competence. In addition to counting hours of practice, some jurisdictions use portfolios instead of mandatory continuing education programs for quality (competency) assurance.

Some provincial governments — Saskatchewan is not among them — have imposed quality assurance requirements on the regulatory bodies of health professionals. However, because of a 1988 member-initiated motion, in order to re-license, members of the Registered Psychiatric Nurses' Association of Saskatchewan (RPNAS) must attest, by a signed document, to the continuing professional development activities in which they have participated during the previous year, including how many credit hours equivalency

each activity represents. A target date of 2000 gave the RPNAS a 12-year lead-time to acclimatize the members, develop, consult on, and implement the requirement.

The Saskatchewan Registered Nurses' Association (SRNA) presently has no quality assurance program in place. However, it endorses lifelong learning and endorses statements that reflect this value in its standards as well as ethics documents about the nurses' responsibility to maintain competence and currency in practice. Over the last few years, a committee tasked with developing a quality assurance program to fit the needs of registered nurses in Saskatchewan is recommending a member-developed program, believing it to be more palatable than one imposed by government.

I have been active in my professional association(s) during my career and keenly interested in competence. About the time I applied to the Master of Adult Education program at St. Francis Xavier University, I attended an invitational conference on continuing competence sponsored by the SRNA. In 1996, Debra Witmer of the College of Nurses of Ontario (CNO) presented a session on the CNO's use of portfolios in their quality assurance program. It was at this point that I began considering portfolios and competence as a focus for my study. I was appointed to the SRNA's quality assurance committee in 1998 and assumed the chair of the committee in 1999. The mandate of the committee complemented my study interests. In consultation sessions sponsored by the SRNA as a means to design a quality assurance program palatable to nurses in Saskatchewan, members of the SRNA identified many of the elements I use as ones that are palatable and necessary for a quality (competency) assurance program.

Problem Statement

As I began researching the literature for my study, I was unable to find research that identifies nurses' perceptions about what information and supports they require for developing a portfolio to use to demonstrate their continuing competence. This represents a gap in the literature, despite the increasing number of articles on using portfolios for various applications, including competence assurance. Nevertheless, portfolios can benefit the profession because they can assist nurses in demonstrating their continuing competence, thus fulfilling the mandate of the regulatory body to ensure its members are competent and safe to practice. This gap in the literature sparked my interest in designing and facilitating an educational intervention to discover what information and supports nurses need to create a portfolio and their perceived usefulness for demonstrating competence. A key question that framed the research was: Can an educational intervention positively influence nurses' attitudes and beliefs toward the usefulness of portfolios to demonstrate continuing competence? This study is of interest to adult educators who work with nurses in their continuing professional development and, in a variety of ways, to maintain their competence. Continuing competence is of major concern to the bodies that regulate professionals because these bodies set the standards that professionals must meet.

Purpose of the Study

This study examines the usefulness of portfolios to help nurses plan for their participation in monitoring and maintaining their continuing competence. The purpose is twofold: (a) the first is to examine usefulness from the nurses' perspective — that is, to identify their attitudes and knowledge about portfolios both before and after an educational intervention; (b) the second is to examine the usefulness from the regulatory body's perspective — that is to identify whether portfolios used during an educational intervention are useful in documenting new learning in comparison with the regulatory body's codes of ethics, standards, and competencies. This study is also concerned with my own growth and development in continuing professional education of nurses.

In carrying out this study, I administered baseline and post-intervention questionnaires to obtain data about nurses' perspectives and about shifts in their perspectives that occurred when they learned about and used portfolios. Observations during and outside the workshop sessions provided me with another means of collecting data, particularly participants' response to the elements of and development of portfolio components. I recorded field notes for my reference and videotaped the sessions in order to analyze my facilitation skills. Viewing the tapes provided the unexpected benefit of refreshing my memory of the discussions that I did not wholly capture in my field notes. In my study, I used a case study approach and collected qualitative data primarily. A descriptive method was used to analyze and present the data.

Scope and Limitations of the Study

The area of this study is continuing professional development. Its aspect is evaluation, with a specific interest in portfolio development as a means of documenting continuing professional development and as a basis for planning, monitoring, and evaluating ongoing learning and developmental activities. Although peer appraisal can be a part of an evaluation process, it was not part of this study. Portfolios also have utility for prior learning assessment and recognition, and for career advancement; these applications likewise were not part of this study. In this study, using a sample of seven nurses as participants, I compare nurses' baseline and post-study attitudes and knowledge regarding continuing competence, continuing professional development, and the development and use of portfolios. I discuss nurses' reactions to a structured, professional self-assessment based on their regulatory body's code of ethics, standards, and competencies documents. I examine whether nurses believe self-directed learning plans are a valuable aid to continuing professional development. Describing a typical participant is not possible because they varied widely in characteristics, including age (21-59), number of years of practice, number of years in present position (0.5-25), and in nursing (diploma and degree) and other levels of education (certificates to master candidate).

I designed a workshop offered over three sessions. To accommodate shift work and work related travel schedules, I offered Session 1 once and Sessions 2 and 3 twice each. I allotted 3 hours for each session. One participant, who was unable to attend Session 3, completed the post and evaluation questionnaires despite not attending the

third session. The focus of Session 3 was reflecting on and discussing the usefulness of portfolios, professional self-assessment tools, and self-directed learning plans for demonstrating competence. Of the three participants who did not complete the study, one changed jobs and moved from the city; one did not carry out his self-directed learning plan and did not believe he should complete the study; and another stated he was working on the post-questionnaire but was simply too busy to complete it at that point — he did not return the post-questionnaire. Thus, seven nurses (two administrators, two educators, and three practitioners) completed the study. The findings provide insight into the perspectives on the usefulness of portfolios.

A limitation of the study was the 2-month period over which I conducted it. I knew that a 2-month period is not likely sufficient for most participants to complete a career portfolio (the focus of the first educational session) and I had no expectation that they would do so. I did believe the period to be long enough to provide the participants with a foundation and understanding to initiate a career portfolio during or after the study and for completing and maintaining it following the study. I also expected that participants would initiate and complete a learning portfolio (the focus of Session 2), before the end of the study.

Assumptions That May Have Influenced the Study

My personal characteristics and background affect the study. I am a white, middle-class, urban woman. My parents valued education and I have adopted this value. I have taken advantage of many educational opportunities, both formal and informal,

throughout my life and because I do well academically, I am favorably disposed to continuing educational activities.

I made several conscious assumptions before beginning the study. During the study, I discovered two other assumptions I had made of which I was not aware. The first conscious assumptions were that nurses generally participate in continuing professional development activities at a high rate, and that the majority of these activities go undocumented and unnoticed. I believe many nurses undertake many continuing professional development activities without any direct link to maintaining or improving professional competence. Rennekamp and Nall (1994) have made this broad statement applying it to all professions. Nurses, like members of any group, tend to participate in (learning) activities that interest them. Other reasons for participating may include wanting to visit the location of the conference, or attending because a friend is attending. In other words, nurses do not participate in professional development activities based on an identified need to improve their competence in an area in which they are not particularly strong.

I believed that much of nurses' learning is informal and incidental, and that nurses do not typically perceive this as learning. When they do recognize that learning is occurring in these ways, nurses do not view it as valid. I assume that as self-regulating professionals, nurses are keen to maintain and improve their level of competence and that the portfolio is one useful method to assist nurses to this end.

I also believed that knowing where to begin portfolio development can prove to be a challenge. For example, in the prospective portfolio, the nurse completes a professional self-assessment. Based on this, she or he then identifies learning needs to

maintain or increase competence. I first assumed that nurses would assess themselves honestly. I then assumed that once they made a professional self-assessment that they would want to improve any in areas they identified a need.

I also assumed that developing a self-directed learning plan would be a straightforward endeavor for nurses, because of their knowledge of patient care plans. I anticipated that identifying resources could be one area in which nurses might need assistance. I did not anticipate that nurses in the study would need a significant amount of help or encouragement to implement and evaluate their learning plan.

Definition of Terms

I have used several terms in specific ways in this paper. To add clarity to these terms, I am including the following definitions.

Nurse is a generic term for either a registered psychiatric nurse or a registered nurse. In Western Canada, there are separate educational programs and regulatory bodies for each of these types of nurses. (Another body regulates nursing assistants, also known as practical nurses. This study does not include this group.) When it is appropriate, I specify which of these two groups I mean; at other times, I refer to the profession of nursing as a whole. The point I want to underscore is that, contrary to popular belief, it is not true that a nurse is a nurse is a nurse.

Initial competence is the level of competence a nurse has when beginning practice. Graduating from an approved school of nursing and passing a regulatory body's exams for registration are considered proof of initial competence.

Continuing competence is an expectation of the practicing nurse beyond the level and expectations of a new graduate. The regulatory body is accountable to the public and government that its members are competent and safe to practice. How a nurse demonstrates competence is a prime focus of nursing jurisdictions.

Continuing professional education (CPE) is a subset of continuing education, and is grounded in adult learning theory. Continuing professional education refers to any number of formal educational offerings (e.g., university classes, seminars, conferences, and workshops). It fits the more traditional view that to remain competent, professionals have to pay money and get together in traditional classroom settings, in order to learn. In this thesis I prefer the term continuing professional development, which includes developmental opportunities both within and outside the workplace. In these developmental activities the nurse acts in place of another or otherwise fulfills the duties of a position for a period of time. In addition, continuing professional development can include developing resources for others. This could be presenting a workshop, producing a learning aid, a patient resource, or actively participating on a professional committee. Continuing professional development is much broader in scope than continuing professional education, and acknowledges the significant amount of learning that occurs on the job; it emphasizes learning outside of formal educational offerings (Eraut, 1994).

A portfolio is “a *private* collection of evidence which demonstrates the continuing acquisition of skills, knowledge, attitudes, understanding and achievement. It is both *retrospective* and *prospective*, as well as reflecting the *current* stage of development and activity of the individual” (Brown, 1995, p. 2). Trossman (1999) builds on this definition adding the inclusion of a plan to work toward further professional development.

A personal profile is “a collection of evidence which is selected from the personal portfolio for a particular purpose and for the attention of a particular audience” (Brown, 1995, p. 5).

A retrospective, or career portfolio, is a collection of materials such as a traditional résumé or curriculum vitae, autobiographical notes, artifacts relating to an individual’s career, and statements of philosophy of an individual’s professional practice. A retrospective portfolio contains the history of the professional as it relates to her or his career. The autobiographical section can help the author relate certain life events to career choice. Throughout this thesis, I use the term career portfolio but sometimes refer to this as a retrospective aspect of portfolios.

A prospective, or learning portfolio, is a forward-looking collection of materials that includes learning and career development plans. The focus is on learning, development, and growth as a professional. As plans are completed, and learning or career goals achieved, these plans are archived in the career portfolio because they are now historical documents. New plans are developed and placed in the forward-looking portion of the portfolio. This ongoing process supports, guides, and documents continuing professional development and lifelong learning. I prefer to use the term learning portfolio and refer to its components as the prospective aspect of portfolios.

According to Knowles (1975), self-directed learning “describes a process in which the individuals take the initiative, without the help of others, in diagnosing their learning needs, formulating learning goals, identifying human and material resources for learning, choosing and implementing appropriate learning strategies, and evaluating learning outcomes” (p. 18). Cooper (1980) offers a collection of synonymous terms: self-

directed learning, independent study, self-guided study, self-planned learning, self-initiated learning, autonomous learning, self-education, self-instruction, and individual learning. The various terms distinguish this learning from that which is other-directed. Cooper notes this distinction is important because the motivation for self-directed learning comes from within the individual.

One final distinction in terms I wish to point out is from the work of Watkins and Marsick (1990). They differentiate between informal and incidental learning. Informal learning generally occurs outside of institutions, is experiential in nature, and is controlled by the learner. Self-directed learning is an example. Incidental learning may occur while learners are pursuing some other type of learning or may occur without any intent of learning at all. Formal learning is generally offered within an institutional or structured setting, and includes classes, workshops, and conferences.

Plan of Presentation

This thesis is the product of integrating theory and practice (experiential learning) (Kolb, 1984) in my study. In this introductory chapter I have introduced the problem based on my (concrete) experience. In chapter 2, I reflect on the problem in my analysis of selected literature on adult education. In it, I examine the areas of continuing competence, portfolios, and reflection, as it relates to self-assessment. I also include a small section on data collection. Chapter 3 contains a detailed account of my study. In this phase I conceptualize (abstract) the problem and actively experiment (action) by designing and facilitating educational sessions with nurses to develop portfolios. This

experience culminates in a reflection on the application of theory to practice in chapter 4. I analyze, then synthesize what I learned in relation to using portfolios to increase competence assessment and the development of a model. At the end of chapter 4, I offer a series of conclusions and recommendations for action, designed to inform adult and nurse educators, employers, and nursing regulatory bodies. As an analogy, to the adult learning cycle, chapters 1, 2, and 3 can be considered the *what*, the discussion and conclusions in chapter 4 respond to the *so what*, and the recommendations that flow from the study answer the *now what*.

CHAPTER 2

LITERATURE REVIEW: REFLECTING ON THE PROBLEM

This chapter provides the theoretical framework for the study. In it, I review selected literature primarily from nursing and adult education on the topics of continuing competence, including key concepts and strategies for maintaining competence; portfolios, including the usefulness of portfolios for nursing; self-directed learning, including factors that contribute to resistance to self-direction in learning; and reflection, as used for self-assessment. I include a small section at the end on data collection methods that are relevant for my methodology and analysis in this study.

Continuing Competence

Milligan (1998) speculates that competence may be the most commonly used term in education today. This extends into the education of nurses and is on the agenda of nurses' regulatory bodies across Canada (National Working Group on Continuing Competence for Registered Nurses, 2000) and in other countries. In this section, I discuss key concepts, strategies and mechanisms, and supports and barriers to continuing competence.

Key Concepts About Competence

There is a confusing array of terms used by various authors, so for clarity I provide an overview of some of these terms. Parry (1998) differentiates between competencies and terms such as traits and characteristics, skills and abilities, and styles and values. Parry relates that managers are cautioned and taught not to mix up personality

traits of employees with performance in appraisals. Personality is generally accepted as formed early in life and not easily changed; and some argue that personality traits are inherited and cannot be changed. Educators and trainers generally aim to improve performance, not mold personality.

Parry (1998) defines competencies as clusters of related knowledge, attitudes, and skills that influence key aspects and responsibilities of work, which in turn is reflected in on-the-job performance. These competencies can be measured against standards, and they can be enhanced (learned) by developmental activities, although Parry concedes that some (e.g., musical ability, dancing) may be in part inborn.

In the United States, the National Council of State Boards of Nursing (1996) defines competence as “the application of knowledge and the interpersonal, decision-making and psychomotor skills expected for the practice role, within the context of public health, safety and welfare” (p. 5). In Canada, the National Working Group on Continuing Competence for Registered Nurses (2000) has a similar definition of competence: “The ability of a Registered Nurse to *integrate and apply* the knowledge, skills, judgement, and interpersonal attributes required to practice safely and ethically in a designated role and setting” (p. 7). The Canadian definition acknowledges that the practice environment has a direct bearing on competence, such as what the practitioner needs to know. Also, as elaborated on by Campbell and Mackay (2001), the employer has an obligation to provide an environment (climate and equipment) that allows the practitioner to practice to a given standard.

The notion of competencies first arose in the vocations as a means to facilitate mobility and to expand a job-ready pool of applicants for industry (see Goldsmith, 1999).

For example, in the United Kingdom many occupational groups have adopted National Vocational Qualifications (NVQs) to facilitate the mobility of workers. However, Milligan (1998) and Le Var (1996) caution that the approach to assessment adopted along with the NVQs offer little to the profession of nursing. Milligan points out the implication of some of the statements found in the units for NVQs such as, if a skill is demonstrated, then demonstrating the underlying knowledge component is not necessary.

Although some might believe that competence is the pinnacle of performance, they would be at odds with Benner (1984). Benner offers a framework of five stages of effective nursing practice that places the competent nurse at the third level. The five stages are: novice, advanced beginner, competent, proficient, and expert. The novice operates from context-free rules and has no experiential base from which to practice. The advanced beginner has amassed enough experience to demonstrate marginally acceptable practice, and may be able to distinguish meaningful aspects of a situation. The competent nurse has practiced 2-3 years, and is able to deliberately act from a conscious plan of action, and is one whose day is more than a series of reactions to events in the work situation. A proficient nurse comprehends situations as a whole, not as a series of disparate aspects. Finally, the expert nurse operates in a rule-free context. Their experience base allows them to intuitively apprehend a situation and focus on the most salient aspects. Benner advocates a different educational approach for nurses at each level, and explains why some are inappropriate or ineffective in certain stages.

Nowlen (1988) discusses three models of continuing professional development: the update model, the competence model, and the performance model. Most continuing professional education programs fit into the update model, which is based on a positivist

paradigm. The underlying premise is that professionals must remain up to date with current developments in their field. This is a generic approach that presumes that all professionals within a discipline require the same information chosen by the teacher and usually delivered by means of a lecture to a passive audience. This model primarily focuses on information delivery. Certificates provided to attendees document participation, not learning.

In Nowlen's (1988) competence model, in addition to the knowledge that the professional needs, there are also personal skills (e.g., critical thinking or interpersonal relationships), personal traits (e.g., ethical, takes initiative, self-directedness), and a positive self-image required of a professional. Application exercises such as role-plays, case studies, and problem solving help to build competencies needed in the workplace. The major limitation of this competence model, noted by Nowlen, is that its focus remains on the individual and does not recognize the larger systems of which the professional is a part. Furthermore, the competence model describes what competence is and neglects to say what it is not or what it may be.

Nowlen (1988) proposes that what is needed is a new, performance model. He likens it to a double helix. One strand represents the professional, the other, the many cultures of which the professional is an integral part (e.g., family, community, church, professional associations). The performance model goes beyond the update or competence model and includes, as important elements, consideration of the personal and professional life stages through which professionals pass and the varying challenges faced within each of those stages. The professional functions within an interdependent network of systems, and no single approach or method of continuing professional

development or intervention can adequately address the complexity of a professional's reality and the many facets affecting competence. This comprehensive model considers how personal changes, such as a marriage breakdown, affect performance and deals with messy aspects of life such as the effects of substance abuse or addiction. These life events can and do affect professionals' performance and competence. A person may be competent to do something, but in fact may not perform well, for any number of reasons. Nowlen contends that there is a place within continuing professional education to address the broader issues affecting performance. For example, professionals can come together to address issues common across professions. Thus, the categories of continuing nursing, legal, or medical education can be dispensed with because regardless of discipline, these professionals face similar challenges common to their career development stage.

Rennekamp and Nall (1994) describe a four-stage career model for professional development in which they identify the motivation for learning as linked to professionals' career stage. Thus, like Nowlen (1988), Rennekamp and Nall see similarities within career stages, not necessarily linked to a specific profession. The stages they identify are entry, colleague, counselor, and advisor. To attain career satisfaction it is imperative that professionals move out of the entry stage. Satisfaction is possible at the colleague stage for many years, and may evolve to the counselor stage if one continues to develop an area of expertise and gains more responsibility. Professionals in the advisor stage move the profession or organization forward: they are leaders and mentors. Rennekamp and Nall advocate a long-term view that is flexible enough to accommodate short-term changes and vision for efficient and effective use of resources devoted toward professional development.

Initial Versus Continuing Competence

At one time, graduates of a professional preparation program may have assumed their education was over. Shimberg (1987) notes that as early as 1937, physicians supported the idea that a license to practice medicine should not be issued for life, unless the licensee kept current with developments in the field. They proposed that re-examination should take place about every 5 years. Although there was support for the idea, there was also opposition to a requirement to demonstrate ongoing competence.

Re-testing was not implemented for many years, and even today has not been uniformly adopted. Parboosingh (1998) notes that the regulatory bodies for physicians in Canada and Australia avoid testing as a mechanism, arguing that an exam that is legally defensible tests a very narrow band of competencies. Furthermore, during pre-service education physicians are subject to numerous exams and evaluations. Parboosingh asserts that it is time to move from provider-centred to learner-centred education. Despite the fact that a professional's initial education and training is adequate and assures the competence of the beginning practitioner, there is no guarantee that the professional will remain competent.

Houle (1980) argues for continuing learning because "pre-service students do not have time in school to 'cover the ground' and later they will not know how to do so" (p. 85). At the very least, pre-professional education forms "much of every professional's attitude toward future learning and the ability to undertake it has been established by the time of entry into service" (p. 90). He points out that professionals who are taught what to learn are versed in the present, which in an age of increasingly rapidly changing

information and technology soon becomes the past. In contrast, students taught how to learn, are ready to adjust to the future and all the changes it holds.

Like Houle (1980), Eraut (1994) asserts that educators tend to design pre-service curricula with the unrealistic aim of covering all the information that professionals will need in their lifetime. Within the nursing profession, competency documents generally contain the competencies of the new graduate. Many professions acknowledge that the first few years of practice help to develop professionals in their role. This is consistent with Benner's (1984) stages of nursing practice, in which the third stage is the competent stage. Initial education attempts to do too much and does not portray any continuity or relationship with continuing professional development.

Factors Driving Continuing Competence

Although the need for ongoing competence assurance was advocated as early as 1937, not a great deal of progress was made for many years. But during the last few decades many regulatory bodies have discussed, debated, and written about competence in general and continuing competence in particular. What are the forces behind this sustained focus?

Drucker (1969) recorded some shifts taking place in developed societies: the shift from the rural to urban areas, labourers to knowledge workers, and the explosion of information. During the first 500 years after the invention of the Gutenberg Press, 30 million books were published worldwide. In the 25 years immediately preceding Drucker's book, an equal number had been published. Clark (1997) relates this growth to the nursing profession. In 1900, there were 400 medical journals published. By 1992, the number had grown to 7,500. On average, she says, physicians would have to read 19

articles a day, 365 days a year to keep abreast of the information. Clark calculates that nurses have to read a greater number than this, because nurses draw from the humanities and social science areas in addition to medicine, nursing, and allied health. In his book Megatrends, Naisbett (1982) observes that people are “drowning in information but starved for knowledge” (p. 24).

The explosion of information is just one frequently cited factor driving continuing competence. This increase in information production, coupled with rapidly increasing sophistication of technology, new techniques, and innovative practice and treatment protocols has led to waves of change; often, before one change is completely implemented and incorporated, another has swept over the practice arena. Practices and competencies are ever shifting. For example, information generation and availability have increased to the point where Cheek and Doskatsch (1998) identify information literacy as a necessary competency to ensure that nurses are lifelong learners. Information literacy includes accessing information both physically and intellectually. It is more than searching through print or electronic databases. Competency priorities are fluid. The debate continues about how competencies are or should be learned, and how individuals will be accountable for their competence (see Lenberg, 1999; Registered Nurses’ Association of British Columbia, 1998).

One of the defining traits of a profession is its creation and use of a unique and expert body of knowledge (Freidson, 1988). This expert knowledge was only accessible to the profession at one time. However, with the technology of the Internet, this is no longer true. Rodger (1998) reported that according to research done by Yahoo!, a need for health information was the third most frequently cited reason for accessing the

Internet. Consumers today desire very much to be partners in their care; they take the initiative to inform themselves about health issues. Not all the information on the Internet is expert, but there is enough accessibility to expert information to help increase consumers' knowledge and their demand for increased competence in health professionals.

Another competency factor is the policy and legislation that has been passed or is being contemplated in many jurisdictions that requires a quality assurance program whereby members of a profession are accountable to provide evidence of continuing competence. Other Canadian jurisdictions have moved to similar legislation with like requirements. Still other jurisdictions, such as Nova Scotia and Saskatchewan, have moved or are moving toward implementing these measures without being legislated to do so. One of the underlying beliefs is that if a quality assurance program is inevitable, it is better to design and implement something members reach consensus on than to have something unpalatable legislatively imposed. Furthermore, Lenburg (1999) notes that insurance companies are also interested in continuing competence, which is logically tied to legal outcomes and liability, as it is often insurers who must pay. Rising insurance rates make continuing competence of interest to all the current and future members of a profession. Although Houle (1980) suggests that consumer and governmental pressures drive continuing competence, nurses in Alberta are quick to assert that it is their own interest and desire that drives them to maintain their competence (Picherack & Associates, 1998).

Methods for Competence Assessment

The National Council of State Boards of Nursing (1991) identify these methods for competence assessment are client or case review, peer review, and competence evaluation and note that these examples are not exhaustive.

Client or case review is essentially a review of the care given by the nurse, or the case management as reflected in documented evidence. A peer or expert reviews the records against established standards. The NCSBN found that between 1989 and 1992 only one state used this mechanism. No Canadian nursing jurisdictions have proposed this mechanism to assess competence.

In the peer review method “professionals from common practice areas, assess, monitor, make judgment, and provide feedback to peers by comparing actual practice to established standards” (American Nurses Association, 1988). Peer review is also known as peer feedback and peer-appraisal. The preferred term in Canada is peer feedback to distinguish it from the peer review process for publication. Peer review is an essential element of self-regulation. McAllister and Osborne (1997) assert, “Self-regulation strengthens a profession’s credibility, respect, and trust from the community, and builds autonomy and responsibility” (p. 40).

In Canada, peer review has been explored as a mechanism by the nursing regulatory bodies in Alberta, Ontario, British Columbia, and Nova Scotia (Picherack & Associates, 1998). Although there is support for the use of peer feedback, overall, nurses are not comfortable with this mechanism. It is interesting to note that nurses use the peer review mechanism in their disciplinary function as a regulatory body despite their reluctance to use peer review in a proactive supportive environment. This is not to say

that nurses are eager to use peer review retrospectively in response to a complaint or to mete out discipline. Nurses do not consciously equate the disciplinary process with peer review.

McAllister and Osborne (1997) note that the use of peer-appraisal in the workplace can increase clinical performance and personal accountability, and improve quality of care. Their findings show that participants came to appreciate that nursing is not just about caring, knowledge, and technical expertise, but that nursing is also about accountability and supporting their colleagues. Roper and Russell (1997) likewise report that peer review is compatible with shared governance and is a characteristic of professional practice. Furthermore, peer review provides a means to evaluate and improve standards of practice.

Competence evaluation is a structured and formal assessment of the nurse in the practice setting. It uses valid and reliable tools and can use many techniques (e.g., computer simulation, direct observation). This method has not been adopted in any Canadian nursing jurisdictions. The methods the NCSBN identify for competence acquisition are clinical practice, refresher courses, and continuing education. These three are only illustrative and not exhaustive. The first of these, clinical practice infers that competence is gained in proportion to hours of practice. All Canadian regulatory bodies of registered nurses require 1125 hours over 5 years. The underlying assumption is that when employed, the nurse is exposed to ongoing informal peer review, and has opportunities to keep current with knowledge, technology, and practices (Picherack & Associates, 1998). This is reflective of Nowlen's (1988) update model.

Nurses re-entering practice after being non-practicing or when changing to a new area of practice, are required by many regulatory bodies in the United States and Canada to complete a refresher program. In some jurisdictions, successfully completing the program is sufficient; in others nurses must pass an exam set by the regulatory body.

Two camps disagree on whether continuing education should be mandatory. Brockett (1992) sides firmly against mandatory continuing education. He finds the whole notion of compelling people to sit and be lectured repugnant and contrary to the essence of adult education, that being its voluntary premise. Although course instructors can teach to people, they cannot force anyone to learn. Brockett argues that there is no evidence that mandatory continuing education has any effect on professionals' practice or competence.

In contrast, Legrand (1992) favors mandatory continuing education. Legrand argues that many jurisdictions in the United States have a requirement for continuing professional education and says that, as an example, pharmacists would find it odd that there is any debate about this within the field of adult education. Legrand also argues that many graduates of professional preparation programs are socialized into accepting and supporting continuing professional education. Legrand notes that surveys find nurses who are subject to continuing education requirements are very much in favor of mandatory continuing education and do not support removing the requirement. Finally, countering Brockett's (1992) argument, Legrand (1992) cites studies finding a positive correlation between participating in mandatory continuing education and an increase in proficiency in content knowledge and application of the knowledge, positive effects on patient outcomes, and positive effects on professionals' behavior.

Continuing professional education can be conducted by an individual nurse or through formal structures. Offerings through formal structures are often accessed on the basis of interest or convenience rather than need (Johnston, 1993; NCSBN, 1991; Rennekamp & Nall, 1994). Individually planned learning is based on self-assessment, and identified needs are often met through self-directed learning activities. The Registered Nurses Association of British Columbia (1996) notes that there is conflict over the use of self-assessment, because nurses lack the skills to assess their needs and to direct their learning. These findings mesh with Tough's (1979) finding, that adults select and direct a number of learning projects on their own. Although adults in general are able to self-assess their needs and direct their continuing learning, amongst other shortcomings there is room to improve their awareness of the range of resources. One criticism by the NCSBN (1991) is that self-assessed learning goals typically are limited to knowledge and psychomotor skills, not the integrated use of these on the job. Correspondingly, Houle (1980) differentiates between continuing learning (which is necessary) and continuing education (which is not). The NCSBN claims that unless learning is applied to benefit the client it does not add to professional practice. Such learning involves change in practice, and changes typically are inhibited by barriers.

Barriers to Change in Competence Assessment

Besides barriers for individual change associated with learning, changes in ways of assessing competence meet with barriers. Sanford (1989), and Picherack and Associates (1998) identify several barriers to implementing continuing competence requirements and assessments, such as how professional associations define and measure competence. Sanford believes individual professionals' attitudes and beliefs about

competence may stem from fear of perceived negative consequences (more learning, testing, possibility of failure, etc.). Amid the explosion of information, it may be difficult for individuals to sort out what information is central to their practice, and this uncertainty is echoed by Cheek and Doskatsch (1998). In addition, increased consumer or public input into the profession may generate fear, if nurses view this as diluting the self-regulating nature of their profession. Finally, increased professional accountability may be threatening to some individuals.

Picherack and Associates (1998) note several barriers identified by Alberta nurses, such as a lack of time in the workplace to learn from peers and colleagues through coaching or dialogue. Although in-services are often available within their facility, nurses are unable to leave the unit to attend sessions where new skills and knowledge may be acquired. Financial resources to attend educational offerings are scarce (many nurses travel to attend these sessions; this incurs accommodation and other associated travel costs). Rigid shift schedules pose another set of problems to nurses. Finally, for the individual nurse, there is a dearth of timely, up-to-date, easily-accessed information on course offerings and other learning opportunities.

Sanford (1989) finds professional associations also have concerns. If the definition and measurement of competence changes, they may be concerned about how to finance and administer these changes. Furthermore, the professional association may be at odds with competing views of unions and employers. Picherack and Associates (1998) note that these groups perceive and understand each other's role. Nurses expect that their regulatory body will work with unions and employers to balance the conflicting roles, so that all can work cooperatively. Johnston (1993) notes that the employer should have

some say into continuing professional development if they are helping with funding, because there is a tendency for people to participate in activities more out of interest rather than a need related to their professional work. Interestingly, the American Nurses' Association (1988) does not acknowledge in-service education as continuing professional development because they view it as meeting the needs of the employer, not the professional.

Portfolios

An increasing focus of continuing professional development is the use of portfolios. Portfolios are a "time-honored and respected convention" (MacIsaac & Jackson, 1994, p. 63) among artists, photographers, architects, designers, and other creative professionals to highlight the quality and range of their work. When used within these groups, portfolios are a means to showcase the work, talent, and ability of that person. More recently, professionals in health service, business, and other professions are beginning to use portfolios to a variety of ends. In this section, I identify the ends to which portfolios are used, outline portfolio elements, and discuss the benefits, drawbacks, and pitfalls of their use.

Uses for Portfolios

Oechsle, Volden, and Lambeth (1990) attribute the earliest educational use of portfolios to the United States military, in 1945, for educational mobility. Today, educators and many health disciplines including nurses, physicians, occupational

therapists, and dietitians use portfolios and the general literature promotes portfolio use for career changes. Clearly, the use of portfolios is growing, as are its applications.

Several uses for portfolios by healthcare agencies are noted by Brooks and Madda (1999). These include accreditation of a health facility by the Joint Committee on Accreditation of Healthcare Organizations (JCAHO). The human resources department of the health care facility seeking accreditation maintains nurses' portfolios as a record of performance appraisals and competence assurance. Professionals also use portfolios in performance appraisals that are not linked to JCAHO auditing. Individuals use portfolios to give themselves a competitive edge by assisting them to plan their careers and to make career changes. Brooks, Barrett, and Gerber-Zimmermann (1998) promote the portfolio as an excellent marketing tool to use before or during interviews

Brooks and Madda (1999) cite one use of the portfolio as a requirement for maintaining eligibility for licensure by the United Kingdom Central Council (the body responsible for nurses, midwives, and health visitors). In the United States, the Commission on Dietetic Registration (1999) has laid out its requirements for portfolios to maintain eligibility for licensure in 2001 (see also Pertel, 1999).

Within Canada, the College of Nurses of Ontario (CNO) has used the portfolio since 1996 as one option in its competence assurance program. The College of Registered Psychiatric Nurses of British Columbia implemented a portfolio program in 1997. Other Canadian nursing jurisdictions are implementing programs for competence assurance. Bossers et al. (1999) discuss the use of portfolios by occupational therapy students. The underlying belief and intent of its use is that it helps foster professionalism.

Parboosingh and McLaughlin (in press) discuss learning portfolios. They use interactive software designed to promote reflection and to improve practice-based learning that is “designed to assist physicians to apply Schön’s model of reflective practice to their self-directed learning” (p. 6). The physician reflects on the events and hypothesizes about how the events will affect their expertise and their practice. In the next subsection, I examine what constitutes a portfolio, and how contents are similar and different for varying applications.

Elements of Portfolios

The content and style of a portfolio varies with its intended purpose. For example, the retrospective portfolio is the repository of artifacts and attestations of and about a professional’s career. It is more than a curriculum vitae or résumé. It may hold autobiographical details and narratives.

A prospective portfolio looks to the future and the development of the professional. One of the sections of a learning portfolio is a self-assessment. The tool the CNO (1996) uses is designed for nurses to assess themselves— such as whether they work in any of the four main categories of nursing: direct care, administration, education, and research. There are several functional section headings in each category on the assessment form; rating statements vary with the type of position the nurse fills. For example, the communication skills or leadership activities and skills the administrator focuses on are different from those of the direct care nurse. The nurse can total up the score under each section heading and make a learning plan to address the areas with the lowest scores.

A simple learning-style self-assessment is included in the CNO's (1996) Professional Profile to aid nurses in planning learning activities that suit their preferences. The self-assessment consists of six complete-the-sentence items. Another chart, with headings for learning area, learning questions, success indicators, resources, target date, action plan, and code, helps nurses plan for their identified learning. The coding categories are: to change practice, to learn more, or to validate current practice.

Another element of portfolio development is peer review. The CNO's (1996) tool asks nurses to solicit input from two colleagues. This is done by complete-the-sentence statements that essentially ask the peer to identify what they believe the nurse requesting feedback does well and could improve upon. There is room for three items in each category. The CNO suggests that the nurse ask for feedback from a nurse in a similar position (p. 78). The CNO notes that individuals from other professional groups can be asked to give feedback, as can individuals from other organizations if the nature of their work is such that there is interagency work or collaboration.

The CNO's (1996) Professional Profile is the most comprehensive tool of any Canadian nursing jurisdiction with a continuing competence program in place. Other jurisdictions with continuing competence programs in place include Nova Scotia, British Columbia, and Saskatchewan; they have tools from as simple as a log for recording continuing professional development activities to portions similar to (based on) the CNO tool. The tool provided by the CNO includes both retrospective and prospective elements; thus, it is both backward and forward-looking.

Value of Portfolios

There is limited research on the benefits and disadvantages of using portfolios. The research available has been done from the perspective of (a) students and professionals who have completed portfolios, (b) evaluations by managers and their employees using the portfolio in their performance appraisal, (c) professors assessing the portfolios' value from assessing students' learning, and (d) researchers looking at portfolios developed by nurse educators to assess their teaching effectiveness. These findings provide balanced commentary on portfolios, including both the positive and negative aspects of preparing a portfolio, and advice to the uninitiated. In the following subsections, I focus on the benefits and advantages, drawbacks and pitfalls of portfolios, especially from the nurse educators' perspective.

Benefits and advantages. Cayne (1995) concludes that the greatest value of the portfolio is illustrating to nurses that experience, as a method of learning, is just as valid as course work or study days. Using reflection in the development and maintenance of a portfolio may be an important means to further nurses' valuing experience and ultimately themselves. Meeks (1995), who studied the use of portfolios by nursing staff as part of their annual assessment, found that developing a portfolio helped nursing staff to appreciate their accomplishments over a year. In fact, on the ward where the study was conducted, the nurses' enthusiasm influenced ancillary staff to create their own portfolios.

Oechsle et al. (1990) note that a major strength of portfolio use by nurses returning to school is that it is congruent with the principles of adult learning. The portfolio values experience and knowledge, and gives the students some input into and

control over their education. A similar benefit noted by Gerrish (1993) is that portfolios maximize learning because the student maintains an ongoing awareness of learning. Gerrish concludes that the use of portfolios in evaluating student nurse-educators provides the most comprehensive view of their performance because it reflects input from many sources in a position to provide feedback on the performance of the student nurse-educator. Trossman (1999) advocates for their use because they are flexible and tailored to the individual's learning needs.

In support of portfolios, Glen and Hight (1992) find that they are useful as a means to bring about change in the assessment of students of nursing and midwifery, and in the way the colleges of nursing and midwifery develop curricula and relate to the student. Use of portfolios to help change curricula can be considered as formative evaluation because they provide a more-informed base for decision making in curricula development. Glen and Hight believe "innovations such as portfolios should best be seen as points of departure catalysts rather than things to be implemented" (p. 422). Similarly, Ryan and Hodson-Carlton (1997) report their school of nursing was searching for evidence to show that ongoing evaluation through portfolios had resulted in course changes. Research by Scheppner Wenzel, Lunke Briggs, and Puryear (1998) is supportive of this strength. They note that where traditional test methods do nothing to inform further instruction, the portfolio provides a means to do so.

Scheppner Wenzel et al. (1998) cite additional personal benefits such as tracking, fostering lifelong learning, encouraging nurses to practice self-reflection, and encouraging them to assume responsibility for their learning. In addition, portfolio development goes hand in hand with collaboration with others (between and amongst

faculty and students) and aids nurses in placing worth on their innovations in improving their learning (and by extension their patient care) and their accomplishments.

Drawbacks. Although much of the published literature supports the use of portfolios, some authors note the drawbacks of portfolio use. For example, Budnick and Beaver (1984), Cayne (1995), and Koenig (1998) note that a lack of formal guidelines for using portfolios in evaluation increases subjectivity of assessment and that the attitude of the reviewer can negatively effect the awarding of credit. (Occurrences of over-crediting were not mentioned.) Cayne (1995) also notes a lack of guidelines for assessment, particularly in terms of the professional using a portfolio as a requirement for re-registration or re-licensure.

For those seeking academic credit, the language of academia can be a foreign one. Thus, according to some authors, applicants may not present a true picture of their knowledge, skills, and abilities (Budnick & Beaver, 1984; Koenig, 1998). Strong writing skills are required to present a particular aspect of self to the reviewer of the portfolio. The intended outcome of the portfolio is not realized by nurses who lack writing skills, even when they in fact are, know, or can do what is sought. Because it may be only writing skill that is lacking, Budnick and Beaver suggest that an interview be a component of portfolio assessment so that there is an opportunity to clarify or elaborate on any element of the portfolio.

A more sensitive issue affecting self-esteem is raised by Koenig (1998) and Stockhausen (1996). These authors note that a significant investment of the compiler's self goes into developing a portfolio. Finding that one's learning is not up to standard can have potentially devastating effects to learners' self-esteem more so than finding a skill

needs to be improved. More personally, an individual's foibles and attitudes are on display. Although some of Koenig's and Stockhausen's respondents noted that this was acceptable, because the person receiving feedback then had an opportunity to examine and re-evaluate those aspects, others may not be so open to this type of assessment.

One recurring theme is the time required to prepare or evaluate a portfolio (Cayne, 1995; Gerrish, 1993; Marsh & Lasky, 1984; Stockhausen, 1996). In the study by Oeschle et al., participants estimated the time to develop a portfolio ranged from 5 to 51 hours. In Banks' (1993) study, community workers estimated that 100 hours over 3-18 months were invested in the development of a portfolio.

Carpenter (1992) raises the weightiest considerations of portfolio use: legal and ethical issues. Giving an honest account of one's practice may reveal deficiencies and leave a nurse open to accusations of poor practice. The CNO (1996) states that portfolios submitted as part of their quality assurance program will not lead to referrals for disciplinary action. The CNO may contact the nurse about practice issues with a view to assisting the nurse, but they do not turn the portfolio over to their professional practice committee. Ideally, portfolios are used for educational, not disciplinary, purposes.

Another ethical and legal consideration is confidentiality. Because an effective portfolio balances artifacts with commentary or narratives (Melland & Misialek Volden, 1996), information on patient care may find its way into the portfolio. A concern is whether nurses' primary duty will remain to the patient or whether that duty will be eroded in favor of nurses' needs and ends. Carpenter (1992) questions whether patients will seek access to a nurse's portfolio, and if they do, can they then use it against the nurse if they suspect a standard of care has not been met?

The final issue I include is raised by Carpenter (1992) and Cayne (1995), for different but similar reasons, and it involves the creation of the portfolio. Cayne notes that the implementation process for using portfolios needs careful attention. Initiating bodies need to help nurses recognize the utility of portfolios and see them in a positive light. But portfolio development and maintenance is a developmental process facilitated by the process of reflection in its creation. Cayne questions how much help persons can receive in creating their portfolio, before that developmental process is eroded or circumvented. Carpenter asks, in cases where the portfolio creator receives a significant amount of help, whose work is being assessed, that of the portfolio creator, or the portfolio supervisor?

Self-Directed Learning

In this section, I explore self-directed learning as it relates to portfolio development. Self-directed learning has been a focus of attention by adult educators for over 25 years and by nurse educators for almost as long. Brockett and Hiemstra (1991) chronicle the history of adult learning back to Socrates and Plato, thereby exploding the myth that self-directed learning is a passing fad in adult education. In this section, I review the characteristics and variables of self-directed learning. I examine self-directed learning in relation to continuing competence, and end with suggestions to overcome resistance to self-directed learning.

Characteristics and Variables of Self-Directed Learning

Caffarella (1993) observes that self-directed learning has roots in several philosophies of education. From the behaviourist tradition come behavioural objectives within learning contracts or plans, and evaluation criteria against which to measure the achievement of the learning objectives. The humanist and progressive schools see educators as guides and coaches, and give the learner's experience a central role in the learning process. As an example, Tough (1979) and Rogers (1983) assert that, given the choice, adults prefer to plan and direct their learning activities. In true humanist tradition, Rogers (1983) views the responsibility for making decisions about a person's own learning as a highly personal process of learning how to adapt and how to learn. Similarly, Kidd (1975) views the goal of (adult) education as moving the person toward being an inner-directed learner.

Cooper (1980) outlines five basic characteristics of self-directed learning that are consistent with the humanist philosophy and Kidd's (1975) view that the educator's role is to facilitate movement toward self-direction. These characteristics are: learning is initiated by the learner; it is specific to a learner's need; it is directed by the learner; it has a minimal amount of structure, requirements, or assistance from a teacher; and it often results in a unique product, useful to the learner. Candy (1991) goes further than most authors and distinguishes between self-determination and self-management (personality/goal) and in the realm of process and method, Candy separates learner-control and autodidaxy, the latter which he defines as "self-directed learning outside the formal institutional setting" (p.15) In autodidaxy, the learner may not see her or himself as a learner; learning is wholly under the autodidact's control.

Brockett and Hiemstra (1991) dispel some myths related to self-directed learning. For example, self-directed learning is not an all-or-nothing proposition. Brockett and Hiemstra suggest looking at self-directed learning on a continuum, as a characteristic that is somewhat present in everyone. They emphasize that self-directed learning is not carried out in total isolation. Similarly, Tough (1979) finds that, on average, in the course of a learning project, the learner interacts or consults with at least four or five others, and that some consult 10-20 people.

Selection of resources (consulting with others) is one of the 10 variables Cooper (1980) identifies that may come under the control of the individual (self-directed) or some other person (other-directed). These variables are: identification of learning needs, the topic and purpose of the learning activity, objectives or expected outcomes, appropriate learning experiences, learning resources, the environment, time, pacing, methods of evaluation, and documenting an evaluation of one's learning. Cooper notes that the evaluation might be quite superficial or simplistic, and that the documentation of learning may not be necessary. However, because many nurses are subject to mandatory continuing education for licensure or ongoing competence, documentation in this situation may be required.

Knowles' (1975) description of self-directed learning covers the cycle of assessing, planning, implementing, and evaluating; this cycle is very much like the nursing process. The nursing process differs in that the step of diagnosis comes between assessing and planning. Evaluation may not always be the ending point; it can become the starting point for new assessment. Experts on evaluation, such as Guba and Lincoln

(1981) and Burnard (1988), note that the concepts of assessment and evaluation are inextricably linked. Evaluation leads to re-assessment.

Brookfield (1984) points out that self-directed learning is usually purposeful but does not necessarily have carefully set goals; it typically occurs outside of designated educational institutions, and is not usually awarded institutional accreditation. It is voluntary. Brookfield (1986) differentiates between self-directed learning that focuses on techniques, goals, strategies, and resources and self-directed learning that results in a change of awareness. In the latter, the learner becomes aware that knowledge is not black and white, but contextual, existing in shades of grey.

Self-Directed Learning and Continuing Competence

Houle (1980) states, “To achieve its greatest potential, continuing education must fulfill its name and be truly continuing — not casual, sporadic or opportunistic. This fact means essentially that it must be self-directed” (p. 13). Houle believes that students in professional schools should become familiar with continuing education in their pre-service education. He urges educators to expose students to the techniques and resources necessary to continue their learning to gain experience in constructing learning plans. Pre-service education is an opportune time to introduce would-be professionals to the standards and ethics of their chosen profession, along with how they will be evaluated (and by whom) for re-licensure requirements. Over time, each professional will develop a unique approach to self-directed learning. Houle notes, unfortunately, that too many educators of professionals do not believe this facet of education is necessary. The reality is that once into the daily demands of professional practice, most professionals do not have the time to learn how to create a realistic and useful plan of learning to meet their

needs. Houle notes that a focus on formal continuing professional education is at the expense of self-directed learning. He estimates that at least 50% of continuing professional education is self-directed and advocates giving it proper recognition. Even so, he notes that there is an element of self-directed learning in continuing professional education because the professional chooses in which activities to participate.

Knox (2000) builds on Houle's (1980) assertion, by giving specific suggestions as to how adult educators can help professionals with self-directed learning, such as by clarifying the purpose of continuing professional education, setting priorities, reinforcing lifelong learning, self-assessing education needs, identifying and accessing resources, evaluating self-directed learning efforts, and supporting the study of self-directed learning.

As an example of self-directed learning's relevance to competence, Schön (1987) notes that the physicians with whom he worked, saw unique, ambiguous, or contradictory and conflicting features of each patient presenting to them. One diagnostic case was not the same as the next. Their caseloads of patients' presenting problems did not become routine. Self-directed learning allows professionals to respond to each case as individual and fresh, not as routine and stale.

Zemke (1998) also presents an argument for self-directed learning for professionals' competence. He notes that, given the rapid explosion of knowledge and the change, instructors cannot simply identify a learning need and expect to deliver training once a year. Self-directed learning can more immediately meet the needs of the learner. Parboosingh and McLaughlin (in press) similarly believe it is incumbent upon educators to assist professionals with methods to improve the quality of their learning activities.

In contrast, Purdy (1997) notes five instances in which Knowles said self-directed learning was not the most appropriate method to learn. The list of exclusion criteria includes the meeting of external objectives and goals, which fits with pre-service education. However, this should not preclude pre-service educators from using self-directed learning and fostering self-directedness in the pre-professional education of their students. These skills prepare the graduate for the real world. Jarvis (1983) asserts that, once students graduate, many are unlikely to be formally assessed again by an external agency; therefore, they must acquire this skill in their pre-service education.

Furze and Pearcey (1999) conclude that “motivation and self-directedness are intertwined with the experience of continuing professional education to date, with the more motivated nurses being apparently more self-directed and thus undertaking more continuing professional education” (p. 361). They speculate on whether the introduction of the requirement for continuing professional education in the United Kingdom will increase the percentage of nurses who are highly motivated and self-directed.

Overcoming Resistance to Self-Directed Learning

Blackwood (1994) explores how self-directed learning within the confines of mandatory continuing education is possible and desirable. She notes that initially there may be some resistance on the part of both the worker and management to self-directed learning. Given the right support and structure, however, both parties can be moved along. Blackwood emphasizes avoiding an all-or-nothing approach. She suggests strategies such as providing alternative methods of instruction such as videos and self-study models. Blackwood believes that managers must be educated how to interpret mandated requirements to afford more freedom in meeting those requirements. Involving

the learners in the planning of educational offerings as well as using contracts and plans are other suggestions she offers.

In an effort to reduce resistance to self-directed learning, Hiemstra (1994) identifies 78 micro-components under 9 headings. He believes that many people, educators and learners alike, resist self-directed learning because they view it as an all or nothing proposition. He breaks self-direction down so individuals understand they can start small and build on successes. For example, the aspect of goal setting is broken down in to nine micro-components; four headings and five subheadings. First, the learner sets specific learning goals. Second, the learner specifies the nature of the learning experience. Under this subheading are three micro-components; an example is deciding between competency or mastery learning, and pleasure or interest learning.

In the same book, Confessore and Confessore (1994) focus on a single strategy to counter professionals' resistance to self-directed learning. They encourage professionals to understand the need for continuing education and emphasize that self-directed learning, as a strategy for continuing improvement in practices is not only feasible but also desirable. The role of the professional association in this endeavor is essential. Confessore and Confessore conclude that once professionals link continuing professional education with improved practice rather than as a requirement for renewing their license the appropriateness and value of self-directed learning will become apparent.

Maintaining the focus on the professional association, Guglielmino and Guglielmino (1994) argue that accrediting bodies should realize that the brightest and the most talented professionals are unlikely to endure stand-up training, thus such mandates run counter to competence assurance. Senge (1990), and Watkins and Marsick (1993),

emphasize moving toward learning organizations and self-directed work teams respectively. However, Guglielmino and Guglielmino note the work world has been slow to move toward and to foster self-directed learning, despite a demonstrated positive correlation between readiness for self-directed learning and on-the-job performance. The workplace must align itself with what research shows works and what is desired. They advocate that human-resources departments must promote self-directed learning and make it known that they support self-direction. Technological advances such as computers and databases can facilitate locating information necessary for self-directed learning.

A group of arguments often put forth against self-directed learning by nurses (and nursing students) is that they are not very good at it, they do not like it, and they do not have enough experience with it (Kenny, 1999; Nolan & Nolan, 1997a, b). Houle (1980) argues that it is the responsibility of professional schools to equip students to be lifelong learners and to move from the stance of providing preparatory education, to one where the professional views her or himself as taking the first step of a continuing process of education. This shift at the outset of professional education is compatible with professionals' ideals and goals such as striving to be the best and having the most current information and research available for their use. Interestingly, Grant (1998) found that diploma-prepared nurses overwhelmingly preferred self-paced learning modules to the lectures and discussion. Masters' prepared nurses preferred a combination of self-paced modules coupled with traditional lecture and discussion.

Hiemstra and Brockett (1994) acknowledge that assessing the effectiveness of mandatory continuing education is beyond the scope of their research, but report that

introducing self-directed learning elements into mandatory continuing education may make it more palatable and salable to professionals. It may contribute to a sense of ownership of such a program and decrease resistance to mandatory continuing education. Such thinking is reflected in other programs designed and implemented for continuing competence in many jurisdictions governing professionals (see Brown, 1995; CNO, 1996; Parboosingh & McLaughlin, in press; & RNABC, 1998).

At the start of the 21st century, the evidence supports self-directed learning as an important, viable, and necessary element of pre-service and continuing education. In the next section, I focus on reflection as a component of self-assessment.

Reflection

The last decade has seen a considerable number of articles on reflection published in the nursing literature. Increasingly, as nursing curricula have been revised and updated in an effort to support a more professional orientation in pre-service education, methods of assessment have expanded to include more student-centred assessments and self-assessments (Burnard, 1988; Green 1994). In this section, I examine various aspects of reflection and self-assessment in relation to learning, and the usefulness or appropriateness of these approaches in continuing competence.

The Use of Reflection in Learning

Boyd and Fales (1983) define reflection as “the process of creating and clarifying the meaning of experience (present or past) in terms of self (self in relation to self and of self in relation to the world)” (p. 101). The outcome of the reflective process is a changed

conceptual perspective. In support of the focus on self, Clarke, James, and Kelly (1994) note the centrality of self in the definition of reflection.

According to Boyd and Fales (1983) reflection is critical to learning from experience. It is reflection that makes the difference in whether an individual “repeats the same experience several times, becoming highly proficient at one behavior, or learns from experiences in such a way that he or she is cognitively or affectively changed” (p. 100). Benner (1984) echoes the belief that reflection is essential if a nurse is to learn from experience.

As an extension of the belief in the importance of reflection in learning, adult educators have trumpeted the model of reflective practice. Jarvis (1992) states that reflective practice “seeks to problematise many situations of professional performance so that they can become potential learning situations and so the practitioners can continue to learn, grow and develop in and through their practice” (p. 180). In order for this to happen, nurse educators, mentors, and managers who understand the interplay and relationship between theory and practice will play an important role in the development of reflective practitioners.

Self-Assessment

Taylor (1995) states the word assess is Latin for, to sit beside, and asserts that is the ideal vantage-point for assessment. Too often, educators and students alike view assessment as coming down from on high, and from outside the individual. Illustrative of Taylor’s view, MacIsaac and Jackson (1994) note that self-assessment within a portfolio framework allows the learner to examine past work and to reflect upon and evaluate their growth and development. Reviewing past work allows learners to judge the quality of

their work. This forms the foundation for the pre-service professional to appreciate that they are responsible for their own learning.

The value and role of self-assessment are supported in Purdy's (1997) work. He states that nurse education has two ends: individual professional development and professional selection. These roughly correspond to the private need for individualized professional growth and the public need for competent professionals. Legislation governing nursing jurisdictions in the United Kingdom pressures educators to focus on the mandate of professional selection, based primarily on criterion-referenced measures to the detriment of personal growth and self-assessment. However, once the nurse has graduated and obtained a license to practice, self-assessment becomes an expectation of the practitioner, yet schools of nursing do not provide the necessary foundation for this skill. Purdy notes that personal growth is pivotal to the role of the nurse and includes critical reflection.

Crawford and Kiger (1998) query what nurses should reflect upon if they are to assess themselves. Clarke et al. (1994) provide the answer. Four areas to reflect upon are: technical features of practice; practical aspects of practice; the social, political, and economic contexts of practice; and the knowledge of the nurse's individual self.

Reflecting on technical features of practice (e.g., medications, equipment, management) improves efficiency and effectiveness. Practical aspects of practice encompass the life-world of nursing. They are the norms, roles, and routines that affect the work of nurses. When reflecting on this area, nurses consider the appropriateness of an action. Reflection on the social, economic, and political features of practice include how healthcare funding affects nurses' practice; financial constraints and changes in

healthcare policy are two examples. Reflection in this third area is emancipatory, liberating, and transformational on a macro or societal level. Finally, the fourth area is self-knowledge. What does the practitioner bring to the practice of nursing? The autobiographical portion of a portfolio is an example noted by Farley Serembus (2000). Further emancipation may result through individual development, empowerment, and autonomy on a micro (personal) level.

Gerrish (1993) found that student nurse-educators who kept reflective diaries viewed themselves as benefiting by honing their ability to assess their needs and their progress and to analyze and evaluate their experience. They believe they gained the skill of being aware of learning as it occurred. This exemplifies Taylor's (1995) notion of being beside one's self, watching.

One of the advantages of self-assessment is the development of reflective skills. Participants in Scheppner Wenzel et al.'s (1998) study similarly found that reflection fostered self-assessment. Carried out within the context of a portfolio, they posit that this tracking promotes lifelong learning. Priest and Roberts' (1998) findings are similar. The portfolio is a vehicle for reflection and allows for continuous self-assessment while providing evidence of professional growth. This in turn creates a foundation for a lifelong approach to maintaining and measuring competence.

Skills for Developing Reflection

Atkins and Murphy's (1993) literature review of reflection led them to identify the requisite skills for reflection as a gap in the literature. They then analyzed the literature with the intent of identifying a skill set for the process of reflection and identified five skills implicit in the literature. The first skill they identified was self-awareness. They

view self-awareness as an ability to analyze the feelings individuals experience and how they, as individuals are affected by the experience. The second skill is description. Reflection requires that an individual can recall the salient features of an experience and provide a detailed account of their experience. Uncomfortable feelings are noted as a cue to examine a situation more closely.

A third skill for reflection is critical analysis (Atkins & Murphy, 1993), whereby the components are broken down. The person identifies underlying knowledge and creates or explores alternatives. Critical analysis may help to uncover underlying assumptions which, Brookfield (1992) asserts, is essential to reflective practice. Synthesis or the integration of new knowledge with old is the fourth skill Atkins and Murphy identify. This is done in such a way that the problem (or novel situation) the professional faces is solved and possible consequences are predicted.

Atkins and Murphy (1993) identify evaluation as the final skill. This implies the judgment or valuing of a situation, often against standards and criteria. Atkins and Murphy note that there may be other skills involved that they did not discern from the literature. They conclude that open-mindedness and motivation, although not skills, are essential ingredients to the process.

Critiques of Reflection

One of the critiques of reflection and self-assessment is that nurses lack the necessary skills to carry out these activities (Picherack & Associates, 1998; RNANS (Registered Nurses' Association of Nova Scotia), 1997). This criticism is contradicted, however, by the findings of Crawford and Kiger (1998) and Green (1994), in whose studies student nurses were guided through the process of learning self-assessment and

reflection. The skill set has been made explicit by Atkins and Murphy (1993), thus nurses and other professionals (and pre-service students) can be taught these skills to enable those who desire to undertake reflection and self-assessment to enhance their practice to do so.

Benner (1984) asserts that until the nurse is at the competent stage, reflection on practice may be difficult because the nurse lacks the foundation of practical experience on which to reflect. Reflection is appropriate to use, however, when a nurse has had enough experience within a clinical area to be functioning at the proficient and expert stages.

Other researchers have also offered cautions about nurses and reflection. Mackintosh (1998) reports that she is unable to find a consistent definition of reflection in the literature. Furthermore, she compares the use of the term reflection by Dewey, Mezirow, and Schön and finds they are all different. Without a common understanding of the term, she questions the value of reflection to nursing. Mackintosh views reflection as the in-vogue trend and views nursing's embrace of reflection as temporary, lasting only until a new fad is in vogue. Furthermore, she asserts that a framework for the use of reflection within nursing is lacking and raises several issues with respect to using reflection within the nursing profession in general and in nursing education programs in particular. Mackintosh's succinct article is worth reading for a review of other studies that critique nurses' ability to reflect critically.

Usefulness of Reflection to Continuing Competence

Several studies illustrate the usefulness of reflection for continuing competence. For example, Durgahee (1996) studied nurses' reflection one year after graduation. She

found that the nurses in the study had developed the ability to be reflective during their pre-service program. A quotation from one of the nurses in the study is, “I am now more concerned not only about what are my practices but how can I change my practices to a more ideal state” (p. 423). Such statements reinforce that reflection supports self-assessment and self-directed learning.

In contrast, Glen and Hight (1992) do not believe that it is easy to identify or define what constitutes personal or professional development. They advocate always raising the question of whether and how assessment strategies foster the personal and professional advancement of the individual and using selected assessment strategies in a manner which maximizes their contribution to personal and professional development. Taylor (1995) asserts that self-assessment can help strengthen the capacity for self-direction and self-responsibility, two essential elements of continuing professional development.

Perhaps the strongest argument for self-assessment comes from Jarvis (1983): “Self-assessment is an . . . important skill to develop since many practitioners may rarely have their professional performance appraised overtly once they have finished their basic professional education” (p. 103).

Data Collection Methods

According to Merriam and Simpson (2000), the research method should guide the researcher’s selection of methods for collecting data. Quantitative analysis includes statistical and numerical presentation of data, and qualitative analysis renders a

descriptive presentation of data. Thus, the choice of methods to collect data depends on the research question and method: empirical research calls for different collection and treatment of data than does theoretical or historical research. In this section, I discuss surveys, observation, field notes, and videotapes as methods of data collection.

Survey Methods

Merriam and Simpson (2000) categorize questionnaires and interviews strategies as survey methods, the former being written and the latter oral. Here I focus on questionnaires because they are most relevant to my study.

Questionnaires offer the benefit of self-administration. Closed and open-ended questions each have their advantages and disadvantages. A closed question leads the respondent in a particular direction and limits their responses but coding is straightforward because response categories are predetermined. These are generally easy and quick for the respondent to complete, however, there is no room for elaboration or allowance for differences that do not neatly fit into predetermined categories. The research may lack depth when using closed questions (Polit & Hungler, 1999). Careful attention to the wording, format, and order of closed questions is important. In particular, researchers must ensure they are asking only one question.

The open-ended question allows the participant to provide a full range of individual answers. Jackson (1999) notes six instances where open-ended questions should be used. They are: too many possible answers to a question, the researcher does not wish to lead the participant, the research is qualitative in nature, the researcher wishes to consult with the participants, to provide a change of pace for the participant, and in a pilot study where the categories of responses have not yet been established. However, a

potential drawback that Merriam and Simpson (2000) note is that more time is required with open-ended questions, both for the respondent in completing the questions, and for the researcher in coding the responses. Polit and Hungler (1999) recommend combining open and closed-ended questions to offset the advantages and disadvantages of each.

Field Notes

According to Neutens and Rubinson (1997), field notes form the most important part of data collection in qualitative research. They cover anything and everything the researcher believes is important. Descriptions form the basis of field notes. They are used to capture quotations; the thoughts, feelings, and hunches of the researcher; and an evolving interpretation as to the meaning or significance of events. Polit and Hungler (1999) assert that the success of studies using participant observation is dependent upon the quality of the logs and field notes.

Polit and Hungler (1999) suggest that researchers use the following types of field notes. Methodological notes detail the planning and completion details of the research project. Observational notes provide a record of what the researcher saw and heard. Theoretical notes are the “self-conscious, controlled attempts to derive meaning from any one or several observation notes” (p. 184). A summary of field notes helps to establish links between items and can serve to highlight themes. Polit and Hungler add a fourth category: personal notes, which are for capturing the researcher’s feelings.

Sorting out qualitative data from field notes is more art than science. Guba and Lincoln (1981) suggest sorting at least three times, looking for common themes, special themes, and themes of a theoretical nature that enable researchers to establish their own constructs.

Observation

Observation is ideally suited to qualitative research because it enables the researcher to look into issues deeply and comprehensively. Widely used in education, researchers are increasingly using observation (Neutens & Rubinson, 1997) because it offers the benefits of open-ended questions and unstructured interview methods (Merriam & Simpson, 2000). That is, the researcher can probe and explore issues with the participants to clarify and to expand on their responses and ideas. Researchers must be aware of their presence and the potential effect that this can have on participants. Depending on the rapport and nature of the relationship between the researcher and the participants, responses may be less than truthful, inflated, and so on. Observation can take place on a continuum from complete observer to complete participant, with intervening points of the observer as participant, or the participant as observer. Observers must suspend their frame of reference and disregard their personal values, otherwise they run the risk of becoming emotionally involved and less objective. Researchers typically use observation in conjunction with other methods (Neutens & Rubinson).

Videotaping

Videotaping provides a permanent record of events. A review of a video record allows researchers to capture nuances of speech and behavior that may be lost in the observational process. The video record also allows researchers to check the accuracy of their observations and field notes. It is a useful method of self-assessment and of assessing recall (Latvala, Vuokila-Oikkonen, & Janhonen; 2000) and serves to refresh the researcher's memory. Researchers must take care so that the videotape does not interfere with the process under observation and that they make clear the intended use of the

videotapes. Polit and Hungler (1999) suggest that where there are multiple purposes, it may be desirable to get separate consent forms signed.

Summary of the Literature

Many nursing jurisdictions governing registered nurses in Canada, that have continuing competence programs in place, have embraced self-assessment as an appropriate and desirable means of fulfilling quality assurance programs as required by law. Jurisdictions without this legal requirement are piloting or exploring self-assessment and reflection as a means of demonstrating continuing competence. Self-assessment and reflection are acceptable options to members of many professions, and the literature reflects the concept that professionals are in the best position to evaluate their performance and assess their continuing professional development needs.

As a vehicle for reflection and self-assessment, the portfolio provides insights to the professional for areas requiring further learning. Professional self-assessment places the professional in an informed position to be self-directing in their learning needs, learning activities, and subsequent evaluation. Taken together, they form a foundation for demonstrating continuing competence.

Several studies support reflection as a component of self-assessment. Studies done with nursing students while in their education programs and after graduation demonstrate the value of reflection to self-assessment during their education and beyond. More importantly, an expectation of graduate nurses is to reflect on their practice as the foundation of personal growth.

Researchers have several data collection methods available to them and must choose those that are best suited to their research design. Questionnaires are inexpensive and easy to administer. Field notes are the researcher's most important source of data in qualitative research. Observation is becoming more widely used by health researchers, enabling a comprehensive examination of the issue(s).

I identified a gap from my review of the literature; specifically, none of the literature I found addressed facilitating practicing nurses' portfolio development, their learning needs for portfolio development, and their views on the usefulness of portfolios to demonstrate continuing competence. I designed this study to fill this gap in the literature; this is the theoretical framework for the study that follows in chapter 3.

In the next chapter, I describe planning and facilitation of educational sessions to examine nurses' attitudes toward and factors surrounding continuing competence and participation in continuing professional development and report findings on how the educational interventions influenced nurses' attitudes and beliefs about the portfolio's usefulness in demonstrating continuing competence.

CHAPTER 3

DESIGNING AND FACILITATING EDUCATIONAL SESSIONS: THE EXPERIENCE

In this chapter I describe my activities for increasing competence assessment in nursing by promoting a portfolio approach. The purpose of the education sessions was to collect information about nurses' attitudes toward continuing competence and factors surrounding and participation in continuing professional development, to introduce portfolios, to have nurses reflect on the process of initiating a learning portfolio, and to examine whether the educational intervention influenced nurses' attitudes and beliefs about portfolios. First I describe the planning and design process; then I describe my facilitation of the sessions; next I present the findings from the questionnaires; following that, I extract the nurses' learning needs for using portfolios; finally, I report my observations.

Designing the Education Sessions

As a nurse who has been active in my professional associations since I began practicing, I have had a particular interest in the education of nurses, the competence of professionals, and the mandate of regulatory bodies to ensure their members are safe and competent practitioners. My interest in continuing competence has its roots in a motion passed at an annual general meeting of the RPNAS that required a mandatory continuing education program. My activities on behalf of the RPNAS council also led to my being exposed to the use of portfolios, and I was particularly interested in using them to

demonstrate competence. My interest peaked at the time I applied to, and was accepted into, a graduate program in adult education. Ideas began to take shape for a project with nurses in Saskatchewan. The SRNA was just beginning to explore a quality assurance program for their members and I accepted the appointment to the committee and later the chair, believing that serving on the committee would be of mutual benefit.

Accessing information on portfolios in the literature was not difficult. However, I identified a gap in the literature: facilitating nurses' portfolio use to demonstrate continuing competence and their learning needs with respect to portfolio development. This led to my selecting a project design to facilitate an educational intervention to introduce portfolio use to nurses to demonstrate competence.

In the following section, I highlight the activities and decisions I made in developing the educational sessions including; the design of the questionnaires, the design of the educational sessions, selection and profile of the participants, and strategies for establishing a learning environment.

Design of the Questionnaires

I developed pre- and post-session questionnaires that were similar, but with slight modifications in the post-questionnaire, to determine changes in attitude and knowledge as a result of participating in the sessions. Based on field-testers' responses, I made many changes they suggested and estimated the time I should allot for completing the questionnaires.

My revised pre- and post-session questionnaires comprised 27 and 28 items respectively. The questionnaires were very similar. The pre-questionnaire had one question that did not appear on the post-questionnaire and likewise the post-questionnaire

had three questions that were not on the pre-questionnaire. The only other differences were minor wording changes denoting a shift in time perspective. Sixteen questions had only one part; 6 were yes or no and had, as a second part, if yes, please elaborate. Five questions had a range of answers from which to select one answer, and four had a checklist range of answers from which to select as many as applied. One question asked nurses to rate, on a five-point scale, their understanding of the term portfolio.

I posed several open-ended questions about nurses' attitudes and practices regarding continuing competence and continuing professional development including their planning practices and participation in continuing professional development; how they chose continuing professional development activities, and whether and how they recorded the objectives that they set for these activities; and whether they evaluated their continuing professional development activities with respect to contributing to their continuing competence in general, and against specific learning objectives they set for the activity.

I also designed a final evaluative questionnaire of seven questions for participants to give feedback on the usefulness of the sessions and their satisfaction with the sessions in general. I asked participants to give me suggestions to improve my facilitation skills and whether they would recommend the educational sessions to a colleague. I did not pilot-test this questionnaire.

Some Canadian nursing regulatory bodies have adapted some of all of the following documents --code of ethics, standards of practice, competencies documents-- by adding a rating scale for their members to use as self-assessment tools. The rating scale was a 4-point scale with the points named expert, highly developed, refining, and

developing. I deliberately chose an even number of points so that individuals could not check off a mid-point in their self-assessment, thus eliminating the statistical error of central tendency. This forced a determination about their competence.

Design of the Educational Sessions

Drawing largely from my literature review on adult education, other readings, and experiences, I identified the content for my portfolio development sessions. The questionnaires provided some guidance in that the material I chose for the sessions should have provided the answers to all of the knowledge questions in the post-questionnaire.

I designed an educational intervention comprised of three sessions (that I refer to as Sessions 1, 2, and 3), to facilitate portfolio development to demonstrate continuing competence. To ensure I addressed all major activities, I designed the workshop referring to Caffarella's (1994) interactive program planning model. I also drew from Wlodkowski's (1999) motivational principles, Vella's (1994) principles of adult education, and Kolb's (1984) experiential learning cycle and strategies matched to the four learning types his model describes in designing and facilitating the educational intervention. I incorporated Wlodkowski's motivational strategies into my project because the facilitator can influence and contribute to motivation because my experience using them was effective. Motivation is a complex issue and incorporating motivational strategies alone will not motivate adults to learn. There are many other factors such as health and personal issues that are beyond the scope or control of the facilitator. This did not excuse me from considering what I could do, however limited it might be.

I developed a package of handout materials for the participants, that included outlines, some content of my sessions, and references. These also served as pages to record ideas and reactions to the questions for those who chose to do so. I provided a letter size, soft-cover document binder to keep the materials together and made complementary overhead foils for participants to use during the sessions. In the following sections, I first describe the design (content, activity, and process) for each session, then I describe the handouts for the sessions. I also adapted a model of portfolio development for continuing competence to solicit opinions from the participants and included it in the handouts for their information, consideration, and discussion.

I designed the workshop so that attendance at all three sessions was not mandatory. This flexible design met participants' ability to attend and respected the fact that adults lead busy lives with competing demands on their time. Participants able to do so, had the option of attending the full 3 hours of Session 1. If desired, a participant could complete the pre-questionnaire ahead of time, and join Session 1 after the first 1 3/4 hours. (During this first 1 3/4 hours of the session, participants at the session completed introductions, were oriented to the housekeeping items, signed the informed consent to participate in a research study, and completed the pre-session questionnaires.) In the letter of invitation, in initial personal contacts, and at the start of Session 1, I explained that my sessions were designed so that participants could attend, partially attend, or miss Sessions 1 and 3 (if they agreed to complete the questionnaires on their own time). I also explained how this would affect the study and their participation.

Selection and Profile of the Participants

I recruited nurses via my organization's internal e-mail, personal e-mail with those who do not work for my organization, personal contact, and telephone. I also asked participants to personally extend an invitation to any RPNs or RNs they thought might be interested in participating. The initial number of nurses agreeing to participate was 11; however, one moved out of province and withdrew before the study started, leaving 10.

The 10 participants who started the project were RPNs: 3 of them were dually educated and licensed as RNs. All were practicing in a city of about 200,000 in a prairie province and represented four employers, including an acute inpatient psychiatric unit, a secure forensic facility, a community substance abuse treatment facility, and post-secondary education facilities.

Participants varied widely on demographic characteristics. Three participants were male and 7 were female. Their age range fell in every 10-year category from 20-29 years through to 50-59 years. Six of the participants were shift-workers (2 of them covered the 7 a.m. to 3 p.m. and 3 p.m. to 11 p.m. shifts. The other 4 had shifts that rotated over the 24-hour day). Participants' years of active practice fell with the groupings 4-5, 6-10, 11-15, and 21-25. Years in their current position ranged from 0.5 to 21.

The level of nursing education ranged from a single diploma to a baccalaureate degree. Two participants did not indicate any education outside of nursing. Nine of the participants indicated they had other education ranging from 2½ years of university (toward an unspecified degree), through a diploma in mechanical engineering, to a B.A. in theology, to a master of science (health promotion) candidate. No one participant was

typical of the sample. For example, 2 worked as nurse educators, 2 worked as nurse managers, and the remainder worked as direct-care practitioners.

In this thesis, I refer to these nurses by fictitious names to ensure confidentiality. I assign them names that are androgynous to ensure anonymity.

Strategies for Establishing the Learning Environment

The environment is an important consideration to the facilitation of learning. In addition to the physical environment and participants' physical needs and comfort, I considered the learning environment as a whole. The sessions took place in a meeting room, with adjustable, ergonomically designed chairs. Modular table designs allowed for different seating configurations to facilitate different activities and a varying number of participants. Thus, for discussions, I could configure a round table, or I could place rectangular tables in a U-shape for presenting information, or leave the tables spread throughout the room for individual use by participants when completing questionnaires. There was a beautiful indoor courtyard that participants could go to, to complete questionnaires and the self-assessment tool, and smoking was permitted in one small area ventilated with an exhaust fan.

The contacts I had with the participants before they attended a session served to set a positive tone for learning. For example, I stressed the voluntary nature of the project, and I ensured the participants anonymity and confidentiality. This helped to establish the safety aspect of the learning environment. I demonstrated respect for the participants as unique individuals in my interactions and addressed any particular concerns or questions they had. I was able to personalize my interactions because of common experiences shared through work, professional association activities, and

friendship. I also acknowledged that as adults they lived lives with time constraints and demands beyond their workday and my project, and outlined how I had built flexibility into my design to reflect this. Finally, I expressed appreciation for their participation.

Implementing the Sessions

Accommodating shift-work schedules from different facilities proved to be challenging. The two nurses working as educators were participating in the project during final clinical placements and because of this, they worked opposite days. Four of the participants who worked regular day shifts on weekdays traveled as part of their work, and I had to consider their travel schedules. I offered Session 1 once and each of Sessions 2 and 3 twice to accommodate travel and work schedules (including 12-hour shifts).

Session 1

Five participants attended Session 1. Their first major activity was individually completing the pre-intervention questionnaires. After a break, I facilitated a group discussion activity. I used a method of question posing with the participants, which enabled me to determine their current level of knowledge with respect to portfolios in general, and retrospective portfolios in particular. Having the participants respond to questions also exposed them to each other's points of view and helped to spark memories and new ideas. For example, I asked, "what types of portfolios have you heard of or what are portfolios used for?" and, "Do you have any ideas about what a nurse might include in a portfolio?" I recorded their answers on a flipchart. Once they stopped giving answers, I could show an overhead, reinforce the information they had provided, and

highlight information they did not provide or with which they were not familiar. The flipcharts were available for reference to their responses in subsequent sessions, so participants could continue to shape them as they added to them or explored new ideas.

I had several resources available for the participants to peruse. These resources consisted of books, samples of what other nursing jurisdictions used for their competence assurance programs, samples of different grades (qualities) and types of paper, and reference lists on which I identified the resources of which I had personal copies. I shared my portfolio and identified it as a work in progress. I also identified how I planned to improve my portfolio and why I wanted to make those changes. Several nurses stayed and looked at the resources and took what they found useful. Several commented that it was particularly helpful to have my portfolio as an example to peruse. I displayed these resources at every session and at each session different participants reviewed them.

Finally, I facilitated material on how to create one's own career portfolio. Later, when I asked whether any participants were planning to develop a career portfolio, two of the five participants said that they were. Kim quickly asked for clarification, "You mean right now, during these 2 months?" I clarified that I did not expect anyone to complete one during the study, but that they might start it during the study. For example, Lee was interested in beginning a career portfolio believing it to be a good method of demonstrating competence. I acknowledged that I did not expect that they could complete a career portfolio before the second session, or even during the length of the project. Two decided they did not desire to develop a career portfolio, and one was not certain whether developing a portfolio was something she wanted to do at this time.

For the five participants who were unable to attend Session 1, I delivered, or arranged delivery of, the package that included the consent, pre-questionnaire, and demographics questionnaire. Delivery options included e-mail, internal mail, or personal delivery of the questionnaires. I personally delivered four packages and e-mailed out a fifth package. I emphasized to the participants that if they had any questions they should contact me before signing the consent form so we could discuss their concern or question. None of the participants had any questions.

I supplemented my booklet of handouts by adding in my overhead package of materials. Using the computer, I also added the gist of the discussions and material covered by participants in the session, at the appropriate point in the handout booklet. I identified these additions with a symbol so that it was clear what the discussions added, and printed the updated material. Once I had picked up or received the package of material I had delivered to these five participants (all five participants completed their package of materials within 2 days), I delivered the booklets to them, briefly discussed the contents, and explained that I had added in the discussion comments and ideas. I emphasized that, as they reviewed the material, they could contact me by any means for any necessary clarification or discussion.

Session 2

Session 2 was the only mandatory session. Five participants attended each of the two offerings of this session. A review served as a transition between material previously covered the working portion of this session.

During the first activity, participants discussed definitions of initial and ongoing competence and factors driving the competence movement amongst licensed, self-

regulating professions. I used the same question posing approach as I had during the first session to establish their knowledge base. For example, I started by asking, “We all use the word competence, what do we mean when we say it? How do you define competence?” I asked, “Why do you think professional associations are concerned about continuing competence. What factors are driving the interest in competence?”

Participants readily identified all the factors I planned to cover. In this section, I briefly explained Benner’s (1984) Stages of Nurse Development, because only two of five participants attending the first offering of Session 2, and none of the five attending the second offering of Session 2, were familiar with her work. I emphasized that being competent fell at the mid-point in the model, and there were two levels beyond competent. Gerry, who was familiar with Benner’s work, disagreed with her saying that, “I know that after 5-years of practicing I certainly wasn’t an expert.” I asked Gerry how many different positions she had during her first 5 years of work. She said it was quite a few. Benner proposes that after 5 years of practice within a given area, a nurse may be in the expert stage. However, she emphasizes that time in a position, in and of itself, does not lead to expertise. Once I clarified this point the discussion flowed and the participants shared their views. A common reaction was that after several years of practice in an area, many participants did not have a sense of being an expert at anything. Participants were interested in this information and had lively discussions on this model. One participant noted knowing professionals who had practiced for 25 years who certainly were not competent. I made the distinction between a person who has 10 years of experience and one who has 1 year of experience 10 times over. This statement was poignantly

remembered from a workshop years earlier, and most of the participants immediately identified with the truth of that statement.

Next, we made a distinction between continuing professional development and continuing professional education. Continuing professional education (formal classes and workshops) and continuing professional development (developmental opportunities both inside and outside the workplace, such as secondments and acting in others' positions).

I introduced learning portfolios by describing the relationship between career and learning portfolios. I elicited from the participants that the career portfolio was the historical aspect of their career, the repository of the documents of their personal pathway to the present. The learning portfolio, on the other hand, maps a path into the future using learning or career development plans. I emphasized two components of learning portfolios: a professional self-assessment and a self-directed learning plan. As learning plans are completed, nurses file them in the career portfolio and develop new learning plans.

We discussed a few assessment mechanisms and strategies including testing, simulations, case review, performance appraisals, and peer (review) appraisal. Participants both fully supported and had concerns with performance appraisal and peer review. For example, Tracy said she found that performance appraisals, when done well, to be one of the most useful assessment tools. A few participants disagreed and cited examples where their supervisor was not a nurse, "had no clue" about nursing competencies, and had no basis for assessing them. The broad area of medications was cited as a specific example. Two others discussed instances where their supervisor was a nurse. In one case the participant thought that although she herself was competent, even

excellent in many regards, that her supervisor was threatened by her, and rated her poorly. In the other case, the supervisor was seen as so far removed from the realities and demands of practice, that the assessment was not valid. In addition, many noted that performance appraisals are not based on nursing competencies.

Participants saw peer review or appraisal as an important means of assessment because peers practice in the same area, and should practice according to the same standards, ethics, and competencies. Although peers are best placed to appraise one another, the danger of collusion was noted; if you give me a good review, I will give you a good review. Although Saskatchewan nurses do not use peer appraisal, the nurses in my study were familiar with the concept and had definite views about it. In the end, they agreed that it is a skill that must be taught and honed in nurses' education.

For the next activity, I distributed a variety of professional self-assessment tools and asked participants to complete one or two of them, over the next half-hour. I offered particular suggestions to each participant in view of her or his present professional position. I told participants that the self-assessment was for their own personal use, that they did not have to share it with anyone. Immediate feedback on the self-assessment tool was very positive. For example, D'arcy exclaimed, "This is just awesome, this is very impressive. It is so obvious where I have to improve." All the participants later reviewed or completed the other tools handed out. Even where not completed, each participant compared the other self-assessment tools and stated their preference based on various features of the tools during the sessions or the post-questionnaire.

Next, I moved the discussion to self-directed learning. Only one participant had had experience developing and carrying out a formalized self-directed learning plan.

Participants did not have difficulty with the concept of self-directed learning. I pointed out the work done by Tough (1979) and that it was reasonable to assume they likely learned things all the time. However, because this learning is not always deliberate, formally planned, and made explicit, they are probably not aware of the many learning projects they undertook or of much of the learning they experienced. Several participants nodded in agreement and Chris shared some individual learning projects undertaken to meet needs that arose out of the work situation.

The next handout was a template for a self-directed learning. I drew their attention to the similarities between learning plans and nursing/patient care plans as well as the differences and emphasized that some of the skills used in developing care plans were transferable to developing learning plans. To assist the participants in developing learning objectives, I made Gronlund's (1995) book available so that participants who wanted a copy of the section on learning verbs could make one. In his book, Knowles (1975) refers the reader to these same verbs to aid in developing their self-directed learning plans. Most participants took copies of the learning verbs; only Kim had used them before. Interestingly, none of the educators had. I made copies of some of my own learning plans available to the participants, believing that seeing an example, might make it more real and increase their belief in their own ability to create one. Several reviewed my learning plan and said it was helpful.

I distributed and reviewed the professional-development activity record and explained how I envisioned its use in relation to learning portfolios. It was given as a resource to get opinions on, not to complete during the session. Tracy said, "I would do

this. I can see myself taking this to a workshop or conference and filling it out as we go.”

Lee added, “I particularly like the future focus of the *now what?* question.”

The final topic was evaluation of learning. I demonstrated the relation between well-written learning objectives, and the ease of subsequent learning assessments. In the final learning activity, I introduced my model of portfolio development. We reviewed the retrospective (i.e., curriculum vitae, autobiography, philosophy of nursing, learning narratives, and completed learning and development plans) and prospective (i.e., self assessment and self-directed learning plans) elements. After we reviewed my model, I asked participants to review it before the next session, and to be prepared to discuss their thoughts on it at the next session, and to make suggestions to improve it.

I encouraged participants to begin working on a self-directed learning plan that they could carry out before we met for the final session. I allowed ½ hour for this activity. Their learning plan was to flow from an identified need area based on the self-assessment tool they had just completed. Thus, the learning plan as part of the learning portfolio related directly to their professional development and competence. I had resources available in the room during the session for developing their learning plans. They could also borrow resources from me outside of the sessions, or copy what they wanted. Because there were only 3 weeks until Session 3, I stressed that the self-directed learning plans should not be too elaborate, but real enough for them to gain experience in developing and carrying out a self-directed learning project. The learning plan should be useful to them in their nursing practice. They could choose a new area entirely, or build on an area in which they had already done some learning, by looking at that area more broadly or deeply. Before the participants left, I reviewed the plan for Session 3. I

reemphasized that I was available to help them with their learning plans and with locating resources.

The second offering of Session 2 took place on a Monday immediately after work. I had to try very hard to get most of participants to venture answers to questions. For two of the five participants in this particular session, it was the first session they had attended, because they had completed their pre-questionnaires and reviewed the material for Session 1 on their own. They seemed surprised that I was asking them questions on a topic they came to learn about, instead of telling them everything they had to know. I think they expected to show up, listen to a presentation or lecture, take notes, collect handouts, and leave. I do not think they anticipated the level of participation my approach requires, or perhaps they were tired. At any rate, I noted that this particular group session was the most subdued. When I reviewed the tapes, I could find no significant difference in what I was doing or how I was doing it, and am at a loss to account for the difference. However, of the five participants at the second offering, two did not complete the study, and a third was not able to attend Session 3, but did carry out the self-directed learning plan and complete the questionnaires. Conversely, of the five who attended the first offering of Session 2, three had attended Session 1 and four of them completed the study

Session 3

Three participants attended each offering of Session 3. In Session 3 only, I was not in front of the group at the flip chart: I sat at the table with the participants guiding the activities, facilitating the discussion, and taking notes. In Session 3, participants could share their learning plans with the group if they chose to do so. All the participants in the first offering shared their learning plan, none in the second offering did. The participants

had the opportunity to ask questions about anything relating to the sessions and the study. The next activity was a discussion based on a semi-structured series of questions, which provided some direction to the discussion, and enabled me to follow-up on points made in the discussion that I had not necessarily thought of, or that might add to the study.

Lee talked about the usefulness of the self-directed learning plan and said, “I could think about it in my head, but writing it down in steps, in those columns, was really helpful.” Tracy liked the structure and organized approach of the self-directed learning plan.

Several participants identified the model of portfolio development as useful. For example, Tracy said, “The model pulled everything together for me.” Similarly, Terry said, “It simplified it for me. I’m a very visual learner and anytime you can give me a clear, concise picture it helps.” Gerry suggested that the philosophy of nursing be specific to the area of practice, in this case, psychiatric nursing. They thought that the autobiography review would be useful in terms of linking the past to present practice. Tracy liked the idea of journalizing and said, “Any time people can be encouraged to journal, I am all for it. I notice a difference in me when I am regularly journalling [*sic*], and when I am not.”

Chris found the self-assessment very useful and said, “I found that now that I’ve been an educator, away from direct-practice for 3 years, it is really important to look at those competencies to determine what I have to focus on.” The participants identified the competencies as the most valuable of the three self-assessment tools. It was the most useful for focusing in on their learning needs.

This discussion was a forum to stimulate ideas and further thinking on the topics. Participants' exposure to others' points of view and information may broaden their own thinking as compared to if they had been left to complete the questionnaires on their own, without hearing ideas from others. Tracy noted that "discussion was very important. More and more, I am finding I am the type of person that has to bounce ideas off of other people." Similarly, Chris said, "I really appreciated the opportunity to get together with other RPNs, I have been so isolated from other RPNs in my work. It's as Gerry always says, it is so refreshing to be with like-minded RPNs who have a similar approach to and understanding of psychiatric nursing."

Lastly, I distributed the post-intervention questionnaire and evaluation. I did not notice any difference between the two offerings of Session 3. I gathered participants' observations and responses throughout the study. They completed three questionnaires, participated in discussions during the education sessions, and contributed throughout the process. I used field notes to record some of their discussion points that seemed particularly apt. Participants also spoke to me on the telephone, before and after the sessions, and during breaks. I have analyzed their feedback and present the results in the next three sections.

Findings Based on the Questionnaires

My analysis of questionnaires, supplemented by their comments during the sessions and in personal communication, yielded findings on nurses' knowledge and attitude toward continuing professional development and continuing competence, and on

the introduction of portfolios as a means to demonstrate continuing competence. The mean findings include participants' overall satisfaction levels with the sessions, their perspectives and changes in perspective about continuing competence, and their changes in perspective about career and learning portfolios.

Overall Satisfaction With the Process and Content

Participants had several opportunities, both written and oral, to give overall comments on their experience during the study. In the discussion, participants indicated satisfaction with the portfolio development process as I presented it. Two of the features participants noted that were valuable were the opportunity for discussion, feedback, and questions; and the ready access to resources and examples. As well, the participants commented appreciatively on the opportunity to get together with other professionals and share their points of view.

Feedback was positive for portfolios in general and learning portfolios in particular. Participants reported the self-assessment based on the competencies, standards, and code of ethics documents was useful for linking their professional learning activities to continuing competence. However, a few participants suggested changing the rating scales on the self-assessment tool; in particular, they did not like the rating scale not having a mid-point to check off. Others argued that no matter what their skill level, they were always refining and improving a skill. For example, Tracy stated during a discussion that, "After 20 years I still don't feel like an expert in anything. Refining should be understood in any of these." Other participants readily agreed with her and Kelly and Terry added that conscientious nurses are the ones who will always be looking

for ways to improve. Despite the fact a few of them did not like the scale, they had no specific alternative suggestions for its design.

Most of the participants indicated that before the study they had no knowledge of nurses' use of portfolios — not the content, format, or rationale for keeping one. Tracy's response typifies the view of most participants: "I had a view of portfolios as used by other professions, so it was great to see a picture emerge for the use of these for RPNs." Terry thought that the education sessions, "provided me with some answers as to why I've done some of the things I've done" but did not elaborate. Stacy commented, "Learning (knowledge, skills, abilities) is being developed on an ongoing basis. Unfortunately, often we do not take the time to reflect and document this knowledge and identify areas of future growth and development."

The participants agreed that the professional association should consider using some of my materials and methods as part of a quality assurance program for the members. They suggested I make a presentation to the Councils of the nursing regulatory bodies on my study. All the participants said that they would recommend a similar series of workshops to their colleagues.

Lee advocated that the process used in Ontario be implemented in Saskatchewan. The College of Nurses of Ontario requires nurses to complete and maintain a current portfolio. The CNO can ask any nurse to produce her or his portfolio for audit purposes. The CNO audits a percentage of the membership at random on an annual basis, and each nurse selected must submit her or his portfolio for review. Lee believes that the spectre of a random audit would be sufficient motivation to ensure that all nurses were, in fact,

participating in professional learning activities and remaining competent to practice in a safe and ethical manner.

Continuing Competence and Continuing Professional Development

During the sessions the participants discussed and explored the relationship between continuing professional development and continuing competence. Several of the participants viewed competence as linked directly to the job they were currently performing. In contrast, participants view professional learning as keeping up with developments within the profession as a whole. For example, Kelly wrote, “Continuing competence applies to the position (or work you do) you are currently in and continuing professional development applies to the profession you work in. They complement each other.” Lee said, “Competency is the proving of the behavioural aspect of continuing professional development. They are inter-related, you can do things to further develop your skills, but it’s the competence that is shown when you can prove you know the skill.” One comment was that continuing professional development did not ensure continuing competence. Kim commented, “Continuing professional development does not necessarily guarantee competence, although one would hope people use continuing professional development to improve where they need to.” Likewise, Tracy wrote, “I think one leads into and can be an integral part of the other i.e., continuing professional development is a stepping stone or could be a transition to continuing competence.”

Participation in continuing professional development. Participants responded to questions about their beliefs in participation, their actual participation, and they identified supports and barriers to participation. Attitudes toward continuing professional development and continuing competence were expressed in the questionnaire responses.

Participants were asked to consider their own attitude, and that of their employer, professional association, and union. The attitude of each of these can influence the culture and climate toward competence and affect participation in professional learning. The questionnaire separated consideration of the professional association and union; nurses are frequently not clear on the difference between the professional association and the union. Whereas the professional association's mandate is protection of the public (its owners), not the nurse (its fee-paying members), the union is concerned with the economic and other benefits to its members.

Participants began the study with positive attitudes and were favorably disposed toward professional learning and continuing competence and their attitudes remained positive throughout the study. Most participants who completed the study believed that professional development should take place on a continual or ongoing basis. For example, Lee's view is that continuing professional development should be, "Ongoing. Procedures change, theories are adapted. I think the phrase 'The more I learn, the less I know' is true. You could never stop learning, especially in this field."

In the year preceding the study, all but one participant had engaged in at least one continuing professional development activity and half of them in 5 or more, and 39 professional learning activities were cited. The list revealed a variety of activities that illustrates that continuing professional development encompasses more than continuing professional education. Roughly half of the activities did not fall into the continuing professional education category.

Chris's view reflects nurses' participation:

Continuing professional development should be a continuous process. However, I do not believe that all continuing professional development needs to be formally

organized or even formally recognized. It can involve simple things like reading current literature on issues related to nursing. I believe that continuing professional development involves anything that challenges me to think about what I do as a nurse.

Throughout the study, all the participants identified themselves as responsible for professional development activities. When the employer and professional association were identified as having responsibility for professional development activities, it was qualified with comments such as “nice if my employer helps me out,” by D'arcy. Likewise, Tracy said, “It is helpful when both my workplace and my professional association have information...” Chris’s comment was, “I would like to see opportunities arranged by my professional association but for the most part, I see myself as being responsible for identifying and accessing continuing professional development activities.” Stacy had a slightly different view and wrote, “ should be self-directed — however, I think it is also important to communicate your goals and objectives to your employer.” Gerry believes that, “As a professional, you are ultimately responsible. The employer shares a responsibility to support staff to engage in continuing professional development activities through PD funds, time off, etc.” Therefore, although the primary responsibility lies with the individual, participants state that the employer and professional association have a role in providing professional learning activities.

Participants identified employer support as releasing the employee from work to attend professional learning activities and providing them as well. Likewise, professional association support included advertising, promoting, and providing professional learning activities.

Many of the participants described their employers’ attitude toward continuing professional development as supportive, without qualification. Others, however, qualified

their employer's support. For example, Chris said the employer was verbally supportive, but went on to write, "Also, my employer supports only those continuing professional development activities that meet the needs of their program as *they* have defined these needs [my italics]." Gerry asserted that there were inequities in who was supported for what in terms of continuing professional development. This attitude did not change.

In contrast, some participants named the employer, management, or a supervisor, as a barrier to, or discouraging their participation in, professional learning. Two specifically related instances where their supervisor was late or tardy in getting forms signed or approved and consequently, the participants missed the learning opportunity. Participants cited a lack of relief staff as a barrier to participation and reflective of the employer being unsupportive or as Gerry stated, "paying lip-service" to professional learning.

Terry said the attitude of the professional association "encourages members." Terry later added that it is "supportive and necessary — they also provide bursaries." At the end of the study, Gerry's view moved from seeing the RPNAS's attitude as progressive, to calling it proactive and, "requires strengthening of the framework and random auditing (to be better)." Lee said, "The RPNAS should adopt the CNO's process of random auditing of portfolios because only the threat of being audited would make some people create and maintain a portfolio. Throughout the study, the participants viewed the RPNAS's requirement for continuing professional development to maintain licensure as positive and supportive of professional learning.

Only Kim commented on the SRNA; overall, she saw it as discouraging participation because it, "doesn't have continuing professional development. Has it in

standards but doesn't make it mandatory. Does provide some training opportunities." The SRNA endorses lifelong learning and does not mandate continuing professional development.

Other identified barriers to participation included money, time, family, and travel commitments (job related), formal learning, peers, and lack of awareness as barriers. Two participants cited formal continuing professional development activities, but because they did not elaborate, it is open to interpret how they are a barrier (e.g., time, money, learning style preference). Lee identified peers as discouraging participation and clarified this by adding, "People participating that found them not good or useful." Chris also cited a lack of awareness of what is available for continuing professional development. One female participant identified "self (guilt) gender related" as a factor discouraging participation. She did not elaborate on this factor. Adults, in general, frequently cite a lack of time and money as barriers to participation in adult education activities, thus, it is not surprising that nurses also name these as barriers.

Planning. Participants were asked whether it was necessary to plan for their professional learning, how much time they spent planning, what planning tools they used, and how they selected learning activities. Nurses in the study were in agreement that it is necessary to plan their professional learning activities. However, Chris checked both yes and no and elaborated thusly on the "no" response:

I think it is valuable for employers to participate in planning some continuing professional development activities because this ensures that employers maintain an awareness of the needs of nurses in expanding their competency levels. However, continuing professional development activities organized by employers can sometimes be too generic and hence, meaningless.

Despite each person saying it was important, when initially asked how much time they spent planning their continuing professional development, the answers ranged from none to a high of 2 hours/week. Terry recorded this high number and qualified it with “This includes discussion of management practices.” It was not clear from this statement whether the focus of the discussion was management of the patients or the management of the nurses. Overall, at the end of the study, participants rated themselves as likely or very likely to continue to plan their continuing professional development and predicted they would spend more time planning their continuing professional development.

From a list, participants initially checked-off four tools (i.e., reflective journal, performance appraisal, unstructured peer review, unstructured self-assessment) they used to plan their professional learning; space was provided for other answers and participants added self-reflection, peer-feedback, and dialogue with peers as tools for planning learning activities. At the end of the study, additions identified under Other reflected tools discussed or used during the workshop sessions. Identified were: the CNO’s self-assessment tool, the RPNAS’s competencies, and work duties. Tracy said she intended to use “the self-directed learning plan as a guide for now, but will review some tools via some of the [Internet] sites you identified.” An interesting addition that Lee noted, “We are implementing a peer review process at work. I’ll find out what tool is being used (a checklist) and forward to you.” Peer appraisals were passionately discussed during the study but not completed by them or for participants.

From a checklist, participants identified that the following factors affected their choice of professional learning activities: identified learning or development need; location; area of interest; attendance of a friend; and employer support. This last item was

broken down further into paid time off, tuition support, and flexible schedules.

Participants added that funding and availability of relief staff influenced their selection of professional development activities. These have been previously noted in the barriers to participation, but they were raised again as a factor to consider under planning. At the end of the study, having completed a professional self-assessment and self-directed learning plan, Tracy's response reflects the influence of the educational intervention:

I think because I have started a personal plan (based on my learning via these sessions) I will ensure that I am more on top of my learning needs rather than personal interest. I will also review RPNAS competencies with respect to my learning plan.

Recording continuing professional development activities. When asked about where they find a record of their continuing professional development activities and objectives, participants gave a variety of responses. Most commonly identified was a day-planner. The next most frequent answer was the form provided by the RPNAS. For example, Tracy kept the form posted on the personal computer at home. Other responses were; on work forms for employer, personal record, kept brochures, in my mind, and "my brain's e-drive." A portfolio provides a central, and organized place to record continuing professional development activities. Unlike a day-planner, it has some permanence and is not likely to be discarded at the end of the year.

All the participants in the study agreed that it is necessary to record their professional development objectives and provided good rationale. Response themes on recording centred on providing focus and direction, a means of evaluation, record of achievement, and motivation. Chris thought:

I think I've been pretty disorganized with respect to identifying my personal continuing professional development objectives. This has created significant ambivalence on my part, with respect to identifying continuing professional

development activities that I would like to participate in. Recording continuing professional development objectives would assist me in creating a more focused plan of PD.

Gerry had a different view, and said:

Recording your intended objectives provides one with a focus and may eliminate those ‘Why am I here?’ thoughts during an activity. In reality one may depart a conference/workshop etc, thinking ‘I could have done that and perhaps in a more concise or clear way.’ So...writing your objectives supports planning in a concrete way or moves one beyond ‘good intentions’ and supports articulating to peers and employers what you ‘now know’ upon completion of an activity.

Tracy wrote, “Recording objectives is important as it keeps one focused — this is not something I do well — my objectives are more internal.”

Despite stating the value of recording continuing professional development objectives, half the participants recorded these objectives less than 25% of the time. One acknowledged never doing so. Believing something is good or right does not necessarily translate into practicing that behavior. Lee’s response may typify nurses’ actual practice, “I do not formally record my objectives: I guess I usually have my goals in my head for what I want to accomplish with training, in-services, etc.” At the end of the study, participants predicted they would record their professional learning objectives more often than had been their practice.

Evaluation. Initially the majority of the participants (one did not answer and one said they did not know) agreed with the statement that it is important to evaluate their professional development in relation to their competence and against their learning objectives. They provided rationales around the theme of evaluating whether activities met learning objectives, but emphasized that the link to (continuing) competence was not always easy to make. At the end of the study, half the participants linked their responses

on the importance of evaluation directly to competence whereas only one had done so initially. Kim wrote, “If it isn’t meeting needs why do them? Would like continuing professional development to support competencies.” Lee noted, “You can do continuing professional development but not be competent in the procedures/information/etc.” Terry’s response was also along this theme; “You need to know if you actually learned what you set out to — whether you reached your objective is relevant to maintaining your competency.”

Participants’ practice, however, often differed from their belief. Half indicated they did not evaluate their professional development as it relates to their competence or against their learning objectives. Some participants’ responses reflected that they were able to implement new skills, abilities, or concepts or that they had acquired new knowledge [which I interpreted as a positive evaluation]. At the end of the study, participants predicted that they will evaluate their professional learning using strategies learned during the study such as: completing a self-assessment and evaluating learning outcomes identified on the self-directed learning plan study against professional competencies.

Evidence of continuing professional development. With respect to demonstrating evidence of continuing professional development to others, participants initially said they did so in a variety of ways such as: the application of skills and knowledge, and sharing it with others; and records of attendance such as a certificate, transcripts, or a personal record that the participant kept. Participants identified that they shared evidence of their continuing professional development primarily with employers (supervisors, managers), their professional association, friends, peers, and clients. At the

end of the study, almost half the participants identified that a portfolio could be used to provide evidence of continuing professional development.

The learning portfolio as I use it in my study, is composed of a professional self-assessment derived from the codes of ethics, standards, and competencies documents of nurses' regulatory bodies. The learning portfolio provides a package for the setting and recording of learning objectives, provides a record of participation in continuing professional development activities, and evaluation and evidence of learning activities directed toward maintaining competence. Self-determined evidence and verification of learning requirements are set out in the learning plan.

Participants' Views on Portfolios

None of the participants finalized a career portfolio during the sessions, nor had I expected them to do so. Two participants began putting together a career portfolio and three continued to express intentions of completing a career portfolio. For example, Terry had a drawer full of items for a portfolio but noted that drawing the elements together and organizing it required a lot of work. All the participants saw value in developing a career portfolio. They were not opposed to developing a career portfolio; they simply identified time as the main barrier to completing one.

Each participant developed a learning portfolio to one degree or another. Most participants anticipated that learning portfolios could be useful to demonstrate their continuing competence and said that they would encourage others to use them. Two participants, said they did not know if they would encourage others to use learning portfolios. One of these qualified their answer with an "if I find it useful." They were not about to recommend something they knew little about. Kim anticipated that, "Any tool

you can use to organize and report your professional status or improvements is beneficial, especially since your supervisors typically don't have a clue." At the end of the study the participants rated themselves as likely or very likely to continue to maintain a learning portfolio. Only one participant self-rated as not likely to maintain their learning portfolio and did not elaborate further. All the participants found learning portfolios useful and said they would encourage others to use them. Stacy said, "It is practical and makes sense, provides focus." Gerry noted it "should increase your personal and professional deliberate consciousness through fostering recognition of your capacity."

Gerry, discussed portfolios at length with me outside of the sessions, and in her post-session questionnaire reported that learning portfolios:

may potentially assist 'young' RPNs to map their careers. This tool may foster capacity and self-efficacy in professionals through increasing their deliberate consciousness relating to their abilities. The tool may have potential to increase a level of professionalism as participants may increase their ability to articulate what they know and do best. The urgency of RPNs to share with the public and policy makers cannot be understated. Historically, RPNs are viewed as having 'soft skills'...many disciplines claim to 'do' what RPNs do . . . rarely do RPNs challenge this...that the soft stuff is really the hard stuff. Every interaction is for better or worse and even very experienced RPNs run the risk to be ineffective or . . . cause harm.

All participants completed a self-assessment, based on a professional nursing association's standards, competencies, and codes of ethics; they used these self-assessments as the basis for selecting a learning objective. Tracy, Kerry, and Lee commented that this forced them to choose an area of their practice that needed strengthening, rather than choosing an area that simply interested them but in which they were already strong or well developed. Similarly, Stacy commented, "Often people attend workshops/conference because they are offered, not for a specific purpose."

On the questionnaires, the participants identified their most significant learning about self-assessments. Stacy's most significant learning was "the fact that self-assessment tools for nursing actually exist." Kim's significant learning was "the number of areas I could improve my competence." Similarly, Terry wrote, "When done with great honesty, [I] found that there were areas that needed development. I also found that while thinking of myself as old, I'm not, I'm always learning and enthused about my profession from the time I started."

Each participant chose an area they identified as needing strengthening from their self-assessments. Some chose to deepen their knowledge/skill in an area they already had some knowledge or experience in; others chose a new area. The idea of self-directed learning plans appealed to them because they were now keenly aware of how that learning related specifically to their continuing competence. The group was evenly split for the time they spent developing their plans outside the sessions between the ranges of 1-2 and 3-5 hours.

All the participants reported it useful to complete a self-directed learning plan and said they were likely or very likely to continue to use them. Some participants spent more than 10 hours on their learning plan outside the sessions, and slightly more than half spent between 5 and 10 hours. Lee found that, "If you just do it (write it out) it's actually quite easy." Likewise, Terry said it was "very clear and concise. Easy to follow which was important for me as I like to get to the heart of the issue." These comments indicate the participants found no difficulty with planning continuing professional development for continuing competence. This findings supports the contention that nurses are both

able to develop and to carry out self-directed learning plans, and that the process does not have to be onerous.

The participants were unanimous that the professional association should endorse portfolios as one way of demonstrating continuing competence. Kim suggested that completed self-assessments could be forwarded to the professional association as an aid in its planning educational events that correspond to the continuing competency needs of the members. Employers likewise might find self-assessment reports useful for this purpose. Kim explained that if the association or employer had access to the pool of competencies that nurses identified as needing development, that they could select and promote appropriate continuing professional development activities.

Participants identified three things they would tell a friend about learning portfolios. The themes included: a means to identify one's needs, useful in appraisal, help one to map one's professional career, and for career planning. Stacy elaborated on what she would tell someone:

It is an effective way to gather all your information together in one package. As an assessment, it will assist to identify your learning needs and where you need to focus your activities if you want to improve in that area. A learning plan will help to focus your energy on the right activities and will help evaluation if growth and development has occurred.

Nurses in the study acknowledged the effectiveness of a portfolio to plan for their participation in monitoring and planning their continuing competence. They found the results of their self-assessment particularly useful to identify and to plan for their learning needs. Their attitudes were tentatively positive at the beginning of the study, perhaps because they had limited knowledge about portfolios. Their attitudes were emphatically positive at the study's conclusion.

All the nurses in the study saw value in planning their learning based on self-assessment rather than choosing continuing professional development activities based on interest, participating in an activity because a friend was attending, and so on. They noted that the investment of their limited resources pay real dividends to nurses' competence.

The participants commented that the professional association should make the self-assessment tools available to all members on an annual basis. For example, Tracy stated, "I think they would be very useful in terms of assisting people in identifying specifics with respect to how what we learn translates into who we are as professionals." Chris wrote, "Registered psychiatric nurses need to remind themselves of what their strengths are as well as continue to explore areas for growth." In the next section I describe my observation during the sessions.

My Reflections and Observations on the Sessions

The sessions flowed smoothly, with verbal participation by all. Some participants contributed less than others, but all had equal opportunity because I would ask the quieter members if they wished to add to the discussion before I moved ahead in my lesson plan. On other occasions I would ask a less outspoken participant about her or his experience or views in order to begin the discussion. When calling on a specific person, I was sure to ask a question that did not require a factual answer (i.e., one that could not be judged right or wrong).

Overall, participants were excited about the materials, particularly the self-assessment tools. More than one said, "This is just awesome!" They readily expressed the

value of a self-assessment based on their professional competencies, ethics, and standards of practice. Participants particularly emphasized the competencies as useful because competencies immediately highlighted for them areas on which that they needed to work.

The participants seemed genuinely interested in the workshops and appreciated being part of the study, as evidenced by their enthusiastic discussions. The quality of most of the responses reflected their strong belief and commitment to continuing professional development and continuing competence. The topic of nurses' portfolio use was new to all but one of the participants (Gerry). It was a revelation to most of them that portfolios were being used by nurses at all, and they were especially surprised that portfolios were being used to demonstrate competence.

The self-assessment tools based on nursing documents were new to all of the participants. Everyone expressed particular enthusiasm for the conversion of the competencies document to a self-assessment tool. All the participants endorsed this method as one strategy for demonstrating continuing competence to the professional associations. Using the competencies as the basis of a self-assessment to identify learning needs is acceptable and made good sense to them.

The level of interaction between participants before and after the sessions and during the breaks reinforced how important it was to come together with other like-minded professionals. Judging by the passion of their discussions, the topic was of interest and importance to them. In the next chapter I discuss the findings in relationship to the relevant literature.

CHAPTER 4
DISCUSSION, CONCLUSIONS,
AND RECOMMENDATIONS: A CALL TO ACTION

The purpose of my study was to examine the process of introducing portfolios to nurses and to determine the usefulness of portfolios in demonstrating continuing competence. I facilitated nurses' use of portfolios as a means of monitoring and maintaining their continuing competence, as well as a means of evaluating and providing evidence of their continuing professional development activities. I wanted to identify nurses' support and information needs in relation to portfolio development for continuing competence. In this section, I discuss the usefulness of the planning process; the relevance of self-direction and self-assessment in the process; the importance of the findings for portfolio use; and the nurses' learning needs for using portfolios. The discussion is based on information gathered from participants during this study, and the findings are discussed in relation to the literature presented in chapter 2. In the final section I draw conclusions and offer recommendations to adult and nurse educators, employers, professional associations, and for further research.

Usefulness of the Process for Learning

From the beginning, I appreciated the importance of a comprehensive approach to program planning and design. I incorporated Wlodkowski's (1999) motivational strategies into my study, because I agreed with him that the facilitator can influence and contribute to motivation. My study confirmed his contention that motivation is a complex

issue and that merely incorporating motivational strategies will not motivate adults to learn.

Respect for learners as the subject of their learning, creating a safe learning environment, and immediacy, are some of the principles I applied in my study. My practice was consistent with Roger's (1983) humanistic view, and Vella's (1994) and Nolan and Nolan's (1997b) adult learning principles, which are inspired by humanistic philosophy.

I also employed Kolb's (1984) experiential learning cycle and the four learning types his model includes. Cayne (1995), along with other educators (e.g., Glen & Hight, 1992), notes that using an experiential learning process contributes to the development of both facilitators and learners. The variety of strategies and approaches I used allowed at least one matched activity to each learning preference. In this section, I discuss the flexibility of planning and implementation, usage of experiential methods, questionnaire and handout design, and overall participant satisfaction.

Flexibility of Planning and Implementation

I used Caffarella's (1994) interactive program planning model when I designed the workshop. I had used her model once before and found it comprehensive, useful, and easily adaptable. While her model does provide some structure, I appreciated the flexibility of the model and fact that she does not view program planning as a linear process. Caffarella's model allowed me to choose the elements I needed to focus on and ignore those with no bearing on my study without overlooking anything significant. Despite using her guidance overall, I made some modifications.

Usage of Experiential Methods

The participants confirmed that taking an experiential approach to learning was useful. When referring the self-assessment tool, D'arcy commented that completing the competencies document “makes it just jump out at you, what you have to do, what you have to focus on.” Gerrish (1993) had similar success in using teaching competencies in her study with student nurse-educators. She also found that student’s self-assessing competence helped participants in her study develop self-assessment and reflective skills. With reference to the self-directed learning plan, Lee said, “I find that if you just do it step-by-step, it is actually quite easy.” Another advantage to learning by doing in this study is that the participants were enabled to initiate and produce a useful tool, the portfolio, which both affirmed and confirmed their abilities. I was aware from Benner's (1984) work that reflection is necessary if nurses are to learn from their practice. My approach to facilitating portfolio use required the participants to reflect on their experience and their practice. Consistent with Knowles' (1975) advice, I had moved beyond knowledge acquisition whereby the learner simply lists or names things related to content, to knowledge application, which is at a higher level.

Questionnaire and Handout Design

As part of the design process, I developed and pilot tested pre- and post-intervention questionnaires. As Polit and Hungler (1999) observe, it is not always possible to use existing data or instruments; therefore, instruments to collect new data must be developed. My use of a questionnaire contributed to the flexibility of the design and implementation of Sessions 1 and 3 of the workshop in that participants could choose

to complete the questionnaires on their own time, yet still participate in the educational sessions.

Although using open-ended questions can increase the difficulty of data analysis (Merriam & Simpson, 2000), I found that open-ended questions were useful for obtaining potentially important information that I, as the researcher, might otherwise have overlooked or neglected to consider. I was aware that the study participants might dislike the options presented in closed or forced-choice questions, and also that answers to closed questions might be superficial and unhelpful to me in the assessment process. Because I was aware of these points, I followed Polit and Hungler's (1999) recommendation to use a combination of question types. In that way, as the researcher, I could strike a balance between rich, detailed data and answers that do not overburden the participants while offsetting benefits and disadvantages of various question methods.

Overall Participant Satisfaction

Participant satisfaction with the portfolio development process was high. Stacy commented that the workshops were very professional, and well planned and facilitated. Terry said, "This was just terrific, I came here not knowing what I would get out of this, and I am very impressed." All the participants said they would recommend the workshop to colleagues. Furthermore, in discussions they agreed that their professional associations should adopt all or some of the instruments. In the next section, I focus on two of the components of a learning portfolio: self-assessment and self-directed learning.

Relevance of Self-Direction and Self-Assessment

In this section I discuss the relevancy of self-direction, reflection, and self-assessment to practice. I discuss also the value and constraints of the self-appraisal method, and the usefulness of samples and resources.

Relevancy to Practice

Reflection and self-assessment are necessary and assumed skills of a professional. A traditional nursing education, however, often does not equip nurses to develop these skills, nor foster their self-confidence in completing self-assessments. Professional education programs, according to Le Var (1996) and Lenburg (1999), are accountable to the public, and exclusive reliance on reflective methods, such as self-assessment, is often not acceptable in professional education. I found this to be particularly true of the participants in my study, most of whom did not have (extensive) previous experience in reflecting on their practice in a structured way; in fact, several participants would have preferred a mid-point to rate themselves. My infusion of reflective learning methods supports the work of other nursing researchers, such as Cayne (1995), Gerrish (1993) and Green (1994) who have demonstrated that, contrary to earlier studies, self-assessment within nursing education programs is an effective assessment strategy. Despite the effectiveness of self-assessment, Green emphasizes striking a balance between self-reflection and teacher-assessment in order to prepare the student for the realities of professional practice. It was this balance that I strove to achieve.

Participants in my study, particularly those who had practiced for more than 10 years, acknowledged the significant amount of learning that takes place on the job. Participants could also readily identify the rapid changes in knowledge and technology as

driving interest in competence. Because more than half of professionals' learning is self-directed (Houle 1980), Knox (2000) argues that professional programs need to encourage, build upon, and complement participants' efforts to become more self-directed. Despite this support for self-direction, however, I was aware of Nolan and Nolan's (1997 a, b) warning that unless self-direction is properly introduced, that students will resent their professors for not doing their jobs (i.e., teaching them). Therefore, I realized I needed to be very cognizant of how I introduced self-direction.

One method I used to increase self-direction was to adapt a template for a self-directed learning plan as a handout for use in Session 2. I derived my self-directed learning plan format largely from Knowles' (1975) work and also drew upon my experience of using self-directed learning plans and contracts during my Master of Adult Education program and during my Bachelor of Science in nursing program. I took a typical five-column model (Knowles) and added a sixth column, in which I directed the participant who was completing and evaluating the plan to make the link between the learning activity and competence or professional development. This made explicit the intent and outcome of the learning activity in relation to competence. The heading of this column was "What is the relevance to my practice?". I consider my addition important for its use for continuing competence. Participants in my study readily saw how this column explicitly linked a learning activity to their competence as a professional. My focus on relevance supports Candy's (1991) stance that learning is not merely the acquisition of information, but a quest for meaning, and that the focus must be on the relevance or significance to the learner, not on what is learned only.

Other methods I used to increase learner self-direction included demonstrating respect for the learner and promoting learner self-control through the use of the self-directed learning plan. Providing resources and examples also promotes learner self-direction. All these are consistent with Candy's (1991) strategies.

Value and Constraints of the Self-Appraisal Method

As an aid to assessing practice areas in need of improvement, I provided participants with professional self-assessments derived from their professional associations' nursing documents. Participants found these rating scales straightforward, and affirmed their usefulness in diagnosing areas for improvement. Providing an assessment to highlight learning needs was my way of addressing Tough's (1979) concern that adults often do not know what they need to know.

One of the participants, Kim, undertook to compare the documents and determined that the competencies document is the most useful of the three documents to complete (the other two were the standards of practice and the code of ethics). Kim's assessment was that "it makes what you need to focus on so obvious." This statement is in keeping with Taylor's (1995) research on self-assessment and observation. Although participants liked the self-assessments, they noted that not everybody was likely complete them honestly. The need for honesty in reflection is underscored by Jarvis (1992) who notes that honesty is a requirement for reflection. The participants believed that ideally the process of reflection and skill of self-assessment had to start in the nursing education programs. Furthermore, they passionately discussed the value of peer appraisals to balance out their self-assessment. Likewise, Purdy (1997) cautions that graduation from a school of nursing will not make a nurse proficient or even adequate in self-assessment, if

the skill is neither taught nor practiced within the education program. Purdy notes that a nurse cannot graduate based on self-assessments alone; consequently, he values a blend of self, peer, and teacher assessment strategies.

Participants also identified that the self-assessment could be strengthened by the addition of a requirement to include an example with a date. Jarvis (1992) advocates for a structured framework for reflection. Although this additional requirement would necessitate journal writing of practice examples throughout the year, this extra step might add credibility to the process. This process is analogous to Burnard's (1988) suggested process for reflection, which includes reflecting on and recording experiences from the clinical setting within different categories. Similarly, Cayne's process (1995) utilizes a structured framework for portfolio reflections

Participants valued the self-assessment. My inclusion of a self-assessment within a continuing professional development context supported enhancing self-responsibility and learner self-direction, as described by Taylor (1995), thereby promoting professional growth and development.

Usefulness of Samples and Resources

Perhaps the most effective way to illustrate approaches to compiling a portfolio is to have a few samples available for viewing. Participants in my study, like those in Brooks and Madda's (1999) and Farley Serembus' (2000), found it very useful to see and review a portfolio. Reading about the contents, construction, and ordering of them was acceptable, but participants really appreciated being able to peruse one. For example, Lee specifically commented that, "I really liked that you had your portfolio here for us to look through and see an example of how one is put together." Similarly, Tracy said, "Seeing

how portfolios can apply to nursing makes it seem more real.” Nurses must individually decide how best to compile and order their portfolio in a way that makes sense and is useful to them. Providing samples and resources to my participants is consistent with Knowles’ (1975) view of the role of the facilitator as the one who shows the way with examples (the other main function being to design and manage the process of facilitating learning).

Kim noted that, “Seeing the self-directed learning plan helped me to understand how it goes. Even though my plan and objectives were very different, I could work out the process.” Gerry suggested that the self-directed learning plan template that I designed would be improved with the inclusion of an example relevant to psychiatric learning. Lee agreed with Gerry’s suggestion. Similarly, Hiemstra (n.d.) advocates providing students with examples of self-directed learning plans.

In order to develop learning plans I believe it is helpful for nurses to know the language used in learning, specifically learning verbs. Similarly, in his 1975 work, Knowles advocates using these learning verbs. Like medicine and the allied health disciplines, education has a language of its own. A working-knowledge of learning verbs, and how they fit into the hierarchical scheme of learning-domains, may improve nurses’ ability to develop appropriate learning objectives that in turn can facilitate evaluation. Likewise, Caffarella (1994) notes the facilitative relationship between objectives and evaluation. The converse is also true, as experienced by Lee, who states, “I didn’t use them when I wrote my objectives and I think that is why I had trouble with evaluation.” Knowledge of the domains and levels of learning may help nurses ensure that their continuing professional development activities target the three learning domains, and that

not all of their professional development falls at the lowest level. For example, in the cognitive domain the nurse would go beyond recall or recognition, to analysis or synthesis of information. Interestingly, the two nurse-educator participants committed themselves to using the learning verbs in their teaching practice. In the following section, I discuss my findings in relation to portfolio use.

Importance of the Findings for Portfolio Use

In this section I discuss the issue of mandatory versus voluntary portfolio use, the importance of nursing schools to initiate the portfolio process, the capability of nurses to develop and carry out portfolio development, the provision of a structure for continuing professional development, and cycles and helicals.

Mandatory Versus Voluntary

Although participation in my study was voluntary, RPNs could count the time spent in my educational sessions toward the RPNAS's continuing professional development requirement. Although I had a framework and objectives for learning, I designed my sessions so that there was both choice and direction in what they learned. This is consistent with Houle's (1980) assertion that within mandatory continuing education, what a professional chooses to attend reflects some element of choice and voluntariness. Like a stacking Russian doll, my particular design of incorporating a self-directed learning project within a workshop met the voluntary criterion and still complied with mandatory regulatory requirements, which in some ways meets Brookfield's (1984) description of self-directed learning. Many of the participants said that they often undertook professional learning, but did not formally record learning objectives.

Brookfield, and similarly Candy (1991), point out that self-directed learning is usually purposeful but does not necessarily have carefully set goals; it typically occurs outside of designated educational institutions, is not usually awarded institutional accreditation, and is voluntary. Brookfield (1986) makes a helpful distinction between self-directed learning that focuses on techniques, goals, strategies, and resources and self-directed learning that results in a change of awareness. In the latter, the learner becomes aware that knowledge is not black and white, but contextual, existing in shades of grey. Given these parameters, I wondered whether professional associations can mandate portfolio development using a self-directed approach with successful outcomes. Cayne (1995) discusses how portfolio development spurs nurses' professional growth and development and moves them toward self-direction. She found that despite the portfolio being mandated by the regulatory body and early confusion about portfolios, that both the end product and the process of developing a portfolio resulted in nursing valuing their experience and, by extension, themselves.

Participants in my study supported the development of a portfolio, with self-directed learning as an option. They did not see self-directed learning as appropriate for everyone. Similarly, Blackwood (1994) explores how self-directed learning within the confines of mandatory continuing education is possible and desirable. She notes that although both workers and management may initially resist self-directed learning, that with a blend of support and structure, both parties can be moved toward acceptance. Like me, Blackwood emphasizes avoiding an all-or-nothing approach to self-directed learning. She suggests strategies such as providing alternative methods of instruction such as

videos and self-study models, as well as involving the learners in the planning of educational offerings and using contracts or self-directed learning plans.

Importance of Nursing Schools and Regulatory Bodies Initiating Portfolios

All the participants saw value in developing a career portfolio; however, they identified time as the greatest obstacle to developing one. They believed that developing a portfolio from the time nurses begin their education would be most useful. They argued that schools of nursing must initiate the process of facilitating portfolio development during their education, which meshes with Houle's (1980) assertion that educators must teach the skills of self-assessment and self-directed learning in pre-professional education. This is also supported by Freidson (1988) and Glen and Hight (1992) who say that professional schools play a pivotal role in the socialization of professionals. My study showed that initiating a portfolio with a focus on continuous learning could socialize professionals to this value.

Nurses in my study all had positive attitudes toward, and valued, professional learning. Consequently, they supported the requirement of a portfolio option by the regulatory body or professional association. This requirement is not inconsequential. Because they typically approve educational programs, professional associations requiring a portfolio for (re)licensing as part of a quality assurance program will provide the necessary impetus to schools of nursing to ensure that nurses graduating from their programs have the foundation to meet this requirement. This supports Houle's (1980) statement that professionals' attitude toward continuing education is set by their graduation from professional school. This requirement will support further Durgahee's (1996) finding that reflection, in forms such as portfolio development, is integral to

fostering the desire and motivation of nurses to continually grow and improve their practice.

As a result of my study I am further convinced that initiating a portfolio during their preparatory education will enable nurses to maintain a career portfolio with a reasonable investment of time as they progress through their career. This will eliminate the time barrier to portfolio construction that confronts nurses, such as those in my study, who have practiced several years. This is consistent with Brooks and Mada's (1999) research in which nurses found very little time was required to update their portfolio.

Capability of Nurses to Develop Portfolios

Nurses in my study found that the educational session(s) were an aid to them in the development of a portfolio to demonstrate continuing competence. As well, they pointed out that access to a supportive learning environment where colleagues and peers supported them was also helpful to them. They favorably received the availability of resources to view, to refer to, and an informed facilitator to answer questions. Although they might have been able to compile a portfolio to demonstrate continuing competence without the sessions, the nurses in my study agreed that the workshops were valuable, clarified the process and product, and increased their motivation to complete a portfolio. This is consistent with Knowles' (1975) observation that some adults may initially need didactic instruction to become self-directed.

All the participants reported that it was useful to complete a self-directed learning plan as part of their learning portfolio, and said they were likely, or very likely, to continue to use them. Lee noted that, "If you just do it (write it out) it's actually quite easy." Likewise, Terry said it was "very clear and concise. Easy to follow which was

important for me as I like to get to the heart of the issue.” These comments indicate that the participants found no difficulty with planning continuing professional development for continuing competence. This finding confirms that nurses are both able to develop and to carry out self-directed learning plans, and that the process does not have to be onerous. My study also supports Knox’s (2000) assertion that acquiring skills such as time management and goal setting will help nurses move toward increased self-direction in learning.

Provision of a Structure for Continuing Professional Development

Nurses in my study accessed professional development activities for any one of a number of reasons, but meeting an identified need based on an assessment of their competencies was not typically among them. There was an overall lack of planning for professional development, and learning objectives were not explicitly stated. Participants gave little consideration to evaluating continuing professional development activities in terms of contributing to learning objectives or continuing competence. They could provide little or no evidence of either their continuing professional development activities, or articulate how it has contributed to their continuing competence. This finding is consistent with the work of Rennekamp and Nall (1994) who assert that many professionals do not approach their competence and professional development in a structured or organized way.

My study found also that portfolios provide nurses with a structured and intentional way to approach their competence. This finding supports Trossman's (1999) and Jarvis’ (1992) contention that reflection should take place within a structured framework. The career portfolio documents the history and growth of the professional

while the learning portfolio plots their development. The structured professional self-assessment ensures that nurses choose professional development activities to meet competence needs and when used together, the self-assessment and self-directed learning plans provide evidence of participation in and learning outcomes of professional development. The nurses in my study moved evaluation and evidence of learning from the learning portfolio, and archived them in the career portfolio. The professional activities worksheets promoted learning in the workplace, further illustrating the adult education literature's (e.g., Watkins & Marsick, 1990, 1993) claim that the workplace is a rich source of learning. As a leader in nursing education, I am more convinced than ever that linking professional development to competencies ensures nurses spend limited resources efficiently. Nurses can use portfolios to demonstrate competence and in turn, their professional associations can use portfolios as a quality (competency) assurance program.

Cycles and Helicals as Models for Portfolios

During the study I considered the experiential and adult learning cycles, and depicted these two dimensions as a circle. I sought feedback on the model from the participants. One of the participants, Lee, suggested that I move the career or retrospective elements together to form a square base with the prospective elements emerging from it. I envisioned a spiral emerging from the base capturing the cyclical nature of the elements that compose the learning (prospective aspect) portfolio. For the nurse interested in moving vertically (career advancement), the spiral rises vertically out of the base. For the nurse interested in lateral movement (career development), the model can be rotated 90° to the right so that it represents movement forward in time.

As I considered the model over time, I thought a fifth element was needed in the career or retrospective portion of the portfolio. This fifth section would hold learning narratives, and completed self-assessment, (self-directed) learning plans and completed professional-development activity records. This section serves as the bridge, or springboard, between the career and learning portfolios, and explicitly demonstrates the nurse's continuing competence. Now that the model has five elements, I see the base as a star rather than a square (Appendix A). I had told participants that the stars on the cover page of the handouts represented them; that they were the stars of their portfolios. One of the participants said he thought that the analogy or metaphor, "How much twinkle is there in your career (you)?" was more apt. By connecting the circles (cycles) and showing them moving linearly through time (although I do not think it is always that neat and tidy) these circles spiral out in three dimensions, describing a model of helicity. This helix illustrates that neither we, nor circumstances, are ever the same because we are ever in a new place in time.

The reflective process used in portfolio development affirmed that who a nurse is today is grounded in her or his past or autobiography, a shifting, or deepening, personal philosophy of practice, and the artifacts that chronicle her or his history (Clark et al., 1994; Scheppner Wenzel et al., 1998). The past is captured in completed development and self-directed learning plans, and reflections on growth traced through learning narratives. This rich base nourishes future growth and development as a professional. The ongoing spiral of self-assessment, peer appraisals, learning journals or narratives, and current self-directed learning plans extend the growth of the professional nurse upward or outward, forward in time.

Comments on My Assumptions About the Study

The first conscious assumption I made was that nurses participate in continuing professional development at a high rate. With the exception of one nurse who had not attended professional learning activities in the previous year, all the others had, and half had participated in five or more activities. Thus, to a great extent this assumption was accurate.

I also assumed that nurses undertake much of their professional learning without due regard of how it fits into their competence. I found this true of nurses in my study, and consistent with similar assertions made by Rennekamp and Nall (1994), and Cayne (1995).

I assumed that much of nurses' professional learning was informal and incidental and that it went unnoticed and undocumented. Researchers such as Watkins and Marsick (1990) estimate that as much as 80% of learning fits into this category. Nurses were quick to agree with and note the veracity of the statement, they also affirmed my assumption that they did not capture this type of learning in any formal or structured manner.

My assumption that practicing nurses would have little difficulty in designing and carrying out a self-directed learning plan proved to be accurate. In relating the learning plan to the patient care plans that they created I provided an appropriate link between the new and the familiar, which is consistent with a recommendation of Candy (1991). In some cases the participants surprised me. I, like Tough (1979), anticipated that they would have difficulty in identifying resources, but they did a better job of this than I had anticipated. They used the Internet, consulted other people, and looked beyond traditional print resources such as books.

I uncovered two unconscious assumptions that I had made. The first was that participants without children or a partner would have more time to devote to their portfolio and self-directed learning plan. When I was giving an explanation to the participants about why I was asking about their marital status and whether or not they had children, I realized that this assumption was in error. Volunteerism is high in Saskatchewan and with several years of downsizing and a shortage of nurses most people, regardless of family status, will say their free time is very limited.

I also discovered I had assumed that nurses close to retirement would not see the value in completing a portfolio. None of my participants stated that they were reluctant to complete a portfolio because they were too old or too close to retirement. Likewise, in the study by Oechsle et al. (1990), 9% of the nurses completing portfolios were in the 40-60 years age group, which makes them close to retirement. I realize now more than ever the need to critically examine my assumptions for their validity and accuracy. As Brookfield (1992) asserts, this practice is essential in order for me to be a critically reflective researcher and educator.

Summary

From the data and findings, I have extracted the nurses' key learning needs for portfolio development to demonstrate continuing competence. Their needs centre on two areas: information and support needs.

Nurses need to be exposed to the concept of portfolios, and need clarification on the many definitions and terms surrounding portfolios. Based on their questionnaire

responses, their pre-study concepts about portfolios were limited and associated primarily with arts-related careers or finances. Because the nurses in this study had limited knowledge of portfolio use by nurses before the workshop sessions, I believe that nurses, in general, need an array of information provided in a variety of formats. For example, there is a myriad of terms and definitions surrounding portfolios; therefore, establishing some working definitions provides a common foundation on which to build. Then, when a nurse consults the literature for more information, he or she can make sense of the different terms encountered.

A brief history of portfolios and their use is helpful for enlarging the concept of portfolios. Nurses can then consider how their portfolio can be adapted for various uses. They may then be aware that it may be necessary and desirable to select different materials for different applications or to use different methods of presenting the portfolio to different audiences. In addition, the awareness that nurses have used, or have considered using, portfolios for more than a decade may dispel any concern that this is just a passing fad.

Nurses need to know that the contents of a portfolio comprise far more than the traditional résumé or curriculum vita. They need to document competencies and learning gained and consolidated from particular positions they have held. This goes beyond the traditionally identified strengths or skills acquired in a position, by linking it to nursing competencies.

In my study, nurses reported that they kept brochures as evidence of having attended a continuing professional development activity. Whereas brochures may provide evidence of attendance, they do not prove that any learning has taken place. Other

suggested portfolio items are care plans (with identifying patient information removed), lesson plans (for educators), patient handouts that nurses have developed, and videotapes of nurses giving presentations, demonstrating skills for other staff, or educating patients and their families. It is important that nurses include a notation or explanation of the artifact to prevent confusion. For instance, the inclusion of a brochure might confirm attendance at an event; indicate that a nurse presented at the event; or, if the nurse developed the brochure, it could demonstrate skills beyond nursing. The artifacts can make explicit to the nurse or the portfolio reviewer the relevance of the continuing professional development activity to continuing competence.

Nurses in this study identified the usefulness of the workshop session to aid them in the development of a portfolio to demonstrate continuing competence. Participants assessed a supportive learning environment, wherein colleagues and peers support them as helpful. The participants commented favorably on the availability of resources to view and refer to, and the presence of an informed facilitator to answer questions. Resources that I had on hand were reference lists, books, articles, my portfolio, various grades (quality) and types of paper, learning plans, and samples of what other nursing jurisdictions were using as a requirement for continuing competence programs. The participants said that without these resources they might have been able to compile a portfolio to demonstrate continuing competence, but that the sessions and resources facilitated the process.

Conclusions

1. Nurses have a favorable attitude toward continuing competence and continuing professional development. They believe that they are responsible for their continuing professional development and they see their professional association as a means of ensuring protection for the public. This provides a strong foundation for introducing strategies such as portfolios to demonstrate continuing competence.

2. Nurses' rudimentary level of knowledge of portfolio use to demonstrate continuing competence in their professional practice means they are unaware of specific tools to assess their professional competence. An educational workshop provided by a knowledgeable and supportive facilitator is a positive method to introduce portfolios. Nurses have information and support needs in relation to learning about portfolios. A facilitator's thoughtful and judicious selection of presentation material and resources is well received and appreciated by participants.

3. The use of career and learning portfolios and their component parts are one effective and viable method for nurses to document their continuing professional development to demonstrate continuing competence. The elements of the career portfolio form the foundation of the nurse's competence. The nurse's growth and development builds on and extend the knowledge, attitudes, and skills documented in the career portfolio. At any moment, the nurse is more than the sum of past education and experiences recorded in the autobiographical and other sections of the career portfolio.

4. Professional nurses can and should actively participate in monitoring and maintaining their continuing professional development to ensure continuing competence.

The learning portfolio, in particular, requires an intentional and thoughtful approach to continuing professional development with a view to demonstrating continuing competence, and thus is a good medium to achieve this end.

Most of the nurses used an informal system of recording their continuing professional development activities except where they had to submit a record to their professional association. The record was merely that, a listing or citation of the name of the activity, and the corresponding time in the activity. Most said they did not keep a copy of this once they mailed it with their application to re-license. Nurses believe it is important to record their continuing professional development objectives, but again, their practice is not always congruent with their beliefs. The portfolio is a relatively permanent central recording of professional learning to assist nurses to plan for and monitor their participation in professional development.

5. Nurses, like other professionals, find self-assessment a palatable and acceptable method of assessment. Professional self-assessment is the basis for identifying learning needs in the learning portfolio. Tools derived from nurses' regulatory bodies codes of ethics, standards of practice, and particularly the competencies documents, are useful self-assessment tools that help make explicit to nurses, rich targets at which to direct limited continuing professional development resources, where the goal of continuing professional development is continuing competence.

6. Self-directed learning plans and strategies are useful for nurses' continuing professional development. The rate of information and technological change in today's world means that nurses must increasingly rely upon themselves to meet their learning needs. As a component of the learning portfolio, and flowing from the professional self-

assessment, self-directed learning plans provide an effective means to meet the nurses' learning needs. When completed with documented verification and evidence, the learning plans provide part of the evidence of the nurses continuing competence. Few nurses have experience with self-directed learning plans. My study demonstrates that for some nurses, self-directed learning plans are useful.

Nurses believed it was necessary to plan for their continuing professional development but did not always practice this espoused belief. Overall, nurses did not demonstrate an intentional or structured approach to their continuing professional development. Often times their resources were directed toward areas of interest or taking advantage of what was currently being offered not because it met an identified need.

Nurses agreed it is necessary to evaluate their continuing professional development activities. However, in general, they did not do this in terms of how these activities related to their continuing competence. Given that the nurses usually did not formally identify their learning objectives, they could not evaluate their continuing professional development against those criteria either. Initially, they identified that if they had a subjective level of comfort with the material or skill, or believed that it applied to their work situation, then the activity was positively evaluated as meeting their needs. As far as providing evidence of continuing professional development or demonstrating continuing competence, the participants used transcripts, certificates, and participated in discussions, or did presentations. Composed of a variety of components, the portfolio provides a comprehensive approach to professional development.

7. Participants' responses reflect some social needs in relation to their learning. Overall, nurses identified that educational workshops are a useful method to help them to

learn to create the component parts of career and learning portfolios. Workshops that incorporate facilitated discussion as a method of learning provide an ideal forum to share ideas with like-minded professionals.

8. A model of portfolio development is useful for helping nurses to understand how career and learning portfolios come together to demonstrate continuing competence.

Recommendations

In this final section, I make recommendations to employers, professional associations and adult educators.

Recommendations to Employers' Human Resources Personnel

1. Employers can be important partners of nurses in fostering positive attitudes toward continuing professional development and continuing competence. Employers should review and revise their policy and practices and ensure that their practice is consistent with their espoused values. Therefore, I recommend that there be equitable access to continuing professional development activities that does not favor or prohibit participation by individual nurses or groups of nurses.

2. I recommend that employers have a well-developed procedure for support of continuing professional development and ensure compliance with their policies and procedures, and that each person in the approval process must be held accountable for ensuring requests are processed in a timely manner.

3. Employers can support nurses in their continuing professional development efforts by ensuring relief staff are available. Therefore, I recommend that employers

provide relief staff to enable nurses to participate in continuing professional development activities to maintain and improve their competence.

4. By providing continuing professional development in-house opportunities, employers can ensure the subject relates to their organizational needs. Caution must be exercised to ensure that continuing professional development activities offered are relevant and useful to nurses practicing at a variety of levels of competence with a wide range of experience, and in some cases education. Generic programs will not satisfy everyone's learning needs or preferences. Therefore, I recommend that employers review their continuing professional learning offerings to ensure they meet the learning needs of nurses at all levels of development.

5. Given that some 80% of learning occurs on the job, nurses must be allowed to reflect on and make sense of what they learn. Many organizations say they want to be learning organizations, but make no effort to achieve this. Therefore, I recommend that employers build time for reflection into nurses' schedules and that they support self-directed learning activities.

Recommendations to Professional Associations

1. I recommend that regulatory bodies provide and promote continuing professional development topics that nurses identify as necessary to maintain their competence. This can be accomplished by using the results of nurses' self-assessment to plan and provide continuing professional development activities.

2. I recommend that regulatory bodies adopt the use of the competencies document as a basis for self-assessment and make it available on an annual basis. The

other two documents (Code of Ethics and Standards of Practice) converted to a self-assessment should be optional to complete.

3. I recommend that the regulatory bodies explore adapting the CNO's model of self-assessment whereby each area (e.g., communication, patient advocacy) is broken down into skills specific to the four areas of nursing: practice, education, administration, and research.

4. I recommend that regulatory bodies explore the process used by the CNO whereby members are subject to a random audit of their portfolio and a quality control measure of the quality assurance program.

5. I recommend that regulatory bodies explore the feasibility of incorporating the quality assurance program standards and requirements into the blueprint for accrediting schools of nursing so that they teach the components of career and learning portfolios in the nurses' basic education program. The graduate nurse should have a portfolio initiated to demonstrate competence upon graduation.

Recommendations for Adult Educators

1. The workshop is one vehicle to meet nurses' social needs with respect to learning. Therefore, I recommend that adult educators provide nurses with educational workshops to facilitate the process of career and learning portfolios as a means to demonstrate continuing competence. I suggest designing the workshop to meet information needs and provide opportunities for practical experience in developing portfolios and guidance in the preparation and presentation of the portfolio and to meet the support needs of nurses in relation to portfolio development. Including discussion as

an adult education learning and support method will enrich the learning experience and milieu.

2. I recommend that with specific regard to learning portfolios, adult educators can provide assistance by; (a) fostering nurses' professional self-assessment skills, and (b) facilitating skill development to encourage and empower nurses' self-directed learning. Effective skills in these two areas will allow nurses to complete these components of the learning portfolio monitor and plan for their participation in continuing professional development to demonstrate continuing competence.

3. I recommend that adult educators help nurses to learn other skills such as goal-setting, time management, identifying resources, reflective thinking skills, and evaluation of learning outcomes to facilitate their movement toward being more self-directed in their learning.

Recommendations for Schools of Nursing

1. I recommend that school of nursing include in their curricula the development of portfolios to demonstrate (continuing) competence. This includes specific skills in reflection and self-assessment, and self-directed learning, as well as related but more generic skills such as; goal-setting, time management, identifying resources, reflective thinking skills, and evaluation of learning outcomes all of which facilitate movement toward being a self-directed learner.

Recommendations for Further Research

1. Participants in my study were interested in and supportive of peer review. They presented balanced views and were of the opinion that peer appraisal is a skill that can be taught and learned. The literature supports peer review and many regulatory bodies

require or advocate the use of peer appraisal as a part of a portfolio. Therefore, I recommend that research into the use of peer appraisal as part of portfolios to demonstrate competence be undertaken.

In closing, nurses believe that portfolios are a useful means of demonstrating competence. They support regulatory bodies requiring portfolios as a credible and palatable option within a quality (competence) assurance program. Given the time investment to initiate a portfolio after a nurse has been in professional practice for several years, nurses support schools of nursing initiating portfolios to demonstrate competence within their pre-professional education. Adult educators have an important role as facilitators of the process of portfolio development to assist professionals in planning for, participating in, and providing evidence of their continuing professional development. I have found this study increased my own professional learning and helped me to view my profession more positively.

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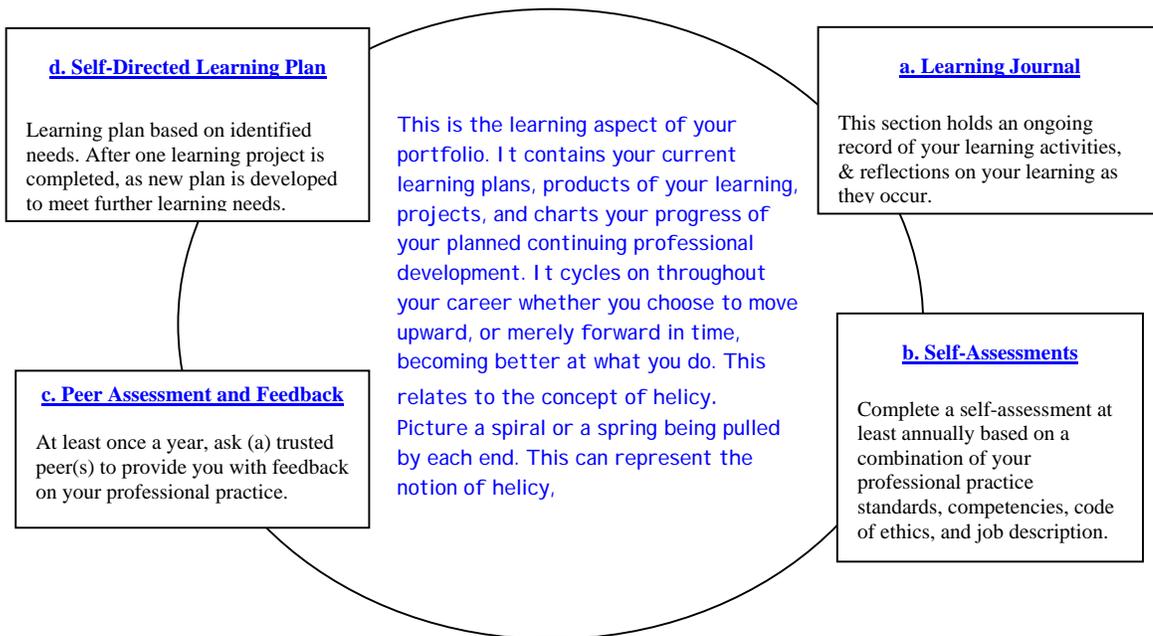
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APPENDIX A

MODEL OF PORTFOLIO DEVELOPMENT

APPENDIX B

MODEL OF PORTFOLIO DEVELOPMENT

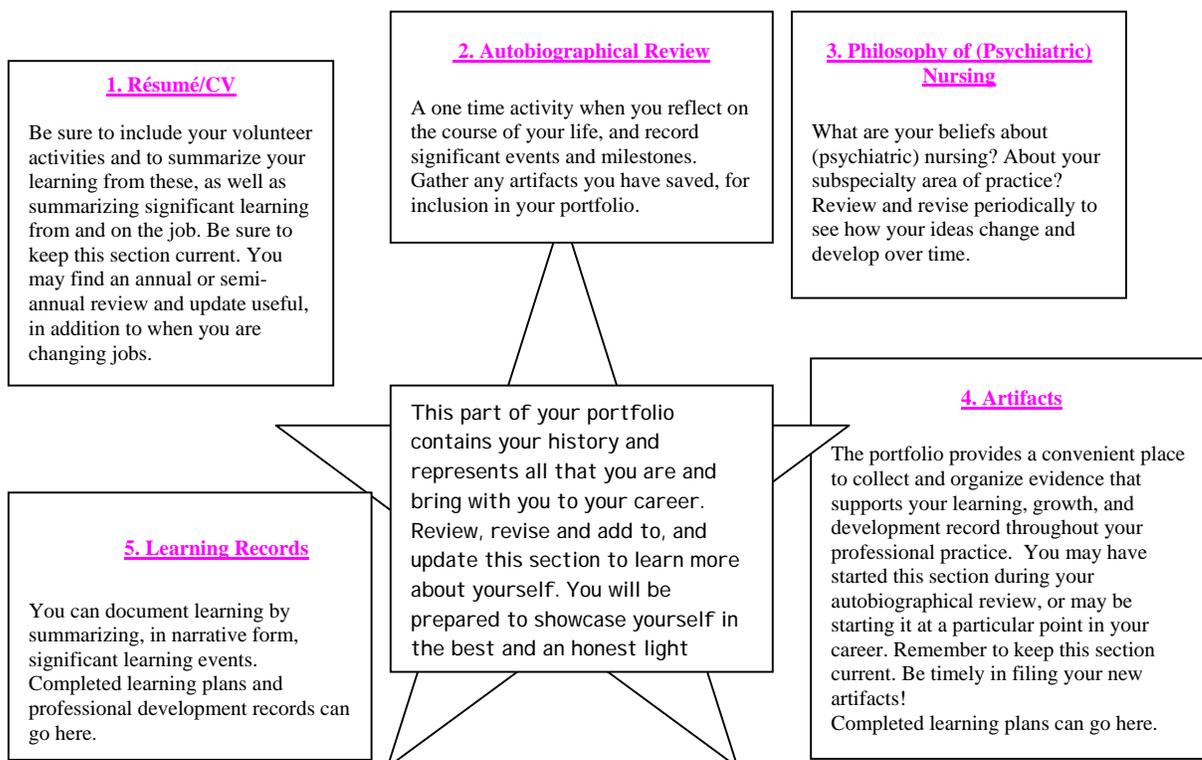


Learning portfolio

(prospective aspect)

Career portfolio

(retrospective aspect)



APPENDIX C

Model of Portfolio Development: Explanatory Notes

The Star: This part of your portfolio contains your history and represents all that you are and bring to your career, or any other situation. Review this section. Revise, add to it, and update it to learn more about you, and you will be prepared to showcase yourself in the best, and an honest, light.

The points of the star represent the retrospective elements:

1. **Résumé/CV** Be sure to include your volunteer activities and to summarize your learning from these, as well as summarizing significant learning from and on the job. Be sure to keep this section current. You may find an annual or semi-annual review and update useful, in addition to when you are changing jobs.
2. **Autobiographical Review** A one-time activity when you reflect on the course of your life, and record significant events and milestones. Gather any artifacts you have saved, for inclusion in your portfolio.
3. **Philosophy of (Psychiatric) Nursing** What are your beliefs about (psychiatric) nursing? About your subspecialty area of practice? Review and revise periodically to see how your ideas change and develop over time.
4. **Artifacts** The portfolio provides a convenient place to collect and organize evidence that supports your learning, growth, and development throughout your professional practice. You may have started this section during your autobiographical review, or may be starting it at a particular point in your career. Remember to keep this section current. Be timely in filing your new artifacts!
5. **Learning Records** You can document learning by summarizing, in narrative form, significant learning events. Completed learning plans and professional development records can go here.

Cycles, Spirals, and Helicy

This is the learning or prospective aspect of your portfolio, the projection of aspects of yourself in the future. It contains your current learning plans, products of your learning, projects, and charts your progress of your planned continuing professional development. It cycles on throughout your career whether you choose to move upward, or laterally, forward in time, becoming better at what you do. This relates to the concept of helicy. (Picture a spiral or a spring being pulled by each end, this represents the concept of helicy.)

a. Learning Journal This section holds an ongoing record of your learning activities, and reflections on your practice and learning as they occur.

b. Self-Assessments Complete a self-assessment, at least annually, based on a combination of your professional practice standards, competencies, code of ethics, and job description.

c. Peer Assessment and Feedback At least once a year, ask (a) trusted peer(s) to provide you with feedback on your professional practice.

d. Learning Plan The learning plan based on identified needs. After one learning project is completed, a new plan is developed to meet further learning needs.