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Integral Analysis of Alberta Registered Nurses' Mandated Professional Learning

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Integral Analysis of Alberta Registered Nurses' Mandated Professional Learning

by

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Abstract

This research explores the influences of continuing professional development (CPD) in nursing as a regulatory requirement for continuing competence. Ken Wilber's Integral theory is the conceptual framework in the development of research questions, methodology, and data analysis concerning the phenomenon of mandatory CPD. Integral methodological pluralism is both the "view through," and "view from," therefore methodological pluralism best informed the research design of this study. The data from the phenomenological interviews anchored the other research methods to holistically reveal the experiences of nurses and nurse administrators in mandatory CPD. The goal of this research is a comprehensive understanding of nurses' experiences of regulated CPD situated in a hospital context.

The themes revealed oppression, heavy workload, avoidance, and hostile work culture undermining the access to, and need and desire for CPD and continual (real-time) competence in nursing. The experiences and perceptions of CPD are significantly influenced by the regulatory continuing competence program, union, and work context. The explored lived experiences of registered nurses and nurse leaders in a medical-surgical unit of a major tertiary hospital show many instances of CPD, though not 'acceptable' within the regulatory regime. The analysis revealed that participation in CPD, healthy work teams, and effective continuing competence programming are critical for continuing competence in nursing. While the regulator focuses on their own compliance with the law, this research provides numerous implications and recommendations regarding nurses' compliance with CPD requirements. Nurses' access to and participation in CPD would improve with shared understandings and collaborative approaches between nurses, employers and regulators.

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Finally, I would like to acknowledge Joy Peacock for her visionary leadership and who is always two steps ahead in the nursing regulatory world and is leading powerful change.

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Chapter One: Background and Research Questions

In Alberta, registered nurses (RN) are authorized to provide patient care that includes high-risk restricted activities as long as they are competent. Though 'competence' is an elusive concept in nursing, it is regarded as a critical factor in patient safety and therefore a focus of regulators who must ensure safe nursing practice. As such, regulators enforce a minimum level of ongoing professional education in each nursing practice year, since it is generally accepted that education is integral to continuing competence. In hospital settings where over 60 percent of registered nurses work in Alberta, these education requirements are exacerbated by multiple factors that impact nurses' actual and reported learning. The purpose of this study was to understand the influences of regulator-mandated professional learning implementation within a hospital work context. Accordingly, this study explored the experiences of Alberta RNs and RN administrators working in a large tertiary care hospital from four ontological perspectives. According to Wilber's Integral Theory, a meta-theory, multiple research paradigms and their corresponding methodologies may be organized into a concise framework of four quadrants (Bohac Clarke, 2019c; B. Davis, 2019). Methodological pluralism brought to light the complexity of system issues, culture problems and disparate viewpoints that influence RN professional learning. Chapter One begins with an overview of the regulatory context in nursing to frame the topic of this study and illuminate the overarching research problem and purpose. Presentation of the research questions and the ensuing methodological approaches include the researcher's perspectives and assumptions.

Introduction and Purpose

RNs in Alberta are mandated by regulators to maintain competence in their nursing practice, but RNs also have competence accountabilities to other authorities such as provincial

policymakers and employers. Regulation, in particular, is often a contentious subject for RNs who must comply with the vague, yet demanding regulatory requirements for education as a competing priority in their demanding daily work.

Regulatory Context of Nursing in Alberta

A Brief History of Nursing Regulation and Learning

Continuing professional development in nursing has been a prevalent focus since the beginning of the profession in Alberta. However, professional education requirements have evolved from being voluntary—encouraged by the beginning nursing association—to mandatory learning required by legislated, nursing regulatory membership. Currently, registered nurses are *self-regulated*, meaning the profession is entrusted with legislative authority to determine, direct, and enforce the practice of nursing in Alberta. The nursing regulator in Alberta is the provincial governing authority who interprets and enforces legislation, including continuing competence learning as expressed in the Health Professions Act (Province of Alberta, 2000). The regulated Continuing Competence Program (CCP) prescribes, monitors, and enforces professional development learning. CCP exists to comply with legislation and to respond to the changing nursing practice in a complex health system.

Since 1916, nursing association/regulator governance has been in existence in Alberta, as started by a small group of nurses in early times (College and Association of Registered Nurses of Alberta, 2016h). This model of governance was that of a nurses' association who set and enforced standards of nursing with a qualifying, entry-to-practice examination, and set standards for nursing education. The association evolved, and in 1984, the proclamation of the Nursing Profession Act evolved the nursing association to become the Alberta Association of Registered Nurses (AARN) (College and Association of Registered Nurses of Alberta, 2016h). At that time in 1984, the new legislation called for mandatory registration and licensure whereby RN

members were required to meet minimum requirements for entry to the profession, and adhere to the standards established by AARN throughout their nursing practice. Significant historical changes to nursing in Alberta occurred when the Health Professions Act (HPA) came into force, November 30, 2005, followed by significant amendments made in March and April 2019. In general, the HPA provides a framework of continuing competence, entry-to-practice requirements, professional conduct and code of ethics. When the Act was proclaimed, the Alberta Association of Registered Nurses became the College and Association of Registered Nurses of Alberta (CARNA). Today, the critical roles of CARNA are to:

- set the qualifications for entering the profession,
- approve nursing education programs,
- issue practice permits to those who qualify,
- develop and enforce professional and ethical standards for measurable nursing performance,
- develop and enforce the continuing competence program,
- collect and respond to nursing practice complaints,
- provide advocacy within the health system,
- provide leadership in nursing, and
- health policy development (College and Association of Registered Nurses of Alberta, 2016j).

Legislation of nursing practice. Nursing professionalism and professional identity describe the nursing profession and articulates the ideals and desired professional behaviour. As partners in health care teams, professional identity sets nurses apart and that reflects the value that nurses bring to the table. Central characteristics of nursing professional identity are found in nursing professional practice documents, nursing education competencies, and research

literature, though still a relatively abstract topic (Ferrell, Christian, & Rachel, 2017). The establishment of professional identity begins with the regulated professional practice documents that describe the minimum expectations of nursing practice and the professional code of ethics but then continues to evolve through professional groups and communities (Andrew, 2012). Continual learning is crucial to professional identity growth and includes establishing one's niche, licensure examinations, career growth, and developing new skills and relationships (Ferrell et al., 2017).

Professional identity is impacted when changes occur within the HPA or Registered Nurses Profession Regulation that change the scope or requirements of the nursing profession (College and Association of Registered Nurses of Alberta, 2016f). These changes may take months to years to process, and any changes to the nursing regulation require extensive member consultation, CARNA Provincial Council ratification, the Alberta Cabinet approval and finally, the proclamation of the Lieutenant Governor (College and Association of Registered Nurses of Alberta, 2016f). Changes to nursing regulation are essential to respond to health system changes and to increase access, system efficiency, and cost-effectiveness of healthcare. RNs are expected to function in any changes to regulation, and the subsequently expanded scope of practice. Members of the public, clients, co-workers, employers or others may report non-compliance with the standards as "unprofessional conduct." Consequently, CARNA may conduct investigations potentially resulting in punitive actions or remediation using the *Practice Standards for Regulated Members* (the Standards) as a legal reference (College and Association of Registered Nurses of Alberta, 2013c). The Standards have five broad categories including 1.) Responsibility, 2.) Knowledge-Based Practice, 3.) Ethical Practice, 4.) Service to the Public, and 5.) Self-Regulation. Each of these categories is broken down further to more specific "practice indicators" that, as stated previously, are used as a reference in reflecting on and documenting

their mandatory continuing competency professional development (College and Association of Registered Nurses of Alberta, 2013c).

Mandated Professional Learning

Overview. In the fall of every year, Alberta RNs record their compliance with mandatory continuing professional development (CPD) requirements of the CCP before they are eligible to renew their nursing license at CARNA. An automated process—called “MyCCP”—is used to track and monitor nurses’ CPD activities that either allow practice-permit renewal if compliant or provides notification of non-compliance to CARNA. It is illegal for RNs to work without a permit (Province of Alberta, 2000), so designated CARNA staff supports registrants if notification of non-compliance is sent by MyCCP. A governing committee of RNs functions to monitor the program, monitor member compliance, perform random member audits and determine consequences for non-compliance. The effectiveness of this program contributes to the substantiation of CARNA's accountability to Albertans of safe, competent, and ethical nursing care.

The three components of the CARNA Continuing Competence Program are 1.) Practice Reflection and Feedback, 2.) Continuing Professional Development, and 3.) Competency Assessment. The program is more or less step-wise, where first, each RN must identify and implement a learning plan based on critical reflection of their nursing practice and peer or administrator feedback. CARNA has defined practice reflection as the review of one's nursing practice to determine learning needs with the purpose of informing the learning plan and to "gain validation through feedback from others" (College and Association of Registered Nurses of Alberta, 2013b, p. 5). Once the learning needs are documented, the registrant determines their learning focus and aligns it to the nursing practice indicators, or the discrete points under each standard that “articulate the expectations of each of the standards—expectations that apply to all

nurses, in all practice settings at all times" (College and Association of Registered Nurses of Alberta, 2013c, pp. 9–11, 2016g). Professional development activities are selected after the determination of the priority focus, as long as the activity aligns with the practice indicator or "learning focus." *Continuing Professional Development* has been defined by CARNA as "the way in which we attain that knowledge, skill, judgment and attitude" in the provision of safe, competent, and ethical nursing care (College and Association of Registered Nurses of Alberta, 2013b, p. 5). The last step of the program is *competency self-assessment*, where the individual reviews their practice according to their selected practice indicator and decides how they have performed according to that indicator and in compliance with their job description and employer requirements. Ultimately, it is up to the individual if they have met their expectations and performed adequately, but if audited, these steps will be judged by the committee for appropriateness and congruity to the RN practice setting and the nursing standards. Thus, RNs are compelled to participate in the program and mandatory professional development activities *with diligence*, to avoid audits (and possible consequences) and maintain their license and viability to work in Alberta.

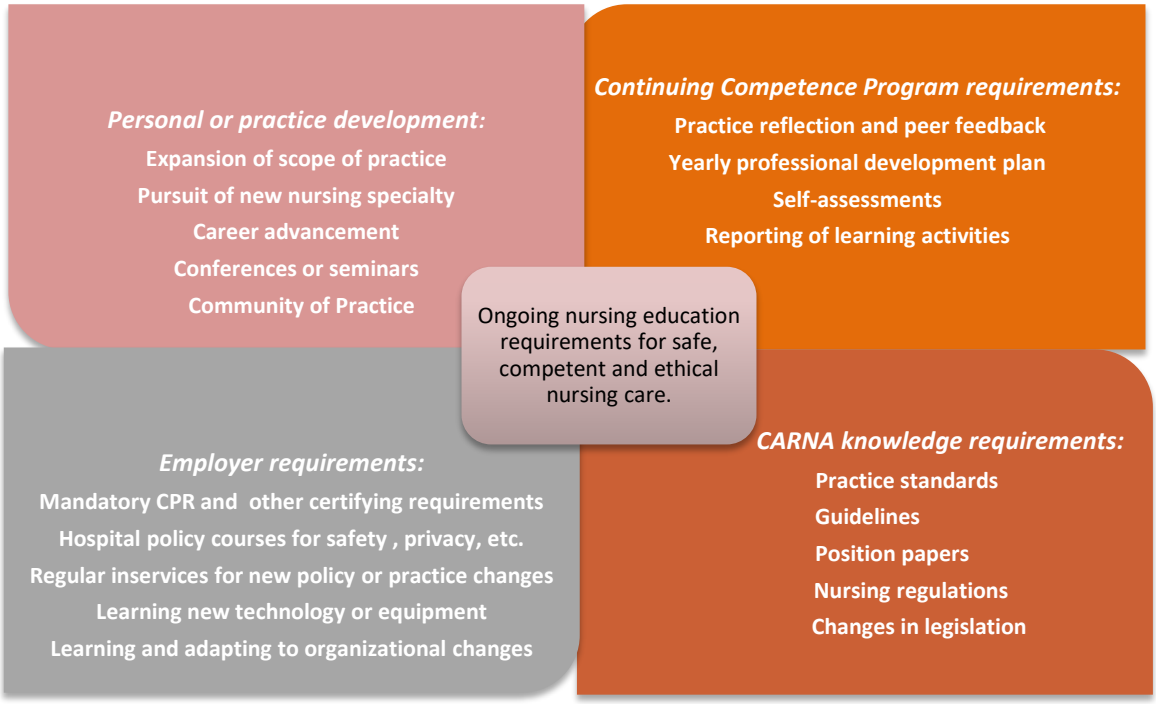
Continuing professional development compliance. MyCCP online reporting program allows many menu options in drop-down lists, including courses, modules, seminars, conferences, in-services, certifying courses, certificate programs, internet searches, and others. In most cases, nurses seek out their own continuing professional development activities and choose one option from the list that could fit their learning plan.

CARNA resources. CARNA offers some opportunities for professional development with the hope that RNs will engage in the essential knowledge of legislation and practice. For that reason, nursing practice resources are available in downloadable documents such as guidelines, position papers and of course, the legislative documents. Learning via webinars and

other modalities are offered by CARNA because reading these documents is not a mandatory activity. However, knowledge of the contents of these is considered by CARNA to be essential (College and Association of Registered Nurses of Alberta, 2016e). Many of the documents have been written to guide RNs in specific areas of practice or to provide responses to changing healthcare systems that impact nursing practice. For example, recently, the "Medical Assistance in Dying" legislation is a revision to the criminal code that has impacted all who work in health teams (College and Association of Registered Nurses of Alberta, 2016c). Another example of legislation is the requirement for an online "Jurisprudence" module to be mandatory in all initial nursing registrations (College and Association of Registered Nurses of Alberta, 2016b).

Scope of required learning. Regulatory requirements for nurses' learning is only one part of many requirements. In fact, continuing professional development requirements in nursing far exceed the boundaries of one, regulator-mandated learning plan. Many forces and influences, such as annual nursing license renewal, certification renewals, employer requirements, and increasing knowledge of changes in the nursing profession and accountabilities, as shown in Figure 1, determine the maintenance of nursing competency for safe patient care. Figure 1 shows *discrete* learning activities from four perspectives in nursing practice that are mandatory education requirements for nurses to maintain or advance their professional practice. The specific regulator-requirements in the Continuing Competence Program do not account for what RNs are actually compelled to learn in practice as shown in Figure 1.

Figure 1. RN's compelled to learn from four separate perspectives



The learning problem. Continuing professional development for RNs is a mandatory obligation, but how Alberta RN learning is influenced from an integral perspective has not previously been studied. RNs are challenged in their professional development when institutional and regulatory mandates demand transformative practice but are also prohibitive because of constraining policies and institutional obligations (Bungay & Stevenson, 2013). There has been an argument that hindrance to professional development impacts patient care (Katsikitis et al., 2013; Phillips, Piza, & Ingham, 2012; Wood, 1998; Yoder-Wise, 2015) and further, limits professional identity development. More research has looked at whether RN knowledge and skills need to be fully leveraged to move the health system changes forward (Kutzin & Janicke, 2015). The keynote message at the International Conference of Nurses in 2015 by Dr. Margaret Chan (Director-General, World Health Organization) punctuated this need when speaking about a report to strengthen the contribution of nurses:

> Again, that report argued that nurses should be able to practice to the full extent of their education and training. The conclusion is similar to the one made 24 years ago: regulatory and institutional obstacles, including limits on nurses' scope of practice, should be removed so that health systems can reap the full benefit of their training, skills, and knowledge. (Chan, 2015, p. n.p.)

A four-quadrant view of the influences in mandatory CPD informs policy and has identified gaps or redundancy in systems while recognizing the strength of the RN collective. This research critiqued CARNA's role to connect and engage the RN membership network as a unified voice that contributes to public policy and nursing globally. In addition to the protection of the public, CARNA provides RNs with the advocacy and knowledge to enhance and protect their practice and professional development (College and Association of Registered Nurses of Alberta, 2016c).

Current Issues in Alberta Nursing Regulation

Redirecting education. From 2001-2016, the cornerstone resource was the CARNA Regional Coordinator Program consisting of nine RN regional coordinators who provided newsletters, online and face-to-face educational presentations (College and Association of Registered Nurses of Alberta, 2016i). In May 2016, the Regional Coordinator Program closed partially based on an independent review that determined that RNs require increased access to learning opportunities (Bim Larsson & Associates, 2014). CARNA must provide professional development opportunities to address the emergent and far-reaching changes to healthcare, such as government initiatives to change roles in healthcare (Duckett, Bloom, & Robertson, 2012).

Broader regulatory trends and issues. Researchers have broadly studied nursing regulation in terms of regulatory role and impact. Some publications have determined a need for greater collaboration and consistency nationally to define nursing and the RN role in healthcare

(Susan Duncan & Rodney, 2015; Flook, 2003; Garrett & MacPhee, 2014; Hadley, 1995). Others echo this but have elaborated on the need for increased attention to system-level problems instead of the focus on individual conduct (Susan Duncan & Rodney, 2015) and more collaborative methods for determining priority education requirements (Libner, 2016). There is also evidence for the need for increased articulation agreements and congruity with other regulatory bodies for flexibility and mobility of RNs' workplace (Wearing, Black, & Kline, 2010) while an overall step back in regulation and a step forward in partnerships and research have been highlighted (Saver, 2010). Though most of the research indicated a need for provincial regulators to work and collaborate nationally, none of the research found used a four-quadrant research approach.

Research Problem and Questions

Context of the central problem

Registered nurses in Alberta are mandated by provincial policymakers and regulators to continually learn and adapt their methodologies in a highly complex health care system.

Problem statement

What are the experiences of nurses and hospital administrators in regulator-mandated continuing professional development in their contexts?

Purpose statement

The purpose of this study was to understand the influences of regulator mandated professional learning implementation on the actual learning of nurses in their contexts. This study explored the experiences of Alberta registered nurses and administrators of tertiary care hospital settings using Wilber's Four Quadrant framework (Bohac Clarke, 2019a; B. Davis, 2019; Helfrich, 2012).

Research questions

1. How do RNs and administrators personally perceive and experience CARNA -mandated professional learning for nurses?
2. How do the interactions with and among RNs, administrators, work teams, UNA, and CARNA, during mandated professional development program implementation influence the nurses' learning?
3. How are the RN professional learning requirements determined and assessed?
4. How are ongoing provincial level decisions made about RN learning requirements and what kinds of enforcement, monitoring and feedback mechanisms support these decisions?

Research Design Overview

This overview of the research methodology briefly explains Integral Theory as the basis of the framework of inquiry in light of the problem of this study. As illustrated in Figure 2 (Adapted from Figure 1 in B. Davis, 2019, p. 2), the Integral Methodological Pluralism approach enabled multiple methods to look at the experiences of RNs and administrators in an Alberta tertiary care hospital, the workplace of the majority of RNs in Alberta. Individual interviews of RNs and nurse manager focus groups shed light on the influences of mandatory professional learning implementation. Analysis of CARNA Continuing Competence Program (CCP) policies informed the policy systems that influence registered nurses continuing professional development. The behaviour of nurses' compliance in mandatory continuing professional development was examined. B. Davis (2019, p. 2) explains that the lines of axes "are not actual fault lines of the universe, but rather as perceptual tools" to break from habits of seeing and looking to different forms of observation.

Figure 2 shows that each quadrant of AQAL defines fundamental viewpoints along two axes divided according to individual or collective, interior or exterior. Research contexts are explained further according to the AQAL framework in Figure 2 in the following sections.

Figure 2. Research design perspectives in the Four Quadrant Framework

	Interior	**Exterior**
Individual	**Upper Left Quadrant** SUBJECTIVE Phenomenological First-person, RN point of view Interior individual – "I."	**Upper Right Quadrant** OBJECTIVE Quantitative Third-person, assessment and evaluation Exterior individual- "what he or she does."
Collective	**Lower Left Quadrant** INTERSUBJECTIVE Ethnographic Second-person, administrator point of view Interior collective "we" experience	**Lower Right Quadrant** INTEROBJECTIVE Complexity theory Third-person, policy systems perspective The social exterior or structures; "What they do."

All Quadrants All Levels: AQAL

The framework of this research is contained within Ken Wilber's integral analysis of AQAL (Wilber, 2010). Ken Wilber is the founder and philosopher of the integral theory that has maps human relationships with pluralism and intersecting worldviews (Haigh, 2013). Integral

theory is all-encompassing and includes all quadrants, all levels, lines, states and types, hence the acronym, "AQAL." Simply put, AQAL maps four critical perspectives and unpacks each into levels of development, lines of intelligence, states of consciousness and types of individuals (Wilber, 2005). Bringing the AQAL framework to bear on the problem lends to research approaches that are more rounded and multifaceted and identifies blind spots or missing perspectives from existing literature (Gunnlaugson, 2005). Though a great strength of AQAL, one of the greatest criticisms of the model is the claim to be “all encompassing” (B. Davis, 2019, p. 3), therefore individual efforts to use the full extent of the AQAL framework is generally overwhelming for one researcher (Bohac Clarke 2019b). Consequently, this research was delimited given the magnitude of AQAL methodology in its entirety, though the Four Quadrants framework enabled success in revealing truth from multiple ontologies. The future opportunity exists to strategically expand on this research using other elements of AQAL in subsequent research projects.

Summary of Key Contextual Influences in the AQAL Map

There are four key contexts in the AQAL Map. The first addresses the challenge for CARNA to assure the public of safe, competent and ethical nursing care, despite the lack of clarity on how mandated professional learning influences RNs and administrators to achieve desired outcomes. Secondly, the Continuing Competence Program is faced with legislative changes within its structure and will have to determine the evaluation of RN performance. Third, it was unknown how the workplace culture influences mandated RN professional learning, considering the complexity of work teams, hierarchical leadership, and systems (Bungay & Stevenson, 2013). Current research shows that leadership in health systems work under duress to ensure staffing is appropriate for the level of care needed while responding to concurrent changes in staff scope of practice, staff shortages and healthcare team staff mix and organizational

restructure (Curtin, 2003). Fourth, RNs are required to be transformational in their practice while they keep up the professional development requirements to maintain their license and avoid punitive measures. Current research has shown work-life balance, and the expensive cost of education are deterrents, especially where there are poor workplace support and no mechanism to engage in the process (Holland, Tham, & Gill, 2018). See Figure 3 below that shows the vicious cycle of CPD requirements that are paradoxically thwarted.

Figure 3. Vicious Cycle of Responsibility (Vernon et al., 2011)

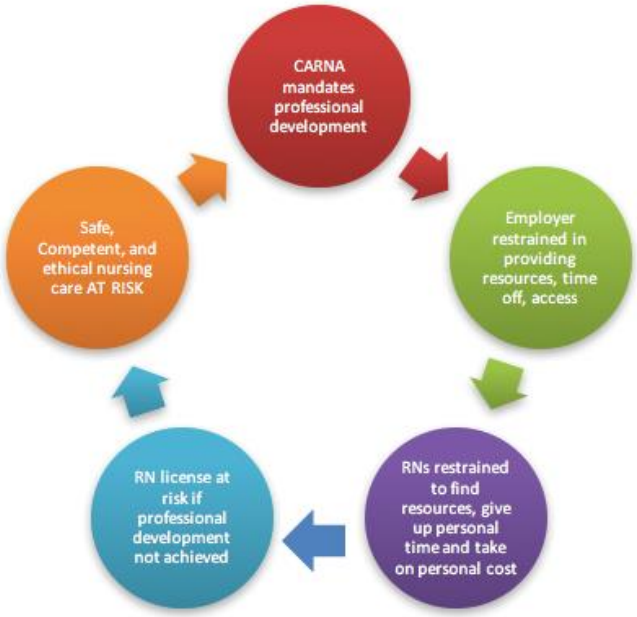


Figure 4 shows the nested nursing context points within the four-quadrant framework. These perspectives inform regulatory practice, collaboration-building capacity and policy frameworks and bring an integral understanding of the role of the RN and mandatory professional learning.

Figure 4. Nested nursing contexts within Wilber's Four Quadrant Framework

Upper Left Quadrant	Upper Right Quadrant
SUBJECTIVE (phenomenological)	OBJECTIVE (Quantitative)

RN 1st person point of view Obligated to safe, competent and ethical practice Seeks professional development to improve own practice and meet legislative requirements Carries responsibility to learn and comply with scope-of-practice changes Does not have a mechanism to collaborate	Assessment and evaluation Continuing Competence Program Self-Assessment Audits and peer review Reflective practice not measurable Safe, competent and ethical practice not measurable Collaboration and increased networks needed to inform the success of the nursing practice
Lower Left Quadrant INTERSUBJECTIVE (ethnographic) Administrator second-person point of view Ensures staffing of mixed healthcare teams Enables professional development Establishes systems of evaluation Determines workplace learning Determines the evaluation of performance	Lower Right Quadrant INTEROBJECTIVE (policy systems) CARNA Responds to legislative changes Determines mandated professional learning Enforcement of the Practice Standards Builds the RN network Impacts healthcare policy

Establishes inter-relationships Job satisfaction and retention	Determines the evaluation of professional practice

Rationale and Significance

There are significant contributions from this study to the body of knowledge regarding nurses' experiences and their learning in the complex systems where they work. Moreover, the phenomenon of mandatory nursing continuing professional development (CPD) in Alberta is understudied, where this study provides a rich basis for policy development and further research.

The key to the rationale and significance of this research is rooted in the remarks of Dr. Margaret Chan (Director-General, World Health Organization) where she spoke about the removal of "regulatory and institutional obstacles" so that health systems can effectively experience the full benefit of RN knowledge and skill (Chan, 2015, p. n.p.). Further and ongoing legislative changes impact CARNA's authority and the need for RNs to engage and ensure learning is transformational in their registered nursing practice and the formation of professional identity.

Simultaneously occurring over the last century, health systems changes have also been significant:

> A dense network of organizations—research centers, pharmaceutical companies, hospitals, medical schools, health insurance companies—have meshed into a highly sophisticated medical system that would have been unthinkable just a century ago. Over the last century, this network contributed to adding nearly 20 years of life expectancy for the average person in the United States. Infant mortality has been reduced by 90 percent and maternal mortality by 99 percent. Age-old scourges like polio, leprosy, smallpox, and tuberculosis are mostly part of history books, even in the poorest countries in the world. (Laloux, 2014, p. 4)

According to Laloux (2014), organizational culture is enacted by those in the lower-left quadrant (RN leaders in this case) with the moral authority (CARNA) of the lower right quadrant that dictates supportive structures, processes, and practices. Laloux referred to the characteristics of healthcare organizations when he comments on the drudgery of working within organizations for those who work at the "bottom of the pyramid" (Laloux, 2014, p. 3). These are people at risk who have lost passion or purpose, and their work is meaningless. In particular, Laloux has said: "We have turned hospitals into cold, bureaucratic institutions that dispossess doctors and nurses of their capacity to care from the heart" (Laloux, 2014, p. 4). With that said, much has also been written about strengthening workplace culture with collaborative policy building, collaborative learning, patient safety focus (Goh C., Chan, Kuziemsky, & Goh, 2011). Transformative leadership styles, the importance of strategic planning and vision have also been cited as strengthening factors to workplace culture (Laloux, 2014; Salmela, Eriksson, & Fagerstrom, 2013). A healthy culture that values learning and advancing patient care retains skilled and knowledgeable RNs (Cooper, 2009). The shared values of safe, competent and ethical nursing care may be the common denominator between administration and RNs toward a more positive influence in nursing professional development.

The findings of this research with the integral approach are especially crucial with legislative changes but also in light of the complexity of the systems involved and the demands each have to ensure RNs deliver safe, competent, and ethical nursing care. The influences of mandatory CPD inform regulators, RNs and the public of the actual learning that takes place and what is reported in the CCP. Implications of this research are vast since there is no known measure of continuing competence or known outcomes despite complex reporting programs. This Integral research also informs patient safety research in light of

what the learning capabilities and opportunities are in the workplace that advance continuing competence and safe patient care. Finally, insights gained from this research will add to policy development frameworks and the dearth of literature on mandated nursing professional learning.

Researcher Biography

Since I graduated from the University of Alberta Nursing diploma program in 1991, I have been involved in health care in many capacities. I initially worked in the Neonatal Intensive Care Unit (NICU) at the University of Alberta Hospital, where I saw my future in nursing and successfully took the Neonatal Certificate Program through the University of Alberta. Nursing in this context was challenging but very inspiring for me, though unfortunately short-lived due to health care budget cuts. As a result, in 1994, I lost my full-time position in NICU, and for two years, I worked casual hours to continue my nursing practice and support my family.

In 1996, I was very fortunate to start a new position with daytime hours that would be more consistent for my family. The nursing specialty in diagnostic vascular studies was a steep learning curve for me that also required an additional certification. After completing a year-long internship and successfully writing the international board exams, I held dual certifications as a registered vascular technologist and registered nurse. The vascular testing clinical specialty was very new then, but soon became broadly recognized as an efficient, non-invasive and highly effective way to diagnose vascular disease. Ankle-brachial indices are the mainstay vascular assessment relied upon in wound care and to this day, and I continue to teach this specialty in a yearly, three-credit distance learning program to RNs and other health professionals. I am privileged to participate and contribute to the work of non-invasive diagnosis of treatable, preventable, but very serious health conditions.

Systems changed, and our medical director retired so I transitioned the vascular practice to the radiology department at the University of Alberta, where I went on to provide training to staff in the University of Alberta Hospitals Radiology Department so these vascular examinations could be offered widely to inpatients and outpatients at the hospital. Soon after that, I was then offered a position at NAIT, where I developed the vascular, three-year curriculum, and then taught in the Diagnostic Medical Ultrasound Program for five years while I simultaneously obtained a Master's degree in adult learning and technology, my new passion.

To continue my passion in education, I accepted a position at MacEwan University as the Coordinator of the Clinical Simulation Centre where, during my six years, I saw the Centre grow from one being rarely used, to a dramatic, fully booked centre and simulation learning integrated into the nursing curriculum. To champion this growth, I worked toward technology integration, created policies and procedures, established the educational support team and committee, and championed simulation education interdisciplinary projects. Now, undergraduate nursing students may learn high acuity, low-frequency patient care safely in simulation before contact with actual patients.

Since January 2016, I am employed as the Senior Manager of Professional Development and Knowledge at the College and Association of Registered Nurses of Alberta. It was at this juncture where I started to reflect on professional learning, and when I look back on my own professional history, I see my pattern of learning and changing driven by government or organizational changes, career developments, and practice changes. Along the way, I had to adapt and adjust, sometimes resulting in very challenging learning situations. Though I am proud of my experiences and what I have learned, I desire to know more about the learning experiences of nurses. I hope this research significantly adds to what is currently known about nursing continuing professional development.

Researcher Assumptions

My key assumptions in this research originate from my experience working as an RN, especially from my very recent clinical rotation on a medical unit in a tertiary hospital (for one month in March 2016). My first assumption is that RNs are very stressed with the many demands imposed on them to maintain their license and their workplace requirements. I overheard a conversation between two RNs working nightshift that each was planning to take a vacation day to complete these professional requirements and provide "proof" to the employer or to CARNA as required of them. They lamented this loss of a vacation day while balancing their personal lives and families. My second assumption is RNs have limited intrinsic motivation to complete mandatory professional learning as they would rather spend their time learning about subject areas that advance their practice and improves their work. My third assumption is that the employer/administrator also feels imposed upon by CARNA for their mandatory requirements and having to accommodate and encourage RNs to complete these requirements. I assume that administrators are also working in a highly complex administrative position and have frustrations with the many health worker qualifications and building cohesive health care teams. Mandatory education may be an unwanted necessity for administrators to concern themselves with.

Definitions and Acronyms

The common acronyms and terms used in this research are explained for clarity.

Alberta Health Services (AHS) is the health care service provider and the employer of the nurses in the context of this study.

College and Association of Registered Nurses of Alberta (CARNA) is the Alberta nursing regulator who has a dual mandate to protect the public and advance the profession.

Continuing Competence is the demonstration of nursing practice, knowledge and ethos that is proven to be evidence-based.

Continuing Competence Program (CCP) is the CARNA program that monitors, guides and tracks RNs continuing professional development activities in a prescriptive way on a yearly basis.

Continuing Professional Development (CPD) refers to learning that is transformative in changing RN practice. The keyword is "transformative" because of the nature of behaviour change that is desired.

Health Professions Act (HPA) “is the framework for governance, registration, restricted activities, discipline and continuing competence. It defines the requirements that regulated health professions in Alberta need to follow to provide safe and competent care to the public” (College and Association of Registered Nurses of Alberta, 2018c).

Mandated refers to the required continuing professional development essential for RNs to change their practice within the legislated scope as determined by regulators, employers, individuals, and others.

MyCCP is the online form that RNs must report into each year to plan and report their continuing professional development.

Practice Standards for Regulated Members (the Standards) describe what required behaviour of every registered nurse is that may be used to evaluate performance (College and Association of Registered Nurses of Alberta, 2013c).

Registered Nurse (RN or “nurses”) is an individual who has met all qualifications deemed necessary by the regulator, is granted membership status and is inducted into the nurse register at CARNA.

Registered Nurses Profession Regulation (regulation) is what defines the scope and “rules” that govern registered nursing practice in Alberta (College and Association of Registered Nurses of Alberta, 2018c)

United Nurses of Alberta (UNA) is the nurses' union with members who are working in the major tertiary hospital, the context of this study.

Chapter One Summary

Chapter One provides the context of nursing regulation as it relates to registered nurses and their legislated responsibilities to continually learn and adapt their practice. The focus on continual growth in nursing knowledge and skill is necessary to continue competence; however, little was known how RNs experience their learning. Nursing administrators are situated in healthcare system complexity, and have a vital role in enabling and enhancing nursing CPD; however, little was known about their experiences with this phenomenon. The research problem is multi-faceted in which Integral Methodological Pluralism is the best approach to explore it. This chapter provides an overview of AQAL that is the infrastructure of the research design. Following this background and introduction to the research design, Chapter Two reviews the literature and Chapter Three details the research methodology that best fits each of the four AQAL quadrants.

Chapter Two: Literature Review

The purpose of this study was to understand the influences of regulator mandated continuing professional development of nurses in their work context. The four ontological quadrants of the Integral model served as the conceptual framework for the whole study, and as such, this critical literature review was also organized according to this framework, given the ontological complexity of the research problem (Bohac Clarke, 2019b).

This literature review explored each ontological quadrant separately in keeping with the Integral Methodological Pluralism (IMP) approach to look separately and then holistically (Shea & Frisch, 2015; Wilber, 2005). There was interconnectedness seen in the literature reviewed per quadrant, and the themes informed the big picture within the conceptual framework. The ontological quadrants with major areas of review are organized as shown in Figure 5 (Adapted from Figure 1 in B. Davis, 2019, p. 2) below.

Figure 5. Research design perspectives in the Four Quadrant Framework

	Interior	**Exterior**
Individual	**Upper Left Quadrant** SUBJECTIVE Phenomenological First-person, RN point of view Interior individual – "I."	**Upper Right Quadrant** OBJECTIVE Quantitative Third-person, assessment and evaluation Exterior individual- "what he or she does."
Collective	**Lower Left Quadrant** INTERSUBJECTIVE Ethnographic	**Lower Right Quadrant** INTEROBJECTIVE Complexity theory

	Second-person, administrator point of view Interior collective “we” experience	Third-person, policy systems perspective The social exterior or structures; "What they do."

Structure of the Literature Review

Literature Review Method

The Integral ontological framework guided the literature review method to ensure each quadrant was reviewed individually and thoroughly. As such, the research problem and questions were positioned within the Integral quadrants according to their ontological perspectives and corresponding topics were searched. Major databases were searched to include CINACL, MEDLINE, Ovid Nursing Journals, and ProQuest Nursing and Allied Health Source ideally for original research, both qualitative and quantitative. Case studies, literature reviews and commentaries were reviewed to supplement original findings, and grey literature was valuable to provide information about regulator and union history, mandates, and intersections with RN learning. Websites for CARNA and UNA provided valuable documents and information about their organizations and policies.

Overview

Findings of this review show tensions between RNs, regulators and employers. RNs view CPD as an obligation of their license renewal, but they also positively accept it as a way to stay current, advance their skills, and increase their satisfaction with their work. Employers recognize the legislative obligation but also have difficulty enabling learning opportunities due to staffing issues and varying attitudes toward CPD. Associations and regulators enforce the legislation for RN CPD and monitor results to verify the competence, but also to promote the notion of life-long learning and adaptability.

Understanding the factors that influence RN mandatory learning informs planning, policy, and budgets as found in other studies (Wynne, 2015). The CARNA mandatory education requirement ensures that access to professional development is the essential element in the mandatory requirement and reporting. The nursing literature has used the term, "Continuing Professional Development" (CPD) ubiquitously, and it is a prominent part of many professional lives outside of nursing. The notion of CPD, however, is poorly defined and heterogeneously accepted amongst associations, professionals and employers (Friedman & Phillips, 2004; Hegney, Tuckett, Parker, & Robert, 2010). Professional associations have reported CPD to be a means of gaining career security, protecting the profession and providing transparent accountability to the public and stakeholders, where individual professionals report that CPD is training, skills development or a way to advance their career (Friedman & Phillips, 2004).

Presentation of the Literature Review

The first section of this literature review covers continuing professional development in nursing, including what it is and why it is important. The next four segments of the literature review covered topics and perspectives situated within the four ontological quadrants. The Upper Left Quadrant review related to how RNs experience and perceive continuing professional development. Next, the Lower Left Quadrant guided review of the literature on the administration and culture where RNs are situated and experience CPD. The Upper Right Quadrant included assessment and monitoring of RNs in terms of their regulated obligations to complete CPD tasks. Exploration of the Lower Right Quadrant applies complexity theory to understanding policy systems in regulation of CPD. Following the review of topics within Integral quadrants, this literature review investigated topics further as they naturally emerged out of the search criteria. These topics include workplace, regulation, nursing culture and challenges

impacting RN learning. The final sections explores systems theory and the final chapter summary.

Key search words: Nursing professional learning, transformational professional nursing learning, continuing professional development, continuing competence, mandatory learning.

Continuing Professional Development Overview

The Practice Imperative

Continuous Professional Development (CPD) is an essential component of nursing regulator continuing competence program. CPD has been defined as any education after entry into the profession and is linked to the concept of "life-long learning" as that which is a commitment to learning to continually enhance professional practice, maintain continuing competence, and achieve advanced career goals (Brekelmans, Poell, & van Wijk, 2013; Cooper, 2009; James & Francis, 2011). Professional development experiences are designed to “advance knowledge, skills, and attitudes of registered nurses for the enhancement of practice, patient care, education, administration and research” (Murphy, Cross, & McGuire, 2006, p. 368). Apart from the maintenance and further development of knowledge and skills, continuous professional development enhances personal learning and qualities (Ross, Barr, & Stevens, 2013) and outcomes of CPD are the continuous improvement of health services and health outcomes (Nsemo, John, Etifit, Mgbekem, & Oyira, 2013).

Globally, the RN license is contingent on demonstrating continual learning in order to “maintain the trust and confidence of the public” (James & Francis, 2011). CPD in nursing is distinguished by the concept of development of nursing practice, knowledge and nursing professionalism, whereas *competence* is the demonstration of nursing practice capabilities that are proven to be ‘evidence-based' for public transparency (Brekelmans et al., 2013; James & Francis, 2011). Bassendowski and Petrucka (2009) discussed the continuing competence

program in Saskatchewan, Canada, with characteristics that promote reflective practice and integration and life-long learning. Effective CPD in this Canadian program is dependent on the support of the employer, a moral commitment, and is influenced heavily by the practice setting as it can be "facilitated or hindered by the environment in which individuals practice" (Bassendowski & Petrucka, 2009, p. 553). Results of the Bassendowski and Petrucka (2009) study of locus of control indicate 90% of RNs (participants) agreed that reflective practice, lifelong learning, and integration of learning into nursing practice are all necessary. However, excellent and negative viewpoints of mandatory CPD are identified in other literature. For one, mandatory education as directed by the nursing regulator provides accountability for the regulator mandate to assure public safety. The main argument to this proposition, though, is whether the mandatory learning actually transforms practice (James & Francis, 2011). There is a research need in this area to develop evidence that shows CPD linkages to nursing practice outcomes since the main goal of CPD is "effectively prepared and continually updated nursing workforce that is essential to the maintenance and improvement in the quality of care" (Levett-Jones, 1994, p. 231). This goal includes improvements to professional knowledge, currency with technology, and adaptability to rapid, frequent changes in healthcare (Ross et al., 2013).

Most RNs participate in CPD, and it has been argued whether the mandatory status is a hindrance to motivating RNs. The voluntary or mandatory status of CPD have little effect on the accrued learning hours and Nalle, Wyatt, and Myers, (2010) found that voluntary participation actually fosters motivation toward CPD. Those who do not participate are resistant to change, and learning would not be meaningful anyway. Some recommendations made by James and Francis (2011), was to incentivize continual learning and reporting by shifting the locus of control to the nurse-learner in an enabling and facilitative environment. Such an environment encourages self-directed learning and motivation (Brekelmans et al., 2013). Providing choice for

the self-determination of learning topics and modalities has been deemed in improve the sense of locus of control and is an important success determinant of CPD programs (Bassendowski & Petrucka, 2009; Lily Dongxia Xiao, 2008). Brekelmans et al. (2013) suggest a network theory approach to the development of CPD strategies to enable the emergence of relevant topics and strategies and outcomes that shape individual clinical areas. Time off, financial aid, in-house learning opportunities, and choice of topics all help to motivate nursing learning while simultaneously instilling a sense of responsibility and accountability to learn continually. The International Council of Nurses (ICN) made a statement that continuing professional learning is the responsibility of nurses and accountability to the public but is a shared stakeholder responsibility. Stakeholders such as the public and patients, government, nursing regulators, nursing individuals, employers, educators, and nursing associations all have a role in ensuring public safety (James & Francis, 2011).

The Workplace Imperative

Registered nurses experience high motivation but also many challenges in mandatory professional learning. The research is not abundant, but overall it seems RNs embrace and appreciate continual learning that improves their clinical care or advances the nursing profession (Bahn, 2007; Bassendowski & Petrucka, 2009). Mandatory CPD, however, also brings many challenges as demands for learning originate from many sources such as employer, regulator and personal interests or perceived professional requirements (Gould, Drey, & Berridge, 2007). To name a few examples, cardiopulmonary resuscitation and workplace safety certifications need yearly renewal, in-services for new technology or procedures happen weekly, the roll-out of new workplace policies and many others. Not all of the mandatory learning is seen as necessary to improve patient care, and there are suspicions that the mandatory nature is to benefit quality assurance practices or decrease the workload on healthcare team members (Bahn, 2007).

Along with the perceived vagary of purpose, there is also the uncertainty of how their learning is measured (Nsemo et al., 2013). Overall, the quality and relevance of the mandatory learning are in question while challenges are faced with personal life obligations or extra expenses related to the additional learning (Bahn, 2007; Cooley, 2008; Gould et al., 2007; Prater & Neatherlin, 2001). It has been recognized that leadership is vital to support and provide a work culture conducive to learning (Gould et al., 2007; Govranos & Newton, 2014; Thomas, 2012; Waddell & Pio, 2014).

The Ethical Imperative

Nurses are morally bound to detect and address patients' concerns safely and ethically adequately. The roots of safe, ethical nursing care arise from professional membership/regulation who define in terms of helping individuals "regain a sense of well-being or lessen(s) the impact of the harms inevitably experienced in the course of living" (Grace & Robinson, 2013, p. 124). Membership in such a profession is, in effect, a ‘promise' to the public via explicit codes of conduct and ethics, and the expectation is to enact these responsibilities autonomously. The International Council of Nurses (2012, p. 1) articulated the four fundamental responsibilities of nurses within their code of conduct document: "1. To promote health, 2. To prevent illness, 3. To restore health and 4. To alleviate suffering". The *ICN Code of Ethics* (International Council of Nurses, 2012) further unpacked the core nursing responsibilities to elements addressing nurses and people, nursing and practice, nurses and the profession and nurses and co-workers. Themed throughout this code of conduct is the nurse autonomy to conduct nursing services to individual, families and community and in doing so, they use judgement, initiates action, and assume the role in determining and implementing acceptable standards. Key to these accountabilities, "The nurse, carries personal responsibility and accountability for nursing practice, and for maintaining competence by continual learning" (International Council of Nurses, 2012, p. 3). As a profession,

nursing is expected within its scope of practice to have autonomy over its knowledge development and practice activities whereby it seeks to attain the ultimate goals or four fundamental responsibilities.

Recognizing that in an ever-changing health care environment, registered nurses (RN) of Alberta are required to continually learn and change their methodologies to stay current in nursing practice, healthcare and technology (College and Association of Registered Nurses of Alberta, 2016e). As there is a "regulatory and industry-driven imperative to equip nurses with specialized techniques needed in a highly complex technological healthcare environment" globally, registered nurses have the desire to advance their knowledge, however, are challenged to do so (McAllister, 2011, p. 43). System and organizational constraints hinder professional education endeavours and limit abilities for RNs to practice to their fullest capacity.

Upper Left – Subjective Ontological Quadrant: Registered Nurses Experiences and Perceptions of CPD

Nurses' Perceptions of CPD

The underpinning of motivation and perceived importance for CPD is the ethical imperative to improve patient safety and nursing practice and to improve ones' status. (Govranos & Newton, 2014; Tabari-Khomeiran, Kiger, Parsa-Yekta, & Ahmadi, 2007). Some nurses view their work in itself as a process of learning (Beal, Riley, & Lancaster, 2008; Brekelmans et al., 2013; Govranos & Newton, 2014) with senior nursing staff and one-to-one learning seen as invaluable strategies to maintain skills, professionalism and their nursing license (Govranos & Newton, 2014). The purpose for CPD as perceived by RNs seems to be divided between improving patient bedside care and advancing one's level of status or position (Gould et al., 2007; I. Pool, Poell, & ten Cate, 2013). Many RNs place demands on themselves to advance their learning outside of their work on their own time and money (Govranos & Newton, 2014).

The workplace has been cited by RNs to be an essential *source* of education (Nalle et al., 2010). Sessions may be arranged for RNs in clinical areas and are found to be well-attended and valuable (Bahn, 2007) as long as the topic was found to be relevant. If irrelevant, learners are not likely to change their practice (Nsemo et al., 2013). Topics that were suggested to be the most relevant were related to patient safety and those specific to individuals' practice area, but few CPD opportunities focused on these (Nalle et al., 2010). Others suggest that the nursing regulator select topics that pertain to nursing leadership or professionalism (Nalle et al., 2010; Nsemo et al., 2013). Workplace-located CPD is seen as successful, though often RNs are challenged to attend CPD sessions with commonly unsuitable dates and timings, uninteresting or irrelevant topics, or located in inaccessible places (James & Francis, 2011). Often too, sessions are cancelled due to staff shortages, and many sessions are criticized for boring delivery or uninteresting topics (Bahn, 2007).

RN Learning Characteristics

"Curiosity, readiness to know more about anything relating to working in the clinical area, willingness to ask questions or to get help, and involvement in any activities that could increase professional abilities were seen as important personal characteristics that influence competence development in nurses" (Tabari-Khomeiran et al., 2007, p. 216). Other characteristics seen as successful professional learners are confidence and commitment to the profession, while other characteristics such as age influence the continuing professional development as older nurses require different learning topics and modality compared to younger nurses (I. Pool et al., 2013). Age has also been a discriminatory factor in another study by Duff, Gardner, & Osborne (2014), where mature-aged nurses value learner-centred, peer-to-peer coaching, while younger nurses preferred group activities and debriefing sessions. More mature nurses have identified that regular education updates are essential to cope with the rapid changes

in the healthcare environment (Duff et al., 2014). Comments from one study by Bahn (2007) were that nurses want to improve care and be proficient in their care as they are entrusted by physicians to do so. Other reports indicate that RNs seek CPD because of a specific knowledge deficit and feel obligated to keep up with their peers and new graduates (Bahn, 2007).

Motivation is one of the critical characteristics of the success of continuing professional development (James & Francis, 2011; Murphy et al., 2006). Motivation may be driven from several factors such as fear of failure or drive for success or yearly registration renewal, but for the most part, RNs are more motivated by the drive for increased knowledge, career advancement and professional competence that compliance for licensure requirements (Nalle et al., 2010). Other motivating factors may be to update qualifications or promote personal status or satisfaction or simply to access employer dollars to attend off-site education (James & Francis, 2011; Murphy et al., 2006; Yfantis, Tiniakou, & Yfanti, 2010). Regardless, motivation is stemmed from a strong sense of purpose and applicability personally and to practice (I. Pool et al., 2013) and is perpetuated by the increase in focus and productivity (Yfantis et al., 2010). Nurses are also motivated by the outcomes of continuous professional development such as increased confidence, more significant collaborations, networking, influencing changes in health service, greater satisfaction, expectations of promotions, greater awareness of values, quicker identification of concerns or issues in the profession, and greater clarity and understanding overall (Murphy et al., 2006). CPD is viewed to increase the status of the profession and demonstrates personal competence in the profession (Nsemo et al., 2013; Yfantis et al., 2010). Mandatory continuing professional learning may be demotivating to those who strive to attend learning sessions but must adhere to stringent rules and parameters for their learning (James & Francis, 2011; Murphy et al., 2006).

Learning Preferences

RN CPD preferences are seen predominantly as face-to-face learning in a mentorship (Bahn, 2007; Gould et al., 2007; Govranos & Newton, 2014; Wynne, 2015; Lily Dongxia Xiao, 2008). As such, on the job learning shows the greatest impact that suits the nature of nursing rather than overly-academic evidenced-based learning. Face-to-face learning opportunities also consist of conferences, workshops, classroom work, lectures, nursing rounds and others, while online opportunities present anytime-anywhere learning and access is workable for shift workers and those with substantial personal obligations. Xiao (2006) discussed the experiential aspect of learning on the ward as being more learner-centred and more likely to reach deep reflection on practice and commitment to practice change, while lectures do not promote deep learning. More informal learning is also preferred as shown in a study by Bahn (2007, p. 719) to include "…just working and listening to other professionals" or "…working with colleagues that are more experienced." Alternatively, "Critical incident analysis is a good learning tool…as a team rather than individually…" Some have written that nursing CPD should return to traditional caring values and promote more clinical training (Gould et al., 2007).

The online modality presents opportunities for networking and conversation enriching the learning experience; however, some may have challenges with technology skills or access and can be isolating (Ross et al., 2013; Wilkinson, Forbes, Bloomfield, & Gee, 2004). In spite of the barriers of online learning for RNs such as limited internet access or insufficient time (Atack & Rankin, 2002), Bahn (2007, p. 719) found that nurses reported they regularly access online articles and web resources that "…could be instrumental in promoting and encouraging a culture of lifelong learning in nursing". Success factors for web-based learning are associated with social support and positive attitude (Chiu, Tsai, & Fan Chiang, 2013).

Nursing characteristics, perceptions and learning preferences shed light on the lifeworld of RNs in their professional caregiving role. What we can see from this review is that RNs are generally motivated, ethical and self-directed in their learning. There are debates as to whether a mandatory status is needed given the high motivation for CPD. RNs are met with challenges in their workplace where it is viewed as also their optimal learning environment as they prefer experiential kinds of learning that directly transfer to their practice. RNs enjoy collaborations and peer learning within their context and seem to seek these opportunities readily. Significant challenges are the fiscal and time responsibilities associated with seeking CPD on their own and a work environment that cultivates open, and supported learning is most desired.

Lower Left – Intersubjective Ontological Quadrant: CPD in the Workplace

The Significance of Teams and Leaders

The workplace is a critical element in RN CPD as it reflects the "meaning-making" in the Lower Left quadrant—or the ethnographic observations of nursing teams (Bohac Clarke, 2019b, p. 53). The workplace barriers and challenges of CPD that are related to patient care, and maintenance of professional registration (Coventry, Maslin-Prothero, & Smith, 2015) stand out in ethnographic observations. Historically, nursing CPD in the workplace has been considered "non-essential" in many healthcare organizations, however, in recent times, rapid changes in technology and innovations have increased the learning needs of nurses (Covell, 2009, p. 438). The integrated review by Coventry et al. (2015) revealed many influences on RN CPD, including workplace culture, leadership, workload, and license requirements. Staff shortages and high workload assignments were significant limiting factors to RNs access to CPD, but workplace financial constraints and lack of support and strategy were also significant challenges (Hegney et al., 2010; Nalle et al., 2010). As a result, many RNs reported feeling pressured to access CPD in their personal time, where they encumber the financial and time burdens to do so (Bahn, 2007).

CPD-related workplace issues and lack of support are ranked by RNs to be in the top five workplace issues (Hegney et al., 2010). Directly related workplace factors affecting RN CPD include the workplace environment, RN personal characteristics, job-related issues such as shift coverage, and numbers and nature of learning opportunities (Tabari-Khomeiran et al., 2007).

Team influences. Positive workplace influences are seen in research where leadership supports CPD attendance and corresponding practice changes (Gould et al., 2007); however, negative research findings abound. RNs report many negative views of employer approaches to CPD and in some cases, there is the perception that employers do not provide continuing professional development as promised and subsequently, nurses feel there was mere "lip service" paid to attract them to the job (Gould et al., 2007, p. 606). Other negative views are that employers do not provide CPD; instead, they provide "training" that protects them in litigation or enact quality assurance policies (Bahn, 2007). In some cases, employers have held the threat of job loss as a reason for participation in particular CPD activities (Bahn, 2007) while in another extreme case, it is suggested that managers impede CPD to avoid RNs gaining advanced knowledge compared to themselves (Gould et al., 2007; Murphy et al., 2006). For the most part though, when leadership discourages CPD, it is because of complicated shift coverage and financial constraints (Nalle et al., 2010; Nsemo et al., 2013; Yfantis et al., 2010). Effective support is challenging for workplace leaders because it requires seamless access to CPD activities, and evenly balanced patient-care to learning ideology (Beal et al., 2008). RNs are encouraged when learning opportunities are provided by employers, as staff satisfaction and retention are increased. The mutual, employer-nurse participation in CPD cultivates a “culture of excellence” (Levett-Jones, 1994, p. 231; I. Pool et al., 2013) while a lack of employer-offered CPD influences nurses’ decisions to leave the profession and retire early (I. Pool et al., 2013).

RNs need employer support, or there is a loss of a sense of equity and locus of control (Bahn, 2007; Bassendowski & Petrucka, 2009).

Workforce Complexities

Nursing leaders work in managerial-based, complex workforce environments that complicate process and policy implementation (Bungay & Stevenson, 2013; Susan Duncan & Rodney, 2015). Healthcare teams are comprised of registered nurses, licensed practical nurses, healthcare aids, physicians and others with each of these regulated from their own professional regulatory body with significant differences in education, scope and capability but also significant overlap. While registered nurses experience changes to their mandated CPD requirements, healthcare leaders must concern themselves with the other team members experiencing professional learning demands. Leaders design workload and staff skill mix under these circumstances with difficulty, because of the multi-professional teams with complex professional requirements impacting the workforce and the system widely. For example, when registered nurses expanded their scope to draw blood from clients, employer-led certifying programs had to be designed, a process to record and report certifications had to be designed and implemented, other hospital departments had to become engaged in the change such as the blood lab, and physicians had to be adequately informed.

Resource Shortages

Staff shortages and fiscal restraints are an additional factor to consider when mandatory CPD is implemented. Staff who require education often require organizational managers to support the cost of the learning as well as time off from work. Often replacement is impossible, and leaders must simply "make it work" (Bungay & Stevenson, 2013, p. 73). The whole process of planning and implementing regulation changes were described as "*stressful*" (Bungay & Stevenson, 2013, p. 74). The quandary is how RN professional learning and transformation may

be supported where there is prevalent staffing and fiscal restraints in a predominantly hierarchical and managerial system (Gould et al., 2007; Govranos & Newton, 2014; Thomas, 2012; L. D. Xiao, 2006).

System Changes

Re-structuring in all organizations has an impact on nurse leaders' implementation of mandatory professional development. Bungay and Stevenson (2013) reported that new reporting structures and organizational policies were constant in the regulatory body and within the healthcare organization. It was deemed "*impossible"* to actually designate a single point of contact to work with the regulator (Bungay & Stevenson, 2013, p. 73). Nurses are embedded in the health system, with 65% of RNs who work at the bedside in clinical hospital settings in Alberta. In this setting, RNs have been impacted by the criticized Alberta workforce planning shortcuts and lack of evidence-based planning in staff mix (Duckett et al., 2012; Robinson, 2009). In particular, healthcare teams (staff mix) is planned around health delivery models that provide fiscal advantage instead of improved patient outcomes (Goodman, 2014; Robinson, 2009). This news is dismal for RNs to are expected to lead these teams clinically that cut corners on appropriate clinical skills (Freund et al., 2015).

Workplace Culture

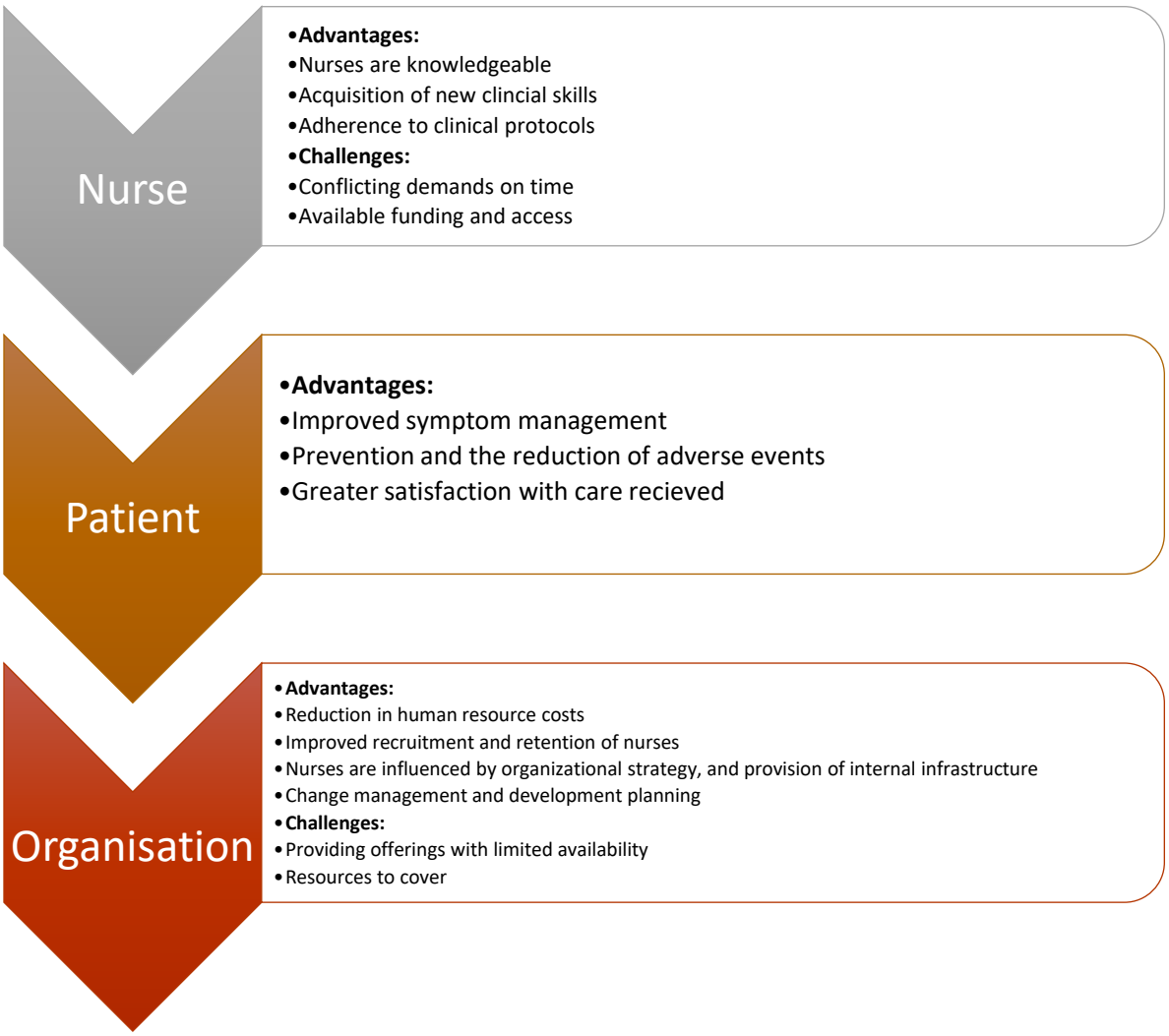
Many factors impact the workplace culture. Developmentally healthcare organizations may be at what Fiandt et al. (2003) terms the "blue" or "orange" level where research shows organizations to be hierarchical, managerial and transactional (Bungay & Stevenson, 2013; Coventry et al., 2015; S. Duncan, Rodney, & Thorne, 2014; Henderson & Fletcher, 2014; Tabari-Khomeiran et al., 2007; Tame, 2013). Though RNs have advanced developmentally with increased skills and knowledge since 2010—and have the capacity to push health systems to higher developmental levels—they work within an environment that does not yield innovation,

professional development or satisfaction (Canadian Nurses Association, 2019; Coventry et al., 2015; Susan Duncan & Rodney, 2015; Fiandt et al., 2003). Other sources described the RN workplace culture as disempowering (André, Sjøvold, Rannestad, & Ringdal, 2014), stagnant and routinized (Scott & Pollock, 2008), disengaged, passive and resource-poor (Henderson & Fletcher, 2014).

Developmental aspects of the healthcare organization and leadership are intersubjectively linked to the experience of RNs within that context. The link is weak and mostly one-way as, administratively, the leadership approach is mostly hierarchical, managerial and transactional (Bungay & Stevenson, 2013; Coventry et al., 2015; S. Duncan et al., 2014; Henderson & Fletcher, 2014; Tabari-Khomeiran et al., 2007; Tame, 2013). RNs on the other hand, have advanced their collective knowledge within their profession and as a community since as of 2010 (Canadian Nurses Association, 2019) when required minimum education for entry to practice transitioned from a two-and-a-half-year diploma to a four-year degree. Developmentally, RNs have achieved higher knowledge; however, with 65% working in clinical hospital settings in Alberta, they live their professional life within the healthcare system and administration that remains the same. Frederic Laloux (2014) describes organizational development using AQAL metatheory as a framework. The same framework applies nicely to this discussion as a poignant means to describe the administrative structure where RNs work. The framework of analysis of this section is based on the work of Laloux, who rigorously applied the principles of integral metatheory to conclude developmental, organizational levels.

Figure 6 below summarizes the advantages and challenges of workplace CPD as “Levels and types of outcomes achieved from organizational investment in nurse CPD” (Bahn, 2007; Brekelmans et al., 2013; Cooper, 2009; Covell, 2009, p. 439).

Figure 6. Organizational Investment in RN CPD



Paradoxical Tensions

In some cases, tensions arise between front-line managers and RNs over the value and contribution of CPD to the workplace. There is actually very little evidence that CPD improves patient care and system improvements and sparse research to support CPD effectiveness (Nolan, Owen, Curran, & Venables, 2000; Wynne, 2015). On the contrary, however, workplace managers place pressure on nurses to learn and maintain continual competence to adapt to and change practice methodologies in rapid health system changes and new developments in clinical practice (Bahn, 2007; Murphy et al., 2006; Nsemo et al., 2013) In these cases, tensions develop

between front-line and upper management to enable CPD. Ensuring that nurses have up-to-date knowledge is an employer imperative; however, cost-prohibitive challenges are perceived by RNs to be unsupportive especially when staffing is not accommodated for, or learning opportunities are not promoted openly (Bahn, 2007; Covell, 2009).

Learning and Professional Culture

Donald Schön (1995) talks about the unique epistemology that institutions and professions hold that contribute valuably to culture and professionalism. Institutional structures and practices build in and infuse knowledge in particular ways and especially in autopoietic systems. What makes it the system autopoietic are the "swampy lowlands" that Schön (1995, p. 28) where the problems are messy and confusing, but of the greatest human concern, compared to the technical, easily solvable problems at the higher levels of organization. The higher level knowledge is more apt to be derived from a theoretical or research-based premise that provide structure to their knowledge base, but the knowledge formed in the lowlands is formed in real-time with reflective practice in action. Reflective practice in action is not the consciousness of looking back or looking forward on one's practice, rather it means reflecting in-situ when changes can be made to alter outcomes of critical situations (Schön, 1995). Ways of knowing in situations of uniqueness, complexity, uncertainty or conflict lends to a different conception of competence versus simpler views of application of theory to practice. In the former, there is knowledge in action—tacit knowledge. The epistemological view in this context, is rooted in the theory of inquiry by John Dewey where doubt inherent in complex situations creates inquiry in the reflective practitioner (Schön, 1995).

Schön's (1995) seminal work sheds light on the experiential learning of nurses and suggests the culture of the nursing profession is influenced by and in practice settings. More contemporary work by Cruess, Cruess and Steinhart (2019) discusses medical professional

identity as what graduates “think, act and feel like a physician”. The authors argue that professional identity should be part of core curriculum in medical programs so that professional behaviour “springs from the individual” when in their practice context (Cruess et al., 2019, p. 642). Professional identity combines one’s view of themselves with the view of those proximal to themselves, but heightened by the important feeling of competence. Competence achieved by professional practitioners is rooted in social constructivist learning theory (Cruess et al., 2019). The shared experiences within the communities of practice in the “swampy lowlands” co-creates the knowledge and practice of nursing in action. Professionalism and nursing culture is the mix of navigating organizations, work, teams and the associated epistemology that evolves from these. Learning is inextricably linked to culture.

Upper Right – Objective Ontological Quadrant: Evaluation of Nursing Practice

The Upper Right Integral quadrant of this framework looks at the “most familiar” of research measures as it is the “structure-function” of the topic explored (Wilber, 2010, p. 74). This quadrant covers how RN mandatory professional development is assessed and evaluated from the perspective of regulatory mandated professional learning. The evaluative perspective reflects the actual behaviour or enactment of the mandated learning and known outcomes. RNs who experience mandatory professional learning implementation also experience formal, informal and self-assessment.

Formal Assessment

Registered nurses are assessed by CARNA to ensure they have met requirements for annual continuing competence learning. RNs must complete annual renewal requirements before registration, or the automatic registration system will block the process. Even once the appropriate sections are completed, random audits occur where member profiles are randomly selected and examined to ensure the recorded learning objectives are relevant, that learning

activities are completed and that the practice reflection shows how learning has influenced practice. (College and Association of Registered Nurses of Alberta, 2013b, p. 33). A committee of volunteer Alberta RNs reviews random audit selections to determine that the competency has been met or that remedial action must occur. Remediation may include attending an education session, receiving a consultation with a Continuing Competence Consultant, revising the learning plan, submitting an employer reference, and/or completion of remedial courses (College and Association of Registered Nurses of Alberta, 2013b, p. 35). Employers are participants in the practice reflection as they are often referees and are often reporting aspects of the RN performance review to CARNA. “Your manager/employer does/should assess your practice as part of your performance review and provide opportunities for learning, such as in-services on new technologies, medications, best practices, and new policies and procedures, etc.” (College and Association of Registered Nurses of Alberta, 2013b, p. 98).

Conduct

The CARNA standards are "an authoritative statement that describes the required behaviour of every nurse and is used to evaluate individual performance" (College and Association of Registered Nurses of Alberta, 2011, p. 11). Though RNs are authorized to practice in a variety of settings performing a variety of restricted activities under the Nursing Scope of Practice (College and Association of Registered Nurses of Alberta, 2011), all RNs are expected to perform their nursing duties according to CARNA standards and guidelines. CARNA Conduct will review reported unprofessional practice if nursing practice falls outside of these standards and guidelines. "Unprofessional practice" is interpreted from the Health Professions Act and described in the Practice Standards document (College and Association of Registered Nurses of Alberta, 2013c, p. 14). Once the complaint is determined viable, the complaints process encourages resolution outside of the complaints process but may progress to

a hearing tribunal, further investigation or a committee conduct review (College and Association of Registered Nurses of Alberta, 2016a). Assessment of RN behaviour occurs should the complaint of unprofessional conduct escalate to a hearing tribunal. If found unprofessional, appropriate remediation is determined. Results from hearing tribunals are required to be published in "Alberta RN," the CARNA publication.

Self-Assessment

Part of the system of annual registration is the self-assessment section following the continuing competence recording activities. Self-assessment is guided reflection and involves articulating the influence of learning on actual nursing practice. Self-assessment asks whether you have met your learning objectives, achieved professional or personal growth, and how did the learning impact your practice. At this time, you may evaluate that you did not meet your learning objective and will then create a new plan for the following practice year (College and Association of Registered Nurses of Alberta, 2016g).

Lower Right – Interobjective Ontological Quadrant: Regulator Role in CPD

Regulators influence the behaviour and attitude of RNs in participating and applying CPD in their practice. The Lower Right Quadrant of Wilber's Four-Quadrant ontological framework is the interobjective view of mandated CPD in terms of “The nested, overlapping, and interlacing systems that may include us, but that most often transcend us” (B. Davis, 2019, p. 8). For example, regulators wrap safety and ethics into the notion of competence, and therefore CPD is an expectation to show their accountability to these factors. The expectation of RNs is for CPD to be transformational as required by the Continuing Competence Program so that RNs learn to apply new knowledge and adjust their practice. The following section reveals the discourse around the concept of nursing competence from a global perspective and the argument of its validity, reliability and necessity as an assessment method of transformational nursing practice.

Nursing Regulation for Recognition and Public Protection

Education and nursing practice to capacity is the paradox of the healthcare 'system' because regulators and healthcare organizations both work toward improved healthcare and patient safety, however, seemingly work apart from each other. Research by Bungay & Stevenson (2013) is of nurse leaders' experience of mandated professional development learning implementation in a Sexual Health Clinic in British Columbia, Canada. This particular research is especially relevant to the Alberta context and helps to shed some light on the complexities and paradoxes of mandated professional learning influences. The Bungay & Stevenson (2013) research highlights the benefits of nursing regulation to healthcare organizations where regulation "enabled public and legal recognition of nursing's autonomy in sexual health care while also establishing a normative, evidence-based standard for sexual health nursing practice throughout the province" (Bungay & Stevenson, 2013, p. 72). This importance of regulation to healthcare organizations is recognized in other research (Garrett & MacPhee, 2014; Hadley, 1995; Libner, 2016). The challenges highlighted by Bungay & Stevenson (2013) are echoed in other research as to how these challenges influence mandatory CPD (Susan Duncan & Rodney, 2015; Garrett & MacPhee, 2014; Hadley, 1995). The importance and challenges of regulation and CPD are discussed in the following sections.

Competence

Viewed by nursing regulators, the achievement of competence occurs by meeting learning requirements for yearly license renewal. Nursing regulators define the requirements of nursing education, scope-of-practice, and certified (expanded) practice including restricted activities and when changes take place to those elements of nursing practice, RNs are expected to learn and change their practice as necessary. The nursing practice guidelines and standards are the primary methods of communicating these changes and articulation of specific practice

competencies. From there, nurses are expected to read, understand and enact legislative requirements as described in these documents. This legislated requirement is called *jurisprudence* and is a legal obligation of RNs. Workplaces or CARNA commonly offer educational offerings to learn these guidelines and standards in a variety of modalities.

In one study by Tabari-Khomeiran et al. (2007, p. 212), *competence* was defined by the participants as "the abilities individuals possess that enable them to perform their duties and meet other people's expectations." Competence-based learning in nursing is not new and was introduced to harmonize and standardize required knowledge for practice and nationally recognized qualifications (Austin, 2019; Ross et al., 2013). Competence in practice is poorly described overall and loosely defined by regulators and employers. "Frequent" and "applicable" learning are the only standards applied to maintain competency that presents with some obvious difficulty in measuring or reporting (Duff et al., 2014; Ross et al., 2013). As reported by others, competence learning has been viewed as iterative and integrated with nursing work and as such, requires the constant interaction with work and reflection (Beal et al., 2008; Tabari-Khomeiran et al., 2007). The distinction of "competence" versus "competency" is where the former relates to a state of being, while the latter relates to a state of doing or demonstrating (Austin, 2019). Discrete phases of competence were identified as motivation, support and new knowledge, applying to the level of experience and current knowledge, and integration into practice.

Reporting, Audits and Conduct

As described earlier, RNs are evaluated for competency yearly. At this point, RNs self-report their CPD activities with their practice reflection and self-assessment in an online report before their license renewal (College and Association of Registered Nurses of Alberta, 2013b). These online reports are detailed to ensure that the Nursing Practice Standards are appropriately selected and connect to the learning activity. RNs then self-assess whether they have met prior

professional learning goals and helps to define the subsequent year goals. For the most part, this process is fully automated and self-directed for RNs to participate, but the registration process is incomplete without the CPD, reflection and employer referral completed. If the online report system detects a field that is not complete, the license renewal will not progress, and re-licensing is at risk.

Conduct is the last resort of suspected unsafe, incompetent and unethical practice. Formal investigations, reviews, interviews, and hearing attendance highlight the activities that may have to take place when there are serious practice concerns (College and Association of Registered Nurses of Alberta, 2013b). Conduct is the final step in nursing practice evaluation, and though it resonates as mostly punitive, the purpose is to take an in-depth look at individuals' matter and help to remediate as best as possible.

CARNA Assessment of Registrants' CPD

CARNA directs RNs to practice and report CPD is specific ways to be and "show" compliance to the regulations and HPA. The online report, called "MyCCP," was described briefly in Chapter One as the guide and data collection tool for the Continuing Competence program at CARNA. Though this tool collects yearly reports from every RN in Alberta, the data is not collated, nor analyzed. The CARNA Continuing Competence Program states explicitly that "The only time we review the details that have been entered into MyCCP is when a member reports that their record is incomplete but has held a permit and practiced during the year or to do a follow up with a member who was previously reviewed" (College and Association of Registered Nurses of Alberta, 2013b).

Continuing Competence Challenges in Regulation

Continuing competence programs exist in nursing regulatory systems across the world. Research on these programs are critical of the efficacy of such programs and whether they are

meaningful to the mandate of public protection (Vernon, Chiarella, & Papps, 2011; Vernon, Chiarella, Papps, & Dignam, 2013). Vernon et al. (2011) described the tensions and responsibilities between nurses, employers and regulators and the lack of understanding and precise interpretation of competent practice. Besides the lack of clarity, there are no *clear* correlations between professional development and improved patient care seen in the literature (James & Francis, 2011) and efforts are nurse-centric instead of patient-focused or team-based learning (Dobson & Hess, 2010). Many topic areas available for RN professional development are not crucial to the issues of the time (Nsemo et al., 2013) and cannot be considered a guarantee of safe, competent and ethical nursing care (Vernon et al., 2013). Reconceptualization of continuing competence is being explored in nursing regulation globally (Motluk, 2019).

Workplace-Regulator Disconnection

In the study by Bungay and Stevenson (2013), 16 nursing leaders described the process of mandatory professional development as resource-intensive, lengthy and "frustrating" (Bungay & Stevenson, 2013, p. 72). The frustration for these leaders was due to the limited information provided by the provincial regulator about the specifics of nursing practice that would be “allowed” and which of those could be practiced independently and those that could be practiced collaboratively. Poor information sharing and collaboration in policy implementation is seen in other research: “Where the regulatory and professional pillars are decoupled, such as has occurred in some Canadian provinces (S. Duncan et al., 2014), we see particular challenges” (S. Duncan et al., 2014, p. 628; Susan Duncan & Rodney, 2015).

The Health System Paradox

The ideals and standards that are clearly articulated by the International Council of Nurses, the World Health Organization, and Nursing regulatory bodies, Boards of Nursing and Nursing Associations globally are situated within a paradoxical health system. Difficulties to

optimally perform within the nursing profession are met with power differentials in health care teams, particularly between registered nurses and physicians. Traditionally, nurses have always provided patient care assessments and conducted interventions as determined by medical determinations (Scott & Pollock, 2008). To this present day, these medical determinations are called “Doctor’s Orders.” What separates but contributes significantly to patient care is the contribution to medical science by providing the unique and holistic interpretation of patient “as a contextual being inseparable from his or her life circumstances” (Grace & Robinson, 2013, p. 30). Thus, nurses contribute the important lifeworld they share with patients with an understanding of the scientific aspects of the medical approach but also the individual responses to illness and related needs (Goodman, 2014). These contributions require communication, respect and autonomy in workplace teams.

Further team dynamics are complicated by other echelons of nursing practice, which include Licensed Practical Nurses and unlicensed healthcare aids. More frequently, RNs are expected to lead these nursing teams and take on charge nurse roles with particular administrative duties such as processing paperwork, managing human resources, and assuming accountability of all the patients on the unit. These two additional team dynamics create tension between the nursing types and frequently concerns for patient safety, protection of scope of practice and stressful responsibilities cause workplace incivility (S. Duncan et al., 2014).

Regulation and Effects on Employer Organizations

Part of the paradox of the healthcare ‘system' are the organizations that work toward common goals to improve health and patient safety seemingly work apart from each other and yet significantly impact each other. Research by Bungay and Stevenson (2013) of nurse leaders' experience in British Columbia, Canada looks at this paradox, and the layers of complexity each

must work within. This research points to the interrelationship of regulatory bodies and healthcare organizations.

In the study by Bungay and Stevenson (2013), 16 nursing leaders described the benefits of nursing registration to be beneficial because it "enabled public and legal recognition of nursing's autonomy in sexual health care while also establishing a normative, evidence-based standard for sexual health nursing practice throughout the province" (Bungay & Stevenson, 2013, p. 72). The difficulties expressed by these leaders were broken into two categories: a) preparing for certified practice and b) the certification process. The preparation for certified practice was a 5-year, resource-intensive and "frustrating" process (Bungay & Stevenson, 2013, p. 72). The issue of regulation relates to the amount of regulation needed, as healthcare is often regarded as "excessively regulated" (Saver, 2010, p. 6). The problem of over-regulation is that employers and organizations are stunted in their ability to take their own steps in their business of delivering health care services. Saver (2010) recommends that regulation should be well-designed to allow employer innovation and minimize the unintended effects. Previous views that regulators should maintain distance from individuals and employers to avoid conflict of interest are now antiquated (Saver, 2010).

In addition to the expanded scope and newly defined practice changes for RNs, organizations and leaders were simultaneously working with changes made to Licensed Practical Nurses and Nurse Practitioners. Nursing practice was broken down into layers of specific interventions and specialty areas of practice based on certifying processes with corresponding education requirements and levels of formal post-secondary education and corresponding designations. Each of these designations is associated with different regulatory bodies (Garrett & MacPhee, 2014). The impact of new regulations of professions not only impact beside nursing care, but also physicians who collaborated closely with nurses to enact patient care, pharmacy

services, laboratories, and other services related to diagnosis and treatment. Nursing leaders have to work with the complexity of nurses changing regulation at the individual nursing level but also on the broader system to ensure all aspects work together (Garrett & MacPhee, 2014). Coordinated approaches led by the Canadian Nurses Association to streamline and clarify regulation across nursing professions has taken place (Garrett & MacPhee, 2014).

Nursing Unionization

Following the Second World War, Canadian nurses began to work in hospital settings instead of private duty. Hospital training became predominant as was retention of their trainees to work on the wards as general duty staff nurses to provide bedside care. Postwar working conditions were poor. Nurses worked under very demanding 12-hour shifts daily, but due to shortages, hospital administration could not accommodate fewer hours of nursing work. Lack of salary standardization, demanding responsibilities, and long hours, combined with non-nursing work such as housekeeping added to growing discontent. Despite these conditions and the inadequate acknowledgment of nursing contribution nurses initially regarded collective bargaining that's unethical. They felt the paradox of the nursing tradition to care and dedicate themselves versus the demands being made for better conditions. As such the Canadian nursing association was not in favour of nursing unionization and a statement in 1946 declared a resolution that's supposed "any nurse going on strike at any time for any cause" (Richardson, 2005, p. 215). It was not until 1967 that a single bargaining unit with one collective agreement was formed in BC out of the registered nurses Association British Columbia. Many benefits came out of this arrangement, including better working conditions, better salaries reduced workweek and an end to discrimination in hiring practices. In spite of these benefits enjoyed by nurses and BC, Alberta nurses continued to work with employers in semi-successful joint agreements until 1977 when the United Nurses of Alberta (UNA) was formed to negotiate

collective agreements that "regulate salaries, benefits, schedules and working conditions of members" (United Nurses of Alberta, 2016, p. n.p.). In the present time, collective agreements continue to be salary focused (since 1977, nursing wages have quintupled), but negotiations also greatly influence patient care issues, and other conditions of employment (Richardson, 2005). For example, UNA works to resolve member disputes with employers and champions workplace rights. The union may also represent members before Labour Relations Board hearings, professional bodies' disciplinary meetings and other quasi-judicial groups (United Nurses of Alberta, 2016).

The impact of UNA in Alberta. The United Nurses of Alberta is a significant force both within the nursing workplace but in government policy, support of unions outside of nursing and in influencing education. Significant power has been demonstrated to impact government decisions, and several incidences of strikes or other actions of defiance such as work-to-rule have been advocated and facilitated by UNA, sometimes resulting in serious legal consequences. Well beyond workplace conditions and salary negotiations and benefits, UNA takes positions on matters such as nursing education program changes, nursing research, and develops education sessions for nurses. They have also been involved in the prevention of healthcare privatization, Licensed Practical Nurse scope changes and many other examples of societal and healthcare matters (United Nurses of Alberta, 2018). Some UNA interests align with CARNA, and others align with the employer and are acted upon jointly, however, some positions taken are in opposition. For the most part, UNA and CARNA work separately and each with their impact on nurses and the employer, though UNA has a significant impact ethnographically in the RN workplace because of how it works to set conditions of employment.

Nursing Regulation as a Complex System

Complexity

The lower quadrants of Ken Wilber's Integral Methodological Pluralism framework is a lens from the Lower Left “we” to the Lower Right “its.” These ontological quadrants look at the “situated, distributed, shared, embedded, nested, systemic, and ecosystemic aspects” of the phenomenon (B. Davis, 2019, p. 8). Nursing regulation fits in the Lower Right interobjective quadrant as it is a complex system. B. Davis (2019) asks if a system can be modelled, and "governing rules discerned," which is a relevant question to understand CPD as experienced and practiced by nurses as they are situated within regulation governing CPD. Complexity theory is applied here to frame the inquiry of how mandatory learning is determined and known from a policy systems perspective. This quadrant ontological lens contributed to the knowledge of how groups and individuals make sense of their experience (Bohac Clarke, 2019b). Complexity theory is presented in this section to set the stage of policy analysis.

Complexity theory. Complexity theory has been applied in healthcare to examine the interactions of agents or elements within the system, particularly in subsystems such an intensive care area (Kannampallil, Schauer, Cohen, & Patel, 2011). Kannampallil et al. (2011, p. 944) define complexity as “the interrelatedness of components of a system.” Kowch (2013) defined complex adaptive systems as systems of people who interact in an environment. This system consists of many agents with unique behaviour according to its local interaction. A complex adaptive organization is an "open system" of interaction between large numbers of people and institutions (Kowch, 2013, p. 163). Specifically, complexity theory describes the behaviours and interactions between people (agents) linked together by relationships. As simple as it sounds, the mapped network describes powerful and intricate patterns of influence, system capability and capacity and many other descriptive qualities of the system. Kowch applied complexity theory to school leadership to study the characteristics of a complex adaptive system that is "constantly changing, community-minded, value-based social systems" (Kowch, 2013, p. 165). The qualities

of a complex adaptive system encompass organizations that consist of autonomous groups with interconnected people (agents as they are known) who share influence and information in unstable (ever-changing) environments. These networks may be mapped according to social networks or policy networks. Using Kowch's (2013) four categories of leader network characteristics, this study frames nursing regulated mandatory learning in Alberta.

Relations

These are the relationship ties defined between CARNA and other influencers or agents. These relations may have characteristics that are bureaucratic, knowledge exchange, personal support or technical/process-oriented. Each of the relationship ties may also be strong or weak, reciprocated or not, and ties may constantly be changing as individuals move to different positions or groups change. Relations relative to CARNA include the lines to members, national nursing associations, nursing school programs, government, public, nursing employers and nursing unions. In the context of mandatory CPD, relations to members are strong, but distant one-way lines because of the nature of the obligation of members to comply with legislation. Figure 7 depicts an outline of a simplistic version of complexity mapping.

Structural Features and Patterns

This category describes the qualities of the actual mapped network structure. There are three main structural features of the mapped network. The first is "centrality," that describes the degree to which organizations are organized around any one node to form a dyad and the distance between dyads. For example, one node may have several close ties that form a dyad, that have long-distance connections to other dyads. This example could apply to one leader of CARNA with close reporting structures, such as a team of consultants and admin support. When this team is closely related to long-distance, weak ties to other dyads (or departments, perhaps), it is weakened due to its vulnerability to change. Strong centrality is loosely dispersed and has

strong ‘betweenness' to other dyads. That said, high centrality clusters are frequently regarded as information hubs. The density of a dyad is the number of ties existing compared to the total possible number of ties. Betweenness, as mentioned earlier, is the measure of two-way ties around the central node. Clusters describe smaller subsystems within the network that can stop information flow.

Capacity

The ability of the network to organize itself and accomplish work, make decisions and create policy. Capacity can be characterized by the ability to manage complex tasks, generate answers to new problems, rise above self-interest, and is cohesive within the network. Generally, there are clear concepts of roles, values, ethics, and the ability to generate new information (Kowch, 2013). Capability is the ability to accomplish tasks resulting from an interplay and the ability to adapt. The degree of capability describes the capacity in that the system may change and adapt to those changes quickly. Some systems could fall apart if someone leaves the system making is poorly adaptive.

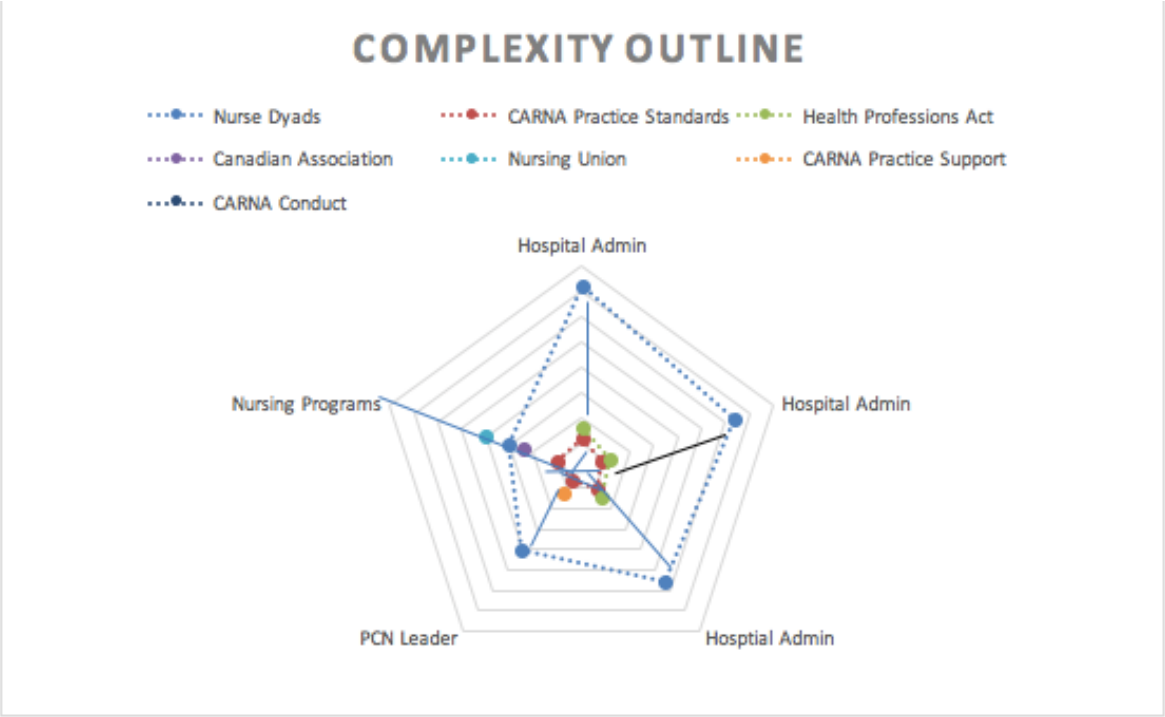
Network Dynamics

Six qualities describe the network dynamics to include the nature of types of relations, changes in actors, resonances, attractors, and the capacity to organize interests and do work. In general, these qualities describe the intensity of relations and in terms of the “system centrality, density and clusters” (Kowch, 2013, p. 170). Attractors are very important to this research as they are the motivated actors within the system that amplify innovation and engage leaders or agents to change. “Attractors could also be critical pieces of information for designing robust leaders networks and studying shifts in emergence levels…” (Kowch, 2013, p. 170). Attractors in this study may be front-line leaders who "allow new behaviours to emerge" (Chaffee & Mcneill, 2007, p. 233).

The College and Association of Registered Nurses of Alberta exist within the healthcare ecosystem as a complex adaptive system. As an even smaller cluster within this ecosystem is the mandatory learning program called the Continuing Competence Program in CARNA. As seemingly small this program is with only three administrative individuals and a committee, it has a staggering reach that can only be depicted as single lines of connectors in Figure 7 because if drawn out, this map would not be readable. Hence it is only an outline and only a sketch of interactions as determined by available research and website information. The interconnecting lines of mandatory requirements of the program impact every registered nurse of the 37,000 membership in Alberta and have lines to government, other nursing associations and regulators, and nursing education programs. Learning requirements as determined by evidence and practice reflection are also determined by the two-way connections between government, health interest groups and research such as patient safety and internal CARNA departments such as Conduct and Practice Support. The lines to RNs are one-way distal lines for the most part, and interestingly, there are no direct lines to RN workplace organizations or nursing unions and the lines connecting RN dyads are dotted lines only. The strengths as seen in this map are the tight clusters around RNs within their dyad (only depicted as a single blue dot in the map) and the interconnections between nurse dyads albeit dotted lines only. These show themselves as knowledge hubs with betweenness that increases capacity and adaptability. CARNA as an organization also shows similar qualities as an embedded cluster but is tightly associated where risks may be assumed in terms of capacity and adaptability, but close associations to policy and legislation make CARNA a vital knowledge hub. Of significance to the analysis depicted in the sketch is the lack of lines to the organizations who could be considered the attractors or agents of change. The most significant weakness to the adaptability of the complex adaptive system is the

lack of connections because the goal of nursing CPD is to increase the knowledge and adaptability of registered nurses.

Figure 7. Outline of CARNA Network Map



Review of Quadrant Findings

The Lower Right Quadrant of Wilber's Four-Quadrant framework concerns the intersubjective network view. As such, the College and Association of Registered Nurses of Alberta (CARNA) exist within the healthcare ecosystem as a complex adaptive system. Complexity theory and network mapping are useful to view the strengths and weaknesses of the network system. CARNA, a relatively small corporate, board-led organization, has incredible accountability to assure the public of safe, competent and ethical nursing care. A network diagram illustrates the complex adaptive system showing strengths in knowledge hubs but vulnerabilities to poorly adapt the 38,000 members as nested within the complex interactions with organizations, government, media and others. Of significance to the analysis, is the lack of lines to the organizations who could be considered the important attractors or agents of change.

Weak lines to organizations negatively impact the adaptability of the complex adaptive system because the reach of change agents to nurses is lessened. Thus, the goal of nursing CPD to increase the adaptability in practice depends on the adaptive nature of the system.

Considering the long, distal associations between CARNA and RNs, along with the dotted, segmental lines between RN clusters, evaluation of RN behaviour in CPD is of particular interest. Data of RN behaviour relevant to their yearly reported mandatory CPD should show nurses performing safe, competent and ethical nursing care. CARNA may be more assured of fulfilling its mandate with gaining clarity and understanding of RN CPD.

The Upper Left ontological quadrant guided the literature review of the RN experience in mandated professional learning to better understand the influences. Though there were no phenomenological studies of Alberta RNs to draw from, what we can see from this review from a global view is that RNs are generally motivated, ethical and self-directed in their learning. They are also highly motivated and self-directed in their learning, so there are debates as to whether mandatory status is necessary. The RN preference for experiential and on-site learning is a good indication that they value learning with direct application to practice. This applied learning is critical to ensure that RNs are current in their practice in these rapidly changing health care systems.

The Lower Left Quadrant of the Integral ontological framework looks ethnographically at the workplace of RNs. The particular interest in this research study is the look at tertiary care centres where RN clusters are embedded within a very large dyad and so on. Managerial, hierarchical cultures still exist and constraining budgets, shortages and good intentions create workplace tensions. A vicious cycle of demands and constraints risk patient care and well-being of RNs.

Significant publications from organizations such as Sigma Theta Tau International have acknowledged the importance of leadership influence at the bedside but recognizing the organizational barriers to that end (Dobbins, 2011; Erickson, Jones, & Ditomassi, 2013). Erickson (2015, p. 2) discussed the notions of developing "environments of care" or the "professional practice environment" whereby the practice environment that is responsive to nurses' needs is characterized as caring, respectful and safe. These characteristics were deemed crucial to the nurse-parent relationship and promoting integrity. The professional practice environment is mentioned frequently in the literature that refers to the organizational culture of health professionals' unity and organizational alignment. The foundation of such an environment fosters collaborative decision-making and active participation in change. The role of the "chief nurse" is to facilitate and foster the environment that promotes nurse job satisfaction and nourishes the nurse-patient relationship (Erickson et al., 2013, p. 4). Further, specific organizational characteristics (measurable by a validated PPE survey instrument) of a professional practice environment include the following:

- Autonomy,
- RN-MD relations,
- Control Over Practice,
- Communication,
- Teamwork,
- Conflict Management,
- Internal Work Motivation,
- Cultural Sensitivity. (Erickson et al., 2013, p. 5)

Chapter Summary

Six key findings of this literature review are relevant to inform this research. The first, is that RNs value continuing professional development for many reasons including the expansion of scope of practice that increases patient access to valuable expertise and health service. Relevant learning activities better prepare nurses for patient care as these activities respond to the rapid changes in healthcare and related technology, structures, and delivery. The second key finding is that significant challenges are experienced by employers and organizations to enable and allow access to CPD for RNs. Some of these challenges are high workloads, financial constraints, nursing shortages, and inadequate support and communication. Many RNs seek CPD on their own time for these reasons and experience the financial and time burdens in their personal lives. The third key finding is the cynical view, and "blame" nurses express toward employers and organizations for their challenges in CPD. The research showed harsh judgements of leaders; for example, leaders who want to keep RNs undereducated to maintain their advantage in their leadership role. The fourth key finding is that an encouraging workplace culture can be achieved when obstacles to learning are removed, and CPD is encouraged openly. In particular, a balance between nursing work and integrated learning in the workplace is highly encouraging and valued by RNs. The fifth key finding is the paradox of leadership who value and desire opportunities for RN CPD but have difficulty navigating the systemic challenges and are subsequently faced with workplace tensions. These leaders are caught between complex bureaucracy and the need/desire for access to CPD. Finally the sixth key finding is the external placement but significant impact of nursing unions. In Alberta, the nursing union is the United Nurses of Alberta (UNA), and they have a role in many facets of the RN working life, and most certainly, they have an impact on healthcare organizations. Overall, CPD adds complexity for RN leaders and for CARNA, whose mandate it is to protect the public. Ultimately the vicious

cycle of high learning needs but low capacity to enable learning impacts patient care negatively (Bungay & Stevenson 2013).

Chapter 3: Methodology

This chapter presents Integral Methodological Pluralism (IMP) as located within the framework of ontological perspectives of the Integral model AQAL, which was used as the conceptual framework underpinning the design of this research study. Methodological pluralism was used to investigate the research problem from the four primordial ontological perspectives on the phenomenon, regulator mandated CPD implementation by nurses in their contexts. As such, the four ontological quadrants shed light on the interior experiences or the "I" of the nurses in the Upper Left Subjective quadrant; the interior collective sense-making within the organization in the Lower Left Intersubjective quadrant; the external behavioral observation of nurses' compliance in the Upper Right Objective quadrant; and the exterior collective context of policy systems in the Lower Right Interobjective quadrant. All four perspectives combine to provide comprehensive meaning to the reality of the phenomenon of the mandated learning compliance and reporting of nurses in their contexts (B. Davis, 2019). For the purposes of a research project, the four quadrants of the Integral model can be understood in the context of Kuhn's paradigms and methodological exemplars (Bohac Clarke, 2019a; Kuhn, 1978; Wray, 2011). This chapter explains these paradigms and specifics of the methodology in each quadrant, along with details of participants, data collection and their limitations.

AQAL Metatheory

Due to the complexity of the problem in this research, Ken Wilber's (Wilber, 2005) Integral Methodological Pluralism approach best achieved understanding of the influences of nurses' mandatory professional learning. (Shea & Frisch, 2015). The philosophical underpinnings of Integral theory in this research allowed examination of the research problem through "a multi-theoretical and integral approach" (Divecha, 2019, p. 35). Thus, while this study is not committed to one system of philosophy, epistemological beliefs of knowledge are

drawn from a variety of tools of research derived from both objective and subjective evidence. Integral theory "sets out a core focus on valuing both subjective and objective perspectives"(Divecha, 2019, p. 35).This approach was derived from Wilber's work in Integral metatheory, or AQAL, a "meta-framework"(B. Davis, 2019; Shea & Frisch, 2015, p. 2). As part of the methodological approach of AQAL (All Quadrants, All Levels, All lines, All states, All Types, and All Lines of Development), this meta-framework describes Four Quadrants of irreducible ontological and epistemological perspectives unique to each quadrant (Bohac Clarke, 2019a; Wilber, 2005). The four ontological quadrants organize multiple, yet separate philosophical and theoretical perspectives, so the arrangement applied to any context or problem allows linking of these perspectives. Though this framework enables study beyond the Four Quadrants to levels, lines, states, types and development, the focus of this research was limited to the Four Quadrant perspectives, given otherwise, the magnitude of work by one researcher. The researcher is nevertheless aware of the possibilities of further analysis of the data, using the other four components of AQAL in a subsequent analysis beyond the confines of this thesis (Bohac Clarke, 2019a). Despite this limitation, AQAL provided the opportunity to look at the phenomenon of study from four distinct views out of the eight primordial perspectives arising from the four quadrants (Wilber, 2005).

Wilber's Integral Four ontological quadrants and methodological exemplars

The purpose of this study was to respond to the research problem of influences of regulator mandated CPD implementation of nurses in a tertiary care hospital context, through an exploration of the experiences of Alberta registered nurses (RN) and administrators. In application, the pluralistic methodology implies four research paradigms: in the Upper Left Subjective paradigm following the phenomenological methodology exemplar; in the Lower Left, Intersubjective paradigm the ethnographic methodological exemplar is followed; in the Upper

Right Objective paradigm objective and measurable behavioural observations are used; and in the Lower Right, Interobjective paradigm, a policy analysis is used following a systems approach exemplar. Ken Wilber's Four Quadrant framework guides research, and as illustrated below in Figure 8, multiple methods are shown in each quadrant that follow each of the paradigms and exemplars of the quadrants.

Figure 8. Wilber's Four Quadrants Theoretical Views

Upper Left Quadrant SUBJECTIVE Subjectivist (Ontology) Self-reflective Epistemology Registered Nurses-First person point of view	Upper Right Quadrant OBJECTIVE Objectivist (Ontology) Empiricism (Epistemology) Behavioural or measurable observations The behaviours of nurses completing their MyCPP reports as observed from third-person point of view
Lower Left Quadrant INTERSUBJECTIVE Intersubjective/Relativistic (Ontology) Social Constructivism (Epistemology) Administrator second-person point of view	Lower Right Quadrant INTEROBJECTIVE Complex systems (Ontology) Critical analysis (epistemology) Regulator-third-person point of view

Because the quadrants contain “four fundamental perspectives that can be taken on any phenomena” (Esbjorn-Hargens, 2010, p. 39), methodologically, the Integral framework ensures no world view is omitted or neglected. The Integral ontology, as a “perspectival tool” ensures

that each world views or ontology is clearly delineated and aligned with its corresponding epistemology and methodologies in a logical through-line, which creates a clear audit trail (Bohac Clarke, 2019b; B. Davis, 2019). To achieve the clear and holistic view of mandatory CPD, each quadrant was initially investigated as self-contained as previously described.

The Upper Left quadrant of Wilber's framework entails a subjective perspective where reality is constructed by the individual through their lived experience or "their idiosyncratic truths from a unique pool of experience" (B. Davis, 2019, p. 5). Thus, an individual's subjective reality, though experienced in a socially-constructed world, is evidence of unique ways of being in the world. Phenomenology is the research approach that best draws data in consideration of this worldview.

The lower left quadrant of Wilber's framework is intersubjective as it is drawn from participation between researcher and communities or individuals in an effort to negotiate common agreement on a shared meaning of what is true and real. (Creswell, 2013). These negotiations entail power struggles, and critical theory is one of the theoretical frameworks that is used to investigate the power negotiations and to advocate for social transformation (Bohac Clarke, 2019a). In this approach, there are multiple ways of knowing that make use of methodological approaches where collaborative processes highlight issues and concerns. An ethnographic methodology is one of the exemplar methodologies for this quadrant.

The right Upper and Lower right quadrants are both objective. The Upper Right has a positivist orientation, while the Lower Right endeavours to understand complex social, artificial (E.g., data) and natural systems (B. Davis, 2019). In terms of methodological approaches, the goals of the right upper and lower quadrants analysis differ-the former tends to be reductionist while the latter uses complexity theory as analytical guide (Bohac Clarke, 2019a). Explanation of each of these theoretical frameworks is detailed in subsequent sections.

Finally, Integral Methodological Pluralism "includes the most time-honored methodologies, and meta-paradigmatic in that it weaves them together by way of three integrative principles: nonexclusion, unfoldment, and enactment" (Rentschler, 2006, p. 15). As each quadrant is studied separately, "A clear view of what the problem looks like from each perspective should first be obtained …Eventually the researchers end up with themes in all four quadrants, which address the research questions posed in each quadrant" (Bohac Clarke, 2019b, p. 57). The Integral model then shows the quadrant themes together making it obvious how the themes interact with each other. This "quadrants talking together", or the "transdisciplinary phenomenon", reveals insights otherwise possibly missed as the quadrant themes act upon each other (Bohac Clarke, 2019b, p. 57). Integral theory is illuminating and useful then, because instead of reducing one quadrant to another, each quadrant is understood as "simultaneously arising" (Esbjorn-Hargens, 2010, p. 37). This study demonstrates the careful examination within each quadrant, then the unfoldment and "tetra-arise" of themes.

Rationale

The value of the integral methodological pluralism approach is clear identification of the multiple perspectives where each provides distinct information on the problem. A study of one quadrant contributed significantly to this research on Nurses' CPD, but each still only partial reality. The four quadrants taken together are holistic (Wilber, 2005). "Again, the quadrants are simply the inside and the outside of the individual and the collective, and the point is that all four quadrants need to be included if we want to be as integral as possible" (Wilber, 2005, p. 33). Wilber's metatheory honours each perspective and each of their contributions but while recognizing the limitations and boundaries (Gunnlaugson, 2005). The term "integral" means balance and the four quadrants ensure emphasis on the four perspectives, thereby methodological pluralism ensures integration of the right objectivity with the left subjectivity (Helfrich, 2012).

"By questioning the limiting "exclusivity claims" (Wilber, 2003a) of each perspective that resists or opposes a greater integration, we no longer need to exclude other truths or hold all views as equally true" (Gunnlaugson, 2005, p. 339). This Four Quadrant framework guided theoretical perspectives of the research problem and therefore the methodological approaches toward a comprehensive understanding of the influences on nursing mandatory CPD in their work contexts.

Exemplar methodologies of this research and scope

Ken Wilber's four-quadrant framework shows how any phenomenon may be viewed from an interior and exterior and individual or collective perspectives, and each of the quadrants is associated with appropriate traditions of inquiry. The exemplar methodologies in this study are shown in (Figure 9).

Figure 9. Wilber's Four Quadrant Framework

	Interior	Exterior
Individual	Upper Left Quadrant SUBJECTIVE (phenomenological) What "I" experience	Upper Right Quadrant OBJECTIVE (Quantitative) Behavioral observations or, "what he or she does"
Collective	Lower Left Quadrant INTERSUBJECTIVE (ethnographic) The collective "we" experience	Lower Right Quadrant INTEROBJECTIVE (complexity theory) The social exterior or structures. "What they do"

The upper left quadrant is the subjective knowing of intentional; the upper right quadrant is the objective sensing of the behavioural, the lower left quadrant is the intersubjective

understanding of the cultural, and lower right quadrant is the inter-objective observation of the social system (N. T. Davis & Callihan, 2013). The following section explores each of the traditions shown in Figure 9.

The methodological pluralism approach, with the framework of multiple ontologies has been widely critiqued and criticized. One of the likely reasons is the AQAL theory stems from a non-academic inclusion development (Bohac Clarke, 2019b). The non-inclusion of academic institutions have led to a grudging acceptance of the model. Another problem with AQAL is the inherent expansiveness to the notion of it being a "theory of everything". Research methodologies are daunting, especially for one student researcher when multiple methods are applied, though must be very separate from each other in the research design. As such, AQAL must very practically be approached in teams or stages to fully access the entirety of what it offers. Though, to that point B. Davis (2019, p. 3) argues, "…the intention is not to collect all possible phenomena and perspectives into a single box. Rather, the model is better considered as a framework to juxtapose current strategies of looking at a phenomenon." Though Integral research is still gaining momentum in academia, research applications to date are showing rigorous and holistic results in multiple contexts (Bohac Clarke, 2019a).

Right Lower Quadrant: Policy Systems Analysis

The Lower Right Quadrant of Wilber's AQAL framework focuses on the interobjective systems, such as social systems and their structures or artifacts (Bohac Clarke, 2019a). In this research, I sought to understand the influences of policy structures that directs nurses in terms of requirements for CPD. Policy analysis of the CARNA Continuing Competence Program was the focus in this segment of study. This section explains the policy systems analysis from a critical analysis point of view using a systems framework. Critical policy analysis is differentiated from critical *discourse* policy analysis as, in the latter, there is more emphasis on language and

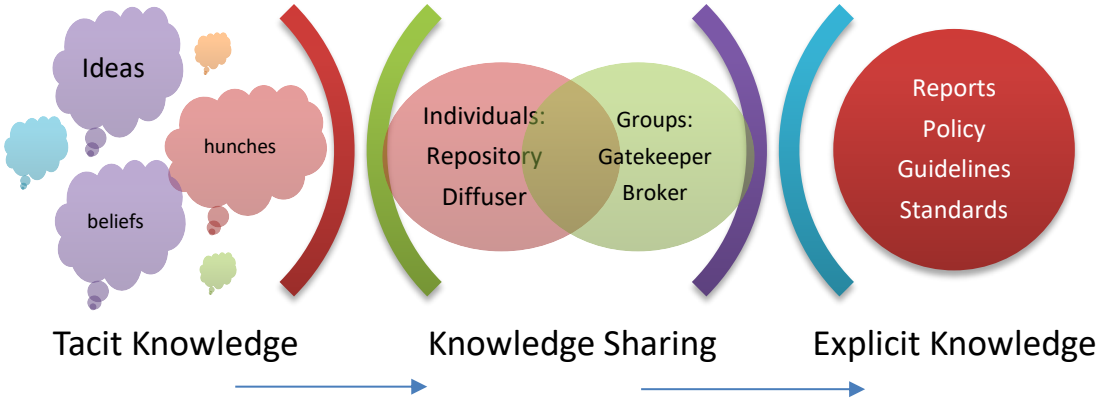
communication. “The systems framework, focusing on empirically investigating how policy is interpreted as it interacts with other systems, provides a means to critically evaluate the policy in context and to pinpoint any unexpected (and unwanted) effects” (Caffrey & Munro, 2017, p. 474). Cheek & Gibson (1997) refer to Foucault (1980) in terms of analysis of the social body—nursing in this case—is understood in multiple aspects at any one time. Foucault (1980) discusses the social body as a consisting of discourses, institutions architectural forms, regulatory decisions, laws and other aspects that should not be dismissed in policy development and implementation in nursing (Cheek & Gibson, 1997). This framework and approach are the exemplar for this research given the complexity of nursing contexts in relation to the flow of regulatory knowledge and discourse to policy and rules of compliance. Regulatory policy holds significant authority and influence on the nursing profession, and to note, potentially under or overserving the profession. For example, tight control over the profession tends to mean that some behaviours are restricted that does not require it, where the opposite is true for under-restrictive regulation where that which should be controlled is not. (Baldwin, Cave, & Lodge, 2012). Furthermore the mechanisms for policy development are diverse and are often linked to evidence-based or evidence-informed practices in methods of development. Evidence however, is only one “force” in policy development (Villeneuve, 2017, p. xi). As other forces may not have been considered in the original CCP policy development, critical analysis of these policies involved the system it influences.

CARNA, as the nursing regulator in Alberta, is a knowledge hub and central to influencing transformational learning in nursing. The mandate for nurses to plan, implement and report CPD focuses on the endpoint of knowledge gain and not the process or the connections needed for successful CPD. There is recent research work that advances the notion of the flow of knowledge within an organization rather than the influence of knowledge sharing or its effects

(Leon, Rodríguez-Rodríguez, Gómez-Gasquet, & Mula, 2016). Organizational knowledge is dynamic and changes with individuals and groups and culture. Much of the knowledge sharing is tacit and forms natural groupings that strongly influence the influence of innovations (Leon et al., 2016). Literature on regulatory policy shows tensions in autonomy of nurses against the restrictive regulatory policies (Cheek & Gibson, 1997; Villeneuve, 2017).

Knowledge flow within an organization may be explicit or tacit. Explicit knowledge is the visible, tangible knowledge applied to various contexts, while tacit knowledge is the personal, intuitive knowledge rooted in values and belief. Explicit knowledge is what drives organizational processes, and is shared in documents, reports, procedures and rules, while tacit knowledge drives innovation and creative thinking. Figure 10 represents the flow of knowledge toward expressed discourse. Tacit knowledge, more hidden, is shared through interpersonal interactions and corresponding emotions, and ideas (Leon et al., 2016). According to Leon et al. (2016), different actors of the organization play roles in tacit knowledge transitioning to explicit knowledge. This policy analysis emphasized the "relations, networks of relations and replace objects" and in doing so considered three kinds of effects: discursive, subjectification, and lived (Pienaar, Murphy, Race, & Lea, 2018, p. 188).

Figure 10. The flow of organizational knowledge



"The way in which policies are developed, represent reality, are spoken about and thought about, is the product of dominant discursive frameworks or discourses, by which we mean certain ways of thinking or talking about reality (see Foucault 1977)" (Cheek & Gibson, 1997, p. 669). The purpose of critical policy analysis in this quadrant is to shed light on the patterns of interactions, how these patterns emerge, and discover the consequences.

Methods

The methods in this section coincide with the Right Lower Quadrant of Ken Wilber's Four-Quadrant framework with inter-objective, third-person perspective of systems. The research question in this paradigm is how are professional learning requirements known and assessed? To shed light on this research question, CARNA policies were examined in terms of the hierarchical flow of knowledge and development, then weighed against a fictitious case study to test applicability.

Beginning with the assumption, as discussed by Travaglia, Robertson, Davidson, & Daly, (2016, p. 436), that policy development occurs "from the 'centre' outwards, but the implementation is 'centripetally' (from the margins in)… it is here that policy meets

'ontological' uncertainty of clinical practice." It is at the clinical level where the policy tensions in the contexts and conditions need to be resolved. Methodologically then, the policy analysis began with a look at the policies themselves for consistency and clarity of language. Starting with this approach of textual analysis, a critique of the ideology, values and origins were deconstructed (Taylor, 1997).

In working from the principle areas of regulatory failure as found by Baldwin et al., (2012), nine main areas were focused on in analysis of CARNA CCP policy:

1. Failure in regulatory instruments where they do not accomplish what they are intended to do.
2. "Creative compliance" or the evasion of rules without breaking their formal terms (Baldwin et al., 2012, p. 70).
3. Problems arising from the lack of evaluation arising from the absence of data and feedback systems.
4. The conflict of the regulatory policies within the boundaries of organizational-employer systems.
5. Lack of accountability, openness, representativeness and transparency.
6. Perversity of regulatory interventions achieving the "exact opposite of their intended outcomes" (Baldwin et al., 2012, p. 73).
7. Uncertainty or ambiguity of knowledge.
8. Misguided perceptions of registrants and their contexts in the policy development (therefore clashing in ontologies and epistemologies).
9. Implementation strategies that do not account for the 'worldviews' of those in context.

As a note, this policy systems analysis is not an evaluation of the evidence used in policy development. Nor did I examine policies based on the notion of "problematization" (originally a term coined by Foucault) that analyzes the problem the policy was meant to solve (Pienaar et al., 2018). I concentrated efforts on externally and internally facing policy and their origins to determine the flow of knowledge and discourse. "Rather than punitively enforcing compliance, systems approaches focus on understanding why workers do not comply and on critically evaluating whether the policy that has been introduced is appropriate" (Caffrey & Munro, 2017, p. 474). The policy analysis then examines policy in context to pinpoint unexpected effects that may lead to inaction. It is then the interaction of the policy with the 'actors' in context that is important as well as acknowledgement of uncertainty (Caffrey & Munro, 2017).

Subjects and Data Collection. Since this portion of the research focuses on CARNA, the subjects of study were the nurse registrants and the data collected were the policies and associated regulatory documents. The data collected started with the CCP policies in direct relation to the requirements and enforcement of continuing professional development. Because these requirements are one part of the Continuing Competence Program, but interface with the other parts, the analysis expanded outward to policies relative to the whole CCP reporting mechanism. Significant overlap and influence was found and therefore required inclusion. Working backward, to the origins of the policies, the HPA and the Registered Nurse Profession Regulations were examined with respect to the CCP policies to examine efficiencies and interpretations. CARNA mandates and overall vision, mission and 'Ends' were compared to the policies to analyze alignment and as a last step, these were evaluated against a fictitious case study to determine applicability to practice.

Data Analysis. Data was compiled into charts and compared according to the consistency in the hierarchical structure of the policy development. I searched for areas where policy did not

properly reflect the requirements of the HPA or Registered Nurse Profession Regulations and I searched for areas where policy requirements went beyond them. Next I considered the policies comparatively and practically as they apply to each other and to the nurses they impact. I extracted the nine areas where regulators may fail (Baldwin et al., 2012) and searched for these potential deficiencies. Lastly, I referred the policies to what CARNA has adopted as their philosophical underpinning for policy development: Right Touch Regulation.

Expected outcomes. It was expected to determine knowledge flow within the policy development process through CARNA to better understand how member knowledge is determined and assessed. The flow was mapped according to the regulatory framework and analyzed as discussed above. The analysis identified policy origins, conceptualization, discourse, consistency, dissemination methods, evaluation, and how it was formed into explicit knowledge, where it is expected that RNs will learn and adapt from.

Ethics. This research proposal depends on ethics approval and consent from the subjects identified at CARNA. Sensitive interpretations could arise, therefore full disclosure of the results and intended purpose of this analysis is planned. Results are shown as objective and policy-based and mapping is intended to inform and predict the flow of knowledge from conception to RNs.

Upper Right Quadrant: Quantitative Behavior Analysis

Each year, at renewal, RNs report their CPD activities and critically reflect on the transfer of knowledge to their practice. This account is triangulated by an employer reference and substantiated by embeddedness in a pre-determined learning plan. These data are stored in software housing a staggering amount of reports reflecting the 38,000+ RN members yearly, yet research of these reports has never been conducted. Rich opportunity exists in terms of confidential text and content analysis to determine self-reported RN learning that adds critical value to the accountability of CARNA. Essentially, RNs are telling CARNA what they have

learned and how they have applied their new knowledge to practice and this research study aimed to quantify the self-reported continuing professional development activities.

Methods

Content analysis of specific sampling provides objective, systematic, and quantitative descriptions of RN behavior in CPD (Neuendorf, 2017). Content analysis is defined in many ways and determined and applied for many different reasons. Neuendorf (2017), offered six definitions of content analysis and summarizes with this:

> Content analysis is a summarizing, quantitative analysis of messages that follows the standards of the scientific method (including attention to objectivity-intersubjectivity, a priori design, reliability, validity, generalizability, replicability, and hypothesis testing based on theory) and is not limited to the types of variables that may be measured or the context in which the messages are created or presented. (p. 17)

Each of the scientific standards unpacks into the positivist paradigm of research methodology with a goal to provide description, prediction, explanation and control. Neuendorf (2017) described each of these standards in detail and are summarized here. For this quantitative approach to be valid and reliable, it is first, important to remain objective. Pure objectivity is difficult to achieve, so terms of this thesis are clearly negotiated and articulated prior to the data extraction and analysis with clearly defined questions. Prior to data extraction, all important aspects of the priori design, including variables, their measures and coding rules are decided upon in advance and strictly adhered to. Reliability is ensured by the selection of the priori design structure whereby the results are reproducible under the same criteria. Validity is assured that results reflect the real meaning of the concept, so the results are expected to be convincing of the real CPD activities of RNs in Alberta. Results are also expected to be generalizable in the sense that findings are universal in the selected sample. Replicability will be found over time as

the method is replicated for other circumstances. Hypothesis, a feature of quantitative study, is tested deductively within this scientific method, whereby the "variables are measured and the relationships between them are measured statistically to see if the predicted relationships hold true (Neuendorf, 2017, p. 20).

Process for determination of variables and coding. The research question that guides this Right Upper Quadrant paradigm of study is how RNs and administrators experience mandated CPD. This quadrant specifically looks at how learning requirements are determined and assessed so variables selected for analysis include those RNs of tertiary centres' reports that indicate successful completion of their CPD and those that report successful application to practice. Selection of CPD activities were correlated to their work practice area to determine the nature of the CPD whether to enhance practice, advance to another practice area, or unrelated. Specific coding structures were determined when the data was obtained from interview scripts.

The interview scripts were carefully analyzed completely separately and objectively apart from other script data analysis. Codes were derived from three different perspectives: 1. What CPD activities did the participant state they accomplished when directly asked, 2. What CPD activities did they say they reported in the MyCCP report structure, and 3. What CPD activities did the participant mention spontaneously during the interview that was not reported in MyCCP. Coding was correlated to these themes. During the process of data collection and coding, it additional data sets were derived based on attitudinal observations or attitudinal statements that were made. The observations of attitudinal behavior lent context to the findings around the interactions within the MyCCP software. The MyCCP software was also examined for its interactive components to determine the interface with registrants when they report their CPD activities. The use of software and the attitudinal observations coincided with the policy

requirements of the CCP program and were highly relevant to the quantification of behavior from the content analysis.

Analysis. Analysis of the behaviours was conducted by charting the behavior codes and cross-cutting the data to find similarities and differences in the subjects. The codes were then separated according to the three questions above regarding what CPD activities they participated in. Secondly the behavioural components representing attitude were analyzed and categorized then synthesized with the former data.

Ethics. Ethics approval was granted for this research and consent letters were signed by participants to share their confidential information about their continuing competence reporting. I took special care in ensuring confidentiality and gave pseudo-names to each participant regardless of whether they desired it or not. RN CPD reports have never been quantifiably studied so special permissions from senior CARNA officers and the CARNA Continuing Competence Committee were sought and obtained. Measures to safeguard confidential information have been taken as per the Ethics Review Board.

Upper left Quadrant: Phenomenological Inquiry

Going back in history, to the 18th and 19th centuries, phenomenology was first conceived as that which could be perceived and thought of in the mind rather than objective reality. Immanuel Kant theorized that a phenomenon exists in the conscious mind separate from the human senses (Converse, 2012). Georg Wilhelm Friedrich Hegel (1977) defined consciousness as the ability of the mind to reflect on itself and explored how knowledge makes its appearance (Converse, 2012, p. 29). These philosophers helped to articulate the original phenomenological thinking, however, the "father" of phenomenology is Edmund Husserl.

Edmund Husserl (1859–1938) was a German mathematician whose philosophical writings are the common ground for phenomenology (Creswell, 2013). Husserl distinguished

phenomenology from naturalistic science as the understanding of thought and experience as a way of describing experience as one comes to know it (Converse, 2012). This research sought to capture the essence of the lived experience of individuals within a group of RNs in a hospital unit context, and as such, develops into a description of the essence of the shared phenomenon, mandatory CPD. The assumption is that the lived experiences are consciously thought of by each individual and the researchers' task is to suspend judgement and analysis.

Ontologically, the phenomenon is believed to be reality that can be described and reduced to an essence (Converse, 2012) A 'phenomenon' is what appears in consciousness and is 'brought to light' (Moustakas, 1994). For Husserl, intentionality is an essential feature of consciousness as consciousness is always directed toward an object (Nelms, 2015). Reality, then, is the undivided consciousness and object within a dual Cartesian nature. Thus as Moustakas (1994) describes [as influenced by Descartes (1912/1988)], a perception of a thing is open to validation and verification by anyone, because objective reality exists within subjective reality. The reality of CPD then, is perceived within the meaning of the experience of the RN and this subjective-objective meaning forms the essence of the perceived influences of CPD.

Husserl phenomenology *describes* the essence that exists independently from the researcher (Converse, 2012) which is the challenge to first understand the phenomenon "intuitively" and "through self-reflection". The resulting "ideation" where the "object [phenomenon] appears in consciousness mingles with the object in nature so that meaning is created, and knowledge is extended" (Moustakas, 1994, p. 3) The researcher in phenomenology *brackets* their own experiences with the phenomenon to focus on the experiences of the participants (Creswell, 2013; Moustakas, 1994). Note that Heidegger's views of phenomenology, hermeneutics, involve the researcher influences the inquiry process and more closely associated with the participant. However, in Husserlian descriptive phenomenology, bracketing

acknowledges the researcher experience but then sets it aside to fully engage in the experience of the participant. Creswell (2006) described phenomenology as a methodology that focuses on the experience of numerous individuals centred within a common phenomenon with the basic purpose of describing a universal essence.

Since the "act of consciousness and the object of consciousness are intentionally related," (Moustakas, 1994, p. 4) consciousness of the object then is persistent beyond emotional perception. Intentionality then, functions to derive meanings out of phenomena, so the challenges in revealing essences is to explicate the direction of the sense of experience, discern what is real and imaginary, identifying beliefs and integrating experience into meaning and essences (Moustakas, 1994). As the researcher then, it is crucial to completely set aside usual ways of knowing so that phenomena may be known naively (Moustakas, 1994). Creswell (2013, p. 77) describes this suspension and "natural attitude" as "epoche". Since phenomenology is knowledge inseparable from experience and intentionality (De Chesney, 2015), I explored the lived experience of RNs, where I reached "epoche" when I set aside my everyday understandings and regular judgements to know the phenomena of mandatory CPD. The phenomena as experienced then, was completely described with all of its essential constituents resulting in textural descriptions of the meanings and essences of the phenomenon (Moustakas, 1994).

Methods

Phenomenological research methods vary significantly from the Husserl descriptive to the Heidegger, hermeneutical approaches. Moustakas (1994) drew from Husserl tradition of phenomenology research methods. The long interview process began with first step which was for me to become aware of assumptions and preconceptions regarding the research problem and questions. The literature review supported this awareness and helped me to bracket these aside. The open interview style included semi-structured, open-ended questions in a relaxed and

trusting atmosphere (Moustakas, 1994). This type of atmosphere was challenging since most interviews were conducted on site at the hospital in a break or meeting room but it is essential to the process to proceed with the participant feeling comfortable and open (Moustakas, 1994). The interviews were recorded to structure the language in two formats, as spoken language and text. I then interpreted the language and the recorded text separately.

Interviews. Moustakas (1994) describes the interview as where participants provide full descriptions of the phenomenon. As such, to set the atmosphere, as Moustakas suggests, I opened with collegial conversation and description of the study to set the context of conversation. Important to this process is interviewing as close as possible to the central question of the research, thus I opened the topic by looking on the CARNA website in the MyCCP online report and asked, "In viewing your Continuing Competence Program profile, tell me about your experience with regulator-mandated continuing professional development." I asked the participants to show me or "walk through" their MyCCP reporting and as they did so, I explored by asking open questions such as, "What made you think of your choices in your actual versus reported CPD?" or "how do you relate to and apply the mandatory requirement in practice?" The line of questions included the time in and experiencing the CPD, through to the conclusion of the CPD experience and then weeks following to finally the reporting period at CARNA. The weeks following the learning experience revealed changes in thinking and reflection. Redirecting the interviewee kept them in the description of their experience if they begin to generalize or deviate from the topic, though deviations were allowed if the participant felt it was related to their learning experiences. Silence was allowed and facilitated to allow the interviewee to reflect.

Data. Data collected from interviews was in the form of written scripts (texts), transcribed professionally (and confidentially) from recordings. As texts, they were not perfect intuitive thoughts of the interviewee but rather interpretive by me who interjected in-person

reflections of the participants meaning during discourse. The narrative derived from the interview process revealed the life-world of the interviewee in the experience (Lindseth & Norberg, 2004). The interviews occurred in shared speech between myself and interviewee where we shared understanding of the interview topic and semi-structured questions. There was opportunity for clarifying and exploration in this process that helped to further define the essence of the experience. In the narrative interview, I encouraged free-telling of the experience while exploring as deeply as possible into the experience in order to understand the unique experience of each individual. The intent was not to generalize responses.

As previously noted, audio-recorded interviews were transcribed verbatim and pauses, interruptions and other notable occurrences are transcribed. Steps to interpretation of the text involved a "working through" between understanding and explanation (Lindseth & Norberg, 2004, p. 149) – or as Lindseth and Norberg (2004) describe, a "nonmethodic pole and a methodic pole" (p.149).

Analysis steps that were taken with interpretation of the text included reading and rereading to grasp the meaning as a whole. During the readings, I had to be open to the meanings and be open to being touched and moved by the nuances (Lindseth & Norberg, 2004) in order to capture the essence. The word, "phenomenon" means "things as intended" and therefore essences are the phenomenon's way of being that can only be discovered in the context and as it is experienced (Dahlberg, 2006). Thematic structural analysis occurred following the reading and rereading stage. This process involved asking questions of the text and group sections of it that answered those questions. Once grouped, they were segmented into meaning units (Moustakas, 1994, p. 14). These units are any pieces of the text that form a similar meaning. Some of the text parts may not form into a meaning unit and can be excluded. Once all the meaning units were

gathered, they were categorized as main themes, themes and sub-themes and results are formulated in everyday language (Lindseth & Norberg, 2004).

Sample. The subjects of this research study are Alberta RN from beginning to late career and who work in clinical settings of medical-surgical units of a large tertiary hospital in Edmonton, Alberta Canada. These nurses were required to complete CPD activities and report them to CARNA in the fall of 2016 where it is possible to request participation in the research by posting recruitment advertisements in their work places. Converse (2012, p. 31) suggests that the usual sampling strategy in phenomenology is with a "snowball", purposeful method that gathers those who have experienced the phenomenon, so participants were asked to recommend colleagues to volunteer. A small sample size of 8 individuals was the minimum number necessary to support validation of data, which was the final number of participants after numerous cancellations of original volunteers. The difficulty was for nurses to leave their work units to attend the one-hour interview session with me at the hospital.

Delimitations and Limitations. Phenomenological research aims to "disclose truths about the essential meaning of being in the life world" (Lindseth & Norberg, 2004, p. 151). With this in mind, there will be no single truth but rather the beginning of understanding of a phenomenon. The interviewees had variable insight to the meaning of their experiences or there was variability in willingness or ability to describe their experiences. However, the interviews achieved more than satisfactory explanations of nurses' experience of mandatory CPD as the participants were able to describe their lived experience in their working context. There was an identified risk in misunderstanding or leading by me, the interviewer. I took steps in this case to remain objective and aware of my own assumptions in order to properly bracket them out of my understanding of the participants' worldview.

Ethics. Ethics review and approval by the Research Ethics Board was successful and accepted in April 2017 as per the research proposal. Ethical procedures such as informed consent from participants, maintenance of privacy, and data validity by peer review (with thesis supervisor) were steps taken to maintain integrity per the ethics approval.

Left Lower Quadrant: Intersubjective Ethnographic Inquiry

Ethnography is the study of shared social patterns of individuals within a partial or entire culture sharing groups. In Wilber's description of IMP, ethnography is the exemplar methodology for Zone 4 – the exterior view of the Intersubjective research paradigm (Wilber, 2005). Typically, a culture sharing group is larger in numbers reaching 20 or more people in which the researcher describes and interprets the shared and learn patterns of values, behaviors, beliefs, and language. To understand these important factors, the researcher must extend themselves for long periods of time to observe and immerse in that culture. While immersed in this group, the ethnographer studies the behavior, language, and interactions among members of that group. Historically, ethnographic approaches were common in research related to anthropology and mostly "primitive cultures". Since these early times, ethnography has been applied widely to many subjects and contexts. In this study, it is the goal of observing social patterns and group meanings through the Zone 4 lens of the outside observer, that was used as guide for the ethnographic approach to the focus group interviews.

The most defining feature of an ethnographic study, is the development of a complex and complete description of the culture of a group though it is not the study of the culture itself but more of the behaviors within the group. To do this, the researcher looks for patterns in social behaviors that are customary or ritualistic, and seeks to understand the group's ideas and beliefs as expressed in language, activities, or behavior within a group as observed by the researcher. These data can only be collected if the culture sharing group has been together long enough to

have such an established shared social behaviors and beliefs. The researcher typically begins with a working theory to explain but they propose to find. Theory is drawn from cognitive science to understand the ideas and beliefs in advance. Ethnographic methods involve extensive fieldwork where data is collected primarily through interviews, observations, symbols, artifacts, and many diverse sources of data. The researcher then relies on the participants' reports of their perspectives where they are reported verbatim and synthesized to develop in overall cultural interpretation (Creswell, 2013). The goal of this type of research is to develop a new and novel understanding of the group in terms of its function and social sharing within the system.

In this research study, the ethnographic approach is what Creswell (2013) termed "realist ethnography" (p.93). In this approach, the researcher reports on an objective account of the situation in the third person point-of-view and in a somewhat dispassionate voice. The researcher then, is in the background seemingly unmoved and who simply observes and reports the "facts". These reports should not hold bias, judgments, or personal motivations of the researcher (Creswell, 2013). Since the researcher must interpret and present accurately on the culture observed, the study participants' views should be captured accurately in text quotations.

Methods

The domain of the lower left quadrant of Wilber's Integral Methodological Pluralism framework describes the intersubjective perspective. For this type of inquiry, we ask what is the meaning being made by the collective or group culture (N. T. Davis & Callihan, 2013). To better understand the influences of RN mandatory professional learning, I further unpacked this meaning to know more about the interactions among RNs, administrators, work teams, and CARNA toward answering the research question, "How do these interactions influence RN mandatory professional learning?"

Focused ethnography is a specific methodology that is used in nursing research to look at a "distinct issue or shared experience in cultures or sub-cultures in specific settings" (Cruz & Higginbottom, 2013, p. 36). As such, this methodology was applied to the nursing culture of sub-cultures such as trauma nursing, operating room nursing, or nursing leadership. The origins of ethnography are rooted in anthropology where studies took place to understand remote peoples of more tribal orientations. Unfortunately, many of these studies are now poorly regarded by indigenous peoples as the researchers positioned themselves within those communities "unwelcomed" and reported findings considered to be "eurocentric" (Cruz & Higginbottom, 2013, p. 37). The lessons learned from these early times have refined the methodology to ensure ethical and unbiased reporting. Three important data-gathering methods triangulate ethnographic findings for this study, is to collect data around the experience of interactions among these groups and in doing so, describe the types of teams and administrative experiences. The ethnography approach then, that was most important for this aim were to conduct focus groups of nurse managers and nurse educators (leaders). Focus groups are widely used in ethnographic approaches in ethnographic research exemplars (De Chesnay, 2014). In this research, semi-structured interviews of three nursing leader groups were conducted successfully. Importantly, findings with this approach in this quadrant contribute to the holistic view of influences in mandatory RN professional learning.

Since ethnographic research has not yet been conducted in Alberta clinical settings where 60% or more Alberta RNs work, the framework is based on current ethnographic research approaches in other, similar settings. The four key areas of inquiry that framed the focus group interviews were 1. Communication strategies and effectiveness, 2. Managerial styles, 3. Workplace stresses, and 4. System complexities. These four elements form the framework of this ethnographic research method as they were the clear themes emerged from the literature review

that have impact or influence on mandatory RN professional learning requirements. This framework contributes to the analysis of the data collected that will ultimately describe the lower left quadrant and contribute to shedding light on the research problem.

Participants

Crucial to the data collection methods, is the researcher situating oneself within the context of those studied, however, there are advantages and challenges to this situational requirement. This *fieldwork* required the respect of the researcher toward individuals in their daily working life and being sensitive to confidentiality and reciprocity (Creswell, 2013). Openness and transparency on the part of the researcher enables access and honesty from the participants. Focus group participants included first level clinical leaders-such as charge nurses and nurse educators who work on the medical-surgical units. One focus group consisted of executive level nurse leaders working at the highest administrative levels in Alberta Health Services, United Nurses Association and the College and Association of Registered Nurses of Alberta. The executive level nurses were profoundly impactful as a direct but distal line to point-of-care nurses and nurse managers. All of these leaders set the culture and define the workgroups while balancing hierarchical demands beyond. These are the leaders responsible to implement changes in policy or compliance in mandatory RN professional education and those who experience complexities, challenges, and accountability in these processes.

Challenges

The final analysis of this ethnographic study culminates in a holistic "cultural portrait" of the group, containing the views of participants and of the researcher (Creswell, 2013). These findings maybe valuable to advancing solutions for the needs of the group and may add to policy frameworks. Careful collection of data required time in the field with careful preparation by the researcher to be sensitive to the groups' cultural nuances. For my part as the researcher, I have

been a nurse for many years, though away from the clinical beside for many of those years while working in other nursing capacities. Fortunately, at the time of this writing, I have recently worked in the field full-time over one month during a refresher clinical rotation. Having fully immersed myself in the work-world of registered nursing, it was a tremendous advantage to having gained sensitivity and to being accepted into the group to do this research. I see this as a significant advantage to gain trust and transparency from the participants of this study.

Ethics

Ethics approval was granted by the Research Ethics Board for the interactions and data collection of nursing leaders/administrators. As stated above, appropriate steps were taken to uphold the ethical integrity of conducting interviews, interpreting and holding data, and privacy laws were respected.

Sampling

Sampling in this qualitative research study required a small group of people who were nested within the researcher's field placement. Sampling in this case, is purposive rather than random with volunteer individuals chosen in advance who suit the characteristics required by the study. Toward understanding of the influences of nursing mandatory professional education, administrators who work as leaders of these nurses in hospital settings within Alberta were selected for sampling in this study. It was essential for this study to include those who, in whole or in part, define the culture of the nurses' workplace. These leaders were those who assign and define the work teams within the unit and involved in the enactment of policy and quality assurance requirements. Importantly, these leaders are concerned with staff development and change management as needed. These characteristics of leader rolls are important to maintain to explain the culture or RNs and administrators. Nursing leaders of "higher administrative rank" contribute to this lens.

Chapter Summary

Wilber's AQAL framework formed the structure of this research approach with each quadrant explored individually and they holistically combined. This chapter began with description and discussion of AQAL metatheory and rationale of this framework in this research proposal. The quadrants were discussed from the theoretical perspective. A detailed discussion of each quadrant methodology followed to include the methods of data collection, analysis, general outcomes and the corresponding epistemological and ontological lens. Each quadrant provided a unique exploration of the problem of how RNs and administrators experience mandatory CPD.

Chapter 4: Findings and Analysis

Research Questions

This study is a response to the research problem, which was to understand the influences of regulator mandated professional learning implementation on the actual learning by nurses in their contexts. This section presents the findings of the following research questions:

1. How do RNs and administrators personally perceive and experience CARNA mandated professional learning for nurses?
2. How do the interactions with and among RNs, administrators, work teams, UNA, and CARNA during mandated professional development program implementation influence nurses learning?
3. How are the RN professional learning requirements determined and assessed?
4. How are provincial-level decisions made about RN learning requirements and what kinds of enforcement, monitoring and feedback mechanisms support these decisions?

This study applies Ken Wilber's Integral Methodological Pluralism approach in the four quadrants of his Integral Model, also called AQAL. For a full study of the phenomenon of mandatory registered nurses' learning, the four quadrants shed light on the interior experiences or the "I" of the nurses in the upper left; the interior collective sense-making within the organization in the lower left; the external behavioral observation of nurses' compliance in the upper right; and the exterior collective context of policy systems in the lower right. All four perspectives combine to provide full meaning to the reality of the phenomenon of the mandated learning compliance and reporting. The four Quadrants of the Integral model can be understood in the context of Kuhn's paradigms and methodological exemplars as he states, "Considerations relevant to the context of discovery are then relevant to justification as well" (Kuhn, 1978, p. 328). In using a methodology of pluralism, the upper left quadrant applies the Subjective

paradigm following the phenomenological methodology exemplar; the lower left, Intersubjective paradigm follows the ethnographic methodological exemplar; the upper right Objective paradigm uses objective and measurable behavioural observations; and the lower right, Interobjective paradigm uses a policy analysis following a systems approach exemplar. This chapter explains the findings and analysis in each quadrant.

Upper Left Quadrant: Phenomenological Approach First-Person Point of View

The upper left quadrant focuses on the first-person, lived experience of registered nurses to focus on the research question, “How do RNs and administrators personally perceive and experience CARNA mandated professional learning for nurses”? The first stage of organizing interview data began with the interview itself and progressed to my immersion in, and thematic coding of interview texts and recordings one individual at a time. The interviews were open and unstructured, with few guiding questions, allowing for as much variability and individuality of thought to emerge. Generally, then, my approach to interview data collection was to bracket my thoughts and immerse myself in the others' worldview. I listened carefully during each interview to capture the mood and essences of each participant interview. Then I listened carefully to each interview recording and read over the transcriptions, where, I circled emergent themes within the text. At one point, I attempted to use a coding software but found it only minimally helpful since it seemed to be less interaction with the original printed scripts. It was a learning curve within the process, but the coding became more natural when the themes emerged combined with my first-hand observations within the interview itself. Refinement of the coding continued in three stages, ending with a final refinement of wording. The coding process occurred with one individual at a time until all eight interviews were complete to a final reduction of themes and findings of this quadrant.

The analytical approach, included characteristics of both thematic and content analysis, with an overlap of methods from each. A thematic approach was taken principally to find meaning within the participant's text (Vaismoradi, Turunen, & Bondas, 2013). As such, the analysis involved individual interpretation of codes and themes and the cross-cutting of data and searching for themes as they inductively emerged. The purpose of quantifying themes was to increase robustness of understanding related to the research question in the upper left and lower left quadrants. In doing so, the quantifying analytical process added context, that which is not always addressed in thematic analysis. (Vaismoradi et al., 2013). Together, they reveal what is true about the phenomenon.

Table 1 summarizes the participants' demographic information and numbers of thematic codes collected for each. Codes were derived from the original interview script beginning with the first coding stage, then with a second and third stage-or iteration of code reduction and interpretation.

Table 1. Participants; Left Upper Quadrant Individual Interviews

Pseudo-name	**Total Number of Codes**	**First-stage coding**	**Gender**	**Career length in years**	**Canadian/Internationally educated**
Darren	47	11	M	30+	Canadian
Jim	34	9	M	10	International
Sarah	15	6	F	44	International
Craig	26	5	M	3	Canadian
Heather	27	6	F	14	International
Victor	37	6	M	3	International
Marie	25	8	F	4	Canadian
Miss M	16	6	F	7	Canadian
Totals	**227**	**57**	**4F 4M**		**4Int 4Can**

The findings in this chapter are presented under each participant heading displaying the second level analysis-or groupings of codes to the third and final consolidation of codes. Only

these final derived codes in the third level analysis are shown in text, though each code is traceable to the original spoken text located in the Appendices. Tracing the inductive method of coding through the document shows the evolution of analysis from the third, to the second, and first, where the code originates in the script.

The final step in the analysis is the linking of final codes from each individual back to the research questions that are further categorized by interview topic. In this step, the codes were quantified under each theme to add context and therefore deeper understanding of the meaning in the themes. Of importance, the quantification did not serve to prioritize themes or add weight to the meaning of them. Charts are used to clearly show the linkages between the final codes and the relevance to the research questions. A summary of final derived codes completes this phenomenological approach in the Upper Left Quadrant.

Darren: ‘Surviving the Workplace'

When Darren and I met, he was very open and motivated to talk about his perspectives and experiences of being a registered nurse for more than 30 years. Darren is well-spoken, relaxed, and casual and had seemingly lots of time to spend with me during this interview. He shared with me that he just started a new role, and he did not have a patient caseload, freeing up his time that day. Darren’s experience in mandatory learning was the focus of the open, semi-structured interview; however, he quickly steered the topic to the challenges and opportunities of continuing professional development in his career. Darren told me of the many influences to continually stay relevant and exceptional in his nursing role, including the pressures associated with mandatory learning requirements superimposed over regular learning for the daily work. Table 2 displays the third stage of thematic codes from the interview. Table 29 charts the second stage of analysis and original script, located in Appendix 4A. Table 30 charts the first stage of analysis and is located in Appendix 4B.

Table 2. Darren-Third stage of analysis

Second stage coding	**Third stage coding**	**Final Codes**
1c. The administration is dissonant from front-line nurses and imposes dysfunctional changes.	1d. Nurse-administration dissonance. Dysfunctional decisions.	1j. Nurse-administration dissonance.
2c. Workloads are a risk to patient safety and nurse accountability to legal and ethical nursing practice requirements. 9c. Innovations and technology changes increase work demands.	2d. High workloads dysfunctional.	2j. High workloads are dysfunctional.
4c. Constant change is ever-present and onerous for nurses.	3d. Dysfunctional constant changes.	3j. Dysfunctional constant changes.
6c. Nursing continues to evolve rapidly.	6d. Nursing continues to evolve rapidly.	13j. Nursing continues to evolve rapidly.
11c. Nurses are held accountable in a quagmire of unsafe conditions.	11d. Unsafe working conditions.	11j. Unsafe working conditions.
5c. Professionalism is wanting to improve patient care continually.	4d. Nurses motivated for patient safety.	4j. Professionals improve patient care.

7c. Nurses must continually adapt to unexpected circumstances or patient conditions to get the work done effectively and efficiently.	5d. Nurses required to be capable of adaptation.	5j. Nurses required to be capable of adaptation.
3c. Daily work requires personal sacrifice.	3d. Daily work requires personal sacrifice.	14j. Daily work requires personal sacrifice.
8c. Sexism has been a challenge for male nurses.	6d. Sexism marginalizing for male nurses.	6j. Sexism marginalizing for male nurses.
9c. Innovations and technology are significant reasons for a change in the healthcare setting.	7d. Technology drives change in the workplace.	7j. Technology increases workload.
12c. Most feedback is incidental and arbitrary.	12d. Feedback is arbitrary.	12j. Feedback is arbitrary.
10c. CARNA demands a reporting process that is meaningless and is therefore viewed as punitive and dissonant.	8d. CARNA process is punitive and meaningless.	8j. CARNA process is punitive and meaningless.
13c. UNA provides much-sought-for advocacy for nurses and helps to enable learning.	9d. UNA is an advocate.	9j. UNA is an advocate.

14c. Nurses must learn far more than what is legally required.	10d. Actual learning requirements beyond legal requirements.	10j. Actual learning requirements beyond legal requirements.

As it is apparent in the final codes column in table 4.2, Darren mainly focused on the impact of the work environment relative to continuing professional development. Structured learning activities are almost inconceivable when, at times, even nurses' basic physical needs are sacrificed to complete the vital work routine.

> Um, some days you start your shift, and in a blink of an eye, five hours has gone by. And it's like, Okay, well I still have to take a drink, or I should go pee. I should actually eat something. (Darren)

There is a constant *need* to adapt and learn in a high-risk patient care environment that overshadows benefits to learning in the workplace.

> It reduces the interest to learn because it just means that they're just going to teach me more so that I have to do more, and then, therefore, it's a, a negative impact, it's not a learning to challenge yourself, it's a learning for survival. (Darren)

Surviving the workplace is aggravated by the dissonance between nurses and administration-employer and CARNA-where regulations and policy must be adhered to regardless of nurses' self-sacrifice. Darren stated, **"**And they are in overcapacity, so you know to "suck it up buttercup" [Laughs] you know it's, and that's how the staff feel at times" (Darren). Unsafe workloads and constant changes in the workplace are extremely stressful, but then the frustration experienced to have to work with CARNA's ambiguous continuing education requirements: "You know so when I look through these, I get kind of frustrated because, um, I understand that they have to be formulated in a politically correct statement. It's pretty widespread as to how you

interpret it" (Darren). Darren has faced sexism and punitive systems in his career but stresses professionalism and accountability in his patient care.

Jim; 'Antagonistic Nursing Culture'

My interview with Jim was energetic and dynamic. I could barely get out an introduction, and Jim was "bursting at the seams" to talk about his experiences as a registered nurse. He has high regard for research and mentioned several times that he was grateful for the work I am doing and the good that research does for nursing as a profession.

Jim was internationally educated and born in the Philippians and has been working in Canada for several years. His viewpoint on nursing in Canada is embedded in his worldly knowledge of nursing in many other countries. He has a forward-thinking, proactive viewpoint on his professionalism, and he voiced the necessity to be "accountable" several times. The third stage of coded themes analyzed from Jim's interview is shown in table 3. These may be traced through the second stage of coding is located in Table 31 in Appendix 4C, and the first stage of coding is shown in 32 in Appendix 4D mapped to the original script.

Table 3. Jim-Third stage of analysis

Second stage coding	**Third stage coding**	**Final Codes**
1f. Nurses are resistant to change.	1h. Nurse resistance to change in the workplace.	1i. Nurses resistant to changes.
2f. Nursing culture is antagonistic. 5f. Workload diminishes the motivation to learn.	2h. Are nurses not individually accountable for learning as they should be?	2i. Nursing culture antagonistic.

3f. Continuous learning benefits patient care. 4f. Motivation and curiosity are essential in nursing.	3h. Nurses must be curious and consistently motivated to learn in the best interests of patients.	3i. Continuous learning improves patient care accountability.
6f. Nurses must strive to be viewed as serious, credible professionals.	4h. Nurses do not appear credible.	4i. Nurses are not viewed as credible professionals.
7f. Sexism negates nursing professionalism.	7h. Sexism negates nursing professionalism.	5i. Sexism negates professionalism.
8f. Nursing in Canada is more advantaged and professional than in other countries.	5h. Canadian nurses are advantaged compared internationally.	5i. Canadian nurses are advantaged.
9f. The value of CARNA and UNA is vague.	6h. CARNA and UNA do not impact nurses' learning.	6i. The value of UNA and CARNA is unclear.
10f. MyCCP is ineffective.	9h. MyCCP is ineffective.	9i. MyCCP is ineffective.
11f. Workplace support for learning is available if chosen.	7h. Workplace learning available if nurses want it.	7i. Workplace learning available if wanted.
12f. Even if comfortable, nurses must demonstrate continual improvements.	8h. Nurses' competence as the ease with skills versus competence as improvement in practice.	8i. Level of comfort not enough to be competent.

Despite the severe working conditions, it is up to the individual nurse to be accountable, and nurses must strive harder in their professional development. Jim's view of nurses in his workplace is cynical, where their professional development attempts are superficial or motivated for the wrong reasons:

> But a lot of them, like I say, go to conferences but how many really listen too? They go there because they get an extra pay because they're paid for their education, but they sleep in the corner. So, it's accountability that is missing. (Jim)

The profession *must advance*, but when Jim faces his obstacles with persistent sexism and cultural marginalism in nursing, his hope is diminished. He stated,

> Because there is still—I mean—uh—I don't like to admit it, there is still sexism in the way we view nursing. It's a "female" profession. But we don't view that in the medical profession where a lot of doctors are female too. We still view it as a male-dominated profession. I mean, we need to get out of the concept, right? (Jim)

By all appearances, the CARNA continuing competence program should make more nurses accountable for their learning to advance the profession; however, the program falls short: "They will ask you about what learning do you have. It is very simplistic. You can just write whatever things I want to write—And so on, right"? (Jim) Overall Jim sees promise in the Canadian health systems, but the nurses need to take ownership to advance themselves in the opportunities that exist.

Sarah; 'Focus on the Task at Hand'

My interview with Sarah was one of the longest and most difficult of the interviews because of her strong accent and her soft-spoken demeanour. Sarah is a lovely lady who has been a dedicated, full-time floor nurse for over 44 years! She has a natural and happy disposition and continues to take pride in her work and separately, her home and family. I emphasize the

separateness, because she very frequently stressed the importance of keeping her home life free of the worries from work, and vice versa, her work free from the worries of her home life. Sarah's experience has taught her the importance of establishing a functional work routine and productive habits so that everyone understands their role and so that her accountability is continuous and predictable from shift to shift and patient to patient. Sarah stresses this with her coworkers and takes the time to teach them the shift routine and sets up workbooks for an easy referral to common questions that occur on the units she works. Sarah's organization and functional routines help when unpredictable events occur, such as a decline in patient condition on the unit. Organized routines ensure work stays up to date, and patients are attended appropriately. Sarah is positively recognized and prides herself on this value she brings to others. Table 4 displays the third stage of thematic coding. The second stage of analysis is shown in Table 33 in Appendix 4E, and the first stage of analysis is Table 34, located in Appendix 4F linked to the original script.

Table 4. Sarah-Third stage of analysis

Second stage coding	**Third stage of coding**	**Final Codes**
1M. CARNA processes are burdensome but mandatory. 2M. CARNA mandates reflection and planning.	1n. CARNA process is irrelevant.	1O. CARNA mandatory processes a burden.
3M. No time for necessary learning activities.	2n. Workload making learning challenging to access.	2O. Learning activities unattainable.

4M. Experienced nurses may set priorities, establish communications, mentor, and guide others.	3n. Importance of experienced nurse leadership.	3O. Importance of experienced nurse mentorship.
5M. I teach others to focus on the job and not to be distracted by personal lives.	4n. The separation between personal and work life.	4O. The separation between personal and work life.
6M. The unit routine is foundational to competence.	5n. Fitting into the unit routine is a fundamental requirement.	5O. The unit routine is fundamental competence.
7M. The best learning is from personal experience.	6n. Self-reflection essential for learning.	6O. Experience is the best teacher.
8M. Added work to the routine is stressful.	7n. Students preceptorship is disruptive to the unit routine.	7O. Work added to the routine is stressful.
9M. Employment changes occur frequently.	8n. The organization or individual can initiate change.	8O. Employment changes frequently.
10L. Competence is continually adapting to change.	9n. Continuing competence is an ongoing learning	9O. Continual adaptation to changes is competence.

Teamwork and professionalism are critical to surviving the workplace and sustaining minimum appropriate patient care. Nurses must focus on the unit routine, and the tasks at hand, to be able to adapt to changing circumstances quickly and efficiently.

> If you have the time to do extra work, like you know, for the nights, you can help them. Because if just one person is crashing [rapid decline in health], everything won't be done. I said the rest get not done! And it will carry on in the following shift. (Sarah)

Nursing competence develops with consistent changing and adapting through work experiences. Through Sarah's many years of work, she gained valuable knowledge and experience:

> I'd come home smelling of penicillin because I have to mix ALL of them. I just adapt to that, like you know? I said, All this because I'm a nurse, you're a nurse, and you have to keep up with your works. So you have to keep up with what is now and compared to before like you know. (Sarah)

CARNA's MyCCP is not viable for everyone since Sarah could not successfully log in or recognize web pages in the CARNA MyCCP program during the interview. Though it is required for practice permit renewal, it is unclear if and how all nurses can log on and complete MyCCP.

> Well CARNA usually tell us, You have to do this. You have to be competent; you have to—How many you have—you have limits like how many you have to attend for the blah blah blah education. That's what my co-worker—my co-worker just said—We have to do this because it's time for our license. (Sarah)

The permit renewal and continuing education requirements are necessary burdens, and the important thing is to stay focused and get the work done when on shift. "When I go home, I don't—I don't bring home my work. When I come back I just face it—oh I am at work now" (Sarah).

Craig; 'Do What You are Supposed to Do'

As a newer nurse, this interview was a very different perspective versus the mid and later career interviews earlier. Craig was relaxed and positive minded throughout the interview, and

he found himself apologizing and reframing his words when something did not sound positive enough. That said, he was honest in his statements, and I reflected on both his initial wordings as well as his revisions. Following the interview and transcription, Craig carefully reviewed his transcript and wrote clarifying comments throughout the script. In the follow-up to the interview, he took the time to look up what CARNA offers and what UNA provides and added in those observations. Craig shows dedication and diligence to ensure he is correct, or he is quick to change his statements. Table 5 presents the third stage of thematic coding of Craig's interview script. The second stage of coding is shown in Table 35 in Appendix 4G, and first stage of coding linked to the original script is displayed in Table 36 located in Appendix 4H.

Table 5. Craig-Third stage of analysis

Second stage of coding	**Third stage of coding**	**Final Codes**
1R. MyCCP is not important until permit renewal time.	1t. MyCCP is dreaded.	1S. MYCCP disregarded until necessary.
2R. Reporting in MyCCP must be valid and verifiable.	2t. MyCCP reports are measurable.	2S. Reporting in MyCCP must be valid and verifiable.
3R. The MyCCP ambiguity is stressful.	3t. MyCCP requirements are unclear.	3S. The MyCCP ambiguity is stressful.
5R. The MyCCP may guide practice evaluation.	4t. MyCCP intended to guide.	4S. The MyCCP may guide practice evaluation.
6R. Competence increases with experience and comfort.	5t. Experience and comfort.	5S. Competence increases with experience and comfort.
8R. Learning activities are not feasible.	8t. Learning not feasible.	6S. Learning activities are not feasible.

7R. Accessing learning activities is a personal choice.	7t. Nurses choose to learn.	7S. Accessing learning activities is a personal choice.
10R. Some learning supports are effective in the workplace.	10t. Effective workplace learning.	8S. Some learning supports are effective in the workplace.
11R. UNA supports learning through contract negotiation.	9t. UNA negotiates benefits.	9S. UNA negotiates learning benefits.
12R. CARNA has a minimal influence on learning.	11t. CARNA has minimal influence.	10S. CARNA minimally influences learning.
9R. CARNA audits are a career-limiting threat.	12t. CARNA is a threat.	11S. CARNA is a threat.
4R. MyCCP does not achieve its goals.	12t. MyCCP ineffective.	12S. MyCCP is ineffective.

The interview with Craig emphasized the notion of 'get the CARNA requirements done when needed, then put it out of your mind until the time comes in the next year.' Craig expressed his pragmatic point of view:

> Uh, it's kind of—I don't know. I just do it when it's due to be renewed. It's one of those things that I don't actually think about that much—Yeah, okay. Um—oh, yeah. I just did it, and I already forgot. (Craig)

Despite Craig's apparent passive tone, he is meticulous in making sure he provides verifiable information to avoid any risk of CARNA audits or negative consequences impacting his practice permit. The difficulty is for Craig to understand what is precisely required:

> I don't know if the program itself does much, but maybe that's just 'cause—I just don't, I don't really like things that are that open-ended. Maybe that's just how—At least in this kind of—I find it's a little bit too ambiguous as to what I need to do to continue my competency, I guess, if that makes sense. (Craig)

Regardless of CARNA requirements for continuing professional development, learning is required for the job, and for continual competence. CARNA does not affect this learning need or Craig's desire for continuing professional development.

> My point here I believe is that I tend to be quite self-directed in my learning, whether that is due to me being a new hire and trying to gain competence in that respect or as I have progressed in my career and trying to learn new things as I go. (Craig)

MyCCP may provide some incentive to pursue learning; however, there are insufficient opportunities for learning, and when there are opportunities, the cost of time and money is a barrier.

Heather; 'Nursing Fundamentals are Not Enough'

My interview with Heather was a whirlwind of information and a few revelations. As I analyzed Heather's script, a few themes started to come together, and I have come to some understanding of what is so frustrating about the MyCCP profile. Heather pointed out a few things: the program purpose is not clear. Most, so far believe it is for the benefit of CARNA but the way it is set up, it appears to be a guide for learning. However, the components of MyCCP are too simplistic for nurses to build learning plans. The practice standards indicators are perceived by Heather to be a fundamental component of nursing practise that is ingrained. To drill down to the lowest practice fundamentals of nursing is not helpful, and it clouds the real purpose of continuing professional development to address a practice problem or advance knowledge.

> I've just always found what I input and show to CARNA, um, the learning that I do in that aspect, I—it's always just very simple, linear—a very linear goal that's easy to achieve, you know, through learning and through information, um, as opposed to more um, you know, more —dynamic goals, which I do do on my own. (Heather)

To revert to basic nursing competencies to ground a learning plan is not continuing competence. Heather brings to light the problem of how nurses orient themselves to fundamentals after achieving higher nursing complexity and specialties? Table 6 displays the third stages of thematic code analysis of Heather's interview script. Table 37 displays the second stage of analysis in Appendix 4I, and Table 38 displays the first stage of analysis in Appendix 4J.

Table 6. Heather-Third stage of analysis

Second stage of coding	**Third stage of coding**	**Final Codes**
1V. Fear of CARNA repercussions influences MyCCP reporting.	1w. Fear influences reporting.	1w. Fear of CARNA influences MyCCP reporting.
2V. MyCCP does not work as intended.	2w. MyCCP ineffective.	2w. MyCCP ineffective.
3V. Workload and work culture are stressful.	3w. Work stressful.	3w. Workload and culture are stressful.
4V. Learning goals to improve conflict.	4w. Conflict inspires learning.	4w. Learning goals to improve conflict.
5V. Nurse managers are a positive learning influence.	5w. Managers encourage.	5w. Nurse managers encourage learning.

6V. Learning goals are personal and intrinsically driven.	6w. Learning personal and intrinsic.	6w. Learning goals are personal and intrinsically driven.
7V. UNA is not influential.	7w. UNA not influential.	7w. UNA does not influence learning.
8V. Continuing competence improves motivation and productivity.	8w. Continuing competence motivates.	8w. Nurses are motivated and inspired by improved competence.
9V. Formal learning activities are not natural in a busy profession.	9w. Learning does not fit into the workload.	9w. Formal learning does not fit in the workload.
10V. Reflection is essential in learning.	10w. Reflection is essential.	10w. Reflection is essential in learning.

Continuing competence increases in complexity during nursing careers and amidst changes and stress in the workplace. Professional development includes deep reflection into the many aspects of what makes one competent, including healthy work teams. Heather's professional development focus relates to improving the low morale in her team.

> I think it's just something over time, um, I think, um, working on the unit where I work too, it was—it was a heavy unit, and you know, the morale was going down, and people were stressed, so it seemed just as an obvious thing to me, that was important, um, especially to have effective, um, relationships with your coworkers. (Heather)

The work team and nursing leaders guide where to improve and advance knowledge. Robust and healthy mentorship relationships are key.

> Union, to be honest, I don't think the union really influences me that much, um, in regards to—to my learning, um. I do feel there is a strong influence from managers, like often my manager will, um, direct certain courses or um, different things to me, um, that she feels was relevant. (Heather)

CCP reporting in the MyCCP platform is mostly irrelevant to the complex, agile learning that takes place at work. The report is for CARNA, not for nurses, so it must be completed according to what CARNA requires under the threat of an audit.

> …CARNA just used this information to um, audit people or make sure that they're up to par, I always have just, um, maybe chosen a goal that necessarily isn't something that I want, that is my primary focus on what I'd want to learn. (Heather)

Learning must be self-directed and focused on individual learning requirements, though the MyCCP report system may compel irrelevant learning. Simply do what is necessary.

> Um, but I found that was kind of hard because you have all these options, so it needs to fit in a specific category, and I, at times, I find um, that that kind of causes um, the system to direct your learning maybe in a different way than you would see in your head and ultimately, you're the one who's responsible for your learning, and you know what you—how you'd want to cater your learning, but sometimes I find I do adjust my goals, et cetera, to fit the system. (Heather)

Victor; 'Learning is Synergistic with Work'

My interview with Victor started stressfully! He rushed in and was worried about having to leave the unit and hand over work to his team. He was willing to interview with me, but he appeared very conflicted at first! However, as the interview progressed, Victor relaxed and shared his thoughts more leisurely and thoughtfully. We started the interview with the MyCCP online profile, and like many of the other interviewees, Victor struggled through each section to

try to describe the meaning. He appeared frustrated with sections of the MyCCP profile and talked about the task as being onerous. Table 4.7 of third stages of coding show the general tone of frustration. Victor is a relatively new Canadian and expressed his views of nursing in light of his worldly experiences. He believes nurses in Canada to be fortunate to work in a privileged health system with highly skilled health professionals. As such, it seems superfluous to him that nurses are so rigidly regulated. Mapping of the third stage of codes from Table 7 may be traced back to Table 39 showing the second stage of analysis in Appendix 4K, to Table 40, the first stage of analysis in Appendix 4L.

Table 7. Victor-Third stage of analysis

Second stage of coding	**Third stage of coding**	**Final Codes**
1zz. MyCCP is a required chore.		1zz. MyCCP is a required chore.
2zz. CARNA is suspicious and punitive.		2zz. CARNA is suspicious and punitive.
3zz. MyCCP does not fulfill its function.		3zz. MyCCP does not fulfill its function.
4zz. Learning is the nurses' accountability.		4zz. Nurses accountable for their learning.
5zz. Learning solves daily challenges.	5zzz. Learning spontaneous as needed.	5zz. Learning is spontaneous, as the need arises.
6zz. MyCCP is prescriptive reporting.	6zzz. MyCCP prescriptive.	6zz. MyCCP is prescriptive reporting.

7zz. MyCCP is unnecessary.	7zzz. MyCCP unnecessary.	7zz. MyCCP is unnecessary because learning is inherent.
8zz. Work demands challenge learning.	8zzz. Learning impossible in workload.	8zz. Workload too demanding for learning.
9zz. Learning is intrinsically motivated.	9zzz. Intrinsic motivation.	9zz. Learning is intrinsically motivated for patient care and work requirements.
10zz. Competence is self-awareness.		10zz. Competence is self-awareness.
11zz. International viewpoints include system perspective.	11zzz. International views.	11zz. International viewpoints include system perspective.
12zz. UNA is a positive learning influence.	12zzz. UNA positive.	12zz. UNA is a positive learning influence.
13zz. Work colleagues model competence.		13zz. Work colleagues model competence.
14zz. The unit routine is the competence building block.	14zzz. The routine is fundamental.	14zz. The unit routine is fundamental to competence.
15zz. Feedback requires empathy.		15zz. Feedback is adversely received.

Learning happens naturally when at work, but CCP reporting of the learning is like trying to 'fit a round peg into a square hole.' The effort to make up content to input into MyCCP is added work and stress, primarily because it is intended to suit CARNA's needs, not nurses. "So, we have to learn, you're learning more at work than with CARNA. CARNA is just formality. It's just for show—not formality. I don't know. But it's not what we need really at work" (Victor). Sitting down to complete the task, paying money for yearly registration, and attempting to enter information that fits the program are the main challenges: "I'm learning like med-surg book everything, so really I'm doing continuing—But I cannot put it here in record, because I have to pick up something what they have" (Victor). Victor does not see the value in reporting into a program that does not pick up weaknesses and does not represent strengths. Instead, he sees the accountability for continuing professional development as solely the nurses': "And, I understand, sometimes, safe, ethical practice is important to be accountable, but it's like—so, you don't have to ask anyone, it's just everybody's—everybody's responsibility what they are doing" (Victor).

Marie; 'Continuing Professional Development is a Personal Accountability'

It was a pleasure to interview Marie as she is open and articulate about her nursing practice. It was immediately striking that Marie expressed her knowledge and obligation to CARNA to report every year in MyCCP. Before showing her MyCCP report, I asked her to describe how she views her competence, and she spoke about accountability and practicing within her scope. Marie emphasized that she should practice within her scope, "not above it nor below it." She also described her accountability as knowing her patients' conditions and knowing her nursing obligations to them. Table 8 shows Marie's third stage of script coding. Coding of Marie's script may be traced back to Table 41, second stage of coding located in Appendix 4M, and Table 42, first stage of analysis located in Appendix 4N.

Table 8. Marie-Third stage of analysis

Second stage of coding	**Third stage of coding**	**Final Codes**
1ad. MyCCP records formal learning activities.	1af. Informal learning unreportable.	1ae. MyCCP does not record informal learning.
2ad. Daily workplace changes require adapting to avoid mistakes.		2ae. Must learn to avoid mistakes.
3ad. CARNA enforces not motivates learning.	3af. CARNA enforces learning.	3ae. CARNA enforces not motivates learning.
4ad. The MyCCP plan does not reflect my real, lived learning.	4af. Experienced learning is unreportable.	4ae. MyCCP does not reflect experienced learning.
5ad. Competent is being accountable for learning.	5af. Competent is being accountable for learning.	5ae. Accountability is competence.
6ad. UNA, CARNA and AHS provide accessible learning opportunities.	7af. Opportunities provided by organizations.	6ae. UNA, CARNA and AHS provide accessible learning opportunities.
7ad. Learning may be troublesome and expensive.	7af. Learning is a hardship.	7ae. Learning may be troublesome and expensive.

8ad. Policies, workplace change, and system structures determine the learning plan.	8af. Learning plan forced.	8ae. The learning plan is not one of personal choice.
9ad. My accountability intrinsically motivates learning.	9af. Accountability motivates.	9ae. My accountability intrinsically motivates learning.
10ad. Nurse educators, managers, are formal and valued learning supports.	10af. Supported by managers.	10ae. Nurse educators, managers, are valued learning supports.
11ad. Workplace colleagues model and share nursing knowledge and experience.	11af. Learn from colleagues.	11ae. Workplace colleagues are essential sources of knowledge and experience.
12ad. International experience provides a unique perspective.	12af. Internationalism unique perspective.	12ae. International experience provides a unique perspective.

Marie has valuable international experience and eagerly learns when the opportunity presents itself. She points out that MyCCP does not reflect her lived learning:

> And I take workshop that is not even related to what I put in my MyCCP. Well if I'm interested through it, I go to that workshop. So I do more than what I write in my MyCCP. If it's given, I'll take it. If it's new to me, I'll take it. (Marie)

Moreover, Marie values learning for excellent patient care: “So it means it it's like more knowing more, involving more, and knowing my patients more. I'm not just like focusing on four

[patients]" (Marie). Personal accountability is the key to competence: "I have to make sure I'm into it, and I'm not violating any any of my patients' rights and not doing overdosing and I I mean accountability. I keep I keep track on that" (Marie).

Miss M.; 'Feedback Critical to Reflection'

Miss M. was my first interview. We had some technical issues such as the recording shut off prematurely because the computer sleep settings kicked in. I should have tested that before our interview, and I should have thought about that potential. Miss M. was very gracious none the less.

Miss M. is a soft-spoken individual who had recently changed jobs to something with more responsibility and commitment, so she was able to reflect on the changes from one to the other. Miss M. is overall oriented toward patient care and follows the guidelines and initiatives of her employer. She is tuned in to new strategies and the objectives of the organization and responds to them by organizing her learning objectives around them. Table 9 shows Miss M's third stage of thematic coding. The third stage of codes may be traced back to the second stage of analysis in Table 43 found in Appendix 4O, and the first stage of analysis with original script is shown in Table 44, found in Appendix 4P.

Table 9. Miss M-Third stage of analysis

Second stage of coding	**Third stage of coding**	**Final Codes**
1bd. MyCCP directs learning goals.		1be. MyCCP directs learning goals.
2bd. Inadequate feedback.		2be. Inadequate feedback.
3bd. Reflection is a learning starting point.		3be. Reflection is a learning starting point.

4bd. UNA provides and supports learning.		4be. UNA provides and supports learning.
5bd. Funding is an obstacle.	5bf. The funding process is an obstacle to learning	5be. Funding is an obstacle.
6bd. AHS directs learning topics		6be. AHS directs learning topics
7bd. Colleagues motivate learning through positive and negative modelling.		7be. Colleagues behaviour motivates learning
8bd. Practice standards indicators are fundamental knowledge.		8be. Practice standards indicators are fundamental knowledge.
9bd. Career progressions drive learning.		9be. Employment changes increase learning
10bd. Daily work necessitates learning.		10be. Daily work necessitates learning.
11bd. CARNA enforces rather than inspires learning.	11bf. CARNA enforces learning.	11be. CARNA enforces rather than inspires learning.

Completing the online MyCCP record is a matter of attempting to understand what the expectations are and then seeking a learning solution that fits the record. The MyCCP record does not reflect the natural, personally-driven learning that took place in the year.

> Complete this profile? Yeah, umm, I'd probably just look at, ahhh, a couple more articles, maybe do another online module and just kinda summarize, kinda, what I've learned and—what kind of insights I've gained from, from everything and what I can take forward into the next year. (Miss M.)

Feedback is an important reflection guide and highly valued when received from a trusted leader, though this situation is not always available. "I don't think I've ever had a official evaluation by any of my managers, which does make it a little bit more difficult to do manager input" (Miss M). Adding to the value of the nurse manager is also feedback from the team and patients. "I, I think feedback, umm, it does, it does matter, ahhh, from colleagues and… patient and managers and such" (Miss M.).

Themes Linked to Interview Topics

The final codes of each interview are linked to the research questions in this second phase of analysis. Grouping and quantification of coded interview themes is collapsed into groupings according to interview topics and aligned with the research questions. This section completes the inductive analysis of those themes to nine final themes from all interviews, as shown in table 10. The themes were counted in this table to add context to the understanding of collapsed themes as previously stated. Each of the coded themes presented in table 10 may be traced back to the first level analysis tabled and located in Appendices 4A-4P.

Table 10. Themes linked to interview topics; Collapsed themes

Interview questions	**Topic: Experiences in provincially legislated continuing professional development.**		**# of responses**
	Collapsed theme 1: Improved patient care motivates learning.		5
	Darren	14j. Nurses make personal sacrifices because of their workload.	

What influences you to learn?	Jim	3i. Continuous learning improves patient care accountability.	
	Heather	8w. Nurses are motivated and inspired by improved competence.	
	Victor	4zz. Nurses accountable for their learning.	
	Marie	9ae. My accountability intrinsically motivates learning.	
What influences you to learn?	**Collapsed theme** 2: Workplace supports available if motivated.		4
	Jim	7i. Workplace learning available if nurses want it.	
	Craig	8S. Some learning supports are effective in the workplace.	
	Victor	9zz. Learning is intrinsically motivated for patient care and work requirements.	
	Marie	10ae. Nurse educators, managers, are valued learning supports.	
What influences your learning?	**Collapsed theme** 3: Learning in everyday work far exceeds the required learning.		7
	Darren	10j. Actual learning requirements beyond legal requirements.	
	Sarah	6O. Experience is the best teacher.	
	Craig	10S. CARNA minimally influences learning	
	Heather	6w. Learning goals are personal and intrinsically driven.	
	Victor	5zz. Learning is spontaneous, as the need arises.	
	Miss M.	10be. Daily work necessitates learning.	
	Marie	4ae. MyCCP does not reflect lived learning.	

What influences your learning?	**Collapsed theme** 4: Workplace obstacles prevent learning		8
	Darren	7j. Technology increases workload	
		2j. High workloads dysfunctional	
	Sarah	2O. Learning activities unattainable	
	Craig	6S. Learning activities are not feasible.	
	Heather	9w. Formal learning does not fit in the workload.	
	Victor	8zz. Workload too demanding for learning	
	Miss M.	5be. Funding is an obstacle.	
	Marie	8ae. Learning may be troublesome and expensive	
What influences your learning?	**Collapsed theme** 5: Workloads unsafe for nurses and patients		4
	Darren	11j. Workloads dysfunctional and unsafe for nurses and patients.	
	Sarah	7O. Work added to the routine is stressful.	
	Craig	3S. The MyCCP ambiguity is stressful.	
	Heather	3w. Workload and culture are stressful	
Tell me more about learning as it relates to changes in the workplace?	**Collapsed theme** 6: Competence is adapting to rapid workplace changes.		4
	Darren	13j. Nursing evolves rapidly.	
		5j. Nurses required to be capable of adaptation	
	Jim	1i. Nurses resistant to changes.	
	Sarah	9O. Continual adaptation to changes is competence.	
	Miss M	9be. Employment changes increase learning	

Interview questions	**Topic: Work colleagues and work teams**		**# of responses**
What is your experience learning in nursing teams?	**Collapsed theme** 7: Male nurses perceive discrimination.		2
	Darren	6j. Sexism marginalizing for male nurses.	
	Jim	7i. Sexism negates professionalism.	
	Collapsed theme 8: Antagonistic nursing culture		3
	Jim	2i. Nursing culture is antagonistic.	
	Heather	4w. Learning goals to improve conflict	
	Victor	15zz. Feedback is received with adversity.	
	Collapsed theme 9: Nurses are not regarded as professionals		3
	Darren	4j. Professionals improve patient care	
	Jim	4i. Nurses are not viewed as credible professionals.	
	Sarah	4O. The separation between personal and work life.	
How do your work colleagues influence your learning?	**Collapsed theme** 10: Nurse colleagues are valuable mentors and role models.		5
	Sarah	3O. Importance of experienced nurse mentorship	
	Heather	5w. Nurse managers encourage learning.	
	Victor	13zz. Work colleagues model competence.	
	Miss M.	7be. Colleagues behaviour motivates learning	
	Marie	11ae. Workplace colleagues are essential sources of knowledge and experience.	

Interview questions	**Topic: CARNA Continuing Competence Program mandatory processes: MyCCP**		**# of responses**
Demonstration of MyCCP reporting	**Collapsed theme** 11: MyCCP learning plan topic is not a personal choice.		4
	Sarah	6O. Reflection and learning are mandatory.	
	Craig	7S. Accessing learning activities is a personal choice.	
	Victor	6zz. MyCCP is prescriptive reporting.	
	Marie	8ae. The learning plan is not one of personal choice.	
	Collapsed theme 12: Inadequate feedback		2
	Darren	12j. Feedback is arbitrary	
	Miss M.	2be. Inadequate feedback.	
How does reflection fit into competence?	**Collapsed theme** 13: MyCCP reporting a meaningless chore.		2
	Craig	1S. MyCCP disregarded until necessary.	
	Victor	1zz. MyCCP is unnecessary but is a required chore.	
	Collapsed theme 14: Reflection is critical in learning.		4
	Craig	10S. CARNA minimally influences learning	
	Heather	10w. Reflection is essential in learning.	
	Victor	10zz. Competence is self-awareness.	
	Miss M.	3be. Reflection is a learning starting point.	
	Collapsed theme 15: Competence is a sense of comfort with fundamental accountabilities.		6

Tell me about your view of competence.	Jim	8i. Level of comfort is not enough to be competent.	
	Sarah	5O. The unit routine is fundamental competence.	
	Craig	5S. Competence increases with experience and comfort.	
	Victor	14zz. The unit routine is fundamental to competence.	
	Miss M.	8be. Practice standards indicators are fundamental knowledge.	
	Marie	5ae. Accountability is competence.	
Interview questions	**Topic: How does UNA, CARNA and AHS influence learning?**		**# of responses**
How does your employer influence your learning?	**Collapsed theme** 16: Employers necessitate and provide learning.		4
	Darren	1j. Nurse-administration dissonance; Dysfunctional decisions	
	Sarah	8O. Employment changes frequently.	
	Miss M.	6be. AHS directs learning topics	
	Marie	6ae. UNA, CARNA and AHS provide accessible learning opportunities	
In what ways does CARNA influence learning?	**Collapsed theme** 17: Learning plans forced and irrelevant.		5
	Sarah	1O.CARNA mandatory processes a burden.	
	Craig	11S. CARNA is a threat	
	Victor	7zz. MyCCP is unnecessary because learning is inherent.	
	Miss M	11be. CARNA enforces rather than inspires learning	
	Marie	3ae. CARNA enforces not motivates learning.	
	Collapsed theme 18: Nurses perceive CARNA as punitive and disapproving.		5

	Darren	8j. CARNA process punitive and meaningless	
	Craig	2S. Reporting in MyCCP must be valid and verifiable.	
	Heather	1w. Fear of CARNA influences MyCCP reporting.	
	Victor	2zz. CARNA is suspicious and punitive.	
	Marie	2ae. Must learn to avoid mistakes.	
	Collapsed theme 19: MyCCP unsuccessful in achieving its objectives.		6
	Jim	9i. MyCCP is ineffective	
	Craig	12S. MyCCP is ineffective.	
	Heather	2w. MyCCP ineffective	
	Victor	3zz. MyCCP does not fulfill its function.	
	Miss M.	1be. MyCCP directs learning goals.	
	Marie	1ae. MyCCP does not record informal learning.	
	Collapsed theme 20: MyCCP adds guidance to learning.		1
	Craig	4S. The MyCCP may guide practice evaluation.	
How does your union influence your learning?	**Collapsed theme** 21: UNA is a valued advocate for learning.		6
	Darren	9j. UNA an advocate	
	Jim	6i. The value of UNA and CARNA is unclear.	
	Craig	9S. UNA negotiates learning benefits	

	Heather	7w. UNA does not influence learning.
	Victor	12zz. UNA is a positive learning influence.
	Miss M.	4be. UNA provides and supports learning.
Tell me about any other influences in your learning.	**Collapsed themes** 22: Internationally educated nurses have unique perspectives of nursing in Canada.	3
	Jim	5i. Canadian nurses are advantaged.
	Victor	11zz. International viewpoints include system perspective.
	Marie	12ae. International experience provides a unique perspective.

Final Interview Themes

The final coded themes of all individual interviews were combined and further collapsed into the similarities of themes. Table 11 summarizes the themes showing the thoroughly analyzed codes.

Table 11. Final Collapsed Themes Individual Interviews

Collapsed themes from Table 10		**Final themes: Left Upper Quadrant**
22	Internationally educated nurses have unique perspectives on nursing in Canada.	1. Diversity adds to collective wisdom.
1	Improved patient care motivates learning.	2. Nurses are responsible for their practice.
14	Reflection is critical in learning.	
20	MyCCP adds guidance to learning.	

21	UNA is a valued advocate for learning.	3. UNA is the only visible advocate.
2	Workplace learning supports available if motivated.	4. Unstructured learning entrenched in practice.
3	Learning in everyday work far exceeds the required learning.	
10	Nurse colleagues are valuable mentors and role models.	
4	Workplace obstacles prevent learning.	5. Nursing blighted by workload.
5	Workloads are unsafe for nurses and patients.	
16	Employers necessitate and provide learning.	
8	Antagonistic nursing culture.	6. Nursing is culturally hostile.
7	Male nurses perceive discrimination.	
9	Nurses are not regarded as professionals.	
6	Competence is adapting to rapid workplace changes.	7. Constant change diminishes competence.
15	Competence is a sense of comfort with fundamental accountabilities.	
11	MyCCP learning plan topic is not a personal choice.	8. Quixotic CCP begets inaccurate reporting.
12	Inadequate feedback.	
17	MyCCP learning plans forced and irrelevant.	
13	MyCCP reporting a meaningless chore.	

18	Nurses perceive CARNA to be punitive and disapproving.	9. CARNA is meaningless and threatening.
19	MyCCP unsuccessful in achieving its objectives.	

Upper Left Quadrant Summary

Table 11 shows the final coded themes that shed light on the influences of mandatory continuing professional development from the upper left quadrant perspective. The themes are the subjective, first-person views of registered nurses in a medical-surgical unit in a tertiary Edmonton hospital. They illustrate the negative, complex culture and processes that impede continuing professional development and nursing practise overall. On the positive side, nurses take accountability for their practice and adapt to change as they need to from their professional points of view. International perspectives lend to professional learning and collective professional wisdom:

> So, I'm still learning as a nurse because, for me, many, many issues are interesting, like what CARNA's expansion is, and how approach to treatment in Canada is. It's ways, it's organiz[ation] So, I am still observing in that. That's the reason for me wants to come to Canada, to see how the health care system is working or what is different. (Victor)

Nurses are dedicated to patient care and self-sacrificing regarding their professional obligations: "Just the busyness to take care of patients but also get your documentation caught up. Sometimes you have to document on your lunch break, so you can get it accomplished so you can go home on time" (Darren). Despite this dedication, workload negates efforts toward professional development:

> But for a lot of my staff, new or even older, they don't even know what the resource—what they're—where they will go—what they will do. They're just so focused on the four or five patients that they have. And they are living in a bubble. (Jim)

As inward-looking as Jim makes it sound, nurses must contend with constant new implementations, where they struggle and must learn to survive:

> I think even for people that already work long time, they still have to learn now. Because so many new implementation, we even cannot go in places. If you want to learn, you will have to learn, like, 24 hours. (Victor)

Formal learning activities are a financial hardship and difficult to access:

> I mean, any kind of conference can be, I mean even just logistically can be tough. Uh, they can be expensive for sure. Sometimes it can be a little daunting. I know you get money from the union and whatnot, but it still costs like four or five hundred dollars, and you're like, I'm already paying six hundred and some to get my registration. So with that, I guess that's a challenge—Logistically, it can be a little tough. I mean, especially like with those leadership courses. There was way more people than courses, so it was always a little tough to get in, and then you go away and then you miss a course. So it was kind of tough that way. (Craig)

Professional development conflicts with the patient care routines on the unit, which are critical to patient safety:

> Like if the nights didn't do that because there was a crashing patient and it was so busy, and the following day, we can tell. In the following day, it will carry on in days. The business of the unit everything is not done and left behind, and it will carry on in the evening like you know. It will just go in circles like that—Oh I see that I said, You have to be advanced—one step ahead. (Sarah)

However, add to the high patient acuity and tight work timelines, there are always new, added responsibilities that disrupt a sense of comfort and competence:

> So, instead of just doing, just doing bedside nursing, I think which they believe—well it's important too, but they also want, instead of having a charge nurse at the desk they want us to be, you know, making all the discharge planning, talking with the doctors, organizing everything in that way but, everything that a charge nurse does but while working, directly at the bedside with the patient. (Miss M.)

Adding to the stress of *surviving* the workplace, is the negative culture:

> I think it's just something over time, I think, working on the unit where I work too, it was —it was a heavy unit, and you know, the morale was going down and people were stressed, so it seemed just as an obvious thing to me, that was important, especially to have effective relationships with your coworkers. (Heather)

However, regardless of the challenges, nurses must attend learning activities that are not necessarily relevant because CARNA requires particular learning methods: "'Cause the only—this is what I say the workshop is—my way of learning *other than the one I'm learning from the unit* [emphasis added], so it's always the workshop I go to" (Marie). Ultimately, MyCCP is unnecessary because 'if you are working, you are learning':

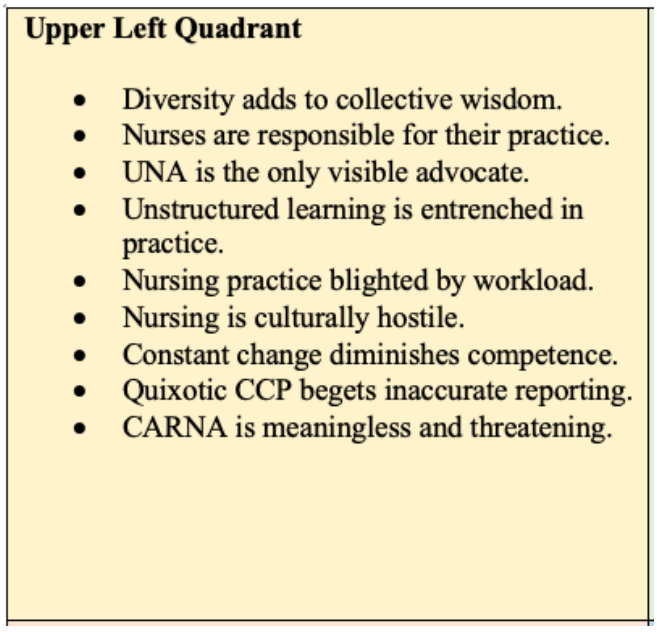
> But of course, people have to have continuing competence. Not assessment, just continuing learning because it's changing. New medication. New policies. New approach to medicine completely. Electronic everything will come. So, it's competence. You don't know computer; you have to increase your competence otherwise— you're at work. Yeah, (Victor)

Moreover, CARNA does not meet the objective to monitor competence when they are oblivious and threatening:

> I find just my experience is being from a floor perspective, that I don't find CARNA is really aware of how things go on the floors… They're very much research based, very much, um, political based to try and make sure that legislations is being followed, so in some ways it can be a punitive source you know if staff members are not meeting the requirements. (Darren)

These upper left quadrant themes address the research question: **"**How do RNs and administrators personally perceive and experience CARNA mandated professional learning for nurses"? As shown in Figure 11, the themes that have emerged in the upper left quadrant contribute to the holistic four-quadrant perspective of the influences following a phenomenological approach. These findings show the impact of continuing professional development influences on practice, theory and further research in nursing and regulation, discussed in Chapter Five.

Figure 11. Left Upper Quadrant final themes



Lower Left Quadrant: Ethnographic Approach Second-Person Point of View

Within the lower left quadrant, the intersubjective view of administrators who experience RN mandatory learning to focuses on the research question, “How do the interactions with and among RNs, administrators, work teams, UNA, and CARNA during mandated professional development program implementation influence nurses learning”? Focus group interviews were conducted in a semi-structured format with a small core of questions, relating to the topic and research questions. Participants were encouraged to elaborate on the issues relative to their contexts. Table 12 summarizes the participants’ demographic and professional information with focus groups one and two interviews of unit managers and educator, and focus group three the executive focus group.

Table 12. Focus Groups Demographics

	Position Held	**Years of registered nurse experience**	**Gender**
Focus Group 1: Nurse managers and nurse educator			
Mr. J	RN, Unit Manager	13	Male
Lady Import	RN, Unit Manager	32	Female
Baby Doll	RN, Clinical Nurse Educator	6	Female
Focus Group 2: Nurse managers			
Dawn	RN, Unit manager	22	Female
Debbie	RN, Unit manager	18	Female
Focus Group 3: Executive nurse leaders			

Christine	RN, Executive Leader, Alberta Health Services (AHS)	Not disclosed	Female
Grace	RN, Executive leader, CARNA	43	Female
Alice	RN, Executive leader, United Nurses of Alberta (UNA)	43	Female

I used the same interpretation and coding technique as the upper left phenomenological interviews using content and thematic analysis, beginning with the interviews themselves. Each group presented themselves with an attitude and perspective that was brought to bear on the interview questions, which I then considered in the analysis of coded themes. Presentation of the focus group findings is under sub-headings with the second and third level of analysis of data thematically coded. Each code is linked to the interview script where the code originated, therefore traceable to the original spoken scripts in Appendices 4Q-4V. The final table in each focus group section contains the third stage of refined codes derived from each analysis stage that may be traced back to the first level script analysis in the Appendices.

Focus Group 1; 'Overwhelming Responsibilities'

Focus group one consists of three registered nurses in the positions of unit managers and one nurse educator working in a medical-surgical unit at a large, central hospital in Edmonton, Alberta. This group was spirited and eager to talk openly about the mandatory continuing professional development requirements of nurses. In their positions, they provide education and must monitor and grant approvals for nurses on their units to attend education sessions and were quick to lament on their challenges to support them in these ways. Scheduling difficulties,

onerous demands on them, and performance issues with their reporting nurses, were some of the problems they spoke about. The CARNA requirement to plan education ahead of the practice year is the least effective, while the on-site, just-in-time learning is the most effective. Though it is challenging to monitor and ensure consistency in education among nurses when learning just-in-time. As this group is cynical about CARNA, they believe nurses to be capable learners in their daily work and will take opportunities to learn when possible despite what CARNA mandates. Table 13 shows the second and third stages of coding of focus group one. These codes may be traced back to Table 45 for the second stage of analysis, located in Appendix 4Q. Table 46 in Appendix 4R, displays the original script showing the first stage of analysis coding.

Table 13. Focus group 1-Third stage of analysis

Second stage coding	**Third stage: Final Codes**
1d. Nurses do not report their continuing compete 21d. CARNA's processes are not understood.	1e. Nurses do not authentically comply with CARNA requirements.
2d. CARNA is a negative presence. 3d. CARNA causes hardship.	2e. CARNA is an oppressive presence.
4d. CARNA is incompetent.	3e. CARNA is incompetent.
5d. MyCCP design does not consider experiential learning. 6d. MyCCP could be made more meaningful.	4e. MyCCP reports should reflect learning as perceived by the learner.
8d. The motivation to learn varies greatly. 27d. Nurses have personal reasons for learning. 26d. Learning requirements are unique to each nurse.	5e. Nurses have nuanced needs to learn.

7d. Peers encourage learning.	
10d. Managers are responsible for providing access to education. 9d. It is part of the managers' job to promote learning. 11d. Managers are the gatekeepers of learning. 28d. Managers value nurses who are motivated to learn.	6e. Managers are the gatekeepers to learning.
12d. UNA is a crucial supporter of nurse education.	7e. UNA supports nurse education.
13d. Managers must prioritize operations. 16d. Managers are overwhelmed with numbers of staff to monitor and support competence.	8e. Managers contend with competing priorities.
14d. Quick, frequent, in situ meetings, help disseminate new knowledge. 18d. Nurse managers accountable for change management. 17d. Administrative implementations add to the workload.	9e. Managers must integrate new implementations into the workload.
19d. Change increases nurse resistance.	10e. Change increases nurse resistance.
20d. Learning is ingrained in nursing practice. 23d. Reflection is embedded in the process of learning.	11e. Nursing practice and learning are interdependent parts of a whole.

15d. Learning opportunities are interdisciplinary.	
24d. Incompetence is hidden in plain sight. (not addressed but everyone knows it is there) 25d. Competence is shared accountability. (peers, managers, co-workers maintain the competence of each other) 22d. CARNA insidiously undermines the meaning of competence.	12e. Nurse competence is hidden in plain sight.

Nurses do learn formally and informally, but CARNA's processes do not reflect true, lived learning, especially for those nurses who are not computer savvy or internationally educated: "…the process and especially the senior nurses who are not computer savvy, it's painful for these poor people to try and get through that process and complete that indicator when I know they're going to four in-services this year" (Lady Import-Focus Group 1). There is a sense of anger and resentment in this group toward CARNA for imposing onerous processes and systems on nurses. They agree among each other that there are several other ways to accomplish continuing competence reporting that would be far more effective and efficient.

> I feel like, have you guys ever looked into the CNA certification? That process I agree with, maybe not the amount of hours that the—you have to get in the five years, but you have to have a certain amount of hours to prove that you've furthered your education in order to keep your CNA certification after you've passed the exam or whatever. Umm, that I could see being beneficial because it forces people to actually seek out educational

opportunities and actually go to these things rather than just picking a random goal of what you think you're gonna do [sic]. (Baby Doll-Focus Group 1)

CARNA seems to leave the impression with nurses that competence is as simple as one learning objective and a simple plan:

Lady Import: It may almost give them a false sense of security in a way, maybe. In that, yeah, yeah, yeah, that's good, I've read this, and I'm done now for the year.

Mr. J: Met the regulatory.

Lady Import**:** Instead of actually having to go to a conference or take a class or—complete something. (Focus group 1)

Throughout the dialogue, these individuals spin ideas off each other and seem to rant openly and angrily about CARNA and how meaningless choosing an indicator is (for example):

Lady Import: (cross talk) What do I—what am I going to do to meet this indicator.

Mr. J.: (cross talk) not that one, not that one, not that one.

Baby Doll: (cross talk) If I can't understand it, I'm not doing that one.

Lady Import: [inaudible] use the same indicator and just do something different.

Mr. J.: Or, rotate [inaudible]

Baby Doll: Mhmm.

Lady Import: Because you don't really know what those damned indicators mean in the first place—and I think a lot of people struggle with that. (Focus Group 1)

They generally believe that nurses accessed education as they need and are motivated by their peers and by interesting conferences or presentations recommended and enabled by them (as managers):

> Lady Import: I think conferences are good too because if you have people that you work with that you are friends with that are going it forces you to want to go as well, you, 'cause it's a social situation.
>
> Mr. J.: Yeah.
>
> Baby Doll: but it's also educational. Like, I've gone to a few because a bunch of people I knew were going, and I'm like, yeah sure, sounds fun, and it gets you out of the hospital…(Focus Group 1)

CARNA does not detect nurses' competence, but it is revealed, however, when adverse events happen or when noticed by colleagues or managers. Before such time, incompetence is hidden in plain sight.

> Somehow, eventually, if they do it enough times, it catches up with them, and it does come out, and then *we* [emphasis added] deal with it. Nobody goes—under the radar for their entire career being completely incompetent. (Baby Doll-Focus Group 1)

Focus Group 2; 'Managers' Moral Distress'

This small focus group of two registered nurse unit managers are also situated on the case study unit of the nurses interviewed in upper left quadrant. This group was softer-spoken compared to focus group one, though shared similar perspectives regarding registered nurses' mandatory continuing education. Some of what this group shared were their issues with continuing professional development in their leadership roles. When asked to discuss the influence of CARNA on mandatory learning, Debbie reflected on the inconvenience, fear, and frustration:

> And, and feeling that you have to have it documented on a piece of paper on a yearly basis, I—in, in this area I find it to be, ah, just another deadline that you're regretting and

then you'll, you know, the whole thing about am I gonna get audited? What's —What are the consequences? And, it's just—it's frustrating at times. (Debbie-Focus Group 2)

Table 14 shows the third stage of thematic analysis for group 2. Table 47 displays the second stage of analysis in Appendix 4S, and table 48 in Appendix 4T shows the first stage of analysis linked with original script.

Table 14. Focus group 2-Third stage of analysis

Second stage of coding	**Third stage: Final Codes**
2i. Nurses are highly anxious about engaging with CARNA. 8i. Completing the unstable MyCCP is onerous.	1j. High anxiety associated with CARNA.
2ii. Nurses cannot report authentically in MyCCP. 14i. Nurses lack the resources necessary to fulfill CARNA reporting requirements.	2j. Nurses unable to authentically report in MyCCP.
3i. UNA, AHS and CARNA are oblivious to their culminated demand on nurses.	3j. UNA, AHS and CARNA are oblivious to the severe impact mandatory education have on nurses.
3ii. UNA benefits are not realistic in context. 13i. CARNA is detached and unsupportive. 10i. The employer is reducing support for nurses' learning.	4j. Organizations do not account for or provide for the necessities of learning.

4i. Short, in situ learning events are not sufficient, meaningful learning. 1i. Nurses consistently gain competence through formal and informal learning.	5j. Nurses require formal and informal deep learning.
5i. Managers cannot access education due to their work obligations. 7i. CARNA requirements are an additional layer of work for managers. 12i. Managers require both clinical and leadership learning, and there is a lack of both formal and informal- contributes to deteriorating skills.	6j. Managers are unable to maintain clinical skills and knowledge.
6i. Managers identify nurses' learning needs and provide opportunities to learn. 11ii. Managers cannot accurately monitor nurses' learning. 15i. Knowledge dissemination is reliant on social collaborations in learning. 11i. Managers must prioritize adequate staffing but are obligated to promote learning.	7j. Managers are unable to monitor and provide learning opportunities to staff nurses adequately.
9ii. The nursing scope is stagnant. 9i. Nurses are not motivated to exceed minimum expectations.	8j. The profession of nursing is dormant.

18i. Nursing capabilities are under-recognized in general.	
10ii. Nurses bear responsibility for their learning on their own time.	9j. Nurses learn on their own time and money.
14ii. Nurses are motivated if they understand the relevance of mandatory learning.	10j. Relevant learning is motivating.
16i. Competence is critical thinking, sound decisions, and proficient clinical skills. 17i. Comfort and confidence are ways of knowing one's competence.	11j. Competence is intelligence and skills proficiency that increase confidence.

Nurse managers are critical to providing their clinical expertise and physical support in the work on the unit; however, they are leaders of critical unit teams. They are caught up in the administrative work to organize schedules, provide permissions to requests, ensure new implementations are successfully rolled out and much more. They are overcommitted in their role.

> But at the same time, you know, I'm a fairly new manager, so I would love to have the opportunity to do more educational, learn more about my position, learn different things, but to do that I would literally wind up being off the unit a great deal more than, um, what I am right now. And that's not good for my unit either. Being away for extended periods of time. (Dawn-Focus Group 2)

The nursing staff numbers are unmanageable in terms of tracking and supporting competence, and they generally feel overwhelmed and must succumb to trusting "it all works out," however, at times, accountability is lacking.

> They all have the education. They know how to fill out the paperwork. But, they choose not to necessarily do it, because they don't see a reason for it. Or, they don't understand how relevant it is. Or, they don't understand that when they do certain things—Well, I keep filling this out, but it doesn't seem to do anything, or it doesn't get anywhere, so why do I continue to fill it out. (Dawn-Focus Group 2)

This focus group expressed a general concern and frustration with how their opportunities for professional development are suppressed by their accountabilities for everyone else while also ensuring priorities for patient care are met. They are relied upon to be a clinical resource, but they feel their skills slip away while they are in their leadership versus bedside role:

> I think we try our hardest, and in the position that I am in, I can speak for myself, I have a clinical component to my job where I'm on the unit. I understand the workflow, I understand the, you know, patient load, I — and I have the right staff on the unit. But, because I lack the hands-on on certain things, I've done my, my clinical competencies. I do them every year—I feel like I'm slipping further and further away from my ability to do that too. And the sessions are getting smaller and smaller. (Debbie-Focus Group 2)

CARNA does not need to add requirements for learning since learning is constant: "... if the legislation says that we have to make sure we have educational hours that we're keeping up to date with the current —I think in our setting, we're already doing that" (Dawn-Focus Group 2). CARNA's continuing competence program is not synergistic with the lives of nurses, making it an imposition and superfluous.

> … rather than focusing on what we're supposed to be doing and doing our nursing care and doing the things —and, and I, you know, education incredibly important and we're doing it every single day, but it almost feels like you're asking me to sit down and record that and take time away from what I'm actually supposed to be doing. Cause, by the end

> of the day, I'm not going to sit down with my journal and write everything down. Because I'm tired by the end of the day. I am—I'm done. (Dawn-Focus Group 2)

The employer provides and promotes learning at the convenience of the employer, not noticing or considering nurses access or availability to participate in it:

> So, um, sometimes the education sessions aren't offered in a way where the staff can—can get there. I mean, We work in a facility that's a twenty-four hour seven day a week facility and yet the night staff is never considered when it comes to education. (Dawn-Focus Group 2)

This group is at the centre of a system tug-of-war where it is seemingly impossible to succeed.

Executive Group 3; 'Just Toe the Line'

This focus group includes executive-level leaders of each, CARNA, UNA and AHS. These registered nurses have each been leaders in their positions for many years, though Christine did not indicate precisely the number of years in her role. The timing of the focus group interview was following contract negotiations between UNA and AHS, so though the session was amicable, the occasional "political" comment arose between the two executives. Nonetheless, the interview was candid and collaborative in sharing views of nurses' education. They were quite knowledgeable about and *resigned to* the general experiences of front-line registered nurses that are challenging. Christine, for example, explained, "So there's there is—always the challenges around staffing and freeing people up for education. That's what managers would say; I know that for a fact" (Christine-Executive Group 3). Table 15 shows the third stage of thematic coding of this focus group interview. These third stage analysis codes may be traced back to second stage analysis codes found in Table 49 in Appendix 4U. Additionally, first stage analysis is shown in Table 50 in Appendix 4V where codes are linked to the original scripts.

Table 15. Executive focus group-third stage of analysis

Second-level analysis	**Third level: Final Codes**
1M. Nurses justify learning on their personal time. 4M. Nurses pay for the learning they require. 11M. Nurses have busy personal lives.	1N. Nurses spend their own time and money on mandatory learning.
2M. Organizations *should* provide and fund mandatory learning. 3M. AHS provides waning support for nursing CPD.	2N. Mandatory learning requirements are poorly supported and funded.
5M. UNA reduces barriers to learning. 8M. Online learning increases access to education.	3N. Online learning and paid days off reduce barriers to learning.
12M. Nurses must learn rote, yearly education in most nursing positions. 25M. Nurses must learn and quickly adapt while prioritizing patient care.	4N. Nurses must manage mandatory learning as an addition to the priority of patient care.
10M. Learning styles and preferences influence learning choices. 6M. Nurses are motivated when education is relevant. 9M. Nurses seek the education they know they need.	5N. Nurses choose to learn according to relevance and preference.

7M. Education requirements vary with professional experience.	
14M. Nurse leaders/managers are learning motivators and gatekeepers.	6N. Managers are the learning motivators and gatekeepers.
15M. Unmeasurable, experiential learning helps to continuing competence. 16M. Nurses should apply experiential learning to their MyCCP learning objective. 24M. Undergraduate programs should include elements of continuing competence approaches. 13M. Completion of mandatory learning does not indicate competence.	7N. Experiential learning enhances competence.
18M. Nurses know their competence from peer, manager and patient feedback. 17M. Nurses must know how to continue their competence.	8N. Nurses enhance their competence as informed by workplace feedback.
20M. Loss of nursing competence is convoluted and challenging to pinpoint. 19M. Nurse managers are accountable for detecting and managing staff nurses' competence.	9N. Nurse managers regulate nurses' continuing competence.

21M. Nurse managers, educators, and senior nurses must provide coaching to increase competence in staff nurses.	
22M. Upcoming changes will increase the need for nursing critical thinking and adaptation.	10N. Organizations continually increase mandatory requirements.
23M. Organizations do not, but should communicate and collaborate for unified approaches to education and implementations.	11N. UNA, CARNA and AHS lack critical collaboration.

Senior leaders of CARNA, UNA and AHS acknowledged the issues and challenges with continuing professional development with nurses on hospital units: “So, um, I think the relevancy of it, uh, is a factor as well. But uh, access and, and uh and cost, that kind of stuff I—I think are significant.” (Alice-Executive Group 3). Though mandatory learning such as recertification programs are necessary each year, nurses must also balance their learning needs according to their practice: “Right, and um, I think that's a real dilemma for some nurses is that they know, what, what competent practice should be, and it's whether or not they are able to, to deliver it” (Alice- Executive Group 3). Strong nursing leadership is a critical factor in continuing competence, where positive reinforcement encourages staff to seek learning:

> And uh, I think that where you have a strong nursing leader in a program or, or unit who encourages their staff and you know, positively reinforces their staff for taking on and seeking out additional education, I think, I think there is a big difference in terms of both what the staff do, and—and what they bring back. (Alice- Executive Group 3)

Some of the best learning is the unstructured, “just-in-time” learning that motivates nurses at the moment.

> So some of the learning that can happen that is the most valuable, the most relevant is what I call that just in time, where someone who has the capacity and capability to say, had you thought about or, I have learned that and then that spikes their interest. (Grace- Executive Group 3)

Executive Group 3 acknowledged the gap and the need for organizations to work together: “I think collaboration is the key. I think that any time we can minimize and get together on something that's meaningful education, we should try…” (Christine- Executive Group 3). There is little hope for better working conditions or functional regulatory programs when the executive group is so well aware of, and resigned to front-line and nursing manager challenges to access and enable education.

Focus Groups Consolidated Themes

As a final phase of analysis, Table 16 shows the combination of each of the final coded themes of the three focus groups. Similarities in themes were analyzed and further grouped in final themes associated with interview questions, presented in Table 17. The notable similarities in Tables 16 and 17 add further context to the analysis of codes, especially related to the authenticity of competence and continuing professional development reporting. There are also similar thoughts about the significance of the role of the unit manager in continuing professional development since they are the enablers, gatekeepers and change agents in the requirements for and access to learning opportunities. Overall, the themes relate to the prevalent issues in nurses' continuing professional development that ultimately impede learning and thwart the forward movement of the profession. Groups one and two especially focused on the issues with CARNA, while the Executive Focus Group Three recognized the importance and lack of support of

continuing professional development. The executive group does not acknowledge that continuing competence cannot be achieved and the associated negative impact on the nursing profession.

Table 16. Focus Groups Consolidated Themes

Focus Group 1: Unit Managers and Nurse Educator	**Focus Group 2: Unit Managers**	**Focus Group 3: Executive Nurses**
1f. Nurses do not comply authentically with CARNA requirements.	1k. Angst associated with CARNA.	1O. Nurses sacrifice personal time and money.
2f. CARNA is an oppressive presence.	2k. Nurses unable to authentically report.	2O. The dearth of support.
3f. CARNA is incompetent.	3k. UNA, AHS and CARNA oblivious to their impact.	3O. Paid days off and elearning increase access.
4f. Experiential learning is unreported.	4k. Mandatory learning not enabled.	4O. Mandatory learning is an extra workload.
5f. Learning is individualistic.	5k. Deep formal and informal learning required.	5O. Nurses choose their learning.
6f. Managers are learning gatekeepers.	6k. Managers restricted in their competence.	6O. Managers motivate and control learning.
7f. UNA supports learning.	7k. Monitoring and providing learning thwarted by manager workload.	7O. Experiential learning enhances competence.

8f. Managers are conflicted.	8k. The nursing profession is dormant.	8O. Feedback informs nurses of their competence.
9f. Managers are change managers.	9k. Learning on their own time and money.	9O. Managers regulate competence.
10f. Resistance increases as change increases.	10k. Relevant learning is motivating.	10O. Expanding mandatory requirements.
11f. Learning is integral to nursing practice.	11k. Confidence, intelligence and skills proficiency indicate competence.	11O. Organizations are aloof.
12f. Competence is knowingly unaddressed.		

Focus Groups; Themes Linked to Interview Topic Item and Collapsed Themes

Table 17 shows the analysis of the final themes of each focus group in reference to each of the interview questions. The number of codes per topic added up in the content analysis increased contextual meaning in the codes. Table 18 shows the further collapsed nine final themes. The interviews were semi-structured with a small core group of questions directly related to the research question, "How do the interactions with and among RNs, administrators, work teams, UNA, and CARNA during mandated professional development program implementation influence nurses learning"?

Table 17. Themes linked to topics and interview questions-collapsed focus groups themes

Interview questions	**Topic: Experiences in provincially legislated continuing professional development.**	**# of collapsed codes**

What influences nurses' learning?	**Collapsed theme** 1: Relevant education motivates learning.		3
	FG 1	5f. Learning is individualistic.	
	FG 2	10k. Relevant learning is motivating.	
	FG 3	5O. Nurses choose their learning.	
	Collapsed theme 2: Nurses sacrifice their own time and money for learning.		2
	FG 2	9k. Learning on their own time and money.	
	FG 3	1O. Nurses sacrifice their own time and money for mandated learning.	
Tell me more about learning requirements ?	**Collapsed theme** 4: Learning opportunities need depth and breadth.		1
	FG 2	5k. Deep formal and informal learning required.	
	Victor	14zz. The unit routine is fundamental to competence.	
	Miss M.	8be. Practice standards indicators are fundamental knowledge.	
	Marie	5ae. Accountability is competence.	
Interview question topic	**Topic: Work colleagues and work teams**		**# of collapsed codes**
What are nurses' experience	**Collapsed theme** 5: Managers regulate nurses' learning.		2
	FG1	6f. Managers are learning gatekeepers.	
	FG3	6O. Mangers motivate and control learning.	

and influence within their teams?	**Collapsed theme** 6: Managers are placed in a paradoxical role.		3
	FG 1	8f. Managers are conflicted.	
	FG 2	6k. Managers are restricted in their competence.	
	FG 3	2O. There is a dearth of support.	
	Collapsed theme 7: Managers implement change.		1
	FG1	9f. Managers are change managers.	
Interview question topic	**Topic: CARNA Continuing Competence Program mandatory processes: MyCCP**		**# of collapsed codes**
MyCCP reporting	**Collapsed theme 8:** Nurses do not report authentically		2
	FG 1	1f. Nurses do not comply authentically with CARNA requirements.	
	FG 2	2k. Nurses unable to authentically report.	
Tell me about your view of competence.	**Collapsed theme** 9: Indications of competence is unclear		2
	FG 2	11k. Confidence, intelligence and skills proficiency indicate competence.	
	FG 3	8O. Feedback informs nurses of their competence.	
Interview question topic	Topic: **How does UNA, CARNA and AHS influence learning?**		**# of collapsed codes**

How does the employer influence your learning?	**Collapsed theme** 10: Nursing positions in organizations necessitates learning.		3
	FG 1	11f. Learning integral to nursing practice	
	FG 2	8k. The nursing profession is dormant.	
	FG 3	10O. Expanding mandatory requirements.	
	Collapsed theme 11: Mandatory learning is an extra workload burden.		2
	FG 2	4k. Mandatory learning is not enabled.	
	FG 3	4O. Mandatory learning is an extra workload.	
	Collapsed theme 12: Organizations oblivious to nurses' experience in learning.		3
	FG 1	3f. CARNA is incompetent.	
	FG 2	3k. UNA, AHS and CARNA oblivious to their impact.	
	FG 3	11O. Organizations are aloof.	
In what ways does CARNA influence learning?	**Collapsed themes** 13: Nurses have angst associated with CARNA		2
	FG 1	2f. CARNA is an oppressive presence.	
	FG 2	1k. Angst associated with CARNA.	
	Collapsed Themes 14: The most valuable learning is unaccounted.		2
	FG 1	4f. Experiential learning is unreported.	
	FG 3	7O. Experiential learning enhances competence.	
	Collapsed themes 15: UNA supports learning.		2

How does UNA influence nurses' learning?	FG 1	7f. UNA supports learning
	FG 3	3O. Paid days off and elearning increase access.
Additional thoughts learning and continuing competence	**Collapsed themes** 16: Nurses' competence is unaddressed.	3
	FG 1	12f. Competence is knowingly unaddressed.
	FG 2	7k. Monitoring and providing learning thwarted by manager workload.
	FG 3	9O. Managers regulate competence

Focus Groups: Final Themes of the Lower Left Quadrant

The final themes are shown in Table 18 complete the analysis of the lower-left quadrant in this research. Each of these final themes contributes to the quadrivium and the holistic analysis of all four quadrants.

Table 18. Focus groups final themes in table 17.

Theme	**Collapsed themes**	**Final theme**
1	Relevant education motivates learning.	1az. Relevant education motivates nurses.
5 6 7	Managers regulate nurses' learning. Managers are placed in a paradoxical role. Managers implement change.	2az. Nurse managers experience moral distress.

10 11 2	Nursing positions in organizations necessitates learning. Mandatory learning is an extra workload burden. Nurses sacrifice their own time and money for learning.	3az. Unrealistic learning requirements are uncompensated.
12 4 3	Organizations oblivious to nurses' experience in learning Learning opportunities need depth and breadth. Resistance increases with changes imposed.	4az. Incongruous organizations hinder learning.
13	Nurses have angst associated with CARNA	5az. CARNA is threatening and irrelevant.
14	The most valuable learning is unaccounted.	6az. CARNA does not recognize learning that advances competence.
15	UNA supports learning.	7az. UNA is an advocate.
16 9	Nurses' competence is unaddressed. Indications of competence are unclear.	8az. Competence not addressed.
8	Nurses do not report authentically.	9az. Competence reporting not authentic or accurate.

Lower Left Quadrant Summary

Continuing professional development is co-created with colleagues and managers in the workplace when it is relevant and often “just-in-time." Newer nurses continue to learn the fundamentals of teamwork and refinement of skills, while experienced nurses seek more in-depth, specialized knowledge. "If it's mandated, it's not relevant to me; I'm not gonna buy into it” (Executive Group Three). A critical part of the manager’s role is to encourage and accommodate learning, however in a system that does not support it. It is an excessive amount of work to monitor, enable, and organize learning and competencies for staff nurses, and it is critical for safe nursing practice. "Our goal, for any new—new roll out our goal, is eighty percent, ‘cause then everybody else will teach everybody else—because it’s impossible to catch everybody…” (Focus Group One). Social dissemination is a challenge when there are many nurses resistant to change, and new learning, mainly because they are expected to "keep up" on their own time. Learning demands from both employer and regulator are onerous and separate from each other. UNA is highly regarded as the sole support for nurses; however, their efforts also fall short within the system that does not support continuing professional development.

> They continue to run them [education sessions]. It's like, well how can you expect —then, and then they turn around, and they come back to us and say, well nobody shows up. Well, that's because you're not setting it up at a time that's convenient. (Focus Group Two)

Nurses working on hospital units have to stay focused on their workload and continue to learn to survive the shift. Attending learning sessions is hazardous. “They're still focused on their patients. If the call bell rings, they know that they're supposed to answer it. They're gonna leave what you're doing, and they're gonna go” (Focus Group Two). Though the three paid education days increase access to attend learning sessions (*if* time off is possible), very often, nurses complete their education requirements on their personal time and money.

> I know there is a lot of concern or, some angst around um, what is stated to be mandatory, but expected to be done on the nurse's own personal time—access and, and uh and cost, that kind of stuff I—I think are significant. (Executive Group Three).

Granting time off for nurses to complete mandatory education continues to be a problem for employers.

> We've gone to, so close to "just-in-time" staffing… Which, I mean, that's why people don't get vacation—Because I think there's, there's an inability sometimes to release staff for education, that's what it is. Because priority always is patient care. And regardless of how we schedule, or what we do with our schedules. (Executive Group Three)

As a result, access to mandatory, formal learning is inadequate and unsafe. "…you're not going to be getting quality learning. You're going to be getting shoestring learning. And, that isn't safe for anybody" (Focus Group Two).

CARNA does not accommodate "shoestring learning" or experiential learning; instead, it demands construed reporting of formal learning. The CARNA system frustrates nurses and nurse managers because the system they work in does not accommodate informal learning, making the report form meaningless. "A lot of them [report fields] don't make a lot of sense. Not—by the end, I'm just like blahhh, blahh" (Focus Group One). Neither employer nor regulator employs a system that supports learning, rather instead systematically deploys requirements that meet their administrative needs. Nurses struggle then, with meeting their own professional development needs, versus the employer needs, versus the regulator requirements.

> Can I personally take it? I would love to. Can I get it into my schedule? Ninety percent of the time is no, which is kinda sad because, you know, there is—the position that we're in is such a steep learning curve. And, there's so much to learn (Focus Group Two).

Further, CARNA processes are far removed from their mandate to protect the public: “I don’t think having nurses choose an indicator protects the public… at all” (Focus Group One). However, experiential learning is deemed most effective:

> And they, they seek opportunity, especially if it's a new skill or a new activity, or a new intervention that they're using on the unit, they really want to understand and learn that, because it is relevant to their practice and they need to learn it to maintain competency. That's very important to nurses. (Executive Group Three)

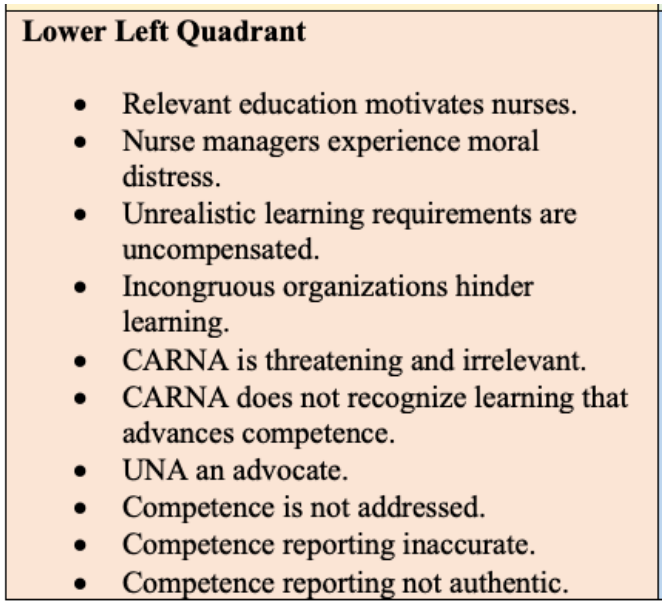
The mandatory continuing professional development requirements of CARNA are then, mostly irrelevant and the result is grossly misrepresented data. Mr. J.: “No. To be honest, the CARNA registration, like, to… anyone can BS their way through that”. Lady Import: “Yeah." Mr. J.: “Anyone can. It’s very easy”. Lady Import: “Yeah. And most do” (Focus Group One).

The question is, then, how does CARNA regulate nurse competence when competence reporting is inaccurate? The most likely answer is that nurse colleagues monitor each other: “Other RNs won’t allow it. No, because then they're picking up the slack, or like I said there's an adverse event, and a patient suffers, and someone definitely notices that. Or they actually own up to it or someone…” (Focus Group One). Competence and incompetence are elusive concepts and may be difficult to detect when defined in terms of insight, critical thinking or sound decision-making. “I've also worked with a very highly educated individual who had no clue how to do different things… [it is] expertise or comfort. And, comfort, I think, has a big factor in competence as well. So, I don't know” (Focus Group Two). Competence is not detected, monitored or supported adequately in nursing.

These lower left quadrant themes focus on the research question: "How do the interactions with and among RNs, administrators, work teams, UNA, and CARNA during mandated professional development program implementation influence nurses learning"? As

shown in Figure 12, the themes that have emerged in the lower left quadrant contribute to the holistic four-quadrant view of the influences in registered nursing. These findings show the impact of continuing professional development influences on practice, theory and further research in nursing and regulation, discussed in Chapter Five.

Figure 12. Final Themes in Lower Left Quadrant



Upper Right Quadrant: Objective Observable and Measurable Point of View

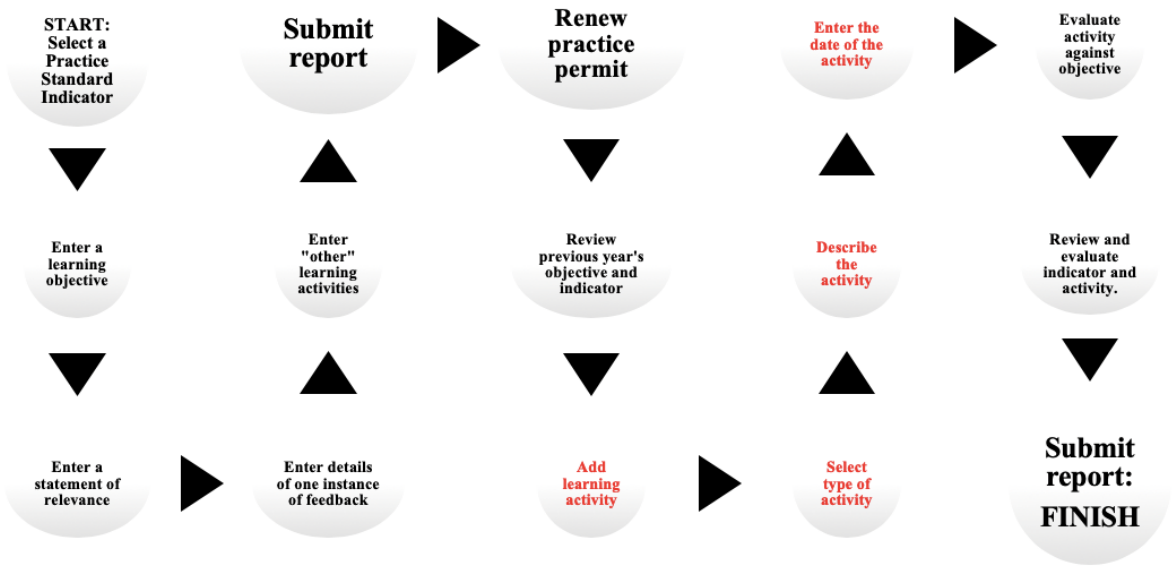
Reporting mandatory professional development is prescribed by the CARNA MyCCP online form that is designed to guide nurses through each stage of the professional development process. The design is therefore intended to be reflective, where one may revisit and make changes anytime, report learning as it happens, ensure compliance with all elements covered, and obtain attestation (College and Association of Registered Nurses of Alberta, 2018a). The MyCCP report form is the data collection and monitoring of continuing competence in the CARNA Continuing Competence Program. The upper right quadrant investigates the actual interactions between MyCCP and nurses who report in it. This section focuses on the research question, "How are the RN professional learning requirements determined and assessed"? First, a

basic representation of the MyCCP program is described, followed by the findings and analysis of reported (stated in interviews) behaviours in the program.

Competence Reporting Overview

The first step in CARNA competence reporting is practice reflection where nurses review the "Nursing Practice Standard Indicators" (College and Association of Registered Nurses of Alberta, 2013c) and how their nursing practice relates to each. The 34 indicators are discreet descriptions of how each of the five practice standards must be met in nursing practice. After reflecting on the Indicators, nurses may decide on where they need to strengthen their practice and may develop an objective. Figure 13 shows a visual overview, as seen below. The only two "provable" pieces of information are: 1. Which Indicator was selected, and 2. That all the steps in the report are complete. Nurses must fully complete this form before they are eligible to renew their yearly practice permit.

Figure 13. High-level flow chart of MyCCP Report



As seen in the flow chart, there are several significant steps. The first three steps, 1. Selection of the Practice Standard Indicator, 2. Enter a learning objective, and 3. Enter a

statement of relevance, are all steps in the *Practice Reflection* stage. These steps, plus the feedback documentation step, are requirements before nurses may reapply for their practice permit. As the process goes, they complete these steps, submit their report, and then exit the MyCCP program to complete the application section in another electronic program. Once completed, they are required to return to MyCCP, to enter the Continuing Professional Development section of the report that includes 1. Reviewing the previous year's objectives and indicator, 2. enter one learning activity (more activities are optional), 3. indicate the type of activity, 4. describe the activity, 5. enter the date the activity took place, 6. Evaluate the activity against the learning objective, and 7, evaluate the learning activity as to how it influenced the nurse's practice. Nurses must complete these steps; then, they may submit the MyCCP report.

Summary of Discrete Actions in MyCCP

Considering the complexity of MyCCP, and the many steps required to complete the MyCCP report, Table 19 summarizes the discrete numbers of actions program codes, "clicks," prompts, and required versus unrequired pages that are shown in the report. Table 51 shows the full analysis of the MyCCP systemization located in Appendix 4W.

Table 19. Tabulated activities and coding within MyCCP report.

Totals Notes	**Clicks**	**Prompts/coding**	**Reporting activities**	**Required versus unrequired**
Total tabulations include optional pages	59 clicks	44 blue buttons Nine green buttons Ten orange buttons Four text boxes 3000 words	Five attestations Seven open, written fields Seven dropdown menus	Eight sections of required entries. There are a total of seven sections

Some totals are approximate		Two text boxes 300 words Eight +expandable windows One grey button 1 area of faded lettering 1 area of bolded lettering 1 area of green checkboxes 1 area of grey checkboxes Two gear icons Red field highlighting Red Asterisks	Three short answers fill in the blanks Three date entries Five full pages of instructions/information Four areas requiring analysis and/or evaluation Seven windows to advance to the next	of CPD activities entries. Twenty-three pages are not relevant to requirements. All fields must be completed Only the Practice Standard Indicator field is reviewed.

Table 51 (Appendix 4W) with the consolidation of findings in Table 19 show a dramatic amount of cues, symbols, pages, and actions nurses must complete for each MyCCP report. The activity is burdensome for a mandatory yearly report, especially given the unnecessary numbers of pages that are extraneous. In addition to the discrete activities and interpretations, there is significant reading, interpretation, and open text writing. The open text writing depends on the high variability of interpretation of what is required to write, therefore leaving interpretation

open to ambiguity and variability in the written answers. Craig verifies the ambiguity of the system as part of his challenge: "Or like, how do you prove it? How is that even learning? I don't know. That's—I feel like they make it really, like, way too open-ended in my opinion" (Craig).

Interviewee Demonstration of MyCCP

Each interview began with asking the interviewee to open their MyCCP record and proceed to "walk me" through their report. This activity was hugely variable in results because the actual walkthrough exercise ranged from not showing me at all, to focusing on minute details instead of the overall scheme. Overall what I did see on average was random scrolling through of the items in the report and describing how the sections would be completed so as CARNA would be satisfied in the results and the individual would avoid an audit. Also, for the most part, the individuals were unable to explain each section relative to what they did or would report. For further understanding of the actual interactions with MyCCP, I analyzed the interview scripts once again, specifically to code all self-described learning activities, goals, practice standards indicator selections, feedback and influence of their learning that was described during any point in the interview. Each code is traceable back to the original script and organized into tables of *what* was reportedly reported, *how* (manner, or demeanour) information was reported, and a final table of what was not reported that interviewees stated they learned.

***What* is recorded in MyCCP.** Table 20 shows the codes of all the times when the interviewee talked about completed learning activities that they *did* enter into the MyCCP reporting software. Key elements of the events described by individuals were coded and categorized. Even when asked directly, many of the interviewees described their learning events in vague terms.

Table 20. Nurses reports in MyCCP

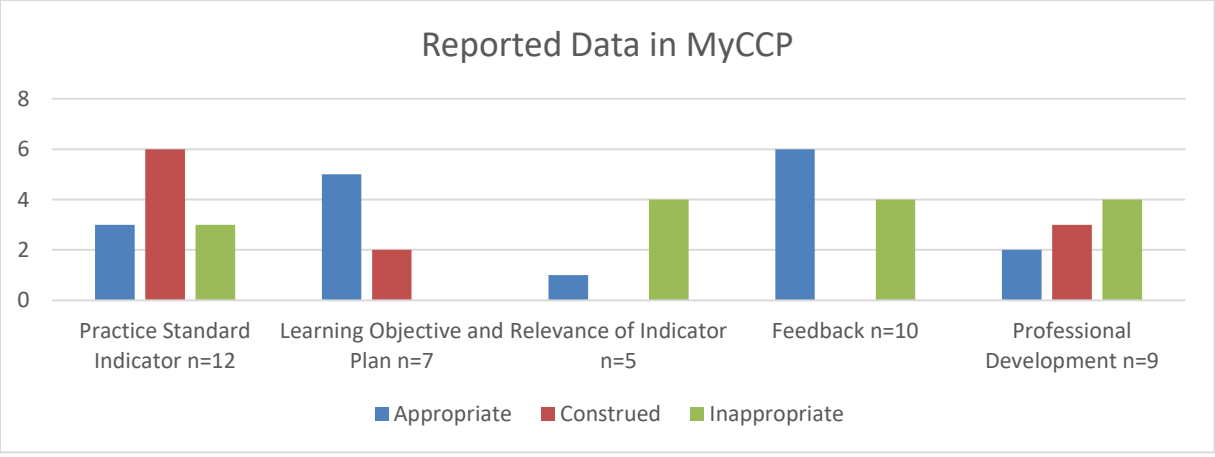
Nurses reports in MyCCP			**Categorization**
Practice Standards Indicator Selection	Darren	94bbb. Random pick	Inappropriate
		94bb. Pick same over and over.	Construed
		94b. I just pick one and try to make it fit.	Construed
	Sarah	5LL. Pick anything	Inappropriate
	Craig	10QQ. Select verifiable indicator	Construed
		31QQ. Pick what is closest.	Construed
	Victor	55zz. Accountable	Appropriate
		16zz. Simply pick out something	Construed
	Marie	24aca. Pick the closest.	Construed
		19aca. Forget what I chose	Inappropriate
		8aca. Scope of practice	Appropriate
	Miss M.	21bcb. Based on career progression.	Appropriate
Learning objective & plan	Craig	4QQ. Choose verifiable goals.	Construed
	Heather	64uuu. Create a goal under pressure	Appropriate
		18uu. Knowledge level goal	Appropriate
		64uu. Learning goal changes.	Appropriate
	Victor	42zz. One topic is doable.	Appropriate
	Miss M.	1bcb. Pain management goal.	Appropriate
		20bcb. Making learning plan meaningful	Construed
	Darren	93bb. Lack of fit	Inappropriate

Relevance of Indicator	Craig	31QQQ. Selection doesn't reflect the goal.	Inappropriate
	Heather	67uu. Does not reflect actual	Inappropriate
	Victor	7zz. Not applicable to me.	Inappropriate
	Miss M.	14bcb. Quality improvement (goal)	Appropriate
Described reported feedback	Darren	95bbb. Thank you cards.	Inappropriate
		97bb. Manager feedback.	Appropriate
	Sarah	28LL Student	Appropriate
		52LL. Supervisor commendation	Appropriate
	Craig	21QQ. Manager	Appropriate
	Miss M.	4bcb. Patient	Inappropriate
		4bcbc. Family	Inappropriate
		6bcb. Thank you card	Inappropriate
		5bcb. Manager	Appropriate
		8bcb. Colleagues	Appropriate
Described reported professional development activities	Darren	77bb. Leadership course	Appropriate
	Jim	48ee. Write whatever you want.	Inappropriate
	Sarah	2LL. Could not sign in	Inappropriate
	Craig	13QQ. Select wound care	Appropriate
	Heather	8uu. Initial goals that inevitably change.	Construed
	Victor	25zz. Capture main ideas	Construed
	Marie	4aca. People I spoke with COACT initiative.	Inappropriate
		4acac. The team I spoke with	Inappropriate

	Miss M.	3bcb. Summarize learning activities.	Construed

Summary findings of reported data in MyCCP. Every code derived from each interview script was categorized into whether the stated entry is "appropriate" as intended by the MyCCP program; or "inappropriate," where an entry was wholly made up or random; or "construed," where the entry was "made to fit" the form. Overall, as shown in table 21, of the codes pulled from the interview scripts, 40% report appropriately in MyCCP; 22% construe their responses to fit the system, and 38% are inappropriate or absent responses. These data are the selected responses from interview scripts that represent what respondents disclosed in interviews from both direct and indirect questions about their entries into MyCCP report form. The difficulty is trying to make lived experiences fit. "Um, to put it into a formulated format like what we have to do for our CARNA, it's a little bit of a challenge because then, Okay, what date did it occur? (laughs)" (Darren).

Table 21. Summary of data entry into MyCCP.



How Data were Entered into MyCCP

Table 22 compiles the codes of reported attitudes and behaviour during the MyCCP reporting process with, again, a resonating theme ranging from positive to tolerance, to

frustration. In my general observations of interviewees, responses regarding MyCCP reporting invoked particular characteristics that are of value to quantify in this research to understand the approaches and attitude toward MyCCP. As mentioned in the previous section, in analyzing the interview scripts once again, I selected responses that were emotional or attitudinal, as self-described by each interviewee. Each response was coded and described as positive if the response is positive and in line with intended outcomes of the program; negative if the response is frustrated, troublesome, or angry; and tolerant if the response was of a minimum, complacent nature. Table 22 shows the compiled results.

Table 22. How RNs report in MyCCP

How RNs report in MyCCP and characteristic code			
Working with system requirements	Darren	94b. I just pick one and try to make it fit.	tolerant
	Sarah	5L. I just fill in what I must so I can renew my practice permit.	tolerant
	Craig	12QQ. Ensure completion	positive
		14QQ. One entry per year	tolerant
	Heather	6uu. Just put something down	negative
		59uu. 300 word max	negative
	Marie	72acac. It is a "robot thing."	tolerant
	Miss M	2bcbc. Required to add more.	negative
Reporting mannerisms	Darren	94bbbb. Take shortcuts to think about it less.	negative
	Jim	48eee. Requirements are simplistic	negative
		30ee. CC a trigger to learn more.	positive
	Sarah	6LLLL. Too difficult to do.	negative

	Craig	1QQQ. Don't think about it much.	tolerant
	Heather	2uu. Only when necessary	tolerant
		60uu. Last minute	tolerant
		48uu. A tool to stay on track	tolerant
		60uuu. Get credit for what I do	positive
	Victor	9zz. A formality	tolerant
		4zz. Just have to do it.	tolerant
		56zz. Try to make sense of it and submit	negative
	Marie	6aca. Keeping it updated	positive
	Miss M	1bcbcb. Make relevant to practice.	tolerant
The emotional impact of the reporting process	Darren.	93bb. CCP process frustrating	negative
	Craig	16QQ. Must prove you achieved your goal.	negative
	Heather	8uuu. Actual learning unacknowledged	negative
		60uuuu. A couple hours at computer	tolerant
	Victor	12zz. Review once per year.	tolerant
		24zz. Like high-stakes exam	negative
	Marie	5aca. Workaround computer issues	negative
	Miss M	20bcbc. Extract meaning from simplistic indicators.	negative
Choosing what to enter in the report.	Darren	92bb. Choose based on the need for work, not legislation.	negative
	Jim	64eeee. Nurses accountable to themselves, not CARNA.	negative

	Craig	1QQ. Do all at once	tolerant
		29QQ. Write for audience	negative
	Heather	16uu. Application-level goals	tolerant
		25uu. Adjust goals to fit system	negative
	Victor	13zz. Low expectations	negative
	Marie	73ac. Personal goals drive learning rather than CARNA.	negative
	Miss M	1bcbcb. Make relevant to practice.	negative
The "end product."	Darren	85bb. Made-up dates of random learning experiences.	negative
	Jim	53eee. CARNA does not determine accountability to learn.	negative
	Craig	2QQ. Forget immediately	negative
	Heather	20uu. Pick something simple	tolerant
		19uu. Goal not authentic	negative
		49uu. Save the wrong articles.	negative
	Victor	27zz. Not enough to help	negative
	Marie	72acaca. Learning activities for the sake of reporting.	negative
	Miss M	3bcbc. I gained insights from learning activities.	positive

Summary of how data were reported in MyCCP. The summary Table 23 shows the final numbers of codes extracted from the interview scripts that show positive, negative or tolerant characteristics of reporting mannerisms and attitude in MyCCP. The codes were

categorized in terms of working with the technology of the MyCCP report; the general mannerism that was self-described by the respondent; the emotional impact of the reporting process; deciding what to report; and how the respondents viewed their final product of the report. The final average percentages of positive responses are 11%; average percent of tolerant responses is 30%, and the average percent of negative responses is 60%. Craig's response is an excellent example of someone trying hard to navigate the system but still experiencing negativity. “That's—Okay, this one's done already so I don't think I can change anything. Yeah. That's not what I want. The program's not the easiest to use, that's for sure” (Craig).

Table 23. Reporting mannerisms

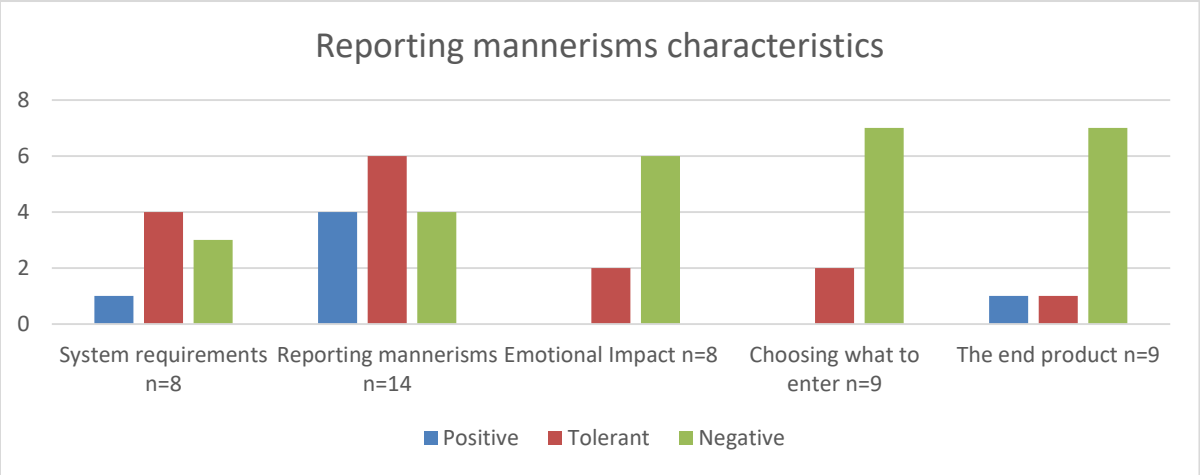


Table 23 shows implications of the emotional toll that MyCCP takes on nurses during reporting each year. The positive responses are few in numbers. Tolerant responses border on passive-aggressive, as nurses seem to provide minimum effort to complete the report and exit—not to be thought of until the next permit renewal time. “I don't technically sit down and actually put them in the computer until the end of the year. Until the bare end!” (Heather). Sarah presents a tolerant tone: “You know what Meagan? [laughing] I’ll just do this one so that I’ll be registered. So I’ll just do this one” (Sarah). The interviewees' view of the product of their report is mostly expressed negatively regarding the content and experience overall.

What Learning was *NOT* Recorded in MyCCP

Table 24 displays the codes of every time each interviewee talked about completed learning activities that they did *not* enter into the MyCCP reporting software. The coded key elements of the report events are categorized. Table 52 located in Appendix 4X shows the full analysis of these education experiences that were spoken about but not said to have been reported in MyCCP. Table 52 (Appendix 4X) and Table 24 (below) emphasize the mismatch in what registered nurses are participating insofar as continuing professional development, versus what they report in MyCCP as their mandatory learning requirement for their registration requirements.

Table 24. Summary of Tables 20-23; Continuing Professional Development Elements of MyCCP Reports

	Unreported CPD Element Described	Number of instances *not* reported in MyCCP
Unreported Continuing Professional Development	99a. Specific education	14
	99b. Change and Adapting	28
	99c. Self-study	15
	99d. Negative experiences	2
	99e. Non-nursing or regular recertification training	10
Unreported methods of learning	98a. Colleague mentorship	9
	98b. Formal, provided resources	5
	98c. Workshops	4
	98d. Educator-provided learning	3
	98e. Experiential learning	2

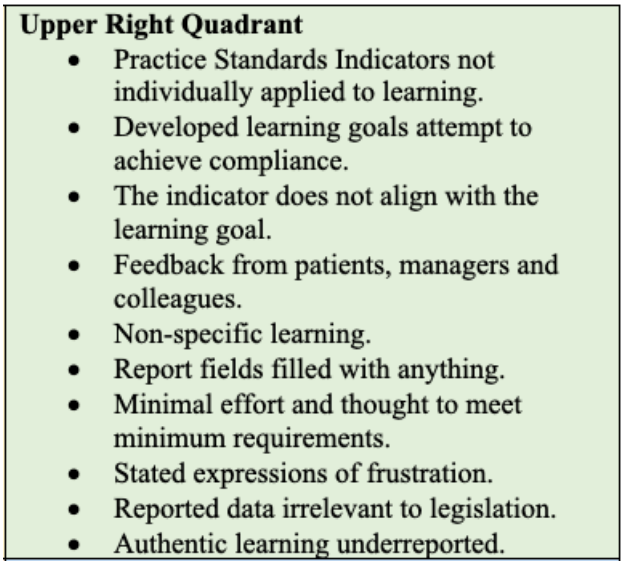
	98f. Internet search	1
	98g. Meetings with administration as indicated a learning experience	1
Unreported Feedback	97a. Feedback is most often informal and untraceable	5
Feedback Difficulties	97b. Obtaining and recording formal feedback is difficult	8
Reflection of learning needs unlinked to Practice Standards Indicators	96a. Career path	5
	96b. Insight	6
	96c. Questions abilities	8
	96d. Adversity	6
	96e. Comparing self	6
	96f. Finding solutions	3
	96g. Personal Influences	3

Right Upper Quadrant Summary

The MyCCP online software is an online record that accounts for the continuing competence of members. Though each year, members are required to log their practice reflections, feedback, and continuing professional development activities, the report is overly-complicated, time-consuming, rigid, and prescriptive. These issues, and the demand for CARNA registrants to complete this onerous process each year does not reward members with the acknowledgement of their lived continuing professional development. "I don't really feel like it's actually reflective of um ... what, the learning that does happen over the year" (Heather).

Though nurses engage in mandatory and non-mandatory professional development activities, generally these are not what are reported in the MyCCP record. The program, therefore, does not accurately reflect the continuing professional development activities, feedback and application of Practice Standards Indicators as nurses talked about in their interviews. The component parts of the MyCCP record require both a high cognitive effort and multi-tasking to achieve the requirements as shown by the number of cues, clicks, pages and open text boxes. Nurses display behaviours of, or talk about their frustration and intolerance related to their participation in the program. Figure 14 shows the Upper Right Quadrant themes contributing to the quadrivium of themes as they arise using a methodological pluralism approach.

Figure 14. Upper Right Quadrant themes



Lower Right Quadrant: Interobjective Systems Point of View

The research problem was to understand the influences of regulator-mandated professional learning implementation on the actual learning of nurses in their contexts. Of the four major research questions, this section addresses the research question: "How are provincial-

level decisions made about RN learning requirements and what kinds of enforcement, monitoring and feedback mechanisms support these decisions?"

With a focus on the fourth research question, this is a critical analysis of the College and Association of Registered Nurses of Alberta (CARNA) policies that regulate provincial level decisions where RN professional learning is mandated: primarily the CARNA Continuing Competence Program (CCP). As a lens for this critical policy review, complexity theory offered "a radical challenge to notions of prediction and control" (Tosey, 2002, p. 5). As CCP is a relatively small group of individuals with an impact on a very large group of individuals, these "agents" of a complex adaptive system may be studied in terms of the local interactions with each their own set of principles (Tosey, 2002). As a complex adaptive system, CARNA CCP consists of the following characteristics: human agents who make individual choices; hierarchical structures and networks; system behaviour that is both patterned and unpredictable; it is a program within a wider system; and no individual or group can determine the behaviour (Tosey, 2002, p. 6).

The analysis of CCP starts with the overarching CARNA Provincial Council approved policy: the Ends; Policy Type I (Ends), (College and Association of Registered Nurses of Alberta, 2016d) that is the framework for all operational policies in CARNA. Since the CCP operational policies exist to govern nurses' mandatory learning, I have pragmatically illustrated the highly detailed policy applied to a realistic nursing scenario. By its very nature, the Integral model (AQAL) as applied through Integral methodological pluralism (IMP), leads to critical analysis – because all the constituents, their power relationships and their contexts are accounted for, and how they act upon and influence each other, are traced. Critical policy analysis "exposes how policy and organizational directions potentially influence people in their daily contexts" (Susan Duncan & Rodney, 2015, p. 28). In doing so, the policies are shown to superimpose

awkward learning processes that impede the fluidity and authenticity of learning in nursing practice. As a result, policy implementation does not enable or enhance continuing competence. Moreover, this analysis uncovers a dearth of monitoring, a lack of factual data, an absence of 360-degree accountability, and overall ineffective regulation of mandatory professional learning and competence. This section brings to light the CCP policy problems that undermine public protection and discusses some ways to strengthen them.

CARNA Ends, Policy Type I

The Ends (College and Association of Registered Nurses of Alberta, 2016d) document contains statements of intended results for which CARNA exists. The Ends provide an overarching framework for CARNA operational policies that meet the requirements of the highest authorities: Health Professions Act (HPA) and Registered Nurses Profession Regulation. The ensuing policies within CCP operationalize how CCP meets the overall CARNA legislative accountability to protect the public. The statement that relates to outcomes of mandated professional learning is: "CARNA exists so that…The Alberta public is assured of safe, competent, ethical nursing care and excellence in nursing practice by an effectively regulated, advancing, and progressive profession at a cost that demonstrates responsible stewardship of resources" (College and Association of Registered Nurses of Alberta, 2016d, p. 1). The policies are developed to effectively regulate the profession, with the implication that nurses continually advance and remain progressive. There is a further interpretation of the above statement in the Ends, section 3, subsection 3, where it states, "Members have sufficient opportunities to acquire and enhance competencies… 3.3. Members have the knowledge and ability to adapt to and function in changing models of care" (College and Association of Registered Nurses of Alberta, 2016d, sec. 3). This Ends statement suggests that CARNA policy outcomes result in nurses having opportunities to acquire and enhance competences and continue to "adapt and to

function" in a context of rapid and constant change. Finally, CARNA's Foundational Pillars are: "Excellence in Nursing Practice: Developing, supporting and celebrating excellent nursing practice" (College and Association of Registered Nurses of Alberta, 2016d, p. 4). Critical to the understanding of CARNA policies is the regulatory philosophy, "right-touch regulation" as described as "a philosophy of using as little regulatory force as necessary" (College and Association of Registered Nurses of Alberta, 2019e). As such, the approach adopts the following six points where CARNA strives to be:

> **Proportionate:** use only the minimum amount of regulatory force needed
>
> **Consistent:** apply rules and standards fairly
>
> **Targeted:** focus on solving a problem while minimizing side effects
>
> **Transparent:** open, honest and user-friendly communication
>
> **Accountable:** subject to public scrutiny and able to justify our actions
>
> **Agile:** adaptable to change (College and Association of Registered Nurses of Alberta, 2019e)

The following section breaks down the CARNA policies that operationalize these foundational terms that are found in the CARNA Continuing Competence Program (CCP).

CARNA CCP

The CARNA CCP is where mandatory continuing professional development is specified and enforced. The CCP website and policies (2014) do not clearly state the purpose of the program except that it is developed and implemented as a requirement of the Health Professions Act (HPA). The HPA requires that programs (i.e., CCP) are established "that *enable* members to maintain their competence and *enhance* the provision of safe and competent service to the public [emphasis added]" (College and Association of Registered Nurses of Alberta, 2018a).

CCP purpose. The CARNA CCP is seen by CARNA as "a crucial part of a nurse's professional responsibility to provide the highest standards of patient care and safety and to provide that care based on best practices and current research" (College and Association of Registered Nurses of Alberta, 2018a). The CCP requirement of nurses is laid out in three parts as specified in the nursing regulations: practice reflection, continuing professional development and competency assessment. Since each of these parts require reporting of personal reflections, personal planning, and acquiring feedback, CCP was seemingly designed for the registered nurse to pinpoint areas of their deficiencies to target their learning plan. The electronic reporting platform, "MyCCP," guides registrants through a prescribed, structured, planning pathway, thereby forcing the sequence and the three-part components of the program.

The only clearly written purpose of CCP is stated on the public-facing CARNA webpage, "What we do," where it states, “CARNA endeavours to ensure that all Alberta RNs and NPs provide safe, competent and ethical nursing care by… Developing and enforcing a continuing competence program to ensure that practicing members are maintaining competence in their practice” (College and Association of Registered Nurses of Alberta, 2019f). This analysis critically examines this “promise” to the public, in relation to the HPA requirement, and CARNA policy statements summarized in Table 25. The following sections step through the analysis illustrated by a realistic (though hypothetical) nursing context and conclude with Table 26 outcomes in the final section.

Table 25. CARNA's Key Policy Statements

Statement source	Key statements
HPA	• Enable and enhance competence.

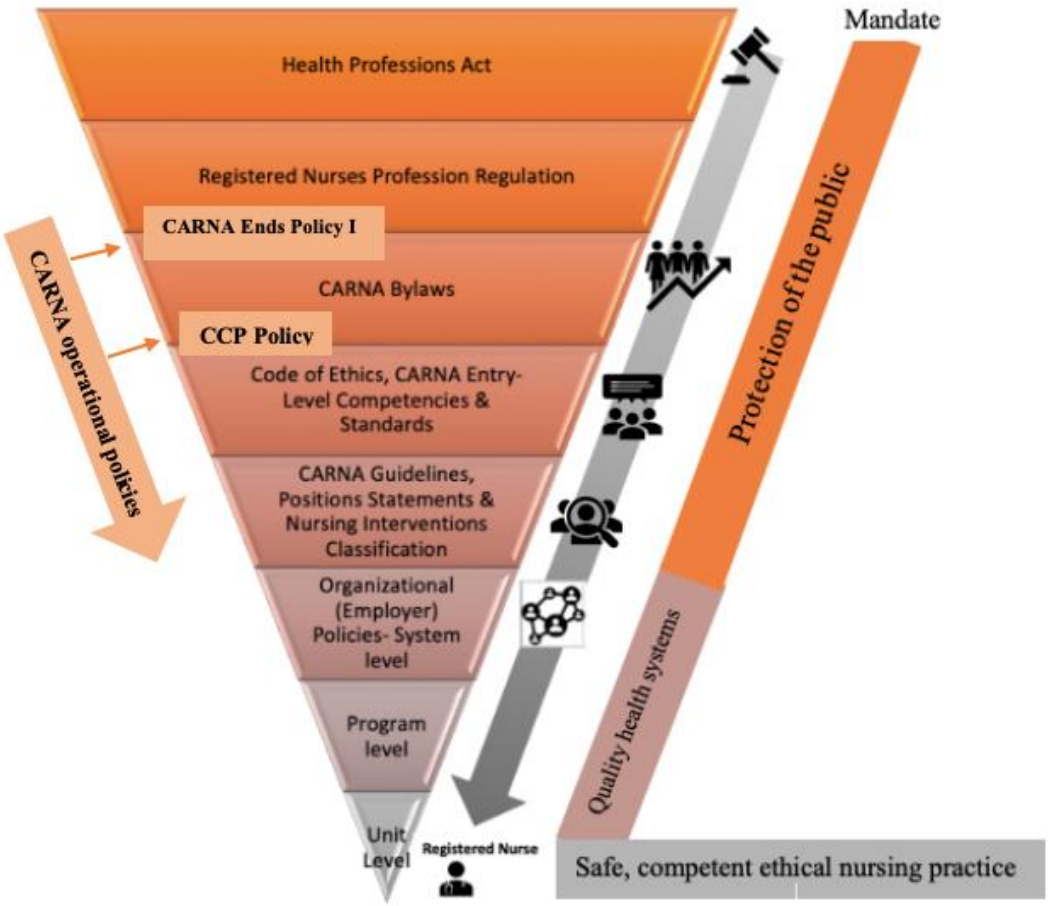
CARNA Ends (general)	• Alberta public is assured of safe, competent, ethical nursing • effectively regulated, advancing, and progressive profession • responsible stewardship of resources
CARNA Ends (related to CCP):	• sufficient opportunities to acquire and enhance competencies • Members have the knowledge and ability to adapt to and function in changing models of care
Regulatory philosophy	Principles of right-touch regulation: • Proportionate • Consistent • Targeted • Transparent • Accountable • Agile
CARNA's website statement of their purpose.	Develop and enforce CCP that ensures practicing members are maintaining their competence.

The Regulatory Framework for CARNA Policy Development

The policies impacting registered nurses are written according to a hierarchical structure originating from the Health Professions Act (HPA) (Province of Alberta, 2009) that legislates all health professions in Alberta. The Registered Nurses Profession Regulation (the regulations) (Province of Alberta, 2019) further specifies requirements of the HPA as it applies specifically to

registered nurses. As the regulator, CARNA must develop and implement operational policies that directly enforce the requirements of the HPA and regulations. As such, CARNA interprets HPA, develops regulatory standards (for approval by the ministry) and subsequently implements and monitors the nursing code of ethics, bylaws, and standards. This framework is shown in Figure 15, as displayed an inverted pyramid with the HPA at the top as a demonstration of the overarching authority it carries and with each lower layer further specifying the requirements of the nursing profession (adapted from College and Association of Registered Nurses of Alberta, 2011, p. 2). The following sections examine the components of the policy framework and brings to light issues and related poor policy outcomes.

Figure 15. Regulatory Framework in Alberta



Conflict of Interest

The framework, as shown in Figure 16, clearly shows nurses at the triangle apex bearing sole accountability toward safe, competent, ethical nursing practice. Realistically, in part, this is because, there is an essential conflict of interest for CARNA to *both*, enable and support nurses while also protecting the public. The conflict of professional self-interest versus protection of the public in which the profession serves results in a forced emphasis toward one side or the other. Since HPA exists to protect the public, and CARNA is delegated to uphold this mandate in terms of professional self-regulation, it makes the most sense for CARNA to emulate the values of public protection in policies-rather than enhancement of the profession. This point is important because if CARNA appears to favour professional self-interest, public confidence in the nursing profession is jeopardized, and the integrity of professional self-regulation is compromised. The conundrum, however, begs the question of how *are* nurses supported and enabled to enhance their competence? If CARNA cannot indeed be seen to enhance nursing practice or assure competent practice, then what does support nurses in this regard? What is left is a dearth of regard and little advocacy for the nursing profession potentially propagating distrust, fear and an overall threatening omnipresence in the CARNA-nurse relationship.

Organizational Accountability

The lower three segments of the pyramid in Figure 7 show, the mission of the organization-or employment context-is “patient-focused quality health systems” (Alberta Health Services, 2018, p. 5). The health services organization specifies and evaluates how service is delivered in sectors of health, but not specifically accountable to nurses' professional mandate or competence. With the employer focus on quality service, and a regulator focus on public interest, it is again emphasized that nurses at the bottom of the pyramid shoulder the entire competence accountability in isolation.

Report Anything

Nevertheless, nurses must report their competence to CCP yearly so that CARNA may be credited for, and appear as though they are upholding public safety as per their mandate. For this acclamation, CARNA has automated the MyCCP process whereby empty report fields are electronically detected, thus not allowing the nurse to access the online permit renewal. This automated process is uncompromising for nurses, but it is the easiest way for CARNA to demonstrate their compliance in CCP. The system functions such that members must report *anything* in each report line so their competence report may be deemed “complete” and competence of the profession is, therefore "proven" when all nurses successfully renew their yearly permit. CCP monitoring is explained further on the CARNA website:

> It is together with RNs that CARNA protects the public. Each of us plays a specific role in this partnership and monitoring member compliance with the CCP is one of CARNA’s responsibilities.
>
> The data you enter in MyCCP represents all of the required elements of the CCP.
>
> The only time we review the details that have been entered into MyCCP is when a member reports that their record is incomplete but has held a permit and practised during the year or to do follow up with a member who was previously reviewed. This is called a directed review (College and Association of Registered Nurses of Alberta, 2019d).

Abandonment

For CCP to indeed assure protection of the public, CARNA entirely relies on registrants to authentically participate, and honestly report in each part of MyCCP. That said, ironically, this reporting process lacks detection of competence and *in*competence despite the detail it requires—whether honest, or not—since report field entries are left unread. CARNA's MyCCP tool appears to effectively "window dress" assurances of public safety by simplistic detections of

complete versus incomplete reports, however, in reality, both mandates to support the profession and protecting the public are unproven. Furthermore, since the public and health organizations yield to CARNA to monitor competence, nurses are effectively abandoned to uphold public safety and professional competence independently.

The following section breaks down the parts of competence detection and looks at CARNA's legislative compliance with the counterproductive additions of requirements outside of the legislative scope.

CCP Policy Analysis Part 1: Practice Reflection and Professional Development

Table 26 illustrates mandatory professional learning requirements as enacted by a registered nurse in a typical (though hypothetical) working scenario. Each policy as it applies within the regulatory framework is applied to the scenario and analyzed following.

Table 26. ***ILLUSTRATIVE SCENARIO PART 1***

SCENARIO PART 1  	Mary, a registered nurse, who works 12-hour shift rotations on a medical-surgical hospital unit, received permission from her manager to take a vacation day off work to attend an education day on wound care. Mary had previously attempted to attend wound care learning sessions held within her hospital employment, but she missed those sessions due to staffing shortages and because of the high workload during her shifts. It was challenging to get this day off because she had just taken a full day off to renew her annual required certifications in CPR and advanced IV therapy. With the CARNA permit renewal time fast approaching, Mary realized that the in-services she attended to learn about the new charting methods or the elearning modules she took on cultural safety (Practice Standards 5.6) (College and Association of Registered Nurses of Alberta, 2013c, p. 7) would not apply toward her

	continuing professional development requirements for her CARNA practice permit (HPA 50(2)(a)) (Province of Alberta, 2009). Mary remembered that she specified in her previous year's 'practice reflection' that she would learn wound care this year, and she recognized that the CARNA-mandated education needed to be completed to report in CARNA's MyCCP reporting program (CARNA Policy 3.4 (1), (2 a-e)) (College and Association of Registered Nurses of Alberta, 2014a). Mary knows that if she does not complete her education before it is time to renew her practice permit, she will not be eligible to legally practice nursing in Alberta (Policy 3.3 (1) (a), and 3.4(d)(i)) (College and Association of Registered Nurses of Alberta, 2014b), derived from CARNA bylaw 19.1) (College and Association of Registered Nurses of Alberta, 2013a). In the meantime, Mary has made several medication errors related to cardiac medications in the past year, since her unit began taking step-down cardiac patients from the ICU. She just kept telling herself that she would continue to learn these medications as the need arises to administer them to her patients. Mary considered the medication errors to be 'normal' growing pains when adapting to organizational restructuring and as long as the patients did not suffer adverse effects, she did not feel the need to report the errors (Canadian Nurses Association, 2017, p. 2,4,7, 16, & 33).
CARNA Policy 3.3 & 3.4	**3.3 Practice Reflection Requirements** 1. Conduct and record a self-assessment of their nursing practice.

(a) Individuals applying for practice permits in the registered nurse and certified graduate nurse categories are required to assess their practice using the CARNA *Practice Standards for Regulated Members*.

3.4 Continuing Competence Program: Continuing Professional Development Requirements

1. Each practice year, registered nurses, nurse practitioners and certified graduate nurses will engage in continuing professional development opportunities, which must include learning activities relevant to the regulated member's practice reflection.
2. Each practice year, registered nurses, nurse practitioners and certified graduate nurses providing professional nursing services will:
    a. *Implement* a learning plan(s) for their priority indicator(s) which follow from the member's assessment of their practice.
        i. Registered nurses and certified graduate nurses will implement a minimum (1) learning plan relative to their selected practice standards indicator(s).
    b. *Evaluate* the influence of the learning on their practice for each learning plan implemented.
    c. *Record* the implementation of learning plan(s) and the evaluation of the influence of their learning on their practice.
    d. *Report* implementation of their learning plan(s) and evaluation of their learning to CARNA when:

	i. Applying for a practice permit in one of the following regulated categories-registered nurses…; e. Record feedback collected about their nursing practice. (College and Association of Registered Nurses of Alberta, 2014b, 2014a)
Nursing Practice Standards 	**Continuing Competence Program Requirements:** College and Association of Registered Nurses of Alberta (CARNA) *Practice Standards for Regulated Members* have been developed to: • promote professional nursing practice • be used as a legal reference for reasonable and prudent practice • facilitate the evaluation of nursing practice The *Practice Standards for Regulated Members* are used by members when annually assessing their nursing practice in order to determine professional development goals to meet *continuing competence* program requirements. (College and Association of Registered Nurses of Alberta, 2013c, pp. 3–4) **5.6** The nurse regularly assesses their practice and takes the necessary steps to improve personal competence. **Canadian Nurses Association, Nursing Code of Ethics (the Code)** One purpose statement from the Code is that "it is a means for self-evaluation, feedback and peer review and is a basis for advocacy." (Canadian Nurses Association, 2017, p. 2) "While nursing practice involves both legal and ethical dimensions, the law and ethics remain distinct." (Canadian Nurses Association, 2017, p. 4)

	"Nurses are responsible for the ethics of their practice. Given the complexity of ethical situations, the Code can only outline nurses' ethical responsibilities and guide them in their reflection and decision-making. It cannot ensure ethical practice. For ethical practice, other elements are necessary, such as a commitment to do good, a sensitivity and receptiveness to ethical matters, and a willingness to enter into relationships with persons who have health-care needs and other problems. Practice environments have a significant influence on nurses' ability to be successful in upholding the ethics of their practice. Nurses' self-reflection and dialogue with other nurses and health-care providers are essential components of ethical nursing practice."(Canadian Nurses Association, 2017, p. 4) "ethical (or moral) indifference. "Implies a failure to assume the ethical responsibilities of the profession, leaving one in a passive state that calls into question the moral integrity of the [nurse] as well as imperiling the obligation to protect the vulnerable patient" (Canadian Nurses Association, 2017, p. 7) "Nurses practise within the limits of their competence. When aspects of care are beyond their level of competence, they seek additional information or knowledge, report to their supervisor or a competent practitioner and/or request a different work assignment. In the meantime, nurses remain with the person receiving care until another nurses is available." (Canadian Nurses Association, 2017, p. 16)

	"Nurses, as members of a self-regulating profession, practise according to the values and responsibilities in the Code and in keeping with the professional standards, laws and regulations supporting ethical practice." (Canadian Nurses Association, 2017, p. 33)
CARNA Bylaws 19.1 	**Duties and Powers** The Competence Committee is hereby established. The Competence Committee may: (a) make recommendations on continuing competence requirements and the assessment of those requirements; (College and Association of Registered Nurses of Alberta, 2013a, sec. 19.1)
Registered Nurses Profession Regulation 19(2)(b-d) 	a reflective practice review includes: (b) The development and implementation of a written learning plan which follows from the member's assessment of that member's practice, (c) A written evaluation of the result of the learning pursuant to the plan in clause (b) on the member's practice, and (d) Feedback regarding the regulated member's nursing practice obtained by the regulated member. (College and Association of Registered Nurses of Alberta, 2016f; Province of Alberta, 2019)
HPA 50(2)(a) 	"A continuing competence program (a) must provide for regulated members …to maintain competence and to enhance the provision of professional services" (Province of Alberta, 2009, sec. 50(2)(a))

Discussion of Policy Analysis Part One

The CCP policy to mandate planning, implementation, and reporting learning activities negates the opportunity and attitude for nurses to contemporaneously learn as needed to be agile and spontaneous in their practice. The HPA and regulations do not state that learning activities and timing of the learning need to be specified. The CARNA imposed policies that demand these additional requirements constrain the nurses' ability to reflect and learn as they need to continue competency in the most relevant manner.

Unnecessary demand for learning activities. The HPA and regulations do not state that learning activities are mandatory; therefore, these are not necessarily required in policy or practice. The "*implementation"* of the learning plan—or mandatory continuing professional development—was added by CARNA along with the details to evaluate, record and report the implementation. The requirement for discrete and specific learning activities negates an agile learning attitude, responsive to the learning needs of the day or moment. The evaluation, recording and reporting of the learning activities are further details, and work nurses must do to enact the policy to involve themselves in learning activities. The HPA and regulations *do* require a written learning plan based on the reflection of the learning need; however, this may be more meaningful to nurses when viewed as the culmination of experiential and formal activities to provide safe, ethical nursing care with continuous evaluation of practice. Continual improvement of practice and career progression could be considered indicative of continuous learning and therefore continuing competence.

Forced one-year plan. The HPA and regulations do not specify that learning activities must be within year intervals. The requirement for learning plans, with defined, discrete learning activities in one year de-emphasizes the *required* adaptive and responsive learning. Prioritization of learning in practice is undermined by what nurses promise to learn at the start of each practice

year. The CARNA-imposed requirement for nurses to plan, implement and report learning within one-year intervals negates a more extended plan, such as a three-year, five-year or perhaps a career-long outlook of individuals' professional learning. The forced one-year time frame constrains and superimposes an unnatural professional learning pattern.

Predicting required learning. The HPA and regulations do not specify *when* the plan must be written; therefore, it does not have to be written at the start of the new practice year. This component of the policy forces individuals to predict what learning will be required. With changes occurring so rapidly in practice, nurses must learn immediately to react and adapt. Medication administration is a good example, because if new medications are implemented as a new requirement and a better option for patient care, then nurses must prioritize that learning immediately to avoid harm to the patient. This policy contravenes the HPA requirement to enable and enhance competence in contexts of change, requiring an immediate change in practice.

Summary

Priority learning must occur when needed in nursing practice but this priority competes with the learning goals associated with CARNA CCP. There is an opportunity for the CCP policy to ask for a summary report of the critical learning activities that took place in the year prior that became most meaningful in work. If focused on continuously improving, and ongoing ethical nursing practice, the cumbersome and unnatural steps of pre-planning, implementing and reporting pre-planned learning is superfluous.

CCP Policy Analysis Part 2: Professional Development Reporting

Table 27 illustrates mandatory professional learning reporting as enacted by a registered nurse in a continuation of the above scenario. Each policy as it applies within the regulatory framework is applied to the scenario and analyzed following.

Table 27. ***ILLUSTRATIVE SCENARIO PART 2***

SCENARIO PART 2  	The continuing professional development must be reported to CARNA (HPA 10(1))(Province of Alberta, 2009) in the online reporting platform, MyCCP. Mary must review the learning plan she developed in the previous year and make sure that her wound care learning event aligns with the practice standard indicator she selected (Policy 3.3 (4)) (College and Association of Registered Nurses of Alberta, 2014b) and with the learning objective she developed at that time. Mary must write a description of the learning event, the date she attended it, and how it aligns with the above (Policy 3.3 (5-6))(College and Association of Registered Nurses of Alberta, 2014b). She must also write about how the learning event applied to her practice, and she must gather feedback about her practice (CCP Policy 4.2, bylaw 19.1(b-d), regulation (19(1)(a)-19(2)(a-d)) (Province of Alberta, 2019)(College and Association of Registered Nurses of Alberta, 2015, 2016f). Mary regretted committing to wound care at the beginning of her practice year because it became apparent to her that a great learning opportunity would have been to attend the learning sessions on cardiac medications (Practice Standards 5.3-5.7) (College and Association of Registered Nurses of Alberta, 2013c). With time and opportunities scarce for learning in her workplace, Mary resigned herself to "doing the best she could" to learn the cardiac medications. Mary asked for feedback from her colleague, Jane, (Policy 3.3 (2) (a)) (College and Association of Registered Nurses of Alberta, 2014b) who told her that she admired how Mary improved her wound care knowledge, but also did suggest Mary read the unit medication guide on cardiac medications (Canadian Nurses Association, 2017, p. 5). (Jane

	remembered a time when Mary asked questions about a particular cardiac drug prescribed for her patient.) Mary entered the information about her wound care course into MyCCP record and how it improved her practice (Policy 3.3 (6)(c)) (College and Association of Registered Nurses of Alberta, 2014b). Mary also entered her colleague's feedback about her wound care practice improvements. Mary then attested her record to be complete and was able to renew her practice permit (HPA 10(6)(c), Regulation 19(2) (a-d) and Policy 3.3 (6 a-c)) (College and Association of Registered Nurses of Alberta, 2014b, 2016f; Province of Alberta, 2009).
CARNA Policy 4.2 	**3.3 Practice Reflection Requirements** 2. Collect and record feedback from others about their nursing practice. Feedback collected can be from a variety of sources. (a) For registered nurses and certified graduate nurses, a portion of the feedback should be from another registered nurse or certified graduate nurse familiar with the registered nurse's or certified graduate nurse's practice. 3. Identify and prioritize learning needs for their continuing professional development based on their self-assessment and feedback obtained regarding their nursing practice; 4. Select and record their priority focus indicator(s). (a) Registered nurses and certified graduate nurse must select at least one (1) priority indicator.

	5. Initiate the development of a written learning plan for each priority indicator identified in their self-assessment of their practice. This includes: (a) developing and recording a learning objective for each priority indicator; and (b) recording the relevance of each learning objective to their practice. 6. Report the following information to CARNA: (a) priority indicator(s); (b) a learning objective for each priority indicator; and (c) the relevance of each learning objective to their practice. **4.2 Monitoring Compliance with Continuing Professional Development Requirements** "Members can report their *MyCCP* record as complete or incomplete. A *complete MyCCP* record indicates that the Continuing Competence Program requirements were met and that the member has: a) *completed* all elements of the continuing competence process for that specific practice year, which includes prioritization of professional development focus, documentation of learning objective(s), documentation of the relevance of this learning to the member's practice, feedback from others about their practice, completion of continuing professional development activities, and evaluation of the influence of this learning on their practice; and b) *entered* information about their continuing competence activities in all required fields of the recording/reporting tool; and

	c) *attested* that the information entered in the recording/reporting tool is true and accurate. (College and Association of Registered Nurses of Alberta, 2015)
Practice Standards and Code of Ethics 	**The Code** states: "Nurses need to recognize that they are moral agents in providing care. This means that they have a responsibility to conduct themselves ethically in what they do and how they interact with persons receiving care. This includes self-reflection and dialogue. Nurses in all facets of the profession need to reflect on their practice, on the quality of their interactions with others and on the resources they need to maintain their own health and well-being. In particular, there is a pressing need for nurses to work with others (i.e., other nurses, other health-care providers and the public) to create the moral communities that enable the provision of safe, compassionate, competent and ethical care." (Canadian Nurses Association, 2017, p. 5) **Practice Standards for Regulated Members**. Standard Five: Self-Regulation. The nurse fulfills the professional obligations related to self-regulation. Indicators 5.3 The nurse follows policies relevant to the profession as described in CARNA standards, guidelines and position statements. 5.5 The nurse practices within their own level of competence. 5.6 The nurse regularly assesses their practice and takes the necessary steps to improve personal competence.

	5.7 The nurse engages in and supports others in the continuing competence process. (College and Association of Registered Nurses of Alberta, 2013c) **Guidelines**. Medication Guidelines provide an excellent example of a policy in practice as they represent a pervasive nursing role and responsibility. "Guidelines are suggestions for members, for enhanced or best practices. Guidelines are statements that identify principles, give instructions, information or direction, clarify roles and responsibilities, and/or provide a framework for decision-making" (College and Association of Registered Nurses of Alberta, 2019b) There are a total of 40 guidelines in the *Medication Guidelines* document with seven guidelines that relate directly to the nurse competence in safe administration as follows: **Guideline 40**: Nurses have a responsibility to report medication errors and near misses according to practice setting policy. (College and Association of Registered Nurses of Alberta, 2019c, p. 34)
CARNA Bylaws 19.1(b-d) 	**Duties and Powers** The Competence Committee is hereby established. The Competence Committee may: (b) review continuing competence requirements on the registration application and renewal of practice permit applications, to determine if continuing competence requirements are met;

	(c) refer a practice permit to the Registrar for cancellation if the committee is satisfied that the applicant has not met the conditions imposed when the practice permit was issued, and (d) undertake any other power or duty given to it under the Act, the Regulations or the Bylaws. (College and Association of Registered Nurses of Alberta, 2013a)
Registered Nurses Profession Regulation 19(1)(a)-19(2)(a-d) 	19(1) As part of the continuing competence program, regulated members must (a) Complete, in each membership year, a reflective practice review, in a form satisfactory to the Competence Committee… 19(2) A reflective practice review includes (a) A personal assessment of the member's own nursing practice against the Nursing Practice Standards adopted by the Council in accordance with the bylaws and section 133 of the Act or any other criteria approved by the Competence Committee, (b) The development and implementation of a written learning plan which follows from the member's assessment of that member's practice, (c) A written evaluation of the result of the learning pursuant to the plan in clause (b) on the member's practice, and (d) Feedback regarding the regulated member's nursing practice obtained by the regulated member. 19(4) On the request of the Competence Committee, a regulated member must provide satisfactory evidence of having met the requirements of

	subsections (1) and (2), in each membership year of the 5 membership years preceding the request. (Province of Alberta, 2019)
HPA 10(1)-10(6)(c) 	10(1) "A program of continuing competence provided for in the regulations" 10(6)(c) "must establish and enforce standards for registration and of continuing competence and standards of practice of the regulated profession." (Province of Alberta, 2009)

Discussion of Policy Analysis Part 2

The CARNA CCP policy for competence reporting is embodied by the MyCCP report to be filled out by registered nurses each year. If nurses successfully fill in each field of the report, they will have completed the requirements of CCP. Effective policy implementation, then, entirely relies on individual nurses' attestation and completion of the electronic report in an honest and meaningful way. There are three reasons why the meaningfulness and authenticity of the reported data may be compromised. The stress and timing of the report, workplace dynamics, and a lack of monitoring all play a potential role in poor reporting outcomes of the CCP program.

Undue stress. The practice permit renewal time each year places undue stress on nurses to complete their MyCCP reports. Though not required by HPA or regulations, the report *must* be complete before nurses' practice permit may be renewed, making it a high-stakes requirement to continue working. The stress and fear may compel one to enter what would avoid drawing attention from CARNA that could delay permit renewal such as audit, conduct or other conditions causing delays in registration. Alternately, the fear of financial security loss and/or

breach of regulatory compliance could compel one to complete the report as they believe CARNA would approve, rather than what they experienced. Moreover, the stress of this high-stakes compliance is further accentuated by the high financial cost of renewal itself. It is unnecessary to make the reporting process a condition of permit renewal, mainly if it lessens the integrity of reporting.

Time burden. The second reason why the report may not be meaningful is the superimposition of work added to the workplace and personal life demands. The reporting process itself is unnecessarily lengthy; requiring high cognitive effort whereby one must reflect and write long segments of freehand text (to design their learning plan, for example). Up to several hours of personal or work time is required to complete the requirements of the report, resulting in potentially rushed or begrudging participation deterring thoughtful entries. The passage of time since setting up the learning plan at the beginning of the practice year is aggravating when the learning requirements constantly change with what is required on the job. It is difficult to remember what or why that initial entry was relevant if many changes and adaptations occurred in the interim. The HPA and regulations do not require an exhaustive, time-consuming report; therefore, the reporting burden should be reduced to increase more valuable participation.

Bait and Switch. The third reason why the reported data may not be meaningful or authentic is the confusing accountability in CCP. The HPA states "must establish and *enforce* [emphasis added] standards for registration and of continuing competence and standards of practice of the regulated profession" (Province of Alberta, 2009, sec. 10 (6)(c)), yet the statement made on the CARNA website on CCP program monitoring is:

> The only time we review the details that have been entered into MyCCP is when a member reports that their record is incomplete but has held a permit and practised during

> the year or to do follow up with a member who was previously reviewed (College and Association of Registered Nurses of Alberta, 2019d).

The statement suggests that CCP reports are generally not monitored, however the Regulations 19(4) state, “On the request of the Competence Committee, a regulated member must provide satisfactory evidence of having met the requirements of subsections (1) and (2), in each membership year of the 5 membership years preceding the request.” There is a dizzying contrast in policy between complete freedom and total accountability versus the extensive testifying and the overt threat of punishment. CARNA appears to grant privilege and power to nurses to carry out the responsibilities of the HPA and nursing regulations, but the situation is essentially a "bait and switch." Nurses are lured into the idea they are autonomously responsible; however, there is the constant underlying threat of loss of membership, and therefore ability to work. The effect of the bait and switch is a radical swing in attitude and behaviour ranging from extreme diligence in the process, to complete apathy or anger. Though CARNA states, “It is together with RNs that CARNA protects the public. Each of us plays a specific role in this partnership and monitoring member compliance with the CCP is one of CARNA’s responsibilities” (College and Association of Registered Nurses of Alberta, 2019d), it appears that CARNA’s primary accountability in CCP is to administer the MyCCP form.

Simplistic Task Setting. As a reporting tool for measuring competence, MyCCP requires the most simplistic of tasks to be reported each year, thereby setting the standard for continuing competence far lower than what likely happens. For example, the requirement is to select one practice standard indicator and describe compliance to it in a practice year, when nurses are most likely compliant to many if not all of the practice standards in the year. Another example is select one learning activity when nurses most likely actively learn each day, and priority learning likely emerges spontaneously during the practice year. If the bar is set at a minimum or below

minimum expectation for the profession, how could nurses know they have progressed? (It is akin to asking a physicist to prove her competence by completing a simple math problem.) The HPA and regulations state that reflection of practice should be measured against the practice standards, while CARNA has specified only one at a time, which seems counter-intuitive in nursing practice. CARNA should encourage comparing to all of the nursing practice standards holistically as this is more reasonable in nursing practice, and allows for agility in determining learning requirements.

Feedback Degrading Teams. Feedback is an essential requirement evident in the HPA and regulations, though problematic in the CCP policy for two reasons. The first problem is the wide-open interpretation of the brief statement on feedback reporting. Simply, "collect and record feedback from others" from a "variety of sources" though "a portion of the feedback should be from another registered nurse or certified graduate nurse familiar with the registered nurse's or certified graduate nurse's practice" (Policy 3.3 (2)(a)). Though a natural and ordinarily collegial mechanism in nursing teams, forced collection of feedback in ambiguous terms, changes the interpretation and variability of seeking and providing feedback. Feedback in the case scenario, for example, presents is an excellent example of how it could work to support a colleague practise and provide safe patient care. However, the ambiguous requirement could also be interpreted by nurses as something that best suits their presentation for the CCP record such as a thank-you card or other superficial accolade (which is actually encouraged on the CARNA website (College and Association of Registered Nurses of Alberta, 2018b)). In reality, some of the most meaningful feedback leading to insightful revelations is spontaneous and unsolicited in high-trust teams or patient relationships. Given the latitude in the policy wording, it is unknown how nurses recognize and report it as a credible part of their reflection and learning, though it should be definable and recognized within nursing teams and a reportable entity in MyCCP.

The second problem is the reward-punishment pendulum that CCP reporting perpetuates, overshadowing the helpfulness of feedback, especially if that feedback exposes the incompetent nursing practice. Essentially, who would volunteer information to CARNA in a MyCCP report that could lead to punishment, i.e., practice permit conditions or conduct? Not to mention, the difficult predicament nurse colleagues face in critiquing one another's practice. The current ambiguously-written requirement to report feedback puts nurses in precariously judgmental positions with each other, rather than promoting collegial learning within high-trust teams and committed mentorships with managers. Small, slight embellishments in this policy could promote these more healthy work environments and high-trust feedback mechanisms instead of horizontal appraisals.

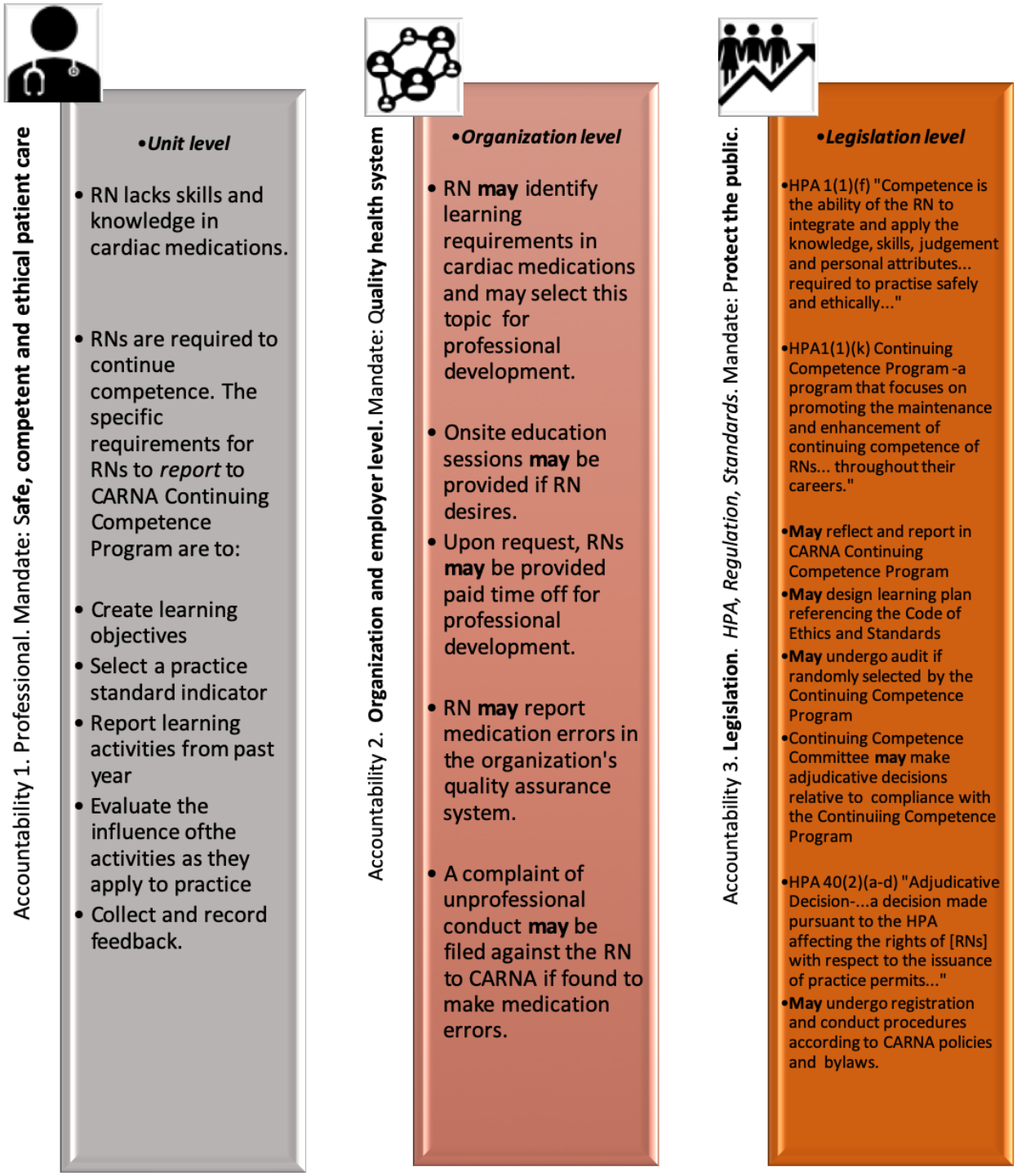
Summary

The CCP policies comply with and even needlessly embellish the HPA and regulations requirements; however, these policy efforts are ineffectual. The authenticity of the report data itself may be anywhere on the spectrum of filling out the online form precisely as CARNA would want to see it (but not necessarily "how it is") out of fear, or filling it with drivel because of the 360 degree lack of accountability (CARNA doesn't check it so why should I care?). Little to no understanding of competence or incompetence could come from the reporting process itself since it is virtually not monitored and there is a dearth of measures and data. The lack of detecting incompetence merely assumes competence, and even detecting incompetence is ineffectual since it is solely dependent on nurses either reporting their own incompetence, or being reported by another, or reporting incompetence of another. The MyCCP reporting method then, is merely a tool to regulate, leaving nurses with the ultimate accountability to regulate themselves and each other.

CCP Policy Analysis Part Three: Competence and Incompetence

Figure 16 illustrates two aspects of continuing competence reporting: competence reporting and conduct reporting. The illustration is a continuation of the above scenario with a focus on the learning requirement for medication learning from the point of view of regulating *in*competence. Each policy is shown as it applies within the regulatory framework is applied to the scenario and analyzed following.

Figure 16. ILLUSTRATIVE Scenario Part Three: Medication Error



(Alberta Health Services, 2018; College and Association of Registered Nurses of Alberta, 2019a, 2019c; Province of Alberta, 2009, 2019)

Discussion of Policy Analysis Part 3

As seen in Figure 16, nurses *may* report their errors or nurses *may* report others' errors. The CCP is designed for nurses to reflect and pinpoint areas to focus on and develop their learning for their continuing competence; however, the entire process amounts to a fear-mongering exercise of exposing oneself or a colleague. The honest, authentic experiences that populated into the MyCCP record are what CARNA relies on to fulfill their mandate to protect the public; however, the process defeats the purpose.

Overreliance on "whistle-blowing." The CCP does not require reporting of perceived incompetence, though the HPA states that the regulator, “must establish and enforce standards for registration and of continuing competence and standards of practice of the regulated profession” (Province of Alberta, 2009, sec. 10(6)(c)). In terms of competency evaluation, the regulatory body relies, in part, on the conduct system of complaints. Evidence is collected to assess competence in the complaint process. This process is very costly and time-consuming whereby lengthy investigations and hearings may take place (though this is rare). Competence should be better monitored and evaluated efficiently to be less reliant on conduct processes because of the significant disruptions and hardships it causes for individuals and employers.

Moreover, cultivation of professional unity and trust is negated by the dependence on the conduct reporting process. The duty to report colleagues is really the passing off the accountability to monitor competence to the team level where reliance on one another and trust is most important for patient safety. The Code speaks to "whistle-blowing" in the profession-and agreed that nurses must advocate for patient safety first-however with this being a standing rule of conduct on the job, the effect on nursing teams may be increased in hostility and perceptions of bullying.

Code of Ethics versus getting "caught." Since regulation of competence is left up to nurses themselves, this third scenario considers the opposite angle of regulating *in*competence. It is evident that individual nurses govern themselves in terms of incompetence as well, based on the nursing Code of Ethics and based their scope of practice per the CARNA nursing practice standards and entry to practice competencies. As shown in Figure 17, the detection of incompetence or meeting learning requirements to continue competence largely depends on the insight and willingness to pursue competence as influenced by the Code or the observations and willingness for a colleague to report the individual. Even at the organization level, something like medications errors *may* be reported in the error reporting systems and so at that level incompetence may be undetected. At the legislative level, nurses must practice according to their competence level, so if they do not, and are "caught," they would face legal repercussions.

Summary

CCP promotes the maintenance and enhancement of continuing competency; however, their methods are unnecessarily arduous, and the measures are void. Nurses, therefore, are entirely left on their own to ensure safe, competent and ethical nursing care, with a performance that is unquantifiable, especially over time as careers evolve. Continuing professional development requirements are therefore entirely up to the individual nurses' discretion, who may engage in *any* level of learning, with *any* significance to practice, and *any* relevance to scope of practice-from nothing to all. In light of the findings and analysis in the right lower quadrant, the key policy statements were revisited with outcomes placed in a third column. Table 28 summarizes the outcomes of the key policies statements.

Table 28. Key Policy Statements: Outcomes summary

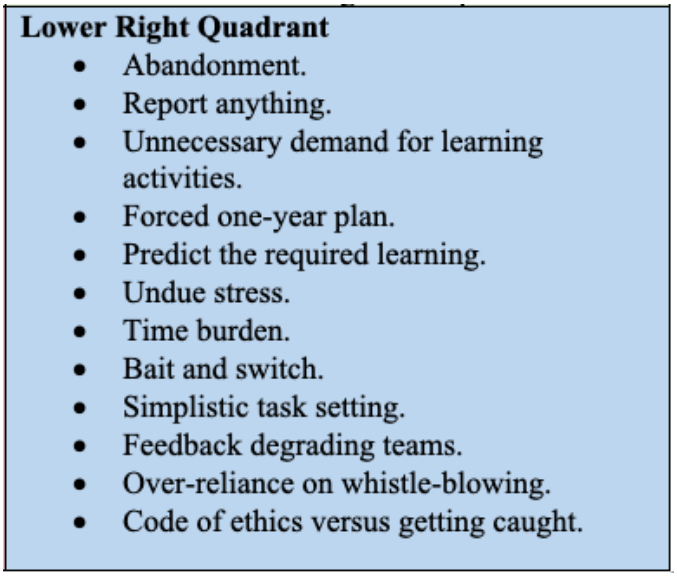
Statement source	Key statements	Analysis of outcomes
HPA (Province of Alberta, 2009)	Enable and enhance competence.	Enabling and enhancing nursing are excluded by the need to protect the public.
CARNA Ends (general) (College and Association of Registered Nurses of Alberta, 2016d)	• Alberta public is assured of safe, competent, ethical nursing • effectively regulated, advancing, and progressive profession • responsible stewardship of resources	• CARNA assures the public of safe, competent, ethical nursing based on the *assumption* that MyCCP reports are authentic and honest, even though honest accounts are discouraged by the inherent program and reporting design. • Public confidence is simply reinforced by policy implementation. • MyCCP reports are not monitored for the content of the reports; therefore, it is impossible to know how the profession progresses. • Nurses regulate themselves as independent of CARNA. • The dearth of MyCCP monitoring brings into question whether the reporting mechanism is at all effective.

CARNA Ends (related to CCP): (College and Association of Registered Nurses of Alberta, 2016d)	• sufficient opportunities to acquire and enhance competencies • Members have the knowledge and ability to adapt to and function in changing models of care	• Prescriptive policies inhibit natural competence-building. • Natural planning and learning methods are not accommodated, nor accounted for in CCP. • Adaptive learning is discouraged by the prescriptive processes in CCP. • The reporting process does not allow for adaptive learning reporting; therefore, it is impossible to say whether nurses adapt and function in changing models of care.
Regulatory philosophy (College and Association of Registered Nurses of Alberta, 2019e)	Principles of right-touch regulation: • Proportionate • Consistent • Targeted • Transparent • Accountable • Agile	• Proportionate: The minimum regulatory force has amounted to an abandonment of nurses, in favour of public-facing appearances. • Consistent: The extensive, mandatory work required by nurses to participate is CCP is ironically unacknowledged by CARNA. • Targeted: The problem of proving professional competence and public safety is solved by a forced structure of reporting that produces ineffectual evidence of competence.

		• Transparent: Communications are deceptively over-promising of public safety and advancing profession. The "bait and switch" of nurse self-regulation damages the trust between CARNA and the nurses they regulate. • Accountable: CCP outcomes are deliberately presented according to CARNA's self-interest to enforce regulations and legislation. • Agile: The high-detail of the policy and program are constraints to change.
CARNA's Continuing competence webpage. (College and Association of Registered Nurses of Alberta, 2019a)	"..continuing competence programs that enable members to maintain their competence and enhance the provision of safe and competent service to the public."	The only enforcement is forcing nurses to fill in form fields in the MyCCP report, by the threat of the continued opportunity to work as a nurse. Many aspects of CCP policy negatively influence nurses' authentic and honest participation in this process. Without any monitoring of the report contents, it is impossible to ensure that nurses are maintaining their competence.

The final themes located in the right lower quadrant are shown in Figure 17.

Figure 17. Right Lower Quadrant themes



Chapter 4 Summary of Findings

Chapter Four presented the findings of this research conducted to respond to the problem that was to understand the influences of regulator-mandated professional learning as actually implemented by registered nurses in their contexts. From the lens of complexity theory, this critical policy analysis sought to understand the influence of "human intervention" and the risks of doing more harm than good (Tosey, 2002, p. 7). Systems and individuals do not always respond as we would like or predict and examples of paradoxes created by policy are seen throughout these findings.

Beginning with the findings and analysis of the Left Upper Quadrant, individual interviews revealed highly complex influences on the mandatory requirements for nursing continuing professional development. For one, nurses must carry out their regulatory obligations without fully understanding or relating to them. Further, these obligations must occur within in a hostile work culture, mired by heavy workload. The Left Lower Quadrant findings and analysis objectified and further accentuated the problems found in the Left Upper Quadrant. CARNA was shown to be an oppressive presence for nurses where nurses may or may not participate

meaningfully in the CARNA CCP. The issues of workload and poor support for nurse managers to enable workplace learning were highlighted. The Right Upper Quadrant findings brought to light the over-inflated MyCCP reporting program that essentially thwarts its own intention to meaningfully monitor and encourage continuing professional development activities. The Right Lower Quadrant analysis and findings of policy systems revealed the origins and mandates that govern the CCP, but also how these also compel nurses inappropriate performance with it. Additional influences of the CARNA CCP policies and processes were discussed. A summary of themes are presented according to the AQAL framework in Figure 18. The themes were each found and analyzed using multiple methods as required within each quadrant perspective. Further analysis of the themes as they interact with each other will be discussed in Chapter Five.

Figure 18. Quadrivium themes

Upper Left Quadrant	**Upper Right Quadrant**
• Diversity adds to collective wisdom. • Nurses are responsible for their practice. • UNA is the only visible advocate. • Unstructured learning is entrenched in practice. • Nursing practice blighted by workload. • Nursing is culturally hostile. • Constant change diminishes competence. • Quixotic CCP begets inaccurate reporting. • CARNA is meaningless and threatening.	• Practice Standards Indicators not individually applied to learning. • Developed learning goals attempt to achieve compliance. • The indicator does not align with the learning goal. • Feedback from patients, managers and colleagues. • Non-specific learning. • Report fields filled with anything. • Minimal effort and thought to meet minimum requirements. • Stated expressions of frustration. • Reported data irrelevant to legislation. • Authentic learning underreported.
Lower Left Quadrant	**Lower Right Quadrant**
• Relevant education motivates nurses. • Nurse managers experience moral distress. • Unrealistic learning requirements are uncompensated.	• Abandonment. • Report anything. • Unnecessary demand for learning activities. • Forced one-year plan. • Predict the required learning.

• Incongruous organizations hinder learning. • CARNA is threatening and irrelevant. • CARNA does not recognize learning that advances competence. • UNA an advocate. • Competence is not addressed. • Competence reporting inaccurate. • Competence reporting not authentic.	• Undue stress. • Time burden. • Bait and switch. • Simplistic task setting. • Feedback degrading teams. • Over-reliance on whistle-blowing. • Code of ethics versus getting caught.

Chapter 5 Implications, Recommendations, Discussion and Conclusions

The purpose of this study is to respond to the overarching research problem, which was to understand the influences of regulator mandated professional learning implementation. Chapter Five articulates and clearly synthesizes the interpreted insights of the findings and analysis presented in Chapter Four. Achievement of these insights integrated peer-reviewed research on the topic, that enhanced reasoning of the speculations as they developed. This chapter discusses the research implications, recommendations, and conclusions of the research questions.

Problems and Implications

As seen in Chapter Four, integral methodological pluralism required analysis within each quadrant separately, staying focused on each ontological and epistemological perspective and corresponding methodology. The problems and implications of this research then, are made clear when all quadrant themes are embroidered together, as they co-arise in real-life context, and are related to the research questions. Figure 19 shows the composite of the final themes per quadrant as was shown in Chapter Four.

Figure 19. Final Table of Themes

Upper Left Quadrant	**Upper Right Quadrant**
• Diversity adds to collective wisdom. • Nurses are responsible for their practice. • UNA is the only visible advocate. • Unstructured learning is entrenched in practice. • Nursing practice blighted by workload. • Nursing is culturally hostile. • Constant change diminishes competence. • Quixotic CCP begets inaccurate reporting. • CARNA is meaningless and threatening.	• Practice Standards Indicators not individually applied to learning. • Developed learning goals attempt to achieve compliance. • The indicator does not align with the learning goal. • Feedback from patients, managers and colleagues. • Non-specific learning. • Report fields filled with anything. • Minimal effort and thought to meet minimum requirements. • Stated expressions of frustration. • Reported data irrelevant to legislation. • Authentic learning underreported.
Lower Left Quadrant	**Lower Right Quadrant**
• Relevant education motivates nurses. • Nurse managers experience moral distress. • Unrealistic learning requirements are uncompensated. • Incongruous organizations hinder learning. • CARNA is threatening and irrelevant. • CARNA does not recognize learning that advances competence. • UNA an advocate. • Competence is not addressed. • Competence reporting inaccurate. • Competence reporting not authentic.	• Abandonment. • Report anything. • Unnecessary demand for learning activities. • Forced one-year plan. • Predict the required learning. • Undue stress. • Time burden. • Bait and switch. • Simplistic task setting. • Feedback degrading teams. • Over-reliance on whistle-blowing. • Code of ethics versus getting caught.

The analysis was painstaking accomplished by constant comparative method, across the four quadrants by looking at each theme, one by one, and tabling the key themes across each quadrant that relate to, or influence that theme. Table 54 in Appendix 5A, shows the cross-quadrant associations between themes, colour-coded to visually identify which quadrants are most abundantly associated with each theme. The analysis revealed problems in each of the themes, and combined according to their interplay with other identified problems. Interestingly, each theme was found to be influenced or explained by other themes somewhat proportionately across the four quadrants. This integrated, holistic interpretation deepened and reinforced the

overall understanding of the problems as they relate to the research questions. Discussion and presentation of the final six integral themes follow the analysis of the problems per research question.

Research question 1. Perceptions and experiences of CARNA mandated learning

Research question 1 asks, “How do RNs and administrators personally perceive and experience CARNA mandated professional learning for nurses?”

The nurses’ perception and experience of CARNA are seen throughout the findings of the upper and lower left quadrants, as well as demonstrated in the upper right quadrant, and most likely stem from the lower right quadrant. In examining across quadrants to answer this first research question, four main themes emerged.

Oppressive. CARNA is seen as an overbearing and threatening presence to nurses that causes significant stress and anxiety. The MyCCP reporting system that seemingly guides CPD activities, and collects nurses’ CPD reports, is a CARNA process that particularly causes a severe strain for nurses. MyCCP reporting is a requirement of the yearly practice permit renewal, which is also a CARNA process that is stressful, expensive, and occurs at a difficult time of year for families. MyCCP reporting system is unstable, complicated to navigate, and does not allow nurses to record their experiential, everyday learning. Despite these issues, nurses are forced to complete the CCP requirements, relevant to them or not, because it is a mandatory requirement for the nursing practice license.

Since the nursing practice license is a requirement of employment, this CCP reporting requirement is extremely high-stakes, placing CARNA in a high position of power. Fletcher, K. (2006, p. 51), characterizes oppression as “unequal relations in a social system by use of power” and groups are oppressed “when forces outside themselves control them." Thus, MyCCP reporting is very threatening for nurses, influencing how and what continuing professional

development activities nurses *report*, and it imposes burdensome pressure regarding what CPD activities they *do* to maintain their competence. CARNA's mandatory requirements for CPD are perceived by nurses to be an irrelevant and heavy-handed process that they must endure and, understandably, they loath to participate in it.

Studies in the pharmacy profession have shown that to move pharmacists and technicians away from the "grudging acceptance" of revalidation [prescriptive measures of continuing competence], they [regulators] must gain buy-in from the pharmacy professionals themselves. Issues with the logistics and implementation of CPD systems commonly impact the professionals' acceptance and adoption of those systems. (Austin, 2013). Though it is complex to resolve such issues, without willing, authentic participation of nurses in CCP, the CPD efforts will not be successful.

Disengagement. Related to the issues of oppression previously mentioned, the MyCCP online software significantly disengages nurses from the CARNA CCP. Nurses emphatically condemn the quixotic MyCCP form for its complexity and irrelevance. For one reason, the CCP design is shown to be exclusive to a particular population of nurses with technological and western language fluency. English is the second language for some nurses, for example, where MyCCP is exceptionally perplexing and stressful, if not insurmountable for some of these individuals. Similarly, Austin & Gregory, (2019, p. 49) describe professional isolation in international pharmacy graduates who must overcome "numerous professional, cultural, linguistic, and other barriers to transcend" where they are led to believe they are "outsiders."

As a finding in this study, nurses do not comply fully with the CCP requirements, and do not honestly report in MyCCP because the system is perceived to be onerous, ambiguous, and irrelevant. The nurses' disengagement with CARNA does not encourage professional responsibility, but rather to do what is minimally necessary to get through CARNA's processes

to appear compliant. They do not believe CARNA cares either way as long as CARNA gets their boxes filled in so they look like they are protecting the public. Disengagement poses significant questions about competence as found by Austin & Gregory, (2019, p. 50), who raise the question of, "…whether regulation—by its very nature and its historically adversarial, legalistic orientation—contributes more broadly than initially thought to the disengagement that appears to be an important feature of competence drift".

Onerous workload. Attempting to be compliant to the CARNA continuing professional development mandates is exceedingly difficult given the already unwieldly work conditions nurses must endure. Nurses are merely trying to survive the workplace, which is continually changing and challenging, so expectations of advanced learning are virtually impossible. In a study of nurses' CPD experiences on a clinical unit, Govranos & Newton (2014, p. 659) found that some nurses appeared apathetic about meeting their education requirements, "due to the environmental constraints and the competing priorities within a work shift such as time, minimal available support and complacency." It seems the workload assigned to registered nurses only accounts for essential nursing service, so with the daily additions of organizational change and the high acuity of patient conditions, nurses operate beyond what is safe for patients and nurses themselves. Govranos & Newton (Govranos & Newton, 2014) are not optimistic and state, "It is unlikely in such a culture of busyness that there will ever be protected education time and many staff cannot reflect on learning while managing the rapidly changing situations."

The CARNA CPD requirements add even more demands and stress to the workload problem. Nurses must comply with planning and carrying out learning activities, whether relevant or not. Because these 'extra' demands from CARNA that do not fit into the already unsafe workload, the CPD activities intrude into nurses' personal lives and time off. Other research studies have found similar CPD challenges in the workplace. One study by Gould

(2007), also finds that nurses perceive employers overlook their personal needs, and heavy workload and inadequate staffing situations cause the obstacles to CPD.

The heavy workload impinges on nurses' human rights and wellness and is often associated with reduced staff retention, patient care, and job satisfaction, in addition to horizontal violence according to Blackstock, S., Salami, K., & Cummings, G., (2018). The motivation for nurses' to advance their practice with CPD must be negatively impacted in such a work climate. Thus, nurses generally only learn what is necessary to provide safe nursing care.

Shoestring learning. The resultant CPD learning in such gruelling work conditions is "shoestring" learning: learn as much as you need and have to so nursing care is appropriate and safe. Learn to survive the shift. Nurses prefer this learning to be acknowledged as CPD because it is enormous in its very nature, and for its high value in adapting and providing safe nursing care. Breckelmans, Maassen, Poell, Weststrate, & Geurdes (2016, p. 14) found similar in their study and state, "…the workplace is a powerful learning environment. However, these workplace learning activities are often not visible and hence more difficult to be influenced by others". Continual changes in patient care, technology, staffing models, policies, quality assurance protocols, and others, necessitate continual learning and adaption.

Though these unstructured learning experiences abound, they are difficult to appreciate and describe formally in the MyCCP report. This quandary is accentuated by the lack of formal, reportable CPD activities since they are rarely accessible or feasible. Therefore, most CPD learning is passive because it is part of the daily work; minimal, as time is limited; and challenging to predict or plan for. However, in a study by Vasli, Dehghan-Nayeri, & Khosravi (2018), nurses do not use information gained in structured learning activities, and there is no positive correlation to nurses' performance. Knowledge translation—or new knowledge applied to practice—more commonly occurs in changing practice, organizational structure, partnerships,

and a supportive learning environment. That stated, advanced learning or formal education is empowering and self-fulfilling for nurses. Continuing professional development is more than 'getting by' in the workplace, as it develops confidence, leadership and self-actualization. Learning for minimal continuing competence may be experiential and work-based in the right conditions, but deeper professional learning is required for nurses to advance in the profession.

Research question 2. Team and organizational influences

Research question 2: "How do the interactions with and among RNs, administrators, work teams, UNA, and CARNA during mandated professional development program implementation influence nurses learning?"

Understanding the influences of the team and organization on nurses' mandatory continuing professional development is extracted from themes in all four quadrants. Individual interviews of nurses describe the challenges of individual ongoing, everyday learning, as well as higher, formal learning that they pursue in groups. Nurse Managers describe in the lower left quadrant, their helplessness to support learning, and their discouragement of how little it is available. The upper right quadrant describes the actual described behaviour of learning and reporting. The lower right quadrant describes the mandatory requirements for learning and associated reporting and enforcement. Described next, are the five themes as they emerged from the cross-quadrant analysis.

Hostility. The interactions between RNs are toxic. There are apparent workplace bullying and horizontal violence prevalent, marked by resistance, sexism, and unprofessionalism. The registered nurses in this study observe and experience dysfunctional peer relationships, and note that many colleagues seem unmotivated, unfocused, rude, and critical. These findings are seen in other research such as Dellasega (2011, p. 26), where out of 303 respondents, 70% reported bullying and 23% of those were nurses on medical-surgical units. The prevalent experiential

learning requirements that rely on mentorship or modelling is impossible when co-workers are unapproachable or critical. Even seeking advice or support on toxic teams must be daunting.

Contributing to the poor nursing culture is that RNs are primarily unsupported and oppressed by the administration. Examples like “skeleton staffing” and tight scheduling do not allow for nurses to have adequate time off and work-life balance because work requirements flow into personal time. In general, the hectic, stressful workplace marked by high demands may contribute to horizontal violence (Bloom, 2019), where, as Adams (2014) describes, “nurses eat their young” subjecting each other with “gestures, slurs, behaviors, or verbalizations that may them feel humiliated, intimidated, and harassed” (p. 206). Personal time is especially essential for registered nurses who often sacrifice their wellness to achieve the essential requirements for patient care while on shift. Healthcare workers, in general, are sleep deprived, with effects ranging from decreased cognitive ability to “irritability, bad mood, reduced communication skills, and ability to cope with the emotional demands of the workplace” (Caruso, 2014, p. 17). Organizations contribute to hostile work environments and indirectly discourage professional development when no time is allowed outside of patient care requirements, and nurses must resort to self-sacrifice to complete their basic work.

Abandonment. Ultimately, RNs hold all of the accountability for their CPD, as it is passed off to them from organizational administrations (AHS, UNA, and CARNA). The mandates of each organization do not acknowledge the interests of the nursing profession, primarily when CARNA must protect the public, and the employer is focused on quality service. The union is the only advocate for nurses; however, their efforts depend on contract negotiations, that are generally focused on salaries. The lack of advocacy for nurses, and CPD unaccounted for do not serve the organizational goals of CARNA and AHS, as CPD is required for nurses to

provide safe, ethical and competent nursing care. Patient care impacts the core mandates of both organizations.

Moreover, the disunity between the three organizations, and lack of nursing association service, contributes to the erosion of the profession with a lack of collaborative effort to advance or even preserve it. The result is, top-down, mandatory processes, meaningful only to the organizations themselves and their own accountabilities. Nurses are left abandoned to manage the requirements for CPD-without adequate provisions, or line of sight to the overall goals-or face punitive measures.

Though autonomy and self-direction is a vital characteristic of adult learning (James & Francis, 2011), and crucial in the nursing profession, the task-driven, heavy-handed reporting requirements negate any sense of control or agency in addressing personal learning needs. The low level of job control; lack of participation in the decision-making process; lack of support from senior staff; and lack of reward and recognition are cited reasons why a work culture erodes (Adams, 2014), and likely also why CPD remains a significant challenge. Less control and fewer restrictive processes may be more motivating and supportive of CPD overall.

Interestingly, a study in the Netherlands on the influences of participation in CPD showed that nurses considered professional and personal development the least essential areas for development (Brekelmans et al., 2016). However, Brekelmans et al. (2016), also pointed out that if the organization placed high importance on professional development, nurses were more apt to seek CPD. Should the organizations unify and elevate the importance of CPD for nurses in this study context, likely more nurses would participate in CPD activities and hospitals would show overall better performance.

Thwarted teams. High functioning work teams are the corner-stone to safe, ethical and competent nursing care. Strong, healthy relationships, including mentorships between nurse

leaders and RNs, are thwarted by workload and poor overall organizational support for nurses and nurse managers. The ambiguous requirements to maintain professional nursing permits such as feedback and whistle-blowing are heavily relied upon by regulatory processes to 'catch' incompetence, therefore likely contributing to workplace hostility. As such, nurses are positioned against each other where they are obligated to monitor and report each other. Nurses work in an environment, then, where they must hide in plain sight, or risk their being marginalized by their group. According to Heaslip & Ryden (2013), nurses risk their 'belongingness' in the work culture if they ask too many questions, and are therefore "better regarded if they managed alone" (p. 100) to avoid drawing attention to their deficiencies. This avoidance leads to "Othering," an environment marked by the 'us' versus 'them' phenomenon (Heaslip & Ryden, 2013, p. 124) likely exacerbated with a whistleblowing obligation.

Feedback is an essential component of reflective practise and continuing competence but also builds effective workplace teams. The feedback requirement is a missed opportunity that could be appropriately leveraged at the organizational level to build mentorships and high-trust teams.

> In this context, peer feedback enlightens and enhances nursing practice through positive communication between two or more colleagues with mutual respect and a mutual goal of developing each other personally and professionally (Eisen, 2001). Eisen suggests that peer feedback promotes shared reflection and reciprocal learning through a professional partnership, and is invaluable to nurses because it emphasizes dialogue and development (Mantesso, Petrucka, & Bassendowski, 2008, p. 201).

Effective use of the peer feedback process benefits those involved by stimulating broader thought and developing personal and professional performance (Mantesso et al., 2008, p. 202).

Feedback is an essential component of reflective learning and is listed in Berings, Poell, & Gelissen (2008, p. 446) as an on-the-job learning activity through collegial social interaction.

Greater organizational accountability for nurses could build up healthy teams that inherently remediate incompetence in a compassionate and supportive way. The conduct processes appear to be the mainstay of regulation, instead of supporting and promoting constructive communication within teams. Promotion of competence, instead of catching incompetence, could avoid expensive and degrading conduct processes while improving patient care and job satisfaction.

Competence undefined. Competence assessment must be informed by peer dialogue and feedback (Franklin & Melville, 2015); however, the inadequate feedback mechanisms and over-reliance on whistleblowing leads to most likely, avoidance of this ‘trouble.' Avoiding the stigmatization of reporting someone, again, abandons nurses by passing off responsibility for competent practice. Nurses are abandoned to individually monitor and rely on their insight and judgement regarding their competence. As a result, nurses define competence by feelings of 'comfort' and 'making it through the day' without hurting their patients. This defined level of competence is basic, instead of striving for improvement, innovation, or excellence. That said, CARNA encourages this minimalist thinking by regulating competence to the most basic, fundamental level of nursing: the practice standards indicators. These are at such a low level that nurses have difficulty relating to them as they practice so far beyond them. Nurses effectively miss the opportunity to be more informed about their competence and develop their insights to fill competency gaps with CPD as a complex continuum formulated by a series of professional events (Austin & Gregory, 2019).

Critical nursing leaders. Nurse Managers have a vital role in cultivating an environment where CPD is valued and prioritized (Clark, Draper, & Rogers, 2015); however, Nurse

Managers' workload with additional leadership responsibilities thwarts their efforts and capacity to promote learning. These individuals are especially challenged with very high demands and accountabilities to all aspects of the nursing role, causing them to experience moral distress. For example, while it may seem intuitive for nurses to seek feedback from managers, nurse managers express in the lower left quadrant, their moral distress related to the lack of capacity to do yearly performance reviews or provide meaningful feedback to their staff of 30 or more nurses. Adams (2014), identified moral distress as defined by Jameton (1993), "a phenomenon in which one knows the right action to take, but is constrained from taking it" (p.288). (Adams (2014, p. 290), goes on to explain that moral distress impacts

> …our bodies and our minds…it affects our patients and the organization for which we work…with constraints placed on nurses' behavior and their ability to fulfill the actions they feel need to be completed. These constraints can be manifested as fear of losing one's job, self-doubt, anxiety about creating conflict, or lack of confidence (McKinnon, 2016).

Though accountable for their teams' continuing competence and learning; patient safety; administrative responsibilities such as budget, schedules, and administrative meetings; implementations of new policy or technology; they must also keep up their clinical skills and knowledge so they can cover patient care on the unit. That said, they spend most of their time managing schedules and relaying administrative information, and other menial tasks that take away from meaningful mentorship and learning opportunities with nurses.

Findings from a study by Gould et al. (2007, p. 606) showed resentment by nurses that managers do not provide opportunities for nurses learning: "Inequality of one form or another was also reported as a barrier to accessing CPD. There were sporadic examples of failure to access training events because managers were not supportive to the individual". Though the

authors report poor managerial support for learning, this study shows there is a high likelihood that poor support may be related to Nurse Managers' workload.

Research question 3. Required learning for continuing competence

Research question 3: “How are the RN professional learning requirements determined and assessed?”

The CARNA CCP, and the employer, AHS, define and monitor mandatory CPD requirements. Regarding the regulatory requirements for CPD, however, CARNA does not explain or describe it clearly or accurately, leaving room for broad interpretation. There are some evidenced-based interpretations of CPD, for example, Knox, Dunne, Hughes, Cheeseman, & Dunne (2016, p. 329): “CPD is the systematic maintenance, improvement and broadening of knowledge and skills, and the development of personal qualities necessary for execution of professional and technical duties throughout the individual’s working life”. General views expressed in this research reflect this encompassing definition, though, further distinguishing the interpretations of CPD by nurses and administrations. CARNA mandates one CPD learning event per year for basic continuing competence, while AHS mandates learning for new policies, technology and or organizational initiatives. Nurses view mandatory CPD as three separate types, including for competence in real-time (continual); for excellence at work; and for personal and professional growth.

Basic continuing competence. CARNA has embodied the continuing competency requirements of the HPA in the CCP, similar to regulatory bodies around the world (James & Francis, 2011). The yearly MyCCP reporting process prescriptively directs each Alberta registered nurse to carry out particular actions in their practice and report back to CARNA in the online form that these were completed. The ostensible purpose for this process is as James &

Francis (2011, p. 132) states, “Being accountable in a professional capacity requires nurses having a commitment to CPD so they can provide competent and quality healthcare."

The CPD requirements, however, are underwhelmingly fundamental, and therefore met with a high level of cynicism of its worth by the nurses who report to CCP. Seemingly, the underlying philosophy of CCP is that nurses are considered competent and patient safety standards are met if they practice according to the fundamental practice standards indicators. The mandatory link of practice standards indicators to CPD activities then has very low relevance to nursing practice. Furthermore, research on the lived experience of health care practitioners have shown that such a “dialectical model of competence” is unrelated to day to day reality (Austin & Gregory, 2019, pp. 45–46). Not only irrelevant, but some studies on the effectiveness of CPD have also shown there is a “lack of evidence to link positive patient outcomes to CPD” (James & Francis, 2011, p. 133), making it difficult to rationalize mandatory CPD at all. The weak link of mandatory CPD to an application to nursing practice are some reasons why nurses do not earnestly participate in CCP, especially since MyCCP is rarely monitored and never measured.

If the expectations of CPD, however, were described appropriately, and in evidence-based terms, it could be meaningful and applicable to nurses. Knox et al. (2016, p. 329), for example, describe CPD and continuing education in “that CPD reflects the need for a lifelong systematic learning experience whereas CE [continuing education] tends to involve intermittent learning episodes." Should CARNA define and clarify CPD as it relates to professional practice, nurses would likely show a more significant commitment to it. As it is, the commitment to CPD is low, and the interpretation and application of it are unbridled.

Organizational learning requirements. In addition to developing a continuing professional development plan based on a single learning activity and a practice standard indicator for CARNA, nurses must meet organizational learning requirements. The AHS

organizational learning requirements relate to quality assurance processes and patient satisfaction that are greatly influenced by the budget and reputation of the institution. So, for example, it may be determined to change the staffing skill mix on health care teams to save money on more expensive labour, so the learning required in this case relates to the staffing model and accountabilities impacting teams. Other examples include the new implementations of technology for clinical care; new approaches to treatment; reorganizations to introduce new patient acuities or patient conditions into a work unit; or new reporting processes. A study by Pool, Poell, Berings, & Ten Cate, (2015) found that professional development directed at daily work and extra tasks appeared necessary at all career stages; however, *continuing* professional development was approached separately from these work demands. Given the magnitude of mandatory CPD at AHS, the additive effect of additional CARNA requirements is arduous.

Nurses' required learning. The mandatory learning requirements, as directed by CARNA and AHS, impact the time and effort that nurses spend to pursue and participate in learning activities. Nurses generally describe three types of learning.

Type 1. Learning to provide nursing care. Continuing competence requires constant learning and adaptation of nursing practice every work shift. Registered nurses determine their learning requirements based first on what they need to learn to get through the day. As reported in other research, continuing education is "a necessary element to being able to provide appropriate care" (Govranos & Newton, 2014). The priority is to learn what is needed for the patient assignment immediately. This includes-but is not limited to-the daily research on patients' presenting illnesses and medical history; their clinical and medical support requirements; the clinical and medical interactions of their therapeutic regime; the psychosocial and cultural implications of their health conditions; and health risks. Each nurse must perform research; collaborate with patients, families and colleagues; and critically analyze the priorities

for the day to improve their patients' conditions and plan for the nursing care. Throughout the shift, patients' conditions change, new patients come into care, and reporting to team members is frequent. Workload considerations should factor time for this type one learning because it is essential for patient care and safety. Workload factors should also include other types of learning that enhance quality and nursing work when needed.

Type 2. Learning for quality improvement. In addition to routine and patient care learning, nurses must address organizational changes, new policy implementations, and new clinical or team methods that impact their nursing practice. This kind of learning occurs daily due to changes within the organization or new research evidence for examples. There are many descriptions of this level of learning, for example, "a process of planned activities based on performance review and setting of explicit goals for good clinical practice with the aim of improving quality of patient care" (Vasli et al., 2018, p. 189). Most of this type of learning relates to meeting organizational goals and performance planning.

Type 3. Learning to thrive. Importantly, nurses identify their own learning needs through their insights and personal observations. They hold themselves to their personal standards and strive to learn and grow in their practice. Potentially, this kind of learning is to advance themselves in their careers; for example, a move in a different career direction or a new clinical context. To thrive in their roles and as individuals, nurses may attend more formal learning events such as conferences or workshops to network with their colleagues and to discover what is new in nursing practice. These formal learning events are challenging and rare to attend because of the associated cost and the personal time required but are highly valued opportunities. Other research categorizes the levels or types of learning that occurs for nurses, for example, Williams, (2010) describes "life-long learning" conceptually similar to Type three learning. Type

three is vital for nurses' self-actualization and self-improvement, thereby thriving individually. This level develops individuals and impacts more in a broad sense than any other learning.

Research question 4. Legislative requirements.

Research question 4: “How are provincial-level decisions made about RN learning requirements and what kinds of enforcement, monitoring and feedback mechanisms support these decisions?”

The policy systems analysis in the lower right quadrant show the Health Professions Act (HPA) mandates CPD for nurses with operationalization and enforcement authority delegated to CARNA. The upper and lower left quadrants show the impact of this requirement, where nurses must participate in the CARNA CCP. The upper right quadrant shows poor participation in CCP.

Self-regulation. The Alberta government/ministry at the provincial level make decisions related to minimum standards of practice across health professions, including nursing. The HPA articulates the legal obligation of health professionals in Alberta, but as a self-regulated profession, CARNA creates the nursing regulations, standards, guidelines, and policies that direct the nursing profession specifically. The overall purpose of self-regulation is for each profession to be governed by the corresponding professionals since they are the subject experts, where requirements are most appropriately determined. CARNA then, as the designated regulator of the nursing profession, writes the Nursing Practice Standards with approval by a Provincial Council and government ministry. CARNA is responsible for the decisions of how to administer and enforce the statutes, and clearly articulate the minimum expectation of nurses, who are held accountable to them.

CARNA must report back to the ministry each year on how it is successfully monitoring registered nurses' continuing competence. Knox et al. (2016, p. 330) report that “CPD provides the framework to ensure health professionals ‘retain their capacity to practice safely, effectively,

and legally within their evolving scope of practice' [23]. As such, CPD is a highly desirable feature of modern healthcare professionalism". However, Austin & Gregory (2019) argue "Historically, regulators have focused on development of assessment tools and approaches designed to detect/identify individuals who were no longer competent, and who thus theoretically posed a greater potential risk to the patients they serve" (p. 45). CARNA's priority mandate is to protect the public, therefore must ensure minimum practice competency is maintained, with CCP design intended to monitor this competence.

CARNA swings from harsh punitive language and processes, but then does not measure, or monitor the outcomes in any way. The bait is "you must," but the switch is "we don't care." CARNA chooses the side of regulation over its dual mandate, association, and therefore anything that genuinely advances the profession in minimized. Their policies and processes, then, are heavy-handed, but their outward-facing messages are altruistic, rendering sense-making impossible. In a study by Vernon, Chiarella, Papps, & Dignam, (2013, p. 65), research findings indicate that the "majority of nurses strongly agreed that, as registered health professionals, they are responsible for ensuring and demonstrating continuing competence, a significant proportion also indicated that the employing organization and/or the regulatory authority were also responsible", similar to the findings in this research study. Despite nurses' need and desire for support to comply with the HPA, CARNA enforces the law simplistically, leaving much of the translation to the nurses themselves. The HPA language is high-level and legalistic, thus, challenging to interpret and apply as appropriate to continuing competence in practice. Without much-needed knowledge translation regarding CCP, nurses face a high level of ambiguity and needless complexity; where nurses, in not understanding, view it as irrelevant and onerous. CARNA does not enable compliance, and without measures, CARNA will never know nurses' competence.

Prescriptive task-setting. The CCP requirements are cyclical each practice year as a contingency for nurses' practice license renewal. The tethering of CCP to renewal makes it a high-stakes requirement. As such, nurses experience increased stressed to interpret and comply with the requirements, especially with the understanding of the purpose and expectations. The *many* menial steps in the MyCCP process require significant effort for nurses to interpret, recall, track, and write out, the year events in their continuing professional development. Even developing a learning plan is such a nebulous activity, that nurses often immediately forget about it. The process does not relate to nurses' practical experience at all, but they must make it fit so they may continue to practice as a nurse. Often this results in made-up entries.

The determination of what and how to learn must comply with CARNA's definition of continuing professional development activities, connections to the practice standards indicators, and the cyclical, prescriptive nature of activities and reporting. Thus, the essential problems with CCP are the discontinuity with nurses, and oversimplification of nursing practice, and the over-burden of reporting in the program. According to Austin & Gregory (2019, p. 45), the conceptualization of competence around "standards of practice, expectations, or statements related to the specific tasks or activities of a profession" has been criticized as being "reductionist in orientation, and incapable of actually capturing the ethical and interpersonal complexity of professional work". The MyCCP is viewed as quixotic and unrealistic because attendance in a single learning event in one year is exceedingly simplistic to maintain competence. Vernon et al. (2013) present findings from their literature review that, "A commonly recurring theme is the need for flexibility with regard to competence assessment" (p.61). Nurses perceive the program to be rigid and inflexible in meeting the continuing competency needs, therefore, generally viewed as meaningless and onerous.

Continuing competence unknown. The main problems with CCP and the decisions made about nurses' required continuing professional development are the complete lack of program feedback, monitoring, and reliable data reported by registered nurses. There are a couple of monitoring methods in CCP, including practice site visits, random audits, and analysis of drop-down menu data such as standard indicator selection, or learning methods selections. Most of the reported data is open text box style with open-ended questions that are never read by anyone except in random audits, self-identifying an incomplete status, or in some conduct cases.

The CCP then entirely relies on honest participation and reporting in the system. It is a reckless assumption because of the lack of monitoring and very little support or encouragement for nurses to participate and report meaningfully. Nurses are never provided feedback about their completed forms (except in unusual circumstances) or their nursing competence likely because the reports are rarely read. As a result, they do not meaningfully report in the reports. The onerous and threatening nature of the program negates honest reporting of actual competence problems.

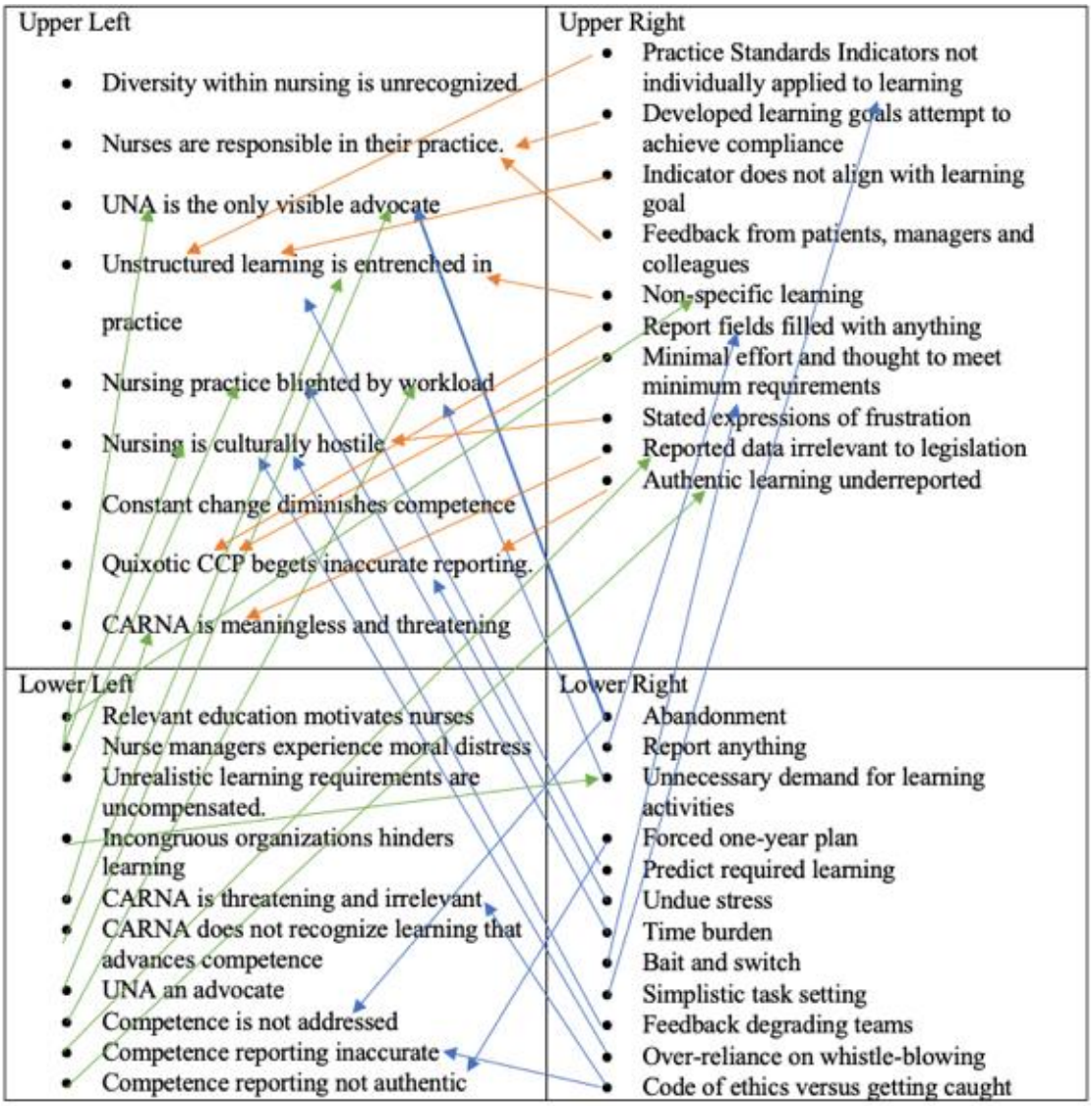
Obligatory whistle-blowing and collegial monitoring, linked to punitive repercussions, further aggravate the problem of dishonest reporting. The potential for exposure is a compelling deterrent to disclose shortcomings. Cabilan & Kynoch (2017, p. 2334) found in their review, that disclosure of practice errors, "… brings a considerable emotional burden to the nurse that can last for a long time. In some cases, the error can alter nurses' perspectives and disrupt workplace relations". As such, nurses are reluctant to provide feedback that would inform their colleagues of competence issues. Many times, stigma is assigned to the whistleblower as a "troublemaker," resulting in hostility and bullying in the workplace (Peters et al., 2011, p. 2908). Whistle-blowing and negative feedback have very harmful effects on nurses with a significant toll on colleague relationships and workplace harmony.

Since this study reports that is it best to avoid disclosure of negative feedback, and provide what minimally "looks" compliant in MyCCP, nursing competence is ultimately unknown. Nursing continuing professional development is ambiguous, and the nurses themselves mainly decide the requirements for professional nursing learning. Essentially, no one knows if or how CCP is meeting its objectives, and it is not even clear what those objectives are. It appears to track the continuing competence of nurses, but there is no data to say it does.

Interrelationships of themes

Figure 20 highlights the interrelationships of themes that holistically explains the phenomenon of nurses' experience of regulator-mandated continuing professional development. As the analysis of quadrant themes unfolded, arrows were drawn from one theme in one quadrant to another in a different quadrant, illustrating the "tetra-arise," or concurrent impact of one theme on another. True to IMP, as Ken Wilber states, "It is not that perspectives come first and actions or injunctions come later; it is that they simultaneously co-arise [actually, tetra-arise]. "Perspectives" simply locate the perceiving holon in the AQAL space" (2005, p. 50).

Figure 20. Interrelationships of quadrant themes.



Integral Analysis Themes

Essential themes derived across quadrants

> Reduction of all of the quadrants to one quadrant is "quadrant absolutism," a wretched form of reductionism that obscures much more than it clarifies; while seeing all of the quadrants mutually arise and "tetra-evolve" sheds enormous light on perpetually puzzling problems (from the body/mind problem to the relation of science and spirituality to the mechanism of evolution itself). (Wilber, 2014, p. xv).

This section illustrates the tetra-evolution of the final six integral themes.

Theme 1. Oppression of nurses

Oppressive forces in the nursing context seem to originate from CARNA, the employer, and perhaps as a product of oppression, nursing teams. Generations of oppressed nurses have likely ingrained hostility in the profession, hence the hostile nursing ‘culture.' The behaviour of oppressed people take on the characteristics and values of the oppressor (Fletcher, 2006), therefore nursing characteristics mirroring the punitive, harsh, whistleblowing rhetoric of the regulator. Should the oppressive methods prevail, nurses will continue in their oppressed behaviours such as horizontal violence, infighting, criticism, bickering and where nurses are “unable to support one another” (Fletcher, 2006, p. 52).

Implications for practice.

1. Disengagement and continuing frustration with CARNA CCP.
2. Low commitment to continuing competence.
3. Low functioning teams.
4. Complacency and fear.
5. Perceptions of administrative abuse.

Simple, small changes in the lens of policy and process development could change the oppression of nurses: Consideration of nurses' viewpoints in policy development; inclusion in decision-making; or empowering leaders to mentor and develop a trust culture are just examples. It starts with listening, transparency, and clear expectations of regulatory requirements; then the development of shared values and trust.

Recommendations for practice.

1. Work with employers to co-develop continuing professional development policies.

2. Engage registrants to improve a shared understanding and co-development of CCP.
3. Create a reporting program that genuinely meets regulatory requirements.
4. Translate and disseminate knowledge about competence.
5. Empower leaders.

Theme 2. Unsafe workload

The work context of nurses in this study is unsafe. Unsafe for their welfare where they often must sacrifice their basic physical and psychological needs, but unsafe for the nursing care they provide because of the onerously high workload. Despite the known research available that addressed the harmful effects of high workloads (Bloom, 2019) the problem persists, is likely impacting systemic operations and ultimately, patient care.

Implications.

1. Possible physical and psychological impairment of nurses and their families.
2. The risk to patient safety.
3. Incomplete work requirements.

This study should be a call to action, especially when nurses cannot even take rest breaks or “bio breaks” during their workday. Since the work structure imposed on nurses is that of a highly-regulated, "standardized factory-production model" (Austin & Gregory, 2019, p. 51), then appropriate working conditions must be met to maintain “production targets," or in other words, patient safety and excellent health services. AHS, UNA and CARNA should determine workload as it should be a unified concept and design.

Recommendations for practice.

1. Inclusive policy development and implementation should include the impact on nurses.

2. Working conditions must meet minimum safety standards.
3. Determination of workload must be reassessed and made more realistic.

Theme 3. Avoidance

As the MyCCP program continues to be the mainstay of CCP reporting, has it become acceptable to CARNA that nurses "grudgingly" accept it without real buy-in from them? Supporting the MyCCP platform to ensure nurses comply with the requirements must be costly and time-consuming for CARNA. Nurses hide in plain sight because they are held to such high accountability for their competence and the competence of their peers.

Implications.

1. Nurses will continue erratic, hasty and dishonest reporting in MyCCP.
2. CARNA will need to increase expensive efforts to mitigate MyCCP problems continually.
3. Nurses will continue to hide incompetence from CARNA, employers and colleagues.

This research addresses the fake but conforming reports in MyCCP to avoid trouble with CARNA. Given this study focuses on the regulatory context, further exploration in the work setting of the avoidance of error is recommended. It is somewhat troubling to uncover the prevalence of fake reporting in such a small sample interview and focus groups.

Recommendations for practice.

1. Increase support and encouragement in the workplace to complete continuing competence reporting on work time.
2. Find ways to improve MyCCP, so it is intuitive and reflective, so there is a perceived benefit to completing the task.
3. Consider safe reporting methods to encourage honest reports of competence.

Theme 4. Continual competence

For continual competence in the delivery of health care, nurses must constantly adapt to change and adjust nursing approaches in their reflective practice. In everyday work, nurses require critical thinking and learning to problem-solve complex patients' conditions and treatments in action. This just-in-time—or "shoestring"—learning is essential and focused as it is just enough to provide safe patient care. Complicating the everyday learning requirements are new technologies, policies, organizational changes and health care strategies that require more concerted effort and sometimes structured learning activities. The substantial learning requirements in regular nursing work are essential but are only partial to the continuing professional development required to advance nurses' practice and competence truly. CPD develops the person holistically with advanced knowledge and skills that brings satisfaction to nursing professionals. However, higher learning or advanced learning in nursing is challenging to access, expensive, and consumes their personal time, making it demotivating for nurses. Further aggravating the problem, the CARNA CCP does not advocate for the encompassing requirements of continual competence in nursing, considering the simplistic requirement for a single objective and a single learning activity. CCP requirements and the associated data collected, do not reflect the necessary CPD to advance nursing as a profession.

Implications.

1. The profession does not generally progress.
2. New required or desired learning, exacerbates stress and workload.
3. CPD efficacy is unproven in continual and continuing competence.

This research sheds light on how nurses perceive and experience their continuing competence learning. The strong ethos and compassion for patients are the key drivers. CPD for continuing competence should further consider nursing context and policy impact.

Recommendations include expanded research of CPD requirements for patient safety. Steps should be taken to remove barriers to all types of CPD, considering cultural and workplace challenges.

Recommendations for practice.

1. Develop clear language about continuing competence and professional development.
2. Decide the levels of learning that continue nursing competence.
3. Develop agility and flexibility in CPD reporting.
4. Organizations should provide relevant learning opportunities to nurses.

Theme 5. Hostile work environment

The work teams are the most influential in learning for continuing competence but are also toxic. The essential problem then is the absence of trust in exposing oneself in their learning needs for mentorship. Nurse managers and nurse educators experience moral distress with high accountability and their workload. Team unity is a significant problem for learning for continuing competence.

1. Nurses continue to practice in fear of exposure and negative repercussions.
2. Work toxicity hiders work satisfaction and employee retention.
3. Nurse managers continue to work undermined in their abilities and contributions.

The ever-changing and high demands for learning in hospital units requires a cohesive team efforts to navigate the complexities of patient care. Work is needed to address the problems that contribute to the toxic nursing culture, including, reconsidering and clarifying the position and imbalance of feedback and whistle-blowing aspects of regulation.

Recommendations for practice.

1. Take steps to increase rational sense-making of nursing legislation.
2. Empower unit managers to mentor and support their teams fully.

3. Improve feedback skills, confidence in and empowerment.
4. Improve accountability and support *for* nurses.

Theme 6. Competence unknown

Nurses' fundamental understanding of learning for continuing competence is not addressed in CARNA CCP, making the program mostly irrelevant to nurses. Without consideration of a shared understanding of what nurses are actually capable of pursuing and how continuing competence is defined, reporting in MyCCP is irrelevant or inappropriate or altogether fake. Given poor participation and lack of program measures, competence is unknown.

Implications.

1. CARNA programming does not adequately fulfill its mandate to protect the public.
2. Incompetence is unknown and ill-defined.
3. Nurses compliance to the law is in question.

Nurses describe their continuing competence learning as what Knox et al. (2016, p. 329) would describe as "the need for a lifelong systematic learning experience" versus what CARNA requires as "intermittent learning episodes." CARNA could benefit from clarifying what is required in terms of education and support for nurses compliance with legislation. As the regulator and association, CARNA must position itself favouring the side of regulation in order to fulfill its mandate to protect the public, however some work to include more collaboration will improve 'compliance' and increase confidence in CARNA's achievement of its mandate. At this point, CCP is inexplicable for nurses, so language and subsequent cognition and action are chaotic. "Their goal is to move away from the inexplicable, toward the unexplained, then through the plausible, and ending with the more plausible, which they continue to update and refine" (Weick, 2009, p. 130).

Recommendations for practice.

1. Reposition CCP to be the "conduct prevention" route in regulation.
2. Focus on organizing versus "the organization" (Weick, 2009).
3. Increase engagement with nurses to ensure regulatory compliance.
4. Define competence and how it is measured, then disseminate this knowledge.

Recommendations for Research

This research brought to light the importance of further research, generally in nursing regulation. The conclusions brought forward here offer insights into the strategic expansion of continued research opportunities. Three specific suggestions are provided.

1. Expand research to other nursing contexts. Given this is a small sample of a single nursing context in Alberta, more research is needed to understand the complexity of continuing professional development in other nursing settings.
2. Continue research into the effects and impact of engagement and knowledge translation in nursing regulation.
3. Increase regulatory research, in general, to look at the administrative policies that impact nursing culture is needed.

As nursing self-regulation has only been instituted in the last 15 years, robust research is imperative for regulation efficacy, especially with trends in changing regulatory scope and practice around the world. In general, research expansion should include regulatory impact and broad collaboration.

Reflections and Conclusion

Personal reflections

I was initially inspired to do this research on regulatory requirements for mandatory education when I did a one-month clinical refresher in a medical unit at a tertiary hospital in

Alberta early in 2016. After many years of being away from bedside nursing, I found myself in shock as to how much nursing practice has changed. On my first shift, with six patients in our care, I was shocked at the high level of acuity of patients! I went in to assist one patient-a very large man-at the beginning of the shift, who was very unsteady on his feet but needed to get up to the bathroom. I helped him to the bathroom, but felt I needed to stay just outside the door because he was very unsteady, and I was anxious he would fall. My preceptor found me there and told me I needed to get to my other patients right away, and that this man "*was just going to have to be OK*." That was my baptism into a whole new world of nursing. A world of ethical dilemmas and moral conflicts that I experienced every shift I worked during that month of clinical refresher experience. Back in my full-time role where I lead a team to develop continuing professional development from a regulatory perspective, I appreciate the need for knowledge translation of nursing standards, policies, and guidelines so nurses apply these in practice and there is some assurance the public is protected. I wondered, however, how to make learning relevant and accessible in the work context I experienced? It is high-stakes for CARNA to ensure knowledge translation, but also high-stakes for nurses at a very personal level. Nurses must comply with CARNA requirements because continuing professional development is tied to the nursing practice permit and therefore tied to their ability to continue in their employment.

Every day, while on shift, nurses must prioritize and make critical decisions regarding their patients, but CARNA and the employer interject their priorities with a significant amount of power and authority. While nurses must self-sacrifice during their work in high-risk workloads, in the middle of it all, they must turn their thoughts to their CCP learning plan and seek out a conference they must pay for on their time off from work, so they can continue to practice nursing. Alternatively, they must find time during their shift to take an online module their employer has deemed mandatory. It seems to be a strange juxtaposition of priorities.

Recognizing the critical importance of nurses' time and concentration on attending to the work at hand, it became of utmost importance to me to understand nurses' experience and perception of continuing professional development to inform my work. It was because of the complexity of regulatory requirements to protect the public, nurses' needs to provide safe patient care, and the employers' need to offer quality health service, that Integral Methodological Pluralism would be the most appropriate research methodology for this research question.

Reflections on Further Research

The *Canadian Medical Association Journal (CMAJ)* article, "Self-regulation in health care professions comes under scrutiny" (Motluk, 2019, n.p.) describes the current state of the views of healthcare regulation nationally and globally. Motluk reports that what is needed is, "sweeping changes across all self-regulating health care professions"(2019, n.p.) to ensure regulators are upholding their mandate to protect the public versus supporting the professions. Fredric Laloux asks, "*To what extent do the organization's accomplishments manifest its purpose?*"(2014, p. 287). When sweeping, organizational changes are required, Laloux (2014) describes several successful examples of the application of AQAL to reinvent organizations. Reinventing regulation could also apply as an extension to this research.

Reflections on the Use of AQAL

"The greatest danger in times of turbulence is not the turbulence—it is to act with yesterday's logic." (Peter Drucker quoted in Laloux, 2014, p. 5). Furthering research with the AQAL framework informs the future of nursing regulation because as shown in this study, "where change occurs in one dimension, there is a ripple through the others" (Wilber, 2014, p. xv). At a time when it is crucial to understand the effectiveness of regulation and future approaches, this study provides the basis for continuing to use the AQAL map as a framework. Such subsequent research with AQAL would much inform engagement and policy in light of

nurses' positions in collectives and systems according to the map (Wilber, 2005). Three suggestions for further integral research are provided.

1. Expand to other regulatory functions such as registration and conduct.
2. Expand to employers and other nursing contexts.
3. Use the AQAL map as a framework to research states and lines of development in nurses.

Importantly, IMP emphasizes holistic research views. As Ken Wilber points out, there should be equal focus on the left side quadrants as the right side quadrants because "Right-hand quadrants of behaviours, processes, and practices are necessary to help the emergence of Integral Left hand dimensions" (Wilber, 2014, p. xvi). As such, regulators benefit in understanding nurses' experience, perceptions, and behaviours, related to regulation to better inform and implement the policy and processes overall. These insights are especially beneficial because the "Lower-Right or "its" quadrant, are *supportive* [emphasis added] structures, processes, and practices" (Wilber, 2014, p. xvi). In fact, a very compelling extension of research would be to explore the stages and lines of development of nursing from the lens of professional identity, professionhood and professional self-worth. Though I was able to briefly touch on the subject, exploration of professional identity was largely delimited in this study. However, through this research, professional identity emerged as a crucial factor in the study of regulation, competence and continuing professional development. Thus, I believe that Integral theory is crucial to the ongoing organizational and administrative research to achieve future efficient, measurable, and meaningful outcomes.

Reflections on Study Limitations

The limitations of this study reflect the complexity and comprehensiveness of IMP. With the multi-method approach, significant time was required to examine each quadrant thoroughly.

As such, since September 2017, when data were collected and examined over the subsequent two years, many changes have likely occurred in regulation, policy, and nursing practice. For example, the CARNA CCP has been undergoing revisions and work has been done to make improvements to the program and online reporting system. As well, CARNA has implemented major engagement strategies. Changes in the workplace at AHS may have also occurred, but are unbeknownst to me at this time. However, it is the purpose of this research to explore the influences of mandatory CPD where findings should inform CARNA, and regulators globally of the impact, effects and efficacy of regulation. Given that the findings and recommendations are consequential to CARNA, great effort has been made to provide a thorough audit trail from all raw rata to analysis to themes. This audit trail is responsible for the large size of the Appendices section of this thesis.

In addition to the above noted time limitation, three significant sampling limitations limit the generalizability of the research findings and conclusions.

1. The sample size of eight registered nurses in semi-structured interviews is small.
2. The sample size of three focus groups of registered nurse managers and nurse educators is small.
3. The sample context is limited to only medical-surgical nurses in one tertiary hospital in Alberta.

It is hoped that further research will expand and embrace AQAL; all quadrants, levels, lines, states, and types to "touch all bases" (Wilber, 2005, p. 7) when examining the influences of policy implementation and other research questions.

Conclusion

This study contributes to the body of knowledge regarding nurses experiences in, and perception of mandatory CPD in their practice. With IMP underpinning this research, the influences of mandatory CPD were explored from Wilber's four Quadrant framework. Significant findings from this research revealed six integral themes that generally describe noxious working conditions that challenge the highly valued and ethical CPD in nursing practice. At best, nurses' achieve the learning necessary to survive the workplace; however, higher learning for CPD required by regulation is not accessible or feasible in most cases. The lack of CPD then cyclically impacts nurses' ability to maintain competence as required in legislation and further erodes nurses' culture and capabilities.

Interpretation of the themes across all quadrants revealed the problems found in this research. The upper left quadrant themes explain the problems from the subjective point of view of eight registered nurses and describe the lived experience of registered nurses in an oppressive system that diminishes continuing professional development and safe nursing. The lower left quadrant is the inter-subjective point of view of nurse managers in three focus groups, where the themes describe what influences and accentuates the problems such as the helplessness and lack of support for nurses working in the oppressive system. The upper right quadrant themes describe nurses' erratic and emotionally-charged reporting behaviour in MyCCP, resulting in a complete lack of useful reported data. The lower right quadrant provides more in-depth insight to, and further explanation of the problems by exposing the self-defeatist policy and processes that add to oppressive conditions and blighted continuing professional development.

Though research on the lived experience of health care practitioners have shown that a "dialectical model of competence" is unrelated to day to day reality (Austin & Gregory, 2019, pp. 45–46), there is hope that Alberta nurses could be the most influential advocate for self-

regulation with better understanding of all four Quadrant perspectives. Implications and recommendations from this study include expansion of Integral research to support IMP research endeavours. Such research would inform the work required to remove barriers and improve shared understanding and overall improve compliance with legislative accountabilities. The vision is for nurses to measurably and recognizably practice ethically, competently, and safely, while fulfilling their potential in life-long learning.

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Appendix 4A Darren-Second Level Analysis

Table 29. Darren-Second level analysis

First level analysis	Second level analysis
4b. Bridge communication between administration and front-line nurses 13b. Administration makes many changes 14b. Management makes changes that are discordant with the front line working requirements. 42b. The employer is obligated to maintain quality or risk losing funding. 62b. Hospital administration expects specific outcomes that are unrealistic at times.	1c. Administration is dissonant from front-line nurses and impose changes that are dysfunctional.
7b. Workload is demanding 35b. Over time, higher acuity patients were assigned to nurses with increased technology requirements. 54b. The flow of work improves as the team members are more familiar with each other. 55b. Relief staff on the team interrupt the normal flow. 18b. Minimum workload requirements exceed nurse capacity.	2c. Minimum workload requirements exceed nurse capabilities.
17b. Patient care and documentation often cannot be completed without missing breaks. 49b. I feel fatigued with change at times. 25b. Sometimes you must sacrifice one obligation to get another obligation accomplished. 24b. Sometimes personal wellness is sacrificed. 37b. Staff get frustrated and tired.	3c. Daily work requires personal sacrifice.
12b. Change is difficult for people 6b. Staff resistance 31b. Sometimes a break from constant change is needed. 11b. The reasons for change are ambiguous 10b. Change is perceived as more work.	4c. Constant change is ever-present and onerous for nurses.
23b. Maintaining safety is the highest priority. 41b. Intrinsic motivation to learn. 75b. I am competent when my patients have not been harmed. 50b. Because I am a professional, I must learn for the patient's sake. 52b. Improved patient care motivates me. 3b. Being knowledgeable improves patient teaching and improves outcomes. 51b. As a professional, I am intrinsically motivated to learn.	5c. Professionalism is wanting to continually improve patient care.

102b. The future will only continue to bring more changes. 32b. The nursing context has changed significantly since career start. The future will only continue to bring more changes. 101b. Constant adaptation is necessary. 100b. Constant change is ever-present. 76b. Learning is constant so it is impossible to document all the competencies.	6c. Nursing continues to rapidly evolve.
29b. With years of experience, you get used to changes and adapting. 30b. Some nurses adapt easier than others. 36b. Adaptable is learning the new skills needed to get the job done efficiently. 56b. Adaptability is inherent in nurses.	7c. Nurses must continually adapt to unexpected circumstances or patient conditions to get the work done effectively and efficiently.
38b. Learning was not supported because of sexist views and therefore there was a lack of mentorship. 33b. Being male gender was not well accepted in the past. 40b. I had to personally overcome the challenge of sexist marginalization.	8c. Sexism has been a challenge for male nurses.
45.b Changes in technology mean a large impact 26b. Innovations in improved patient care increase work demands. 28b. Innovations and research trials may be initiated by physicians or as indicated by research. 48b. I must learn when there are innovations. 3b. Employers provide Learning opportunities.	9c. Innovations and technology changes increase work demands.
58b. CARNA is unaware of what really happens. 85b. The online reporting format is challenging. 93b. MyCCP is frustrating because it is difficult to interpret and find a fit for the learning that has taken place. 89b. The practice standards indicators are ingrained in nurses and they don't think of them. 66b. CARNA and UNA should be advocates for nurses.	10c. CARNA is generally dissonant, with a meaningless reporting process.
65b. Nurses are accountable even if the safety of the situation is out of their control. 64b. CARNA is punitive of nurses regardless of the safety of the hospital context. 8b. Legal penalties are a threat if nursing practice requirements are not met. 67b. Nurses must maintain accountability even when overburdened.	11c. Nurses are held accountable in a quagmire of unsafe conditions.

68b. It seems as though there are more and more short-cuts to patient care, increasing the responsibility of registered nurses at the front line.	
95b. Feedback comes from patients and managers 96b. CARNA can refer to patient feedback cards and letters if I am audited. 86b. It is difficult to recognize and remember feedback received. 88b. Negative experiences are more easily remembered. 91b. Nurses are accountable for mistakes but what they do well is unrecognized.	12c. Most feedback is incidental and arbitrary.
60b. UNA is employee-based 81b. UNA arranges courses appropriate for MyCCP.	13c. UNA provides much-sought-for advocacy for nurses and help to enable learning.
69b. Nurses learn to survive and not for interest. 98b. Nurses learn so much constantly that they should look at learning outside of nursing to enrich their lives. 1b. Learning beyond what is required 87b. Good learning experiences also include the negative experiences	14c. Nurses must learn far more than what is legally required.

Appendix 4B Darren-First Level Analysis

Table 30. Darren-First level of analysis

Questions	Major Theme	Sub themes	Key comments
1a. Let's pull up *MyCCP* on the CARNA website and discuss this reporting process.	1b. Learning beyond what is required	2b. Advancing career	
		3b. Employer provides learning opportunities 3bb. Leadership course	Because they actually will send me to courses, so I actually completed my leadership certificate just in June, so.
2a. What is your role about?	4b. Bridge communication between administration and front-line nurses	5b. New processes require teaching, assessment of the rollout and bringing problems back to administration	So a good example right now is we, you know, we brought forward with the Braden score because of some sort of legal conflict between the original scoring that we had in our documentation, and the one that we wanted to bring forwards. So I'm not sure what the process problem was but it resulted and we had to create new documentation. And then teach the new documentation and then try and get staff to comply with the documentation. So it's been a continual challenging process, to try and get staff to get on board with that. And that's just one small component, you know, there's multiple other areas.
3a. Tell me about the challenges with getting people on board with changes.	6b. Staff resistance		Uh, some of its resistance based on why do we have to do this—you know philosophy?
	7b. Workload is demanding		Um, as I said workload has been increasing with the reduction of staff on the floors, and that puts a strain on the staff to make, uh, a choice as to what can I get accomplished during, during my day
	8b. Legal penalties are a threat if nursing practice		And that is to try and educate them to serve that sort of documentation as part of the requirement of the draw. As well as from a legal

	requirements are not met.		standpoint where if you don't have that documentation, if you brought forward in a court case, you will be held liable for neglect.
		9b. Legislation requires that nurses stay up to date and stay educated.	And it's also part of a learning curve, you know, in regards to, you know, I guess legislation that still we be keep up-to-date…And keep educated.
	10b. Change is difficult for people	11b. The reasons for change are ambiguous	And it is hard to know if it's benefiting the patient, benefiting the institution or benefiting research.
		12b. Change is perceived as more work.	And sometimes even for a frontline worker, we just see it as more work.
	13b. Administration makes many changes		The new goal from an administrative point of view appears to be change is good, so let's change as much as we can as often as we can.
4a. Tell me more about your view of administrative changes.	14b. Management makes changes that are discordant with the front line working requirements.		If you look at how many times policy has changed based on evidence based decision making and learning, management tries to be as progressive as possible. But not always as a progression positive because there's some change roadblocks in regards to accomplishment. You know, what upper management sees and say well this is just an easy fix. When you actually get down to grass roots, it may not be an easy fix. You have to bridge that gap of knowledge from what the administration versus frontline workers experience. You know, on paper it's easy.
		15b. Management has good ideas but not functional to meet the needs of patients.	And we have a high rotation of upper management, we all bring in great ideas, but not always really functioning, you know, in a way that you can keep a good flow for patients, patients' needs.
		16b. Administrative changes are unrealistic with what nurses can accomplish.	And, and you can only do so much in your one day, and like if you have other you know in your12-hour shift…Do you sacrifice going for lunch?

5a. When you sacrifice your break-time, are you referring to how busy your day is?	17b. Patient care and documentation often cannot be completed without missing breaks.	18b. Minimum workload requirements exceed nurse capacity.	Just the busyness to take care of patients but also get your documentation caught up. Sometimes you have to document on your lunch break, so you can get it accomplished so you can go home on time.
		19b. CARNA documentation standards often cannot be met due to heavy workloads.	It's a challenge. Um, when you look at an eight hour a day, of that eight hours , you can pretty much expect based on the number of patients that you are taking care of, at least an hour to two and a half hours of time required to document appropriately, accurately, and in depth like that. You should meet for CARNA requirements. Reality is staff like it that they can actually get one hour.
		20b. Documentation tends to be far to brief.	I think it's too brief in regards to if you need to go back and reference to that information to see how the events transpired, um, the brevity will leave a lot of gaps, um, especially if when you look at the actual day for that staff nurse, they're taking care of five patients.
		21b. Patient case-loads are very onerous and demanding.	
		22b. Staffing assignments are often unrealistic.	Uh, two patients may require two to three staff members to physically actually get them out of bed into a wheelchair. So the allotment of time could be 45 minutes per patient just for mobilization from bed to wheelchair.
6a. What goes through your mind when these situations happen to you in your workday?	23b. Maintaining safety is the highest priority.		Um, well, you're looking at, “Okay, what can you do to create as best a patient environment for that patient to keep respect, to keep quality of care. To ensure that that patient's safe, as well as the staff members are safe.
		24b. Sometimes personal wellness is sacrificed.	Um, somedays you start your shift, and in a blink of an eye five hours has gone by. And it's like, "Okay, well I still have to take a drink or I should go pee. I should actually eat something."

		25b. Sometimes you must sacrifice one obligation to get another obligation accomplished.	Um, (laughs) so for some staff as well as myself, you run into an encounter of the intensity requirements as well as just how you can get all your tasks done in one day may not be met, and you have to pick and choose, you know, what can you do, what can you hopefully pass onto another staff member if they have time to accomplish on the next shift.
	26b. Innovations in improved patient care increase work demands.		When you have that, your requirements of observation increase. You need to do your vital signs far more often, you have to do minimum every four hour checks of the nerve block itself to ensure that the pump is functioning properly.
		27b. Work assignments are not uniform and should not be formulaic.	And other institutions may not have that program. So they may have the same number of patients , they may have the identical type of patients, but the observation levels are a little bit different based on the fact that they're not utilizing this new technology.
7a. Tell me more about who are rolling out these patient care innovations.	28b. Innovations and research trials may be initiated by physicians or as indicated by research.		It, it was an innovation brought forward by the anesthesiologist. They have utilized blocks for patients in pregnancy, you know, um, to reduce the discomfort. So the thought was, "Okay, at the UofA, let's see if we can minimize pain, reduce narcotics and possibly reduce dementia if possible, especially, in our aging population because we do hip fracture repairs age 65 to 105.
8a. What was your reaction when you first heard about this new patient care innovation implementation?	29b. With years of experience, you get used to changes and adapting.	29bb. Constant training.	Um, myself I have been in a process of constant training pretty much my whole career.
	30b. Some nurses adapt easier than others.		So for my other staff members, some of them are a bit overwhelmed, others this is cool, you know, let’s go for it. You know, and if we can make our

			patients more comfortable. You know, it's going to be a little bit more work, but you know we shouldn't have too many of these patients coming through.
	31b. Sometimes a break from constant change is needed.		And that's my one criticism with, um, constant innovation is you need a bit of breathing time to allow learning to actually settle in. If you keep on throwing change on a repetitive basis, you actually will increase resistance just based on fatigue.
			Yeah, you know. So, you know, there's aspects of learning that's really encouraging and progressive, but it has to be balanced with a period of rest.
9a. Based on what you have told me so far, what was it like for you on all of your learning paths?	32b. The nursing context has changed significantly since career start.	32bb. Learning new technology	Uh, I was based on an infant unit. Our technology at that point in time was a portable monitor that would basically do a vital sign of blood pressure, heart rate… Eventually that technology 10 years later becomes closer to the beside, um, the purchases of such increased so that you could actually have higher acuity patients on the floor not requiring ICU because you actually were able to bring technology to the bedside.
	33b. Being male gender was not well accepted in the past.		So that's sort of the beginning of my career so, having to pioneer as a male in the program, uh, promote and encourage other males to continue into the paediatrics and now you know 25 years later, there are far more guys at the "U" in that program are all, they're more accepted.
		34b. Gender discrimination was an added challenge.	I had to pioneer through both discrimination from families as well as from staff members. So that was an interesting challenge.
	35b. Over time, higher acuity patients were assigned to nurses with increased		When you deal with renal patients you're dealing with a little bit more dialysis so the medicine units increased their program or raised their education for both drip dialysis versus machine dialysis.

	technology requirements.		
			So when you look at just, um, the programs, the healthcare, every year there is always something that we need to either change, improve or look at bringing out for keeping patients on a floor level in our institution.
10a. Tell me more about what you mean by adaptable.	36b. Adaptable is learning the new skills needed to get the job done efficiently.	36bb. Learn new skills	Adaptable for the nurses is you, you learn many new skills, you try and see how you can incorporate an ability to get that job done in the least amount of time with the most efficiency possible.
		37b. Staff get frustrated and tired.	When things don't go according to plan or as a result of just you know circumstances that are beyond your capabilities, um, you know staff get frustrated, staff get tired, um, staff sometimes need a break and actually leave the program. You know based on you know, "I just can't take any of this anymore."
	38b. Learning was not supported because of sexist views and therefore there was a lack of mentorship.	38bb. Mentorship	Uh, for myself I have a been a constant learner. And because of the early years there wasn't a lot of options in regards to mentorship for me, um, because I was groundbreaking in a program where, um, — At that point when I first started it was about 50% of the female population of nurses that didn't feel that I belonged there.
		39b. Eventually, men became more accepted in the profession.	As time went on they started to see the benefits of having guys in the program. You know we had a different perspective. Um, we can physically do a lot more than what some regular nurses couldn't do. So you know if they required extra lifting then we're kind of work horse to do that.
	40b. I had to personally overcome the challenge of sexist marginalization.		But it's just you know, it was just a challenge, so I had to look at whatever I was going to learn I needed to learn on my own at that point in time because I didn't have a mentor there to say , "Okay, you know I'll guide you through."

11a. What were your drivers?	41b. Intrinsic motivation to learn.		My, my drivers were just, um, I enjoy learning, I enjoy fixing things. So if there's a problem we solve it. And that's you know always been I think part of my personality where, um, the challenge is there so therefore I, I go for it.
			You know I'll, I'll contribute as a volunteer you know, to you know get into the program find out you know what's new, what's the challenge all that sort of stuff. So-
12a. How does your employer influence your learning?	42b. The employer is obligated to maintain quality or risk losing funding.		we know that programs are required to meet certain challenges, so with the accreditation basically if you meet those challenges then you get accredited and then you have a certain amount of funding as well as a certain amount of, um, what you're allowed to do in your institution. If you fail that accreditation then those cents are taken away.
		43b. Changes made for quality do not amount to higher quality at the front line.	And from a legal standpoint we understand why it went in, from a professional standpoint we understand, but from getting the test done it created a nightmare for everybody and that creates a frustration and that's the, the whole I think problem that we run into from a frontline worker, in the distance between them and the administration, administration has to make a change one way or another whether it's being legally brought forward or they think that ethically this would be a better way to go.
		44b. Communication needs to be funneled from the front line to administration.	And I think that's what they're hoping that a quality team can maybe do is bring it half way up the chain, to say hey…whether that administrative group wants to listen to the frontline workers that's going to be variable based on institutions and individuals that are in those positions
	45b. Changes in technology		And I know it's not going to be just one institutions that's going to be

	mean a large impact		impacted, it's going to be the whole province.
		46b. Multi-generational nurses teach each other new technology.	So this is going to be an interesting development for the new RNs and LPNs helping the old ones to adapt to that program. So sometimes the younger can bring in new ideas to help the older.
		47b. New technology is more work so resistance is expected.	But there's always you know resistance to change no matter what because it's just a lot more work.
13a. How have you been involved in changes?	48b.I must learn when there are innovations.	48bb. New innovations.	Um, it does impact a little bit on my learning, um, you know as we bring in new innovations, you have to learn. And I tend to learn most of the time you know with interest.
		49b. I feel fatigued with change at times.	You know there are certain situations where you know it's just, you're just fatigued and you just can only do so much.
		50b. Because I am a professional, I must learn for the patient's sake.	But, um, I think it's just the difference between a profession and from a profession standpoint you're wanting to be better at what you do, so that you can deliver a better product to the patient's that are receiving them, versus a job.
		51b. As a professional, I am intrinsically motivated to learn.	no this is my profession, I'm proud of it and I want to get as much as I can out of it from just a self rewarding you know sense of "feeling"… really is what it is.
		52b. Improved patient care motivates me.	And you can tell the difference between those that have a different mindset of I'm here because I want to learn, I want to make my patients feel better, I want my patients to be safe, I want my patients to go home.
		53b. Being knowledgeable improves patient teaching and improves outcomes.	And you know sometimes I can be at fault, because it does take more time, till you can lose time in regards to certain aspects but you can gain time in others where if you teach a patient properly… Um, possibly you can reduce further injury for these individuals, possibly make their stay a little bit shorter, and hopefully reduce the amount of discomfort that they feel.

14a. Tell me about how your team impacts you.	54b. The flow of work improves as the team members are more familiar with each other.		So when you have a team that has been working together things will generally flow a lot easier because you will understand your — How your co-worker works, their strengths as well as their weaknesses.
		55b.Relief staff on the team interrupt the normal flow.	But when you start getting a lot of, uh, relief staff coming in, that dynamic change can interrupt the flow of how things are going because you may have to take on more responsibilities in certain areas.
			but I find when we work as a team of people that have worked together on consistent basis, things flow quite nicely and when you run into problems or unexpected events, you can adapt a little easier.
15a. So adaptability is more difficult when the team members are unfamiliar?	56b. Adaptability is inherent in nurses.		You know but then again I think the whole nursing profession now is, adaptability is part of our skill set… Because nothing ever goes as it should (Laughs).
		57b. Challenges are often unexpected and require adaptability.	You know some patients are ready for discharge quite quickly, others aren't, um, patients you know have comorbidities that they bring with them, sometimes we know all of them sometimes we don't. And we don't know them and all over sudden they have a respiratory distress because they're allergic to something that we didn't know about you know it creates a challenge so.
16a. What about the affects of UNA, CARNA?	58b. CARNA is unaware of what really happens.		I find just my experience is being from a floor prospective, that I don't find CARNA is really aware of how things go on the floors.
		59b. CARNA is research-based, political and punitive.	They're very much research based, very much, um, political based to try and make sure that legislations is being followed so in some ways it can be a punitive source you know if staff members are not meeting the requirements.
	60b. UNA is employee-based	61b. UNA and CARNA should work together.	

	62b. Hospital administration expects specific outcomes that are unrealistic at times.		Hospital administration has you know their expectations of what is going to have happened, patients come in, patients leave, perfectly on two feet, you know some occasions they don't.
		63b. CARNA and UNA do not acknowledge the fiscal and legal restraints imposed on hospitals.	Uh, but the problem is an institution runs based on finances and legalities, so you have budgetary restraints, you have fiscal responsibilities where the unions and CARNA don't always look at that aspect as to, you have an institution that has to make their budget,
		64b. CARNA is punitive of nurses regardless of the safety of the hospital context.	and to make their budget they have to increase the amount of patients that are being taken care of by one individual, not always is it safe but yeah if a nurse makes a mistake then there's punitive repercussions as a result.
		65b. Nurses are accountable even if the safety of the situation is out of their control.	And if it's beyond their ability to do that based on just the sheer numbers of patients that they're being responsible for.
		66b. CARNA and UNA should be advocates for nurses.	You know and if CARNA and UNA can get together and look at it and place sometimes a bit of pressure on the institutions and say, "You know what? Based on research you know like this many people being observed by one individual is physically impossible, and you place an undue risk on both patients as well as the staff. We need to look at you know some change in regards how your finances are coming in. Um, you know if it means they're going to have to talk to the government to ask for a loan or what, but you know there has to be an accountability and it can't be on just the frontline workers."
		67b. Nurses must maintain accountability even when overburdened.	And they are in over capacity, so you know to "suck it up buttercup" [Laughs] you know it's, and that's how the staff feel at times.

		68b. It seems as though there are more and more short-cuts to patient care, increasing the responsibility of registered nurses at the front line.	You know are we putting more responsibility on people that aren't qualified to be taking on that responsibility? That's happening you know where they're increasing the scope of practice for the health care aids, the LPNs, it doesn't mean that they're qualified to do that, but we've just you know given them you know a two hour orientation so now they're qualified. So these are some of the, the frustrations the floor nurses do deal with.
17a. What does that do to "learning"?	69b. Nurses learn to survive and not for interest.	69bb. Learning for survival.	It reduces the interest to learn, because it just means that they're just going to teach me more so that I have to do more, and then therefore it's a, a negative impact, it's not a learning to challenge yourself, it's a learning for survival.
		70b. CARNA and UNA need to advocate for change to enable nurses to provide safe patient care.	that's where I really wish that CARNA and UNA can maybe sit down at the table and say, "You know what? You know this is a fiscal responsibility and realities, uh, but we've been in a budgetary saving mode since 1984, and that hasn't changed no matter how much money comes into the province
		71b. Financial pressures have gone on too long.	The administration is always asking us to save money, to cut cost, to you know pair down, well I think the system has been paired down to the point where it has to be injected in this, a moderate amount of finances but being done in a fiscally responsible way.
		72b. Even though services have downsized, patients are sicker and stay alive longer.	"Hey, we've got one more hospital available to take care of you know basically …say Edmonton…rural… 250,000 people since that time period, of that people are sicker also older (Laughs), you know we're keeping people alive more, well then what we used to in the past just because have medications that can increase heart strength, we have medication that help CF patients.

		73b. Administrative expectations have not evolved to the changes in technology or patient acuity. 73bb. New implementations.	So, so anyways, um, yeah, uh, the administration could impact how people feel to learn you know based on it's not you know, it's coming down the pipe because we need to bring these patients out, we have no choice you have to learn.
		74b. The nurse patient ratio is based on a single blueprint, not accounting for diversity or demographics or specialized care.	Then again you can have far more twisted ankles down in Calgary because their snow comes and goes and it's just a one-day event so they might have you know higher fractures of different body parts yeah so- Diversity is present.
18a. Tell me about MyCCP. Let's start with how do you understand competence?	75b. I am competent when my patients have not been harmed.		Okay, um, well if I start my day, take care of my patients. I leave my day and everybody is alive that's competent. Uh, no you know injuries you know based on that.
		76b. Learning is constant so it is impossible to document all the competencies. 76bb. Experiential.	I don't think we actually document as much competency as what we actually do do, because we're constantly learning whether we know it or not,
		77b. I document courses when I take them. 77bb. Leadership courses Rec1a. Administrative meetings. 58:16	And when I was doing my competency because of my leadership role, I was doing a lot of courses so I put my courses up. Administrative meetings.
		78b. Part of learning is adapting and developing. 78bb. Adapting to change	So we're looking at what are we bringing forward to the table, are we bringing, you know learning things, are we adapting, developing, we're doing all that. So then I realized, "Okay, well I guess I can put that in now."
		79b. Analyzing quality data and making changes accordingly is learning. 79bb. Data driven	Now I'm doing audits and as I'm doing audits I'm bring forth the data to the staff and saying, "Okay well these areas that we're improving, these are areas that we need to improve on."
		80b. Yearly learning includes CPR, code training and yearly research days. 80bb. CPR 80bbb. Code training 80bbbb. Research Day	Um, then you look at well I have to deal with my CPR, so my CPR that's a continuing competency every year. I have to do now a fall program that's brand new this year, so that could be put in. And then we have code red, code white, code

			blue, code purple, code green, code brown. I guess that's learning too so that I can go in there. I went to, uh — For the residence they have, uh, a review where they put forward what their research is about, so it's a research day, so I attended that and I listened to 14 residents talk about the different projects. So theoretically if I could remember what day it was and what I had listened to for each of the topics, I could put each of those topics down.
		81b. UNA arranges courses appropriate for MyCCP. 81bb. UNA course	But in reality, I went to a course and that course was, you know, a full day that UNA put on, so I'll put that in, and it's all we put in.
		82b. I enter in my own research study. 82bb. Research study.	You know, because we did, um, a study where we wanted to see one, are we getting our patients up, you know, to get out of bed?
		83b. Colleagues do self-study courses and attend conferences or learn new equipment, so they can enter those into MyCCP, but they don't remember it all.	They had to do CPR, they had to do all their self-studied, you know, tests. Some of them went to conferences, uh, some of them became super-users for certain products. Um, the odds of them remembering to put all that in, they probably won't. They'll probably just think of that one conference they went to and enter that in.
		84b. Most nurses don't remember all the learning they are involved in.	So I think from a learning perspective, the staff are learning constantly, they're just not realizing that they're learning.
	85b. The online reporting format is challenging.	85bb. Made up dates of random learning experiences.	Um, to put it into a formulated format like what we have to do for our CARNA, it's a little bit of a challenge because then, "Okay, what date did it occur (laughs)?"
		86b. It is difficult to recognize and remember feedback received. 86bb. Can't remember feedback received.	Um, we're constantly getting feedback from the administration, "Um, you haven't — You, you did a really good job today with that patient." Most of us take it as, "Okay, yeah, I did a good job. I was just doing my job, but thank you.

		87b. Good learning experiences also include the negative experiences.	Um, you know, uh, for myself you know when I was in paeds, as well as in adults, you know, we go through code situations. Um, generally outcomes can be positive. When they are negative, then you take that with you, but those are learning experiences.
		88b. Negative experiences are more easily remembered. 88bbb. Worst day of my life	Um, negative reinforcement is easier because that sticks with you longer and that's you know what you remember then longer. I remember that day on October 4th, you know that's like the worst day of my life, you know.
		88bb. Negative experience.	You do the best that we can, we learn from it. Possibly go for more learning just to see if you can improve the outcome or be at least a little bit more prepared as to what to expect.
19a. What do you usually do regarding the selection of a practice standard indicator?	89b. The practice standards indicators are ingrained in nurses and they don't think of them.		Because I know that they're supposed to be politically correct in regards to the statements of you know like you know the nurse is accountable at all times for their own actions. Um, if it's a profession, that's just ingrained into you. You actually don't even think of that, you don't, you just make an accountability for what you do for better or for worse.
		90b. As a professional, you learn from your mistakes and you disclose them.	But you learn from that experience. Um, but you don't hide it whereas I think if a person takes the profession as a job they will hide it.
		91b. Nurses are accountable for mistakes but what they do well is unrecognized.	Yeah, it's like we're all going to make mistakes, we're all going to have to be accountable for those mistakes as well as accountable for those things that you do that's well. Uh, we just don't take credit as much as we should.
		92b. The legislation is not thought of as much as the policies they work with. 92bb. Choose based on need for work, not legislation.	A lot of us now are at the point where we just want to make sure that our policies and our standards are based on the institution we're working out of, we don't think of the legislative perspective.
	93b. MyCCP is frustrating	93bb. CCP process frustrating.	You know so when I look through these, I get kind of frustrated

	because it is difficult to interpret and find a fit for the learning that has taken place.		because, um, I understand that they have to be formulated in a politically correct statement. It's pretty widespread as to how you interpret it.
		93bb. Lack of fit 93bbb. Teaching others	So it really was part of my competent-ness but it was actually more in a leadership role to say I'm trying to help other people understand what we're about to do and how we're going to move forward. But it doesn't really fit that because it doesn't really fit any of them (laughs).
		94b. I just pick one and try to make it fit. 94bb. Pick same over and over. 94bbb. Random pick. 94bbbb. Take shortcuts to think about it less.	I know that they had to put as many as they did down and so sometimes nothing really fits and it's like eeny, meeny, miny, moe (laughs), I'll close my eyes and see which one I get (laughing), then I'll figure out if I can do it. Um, and I'm not sure how the rest of my colleagues feel but I think that they're just probably as frustrated and keep on picking the same one over and over and over again because it's just it's less thinking that they have to do.
20a. Tell me how you relate your feedback to this program?	95b. Feedback comes from patients and managers.	95bb. Untraceable feedback from patients. 95bbb. Thank you cards.	Most of the time, you know, like you for myself as well as just listen to others, um, we get constant feedback from our patients, you know, for better or for worse but we just don't think about making a diary to keep track of them. So we… and myself included… usually just stick in, "Okay, I have my progress review this year." You know and you know unless I get a letter or unless you know a, a family gives me a personal card to say, "You know, thank you Darren for you know all the care that you gave us." You know that might put those in but half the time I usually just keep them in a file.
		96b. CARNA can refer to patient feedback cards and letters if I am audited.	And if they even get audited, I'll just bring forward all my letters and let them read them.

		97b. Managers provide feedback that can be reported in yearly reviews. 97bb. Manager feedback.	Um, but for the most part, you know, the feedback is just the formal feedback that we get, you know, from, you know, what we get from our managers just basically saying I had my yearly review, I had to make a few improvements or I had to challenge myself to do this.
21a. Any further thoughts on these topics that influence your learning?	98b. Nurses learn so much constantly that they should look at learning outside of nursing to enrich their lives.	98bb. Learn outside of profession. 98bbb. External engagement	Um, you know off the top my head, you know, like sometimes I think for nurses sometimes it's possibly better to look at learning something outside of what we do. To just encounter other individuals that do different things because sometimes we can just kind of get isolated into — You know I can, I can do this course, I can do that course all based on nursing but is it really going to enrich the person I am? And sometimes I don't think that it will because we do so much constant learning that it might be better to look at something totally outside the box.
		99b. Learning outside of the profession can prevent burnout.	I don't think that we promote enough of is looking outside the profession to basically kind of reground yourself back into reality. Because it's easy to get burned out in this place.
		100b. Constant change is ever-present.	You know so there's always a constant change here you know whether it be you know like I said the programs being changed so therefore you have to make a choice as to how you want to go with the program or you choose to change the program and you know. Some people like to stay on focal, there’s constant change there.
		101b. Constant adaptation is necessary. 101bb. New patient conditions.	Where as when you stay within a program and you take responsibility for the program as well as those patients within the program and then your learn to adapt to off service patients that you don't get normally.

		102b. The future will only continue to bring more changes. 102bb. Future changes	We might actually develop artificial organs that you know can function for our patient uh we might develop skin that can grow over graft that then becomes part of their body and you don't have to worry about rejection. We might be taking care of people that are 120 years of age instead of 101.

Appendix 4C Jim-Second Level Analysis

Table 31. Jim-Second level of analysis

First level analysis	Second level analysis
61e. Change is a natural part of nursing. 47e. Resistance can happen if you try to change too much, too quickly. 1e. Nurses are resistant to change. 43e. Negative perceptions of the change can increase resistance to the change. 44e. Even when change is intended to standardize nursing methods in teams, some members are resistant. 57e. Nursing is becoming outdated because of the resistance to change, especially change in technology. 46e. Nursing as a profession moves and improves very slowly even when new initiatives roll out. 40e. Some nurses do not access even the simplest forms of technology such as email. 42e. Change is more acceptable when there is a direct benefit to nursing practice. 58e. Receiving and reacting positively to feedback is part of the process to change. 41e. I realized CoACT was a system of teamwork that I was already enacting.	1f. Nurses are resistant to change.
63e. Nurses take each other for granted and are unkind to each other resulting in high sick calls. 60e. Many nurses are afraid of change and not having the ability to handle the changes. 7e. Nurses often don't take accountability for their learning. 45e. Lack of trust can keep new initiatives from moving forward.	2f. Nursing culture is antagonistic.
68e. Staying up to date and interested keeps nurses accountable. 17e. Nurses need to advance knowledge for the profession even though it requires sacrifice of personal time and money. 25e. All aspects of the healthcare system must be understood to properly do the job. 27e. The lack of a bigger viewpoint is a disservice to patients who need all the resources within the system to be coordinated. 14e. Learning can happen anytime in a person's life. 37e. Emotionally driven decisions rather than research-based, are not in the best interest of the client.	3f. Continuous learning benefits patient care.
2e. Nurses need to be motivated	

53e. It is more important for nurses to take responsibility and initiative for their own learning and not rely on other influences. 55e. It is important for nurses to challenge themselves. 64e. I t takes personal motivation and initiative to change a negative point of view. 65e. Patients need to be a nurse's first concern. 39e. Nurses must be curious and seek credible research and keep learning constantly. 28e. Nurses must continually question how to become better at their profession. 66e. I stay curious and interested in learning and I explore other opportunities. 62e. Constant questioning and researching is essential to everyday practice. 6e. Nurses motivate each other through social connections.	4f. Motivation and curiosity are essential in nursing.
5e. Nurses are unmotivated to become aware of educational opportunities. 9e. Nurses are not motivated to continue their education. 50e. The motivation for financial benefit is more influential than the learning itself. 24e. Many nurses don't question or see the bigger picture, and instead stay focused on the details of their work. 26e. Most nurses on the front-line do not see the whole picture. 38e. It is difficult for nurses to apply the theory to practice because it always seems like more work. 54e. Motivation is easier said than done because of other 'life" factors.	5f. Motivation to learn is diminished by workload.
8e. Nurses are still trying to professionalize themselves. 10e. I love my profession as a nurse even though others look down on it. 21e. Perceptions of nurses have changed because nurses are highly educated. 22e. Nursing has evolved into a serious profession since its inception. 56e. We cannot progress as a profession if we do not individually challenge ourselves. 59e. Visibility and open-mindedness is essential to ensuring the nursing profession moves forward.	6f. Nurses must strive to be viewed as serious, credible professionals.
18e. Sexism is still a problem in nursing as it is seen as female dominated. The problem is slowly resolving. 19e. Nursing will not be viewed as a serious profession if it is gender-specific.	7f. Sexism negates nursing professionalism.

16e. Internationally educated nurses have many opportunities in Canada to upgrade. 67e. I stay interested in local and global opportunities by staying positive and seeking out many nursing roles. 20e. Nurses in Canada are required to be more skilled and critical thinkers compared to international nurses.	8f. Nursing in Canada is more advantaged and professional than in other countries.
23e. Nurses must try to understand CARNA, UNA and their employer to work within the system. 29e. CARNA and UNA need to move the profession forward 49e. UNA provides paid education days but this opportunity is not accessible enough to benefit everyone. 52e. UNA has a higher value to members because of their role in contract negotiations, while CARNA is simply directive and unpopular.	9f. The value of CARNA and UNA is vague.
30e. Continuing competence is a trigger for nurses to improve and adapt their practice. 48e. CARNA demands that you report your learning but you can write anything you want in the reporting system. 51e. A more directive approach to learning requirements would be more effective.	10f. MyCCP is ineffective.
31e. Nurse educators play a role in researching and disseminating new knowledge. 32e. Nurse educators support nurses in developing their continuing competence and accountability. 13e. The manager's role is to encourage nurses to access learning. 15e. Mangers coach and encourage their nursing teams. 3e. There are benefits in place for nurses to attend learning events as long as you are motivated. 4e. The education days are a good opportunity to participate in learning activities. 12e. Nurses choose not to further their learning because they are satisfied with their pay as it is. 11e. There are learning opportunities available but it is up to the individual to access them.	11f. Workplace support for learning is available if chosen.
33e. Competence is when a nurse feels comfortable with the skills they need to perform. 34e. Competence is not defined by theoretical nursing knowledge. 35e. Continuing competence is evident when there is something perceived as different and improved in practice. 36e. Even when theoretical best practice is presented and modeled, competence is beyond understanding to incorporating it into practice.	12f. Even if comfortable, nurses must demonstrate continual improvements.

Appendix 4D Jim-First Level Analysis

Table 32. Jim-First level of analysis

Questions	Major Themes	Sub Themes	Key Comments
1g. Recording started after interview in progress.	1e. Nurses are resistant to change.		Uhm, I'm not sure if it's a characteristic of nursing…. There are a lot of people resistant to change? Or we're not open to new ideas because we're so used to it? And we are afraid to change our … you know…. Practices?
		2e. Nurses need to be motivated	Unless you can really change the culture…maybe we can demand… Uhm… the change the way we do our registration. To ask members they need to have …. To review and article or something… read and article or something that is relevant to your practice. Or go on a seminar.
	3e. There are benefits in place for nurses to attend learning events as long as you are motivated.	4e. The education days are a good opportunity to participate in learning activities. 4ee. Education days.	Or, you know, when I was on the floor, I make sure I go for those three education days…the three or four education days that they gave us. But you know, those are your own…your own time. It's straight time.
		5e. Nurses are unmotivated to become aware of educational opportunities.	That's 35 people and …I kept thinking only one coming into this seminar…like everybody has their own lives, but you know then I chat with them and they say they didn't even know about that.
		6e. Nurses motivate each other through social connections.	Unless you probably have to organize each other… like come on, let's go. And…and… attend this one.
		7e. Nurses often don't take accountability for their learning.	But a lot of them, like I say, go to conferences but how many really listen too? They go there because they get an extra pay because they're paid for their education but they sleep in the corner. So, it's accountability that is missing.
	8e. Nurses are still trying to professionalize themselves.	8ee. New culture.	In other parts of the world, we're still viewed as like a health care aide. I just came from Bulgaria-my partner and I have been together for 17 …oh 18 years. And they ask, Oh what do you do as a nurse because in Eastern Europe and other parts of

			the world, it's the doctor that managed the unit. And the rest are just dictated by the doctors. So there is a strata that we have to get over it. Right? Uhm, in other parts of the world…even in the US, they… nursing is not as professionalized as Canada.
		9e. Nurses are not motivated to continue their education.	We just started making sure that every nurse is a BScN degree in 2010. So there is still only 7 years so there's still a majority of nurses who still don't have BScN. There are some that say I'm not going to continue my…my BScN. I even ask my staff, can you… you know, Are you not planning to at least do Athabasca, just upgrade to your BScN? And they say what for? $1.25? It's beyond that, it's not just $1.25.
			I would say it is very important that for us nurses, nursing to be viewed as uhm, more seriously by other people. Because there are still…especially immigrants coming over, are you a nurse? So your JUST a nurse. I'm not JUST a nurse, I'm a NURSE.
	10e. I love my profession as a nurse even though others look down on it.		I'm happy with my status with where I'm at. However you classify me. This is a profession I've grown to enjoy and to love. You know you can say whatever you…people can say whatever it is, but I think…you know…there has to be ongoing professional development for every member…in nursing
2g. As a manager, what are the influences on you and RN learning?	11e. There are learning opportunities available but it is up to the individual to access them.		I think, for me, like, when there are opportunities for further I always have my weekly highlights on my monthly highlights … these are the educational opportunities out there. You know…see if you like it. If the onus is practically just making sure that the onus is…you gave them the direction… the onus is. The drive comes from them.
		12e. Nurses choose not to further their learning because	And for a lot of them, you know, just because maybe nursing is not as badly paid compared to other

		they are satisfied with their pay as it is.	provinces or other countries. So their satisfied with their goal, just getting their $35-$50 per hour. I'm good with it. I don't need to learn. So like the you, the drive to move forward is personal. Right? Uhm…for them, a lot of them it's financial.
		13e. The manager's role is to encourage nurses to access learning.	So, Uhm I can see …I can see there's a lot of challenges for them but you know, as for me as a manager, I think my role is to just make sure I encourage them to move on to continue moving forward
	14e. Learning can happen anytime in a person's life.		It's a continuous, continuous cycle. Right? I mean, I went back to school in nursing in my 30's and I'm in my 40's now…I'm…It's didn't even bother me that I'm one of the oldest at the time. No, it's just an age. But that is my perspective on learning.
	15e. Mangers coach and encourage their nursing teams.		I think the onus for managers is to coach them. To coach their staff to be the best that they can be.
	16e. Internationally educated nurses have many opportunities in Canada to upgrade.		Whether you're a foreign nurse, you can strive to be a nurse practitioner or you can strive to be an educator or researcher.
	17e. Nurses need to advance knowledge for the profession even though it requires sacrifice of personal time and money.		Nursing doesn't end at the bedside and for our us to modernize our practice, there has to be research to support it. And for us to have research to support it, we have to have researchers in that role. But for us to support it, we have to have nurses to go into graduate studies, like you, willing to invest time and sacrifice the differentials and the weekend premiums and whatnot.
			Maybe a pay cut just to be able to move forward. I see your role as a vanguard or a trail-blazer in making sure that nursing will be taken more seriously.
	18e. Sexism is still a problem in nursing as it is seen as female		Because there is still… I mean… uh…I don't like to admit it, there is still sexism in the way we view nursing. It's a "female" profession.

	dominated. The problem is slowly resolving.		But we don't view that in the medical profession where a lot of doctors are female too. We still view it as a male dominated profession. I mean, we need to get out of the concept, right? Uh, but it's slowly, slowly going, you know…changing. Slowly …it's a little bit slow.
		19e. Nursing will not be viewed as a serious profession if it is gender-specific.	And I feel like, Oh my gosh, I hope before I retire I would see more… more proper distinction that nursing is not just about female-male. That it is a serious profession. That people has to look in to and that we have different roles.
	20e. Nurses in Canada are required to be more skilled and critical thinkers compared to international nurses.		Uhm, there is a very wide scope of what we can do and what you're doing here. What you associate as nursing, those are aides that are doing them in Canada. We have…we demand…we requested or we require more skill sets…critical thinking abilities from our staff, from our nursing.
		21e. Perceptions of nurses have changed because nurses are highly educated.	It's always the second higher graduates to go into nursing and now it's like, the cream of the crops are going into nursing. The valedictorians and top 10% of the class are going into nursing.
	22e. Nursing has evolved into a serious profession since its inception.		I take ample opportunity to make sure they are aware, and to encourage them to, you know, to do their research and read a little bit more in how nursing has evolved from Nightingale's time to our present time.
3g. And there's CARNA, there's UNA and there's AHS, there's the continuing competence program and uhm… I'm wondering how you might think all those different things fit into how they're influenced in their… in their	23e. Nurses must try to understand CARNA, UNA and their employer to work within the system.	23ee. Healthcare system.	But the onus was on me to investigate to understand what those processes are. And how to connect the dots and that's …that's my… how I … I … I try to navigate through the nursing system.

uhm…professional development?			
			But for a lot of my staff, new or even older, they don't even know what the resources… what they're … where they will go… what they will do. They're just so focused on the four or five patients that they have. And they are living in a bubble.
		24e. Many nurses don't question or see the bigger picture, and instead stay focused on the details of their work.	They just focus on their thing and it's like there's a blind shield that comes forward… where you can only see what you have in front of you. I'm seeing them more … in terms of the nursing practice…if I do see people who question… and who are curious about what other roles are there… they're a minority number.
		25e. All aspects of the healthcare system must be understood to properly do the job. 25ee. Discharge processes.	Oh my Gosh… and I thought we could just discharge because there is always somebody receiving at the other end! A lot of… just…I think uh… and the average, even the majority of the nurses never understand what's … what's on the other side. They're only looking at our side here.
		26e. Most nurses on the front-line do not see the whole picture.	Until I went into management, I never thought what the complexity is. You see things on another level. From the financial to hiring, to union relations
		27e. The lack of a bigger viewpoint is a disservice to patients who need all the resources within the system to be coordinated.	and the more I understand, the more I realize, that we never actually communicating with each other. We are all living on different bubbles. Some were lucky if there is a connection between those two bubbles. A lot of us are floating on islands somewhere, so very disconnected and … you end up with like miscommunication…how did this problem happen.. and where is there delay in discharge. You don't know what resources are there because we didn't bother to know the different roles of nursing are there.

	28e. Nurses must continually question how to become better at their profession.		How can I develop and improve myself? To be a better nurse, a better person, a better care giver, a better researcher… you know we don't have PhDs, but let's continue to challenge ourselves.
	29e. CARNA and UNA need to move the profession forward.		But I think, yah, I think, I don't know, we need to have more push, I think, from a legislative body… whether from CARNA or UNA.. UNA is where, you know… the pay. Maybe more ability of what we can do as a whole, but I think, your job is very important, moving forward. Because then you will be able to establish what the new … how nurses will be in the next 10, 20 years from now down the road.
4g. what about the notion of continuing competence? How does that factor in to uhm the experience of professional development?	30e. Continuing competence is a trigger for nurses to improve and adapt their practice.	30ee. CC a trigger to learn more.	I think the notion of continuing competence is very important for professional development because it triggers you to learn something …to do something. To be able to …you know.. improve your skills sets…improve your practice. And adapt new methods of nursing.
	31e. Nurse educators play a role in researching and disseminating new knowledge.		in the hospital we are limited to our educators and one day… it's kind of like we are putting the onus to them … they are very good educators… they will read the research and they know the best practices have been, depending on what the policy and the procedures of the hospital is. They will tweak it and send it to us to trickle down to us.
		32e. Nurse educators support nurses in developing their continuing competence and accountability.	So I think that needs to be reinforced, if not strengthened in whatever way, shape and form to be able to give members in…in CARNA to uhm…develop their continuing competency. And to be more accountable to it.
5g. So how do you think they know their competence?	33e. Competence is when a nurse feels comfortable with the skills they need to perform.		I think when they are more comfortable… like say a certain skill set they need to perform. Uhm, like (indiscernible) for example, they get more comfortable with practice. I mean, the continuing competency I think with staff, is

			related to their comfortability with their practice.
	34e. Competence is not defined by theoretical nursing knowledge.		Not necessarily on the…on.. on the.. I would say… on the theoretical aspect. Because it is more the practical
	35e. Continuing competence is evident when there is something perceived as different and improved in practice.		If they can relate the continuing competency to a more solid practice where they can see evidence and that it works, then they can say, well… it's good.
			Very theoretical… so hard to mix them into the practice and how they can grasp those concepts and a lot of them are very visual in how they want to proceed in how this certain best practice is supposed to work.
		36e. Even when theoretical best practice is presented and modeled, competence is beyond understanding to incorporating it into practice.	For example, in team nursing, how COACT works… and even now there is still some resistance. Just a simple… making sure we are … our…our teamwork is enhanced, communication is…communication is very important in nursing. You don't even need a research to say that. But still we …how many mis-communications do we find everyday? Tons! Uhm, I was just doing an investigation in one of the patients.. one of the patient's having a medication error. And there are so many opportunities that could have been caught. But it was not caught because those two nurses were fighting. Like I don't care whether you were fighting… you are here … you have to work together. It's not about YOU… It's the patient.
		37e. Emotionally driven decisions rather than research-based, are not in the best interest of the client.	You still need to co-sign, you still have to ask for… you know… it's so hard when a lot of nurses… I'm just thinking a lot because based on what I see think with their heart. They don't see it from the logical perspective….from the research perspective…from…from ideas. From the moment your emotions are reminding that I don't like working

			with you…no matter how many research I will present about COACT and how we should communicate better, that will just go to the trash.
			So, going back to the question, I think once they see that there is a value to their research, that they were able to do it and it's tangible, then they can adapt to it easier. More easily than when it is very theoretical.
		38e. It is difficult for nurses to apply the theory to practice because it always seems like more work.	As research… when you mentioned the word research, a lot of them will just, OK, well I hear you. It's a new policy that you want us to do. It's more work for us…. More this for us. Is there a resistance to change? Is there a resistance to accept new ideas? Or new challenges?
		39e. Nurses must be curious and seek credible research and keep learning constantly. 39ee. Constant questioning.	You know that… you always question because the moment you stop questioning you stop learning. When you stop learning, you stop growing.
		40e. Some nurses do not access even the simplest forms of technology such as email.	. If you want to do this one, send it to me through email. Oh, I have to open my email? Yes, you have to. Right? How would I know that all this information gets filtered, if I get like forwarded information from CNEs about new stuff, I forward it through their email. And at the beginning, like, I monitored how many are really reading these because you can track how many are opening it. You know I was just telling myself, that I just going to be glad if they are only going to be like… I have 30 staff… if I can get 5 staff. So on the first week, I think I got like 7 or 8 who opened it.
6g. CoAct is a new process initiated by AHS. What were your initial thoughts when you first knew you	41e. I realized CoACT was a system of teamwork that I was already enacting.		. But I was in touch with my friends who were in acute care so I'm hearing their story, but the thing is I had the opportunity to build a new team when I was in continuing care. And practically what I was doing

were going to encounter this?			was CoACT. Right? It's no different than primary nursing.
		42e. Change is more acceptable when there is a direct benefit to nursing practice.	We're just enhancing those pieces that are necessary so that we could provide effective nursing care.
		43e. Negative perceptions of the change can increase resistance to the change.	I'm hearing from my staff, was different because they …Oh, you're just the mitigating charge nurse. You're just… so you don't want to pay the charge nurse because of… of… of a cut. They always associated any change with a cut.
			But they see it as any change from the administration is always related to finances and is always related to chop-cuts, job losses, there's always related to you know… anything but.
		44e. Even when change is intended to standardize nursing methods in teams, some members are resistant.	Because in medicine they don't discharge the patient everyday. For us, you are happy, you had appendicitis and appendectomy, you go home tomorrow so you have a new set of patients. So there's the challenge. You want all the admissions to go from one side and then the others don't have admissions too, so it's uh it's a balance that we're trying to figure out, but we have to look at it together. Uhm, there is resistance, there is resistance because they always associate it to losses and …and…and…you know…uhm… I think bottom line is there is a mis-trust between AHS and UNA and how any limitation from AHS is perceived as potential, uhm, loss of members.
		45e. Lack of trust can keep new initiatives from moving forward.	Potential, uhm cut down on things. I think… and I was talking to my manager about it… how did the mistrust go. We can't be distrustful of each other, if we're working under … you know, if we're rowing under one boat. We can't be rowing in different directions. We can't move forward … everything's not about finances. We claim it's about patient care and make sure our

			patient's receive the same care whether they are on this side or on that side.
		46e. Nursing as a profession moves and improves very slowly even when new initiatives roll out.	I think the history is deeper than that. It traces off back in the 90's, so nursing tends to have long memories. We keep on dwelling in the past but we can't move forward unless we unload baggage's from the past. We keep on saying that and we need to move on and learn from those experiences and hopefully, you know, find better solutions in how we can work this out. Things are moving slowly with this COACT.
		47e. Resistance can happen if you try to change too much, too quickly. 47ee. Constant change.	You have to allow 3 months, 4 months, 5 months before you can change … and you don't want to change everyone at the same time too, because then everybody will just be resisting. I think that is where the communication is …where they want to change so many things at the same time. They tend to back out and they say, "now, OK we are winning, so we can push back a little bit more". So, yeah, it's a challenge… it's moving forward. It's not as fast as I said, but, you know, there's still changes.
7g. Can you tell me more about the tensions between nurses and their employers? What is the employer, UNA and CARNA influence on nurses' learning?	48e. CARNA demands that you report your learning but you can write anything you want in the reporting system.	48ee. Write whatever you want. 48eee. Requirements are simplistic	I think CARNA is more uhm…has more pressure, you know in terms of professional development when it is registration renewal. They will ask you about what learning do you have. It is very simplistic. You can just write whatever things I want to write…. And so on, right?
	49e. UNA provides paid education days but this opportunity is not accessible enough to benefit everyone.		UNA? I don't see the push from UNA that much. From my perspective. Uhm, If the member wants to go for education, uhm, they have support but it is only limited, and it's a first come first serve, so, you know, if I am a member and I want to learn, I don't want to be paying for that one, I will want to be the first 10, so like I will wait for next year. And next year you forget,

			like, “Oh, another year again”. So, I don’t know if … I think they should push for it and to be fair, they just eliminate the financial benefits for the few to maximize the benefits of the most.
		50e. The motivation for financial benefit is more influential than the learning itself.	The motivation is not anymore on the learning and it’s more on the financial support they … it’s like a bait. And…you are not benefiting the majority.
		51e. A more directive approach to learning requirements would be more effective.	The union would say, “Hey you guys need to have this X number of education services or learning opportunities to attend this year”. It’s from your union.
		52e. UNA has a higher value to members because of their role in contract negotiations, while CARNA is simply directive and unpopular.	CARNA can support that but, you know from my perspective, a lot of people will always put their… their… their dollar on UNA because they are negotiating for their salary. They’re the ones putting their bread on the table, so you know…”I tell you to do it so you’d better do it!” Uhm, that’s my two cents on that.. thoughts on that issue.
	53e. It is more important for nurses to take responsibility and initiative for their own learning and not rely on other influences.	53ee. Move career forward. 53eee. CARNA does not determine accountability to learn.	I still think of the bigger perspective because…think…the onus is still on the individual. For everything else, because accountability comes from the individual. I want to learn, I want to move forward with my career…I want to investigate this process… I want to…see if there’s new research to support my practice, that onus comes from me. If I’m supported, great!
	54e. Motivation is easier said than done because of other ‘life” factors.		But you know it’s a challenge when I can only speak for myself. A lot of nurses have other issues to address personal, financial, emotional, whatever… so yeah…
8g. Do you have any other thoughts you would like to share?	55e. It is important for nurses to challenge themselves.	55ee. Stay updated.	I think I agree with you think it is important that everybody should be challenging themselves to be competent and to be updated with how we get from there to here and here to there.
		56e. We cannot progress as a profession if we do	We are still doing hand-written charting where no one can read. Papers after papers after papers

		not individually challenge ourselves.	where nobody can read. This is 2017, everybody is using iPads and tablets. Can I move on to electronics now? So that we can avoid medications errors, we can avoid looking at doctor's orders… I don't know what this is… and, maybe I can read it later, maybe not… We need to live in the moment and I think we are still living in the past. And I think unless we are ready to embrace that new challenge, we could not… we don't have the way to tell the world that we are a modern profession facing the modern challenges.
		57e. Nursing is becoming outdated because of the resistance to change, especially change in technology. 57ee. Adapt to new technology.	The culture is like when you talk about something new, something updated, something forward thinking, you're always shooting them down. So I'm telling them "You know what? we live in the—2017", we need to adapt to the current technology, the current updates. Well but not all the progress, …well but maybe they do still live in 2017 because we… we never really… we keep on shooting down good ideas from the get go, we never allow them to blossom.
	58e. Receiving and reacting to feedback is part of the process to change.	58ee. Give FB to move profession forward.	And that's why there's always ongoing research for us to give feedback on how we can proceed with this one because your feedback is just as important as the others, right? But if you're not going to give feedback, we are not going to move forward. "Oh, I don't have time for that one", so then we are shooting ourselves in the foot.
	59e. Visibility and open-mindedness is essential to ensuring the nursing profession moves forward.		So we need to have more visibility of what we are doing and how we are going to move forward. We need open mindedness and how we tackle new challenges and adapt to new trends, new technology and new approaches of healthcare.
			Otherwise, we will be left behind in the last century and we will be frustrated of the changes.

		60e. Many nurses are afraid of change and not having the ability to handle the changes.	Because a lot of them are afraid of change and what is going to come up. “Will I look stupid if I won’t be able to do this one”. If I won’t be able to do this, the younger generations will look back and look down at me and say, “Oh look you are a nurse who cannot even operate this”. So, their…It is more personal, I would say more personal…more personal and psychological than realistic, actually.
	61e. Change is a natural part of nursing.	61ee. Adapt to new clinical approaches.	You are half-way though adapting to new possibilities. If we close our minds to new ideas then, we wouldn’t be here right now, right? If Nightingale didn’t advocate for this organization of nursing, I don’t know what kind of gauzes I would using to change for wounds, right? We would probably be chewing bark and putting them on the wounds! Seriously, I mean like …but we adapt! And, and I’m sure the older nurses who, which, were mostly religious at the time, were probably hesitant too, because like, this was a remedy that my grandmother suggested that would cure wounds. And now we laugh at it, right? But that’s a hundred years ago.
	62e. Constant questioning and researching is essential to everyday practice.		Like, “did you know that Tramacet has acetaminophen content?” “No, I didn’t know”. “Did you do your research?” So you know, so those kinds of things you should, you should think what’s the active ingredient in every generic …you know… generic medication. The faculty can only watch one student at a time, but the onus is still…you know, you still have to question. At the back of your mind, “what am I doing?”
	63e. Nurses take each other for granted and are unkind to each other resulting in high sick calls.	63ee. Reflect on colleague relationships.	And you know, it is a constant, I guess a constant reminder for everyone, a constant reflection too. If I am an individual staff and nobody asks for the whole day, “How are you doing?” I would be

			concerned, are even concerned about me? But then if they have a fight, I guess it is normal for them, so, yeah. I never realized before how we are, for lack of a better term, "bitchy" we are. You know, we are so… we are very unkind to each other. We take things to personally that happened 10 years ago in our friendships. I'm kind of like, "Oh my Gosh, people move on!" If you're not… I… when I went into this role, one of the biggest issues that I had were my sick calls. 3000 hours in one year.
	64e. It takes personal motivation and initiative to change a negative point of view.		In my first week, they said you have to do something about here. This … this… this place is a crap…I was told by one of the night nurses. I was telling them I can't do anything about the crappy place. But you can do something about how you perceive about the crappy place. Right? I can… you know… how you see yourself…how you see the world around you is a big thing. It makes a big difference. I mean there is only one of me and there is a big organization they want me to deal with. I can repaint it if that's what you want…But that's not going to… So it is.. it's sad, lot of it boils down to interpersonal relationships.
		64ee. Self-awareness. 64eee. Question own competence. 64eeee. Nurses accountable to themselves, not CARNA.	So the whole challenge is more personal. And I think just like education it boils down to your own self-reflection, self-awareness of where you're at. If this environment is not making you happy then do something. If..if this practice is making you feel a little bit, you know, questioning about your own way of doing things, read something. If you are not certain about a certain procedure, ask somebody. Ask for guidance, ask for coaching, do something, but you know, it's easier said than done I think for most people.

	65e. Patients need to be a nurse's first concern.		Our customers are our patients and their family. They want us, your demeanor, your face in the morning, how are you greeting me? That reflects nursing care for them. The first person they see in the morning the last person they see on their discharge.
	66e. I stay curious and interested in learning and I explore other opportunities.		So as a personal goal I don't stay too long in one role; for me two to three years is long enough. Because it allows me to explore other opportunities and other avenues… "what are you doing?" I am always curious.
	67e. I stay interested in local and global opportunities by staying positive and seeking out many nursing roles.		When I started my journey I thought, I'm going to retire at 55. I'm going to see how every role works and I'm going to be able to look what the positives for every role so at least, if I end up retiring somewhere in Latin America, in Asia or in Europe, and I'm still healthy, hopefully healthy, then I can do something, then that is something I can impart to them regarding our Canadian system of healthcare.
	68e. Staying up to date and interested keeps nurses accountable.		But you know if we don't keep us individual nurses accountable to our own practice, to our own learning, we can easily lose it.

Appendix 4E Sarah-Second Level Analysis

Table 33. Sarah-Second level of analysis

First level analysis	Second level analysis
1L. The online format of MyCCP is a barrier for some people. 4L. Going through the motions of permit renewal. 69L. Nurses may lose their license if they make mistakes, but the patient is the most important reason to learn and perform nursing correctly. 72L. You are at risk for losing your nursing license if you do not know what to do or you make preventable mistakes. 65L. CARNA sets rules and limits for what you have to do and that you have to be competent.	1M. CARNA processes are burdensome but mandatory.

3L. Reflection is comparing what you have done before to what you do now. 6L. The learning plan is where you plan activities that increase your knowledge.	2M. CARNA mandates reflection and planning.
7L. Attending learning events requires time off work. 9L. Access to paid days allow me to attend learning activities. 37L. Attending learning events depends on staffing schedules. 40L. I will stay behind on the unit to allow someone else attend the event. 55L. Staffing and learning requirements may not be met in times of layoffs when having to adhere to union rules. 56L. There is a need for more ways to provide training for nurses new to the unit instead of relying on experienced nurses. 37L. Attending learning events is challenging when working full time.	3M. No time for necessary learning activities.
10L. The older experienced nurses are knowledge resources on the team. 11L. Because of my age and experience, my peers ask me for guidance. 26L. It is critical for students' success to be mentored by experienced nurses. 28L. Senior nurses are valuable resources for students. 30L. Experienced nurses are respected for their years of work. 45L. I set up systems to make it easier to process orders and expedite patient treatments. 46L. I established communications in the team so there is clarity, especially in emergency situations. 50L. When I learned new skills or knowledge, I shared it with my unit team by logging it on a clipboard. 51L. I created a workbook reference for my team to refer to when they have to research their patient. 52L. Supporting the team learning is valued and rewarded. 64L. It is important for experienced nurses to mentor and allow others to practice. 38L. At times, learning events are social opportunities 70L. Nurses must rely on each other but also there is a duty to correct and report others' unsafe practice.	4M. Experienced nurses may set priorities, establish communications, mentor, and guide others.

12L. Focus on your work and avoid personal life distractions. 14L. I teach others to focus on the work and not on personal problems. 60L. You must focus on your work when you are at work and don't bring your problems to work. 61L. While at work, you have to be focused and calm and take care of patients. 35L. It is healthy and effective to separate work and home lives.	5M. I teach others to focus on the job and to not be distracted by personal lives.
15L. Stick to the unit routine to ensure efficiency. 17L. Learn the routine first. 19L. The unit routine keeps everything clean, orderly, and prevents backlog. 20L. An effective unit routine ensures the work gets done effectively and patient care is not compromised. 21L. It is difficult to explain how learning fits into the routine. 44L. I taught myself the specialized skills and knowledge on the units and set up my own routine. 47L. I have learned many skills in my work throughout my career. 48L. When I learned new things, I had to ask someone to show me how. 62L. Rely on the team and ask questions when you need. 63L. Ask questions and ask for mentorship from senior nurses but you have to try and practice yourself.	6M. The unit routine is foundational to competence.
58L. When moving from one area to another, you bring with you skills and knowledge from where you were and add new. 66L. You will learn what you need to learn based on your practice. 67L. You will learn new technologies as you need to. 41L. I taught myself. 43L. Learning the skills and knowledge from unit to another built upon prior experience and positions held. 57L. Experience is the best teacher, so don't stay in one place for too long. 49L. When I had to learn new things, I had to look it up and research it	7M. The best learning is from personal experience.
22L. Preceptorship of undergraduate students is an additional strain on the job. 23L. I don't like to take students because it is a difficult job.	8M. Added work to the routine is stressful.

24L. Preceptorship requires significant responsibility, time, and focus. 29L. You put your reputation at risk when you take on a student.	
31L. Nurses have complex personal lives to consider in complex shift schedules. 42L. Options were available to move from unit to unit to match personal circumstances and lifestyles. 53L. Administrative changes result in staff layoffs and having to move from one position to another against their wishes. 54L. At times of lay-offs, you must go where there is an opening and hope they will accept you.	9M. Employment changes occur frequently.
33L. Technology and methods change resulting in changes to routines. 34L. You must adapt and keep up with changes. 59L. You must make sure you know what you are doing. 68L. You learn because you have to so you can provide safe patient care. 71L. You must learn what to do in each nursing situation or you risk patient safety. 73L. You must understand your own knowledge level in each situation and ask questions when you need to. 74L. Even after many years of nursing, you have to constantly question and lean on your team.	10L. Competence is continually adapting to change.

Appendix 4F Sarah-First Level Analysis

Table 34. Sarah-First level analysis

1k. So if you could sign in to MyCARNA and show me your competence profile and tell me what you were thinking when you did your continuing competence.	1L. The online format of MyCCP is a barrier for some people.	2L. I am not good at computers 2LL. I can't sign in.	[Laughing]—I don't know—to tell you frankly Meagan—I am not good at computers, that's why. [Laughing] I can't sign in— I can't do it.
2k. So right here it says practice reflection—what does that mean to you?	3L. Reflection is comparing what you have done before to what you do now.	3LL. Compare past/present experiences.	Like what you're practicing before—like you know—is what you have done before? Like you know? And compared like what you are doing now? I guess that's what it says—like you know.
	4L. Going through the motions of permit renewal.	5L. I just fill in what I must so I can renew my practice permit. 5LL. Pick anything.	You know what Meagan? [laughing] I'll just do this one so that I'll be registered. So I'll just do this one. [laughing].
3k. So when you did your learning plan, what were you thinking when you saw those things?	6L. The learning plan is where you plan activities that increase your knowledge.	6LL. Read books. 6LLL. In-service 6LLLL. Too difficult to do.	OK—so this add learning activities to your learning plan—you have to increase more than what you have learned and you have to do more things—like you know. You have to do… What you are doing now is like in-service—and you go read more books—like whatever—you know—just increase your learning. So that's what I understand like you know.
	7L. Attending learning events requires time off work.	8L. I have to attend learning events but it means I have to take time off work to go.	Oh you have to go for this because this is for our CARNA—like our competence—like you know. Oh I say, I have no time, I say, no I say I am working evening at that time, and so I don't have much off like you know. Uh sometimes when I go there I, I have to take off so I can attend the in-service or whatever. Where sometimes

			we're allowed like one day for competency, like you know—like the UNA –not understandable- so we're allowed so I sometimes I just have to take "off" so like I can attend.
4k. What is that like for you to have to take a day off to go?		9L. Access to paid days allow me to attend learning activities.	Well I just take my stat —I have lots of stats. I just say Oh! Just take a stat so I can go [laughing] —I can't go with you guys because everybody is going—I said, I can't go because I'm working but anyway. It has to fit— so OK I'll just take my stat and go, so. It's fine with me, like you know. So I can learn too. [laughing].
5k. Do your peers have a role in your learning?	10L. The older experienced nurses are knowledge resources on the team.	11L. Because of my age and experience, my peers ask me for guidance.	I guess because I'm the number of years of experience and the greatest one of experience so I do at least have them looking after me and say, OK what do you do with this?
			Oh I guess so they ask my opinion first before going like you know whatever they have to do.
	12L. Focus on your work and avoid personal life distractions.	13L. I teach others to focus on the job.	Don't just run and run and you don't know what you are doing…like a chicken with his head cut off. You just run and run! And I said, you have to be calm, I said. You have to be calm—you have to focus yourself what you're doing.
		14L. I teach others to focus on the work and not on personal problems.	So you focus yourself, think what you're doing and I said, if you have problems at home, just don't bring it here! Because it's not nice to bring your problems to work.
	15L. Stick to the unit routine to ensure efficiency.	16L. I ensure the unit is cleaned up and that routines are in place.	Oh ya, everything is clean and everything is clean and everything is cleaned up in the fridge and the medications are all sorted out. That's part of my work! And I said, I have my own routines. So I said, so when I come to work in the

			evenings, I make routines in the evenings because I work on the units.
	17L. Learn the routine first.	18L. What I think is important is to teach the routine so the work gets done.	I have everything like you know so every time if somebody—if I orient somebody on the unit, I have to tell them what I'm doing on evenings. You just carry on and then you'll be finished your work like you know. Yup, that's what I do on evenings.
6k. It sounds like routines work for you.	19L. The unit routine keeps everything clean, orderly, and prevents backlog.		Yup, it works for everybody. Everybody follows and they said—and the unit clerk that I have on a couple of units or 3 units on the evenings. They will know the person that is in charge if I'm not there.
	20L. An effective unit routine ensures the work gets done effectively and patient care is not compromised.		Everybody, like they work evenings and they work nights, and I say, Why do you have to do that? I said, you know what? On nights, there's only 3 people on nights. And there's 5 on the evenings. If you have the time to do extra work, like you know, for the nights, you can help them. Because if just one person is crashing, everything won't be done. I said the rest get not done! And it will carry on in the following shift. Like if the nights didn't do that because there was a crashing patient and it was so busy and the following day, we can tell. In the following day, it will carry on in days. The business of the unit everything is not done and left behind, and it will carry on in the evening, like you know. It will just go in circles like that. So that's why we're doing this, you know it's all good. Oh I see that, I said, You have to be advanced—one step ahead. Like you know.

7k. What's I like, then when you have these extra kinds of things? Like when you have to renew your registration, make sure you get your learning in. Like what— how does that fit in with your routines and keeping one step ahead?	21L. It is difficult to explain how learning fits into the routine.		Well it fits in like other—in a way, like you know. I don't know how they do it in other—like my co-workers, but you know—like you know—It is hard to explain, it seems a simple thing to do. It would be simple, like you know—not complicated for them.
	22L. Preceptorship is an additional strain on the job.	23L. I don't like to take students because it is a difficult job. 23LL. Teach on the spot	I can teach on the spot, like you know. But a student following me, I don't—I don't like it.
			It is really hard and the instructor told me, like K, just ah do what you can but for her if you can try to understand like you know. I know she's not stupid and she's not stupid. She can understand you but like I don't know what what cannot get along with her last preceptor. And I said, I'll try my very best but I can't show you if I can't understand her, like you know?
	24L. Preceptorship requires significant responsibility, time, and focus.	25L. It takes a long time to teach students and there is extra work to check in with instructors. 25LL. Preceptor	But I think we can understand if you really listen and you just focus like you know? So I teach her for six—I think for six weeks. It was like kind of hard—It was rigid like you know—everyday the instructor comes to me.
			Almost every other day. She follows me and she follows her like you know and we sit down like you know what did you do? Like did she understand? I said I think she understand me, she was like you know I said I mean—I said, I think she—she knows what she's doing.
	26L. It is critical for students' success to be	27L. Because I taught this student for six	I said, but she understands what I told her like you know?

	mentored by experienced nurses.	weeks, she was successful and she learned the routine.	So I said to her like I gave her my whole assignment, I said first day is basic but on the third day, I said you have to have my assignment. Whether you like it or not, keep it. And then I said, this is what you're going to do. And she was good! [clap] She finished after that six weeks and then the instructor was really thankful.
8k. That's an amazing story! And I'm, you know I'm curious more about how you were in that situation? Because it sounded … it sounds to me like at first you thought , What? I can't do that! But then you did and she was successful!	28L. Senior nurses are valuable resources for students.	28LL. Excellent instructor	I really said, I can't do this! The other people can do it. Me? I can't do it! For a short period, like you know? And she just kept on telling me, the instructor Sarah, I know you! You're instructor, you're instructor you're a unit manager, you're blah blah blah. Told me, Give it to Sarah, Sarah will straighten her up.
	29L. You put your reputation at risk when you take on a student.		You have to be careful because everybody will be asking Who's your preceptor?
9k. That's a good story! Because, you know what I see from that is that a lot of people really look up to you. And how how —what makes you so good?	30L. Experienced nurses are respected for their years of work.		I don't know! I guess it's because of my couple of years of experience. I graduated in 1972.
	31L. Nurses have complex personal lives to consider in complex shift schedules.	32L. Work requirements impose difficulties on nurses' families.	My years of experience—I graduated in 1972 and I worked from there when I graduated and I'm never stop. I never regret— I'm full time all the time. I never had a a—part time position. I was full time ever since. I had maternity leave. I have two kids. On my maternity leave on that time when I had my two kids was only 3 months. And I had to come back to work because

			they said if I don't come back to work, I will lose my position. So three months after—at that time. Now it's one year—they're so lucky! I said, you're so lucky! I tell the girls, you're so lucky! Your kids are already running around when you come back from school. Mine, I just wean her from breast feeding and I have to come back to work. It's because I only have three months.
10k. So how did you keep up with all of those changes and you're still so good? Because, really I'm sure the nurse you are today is probably very different than the nurse you were back then!	33L. Technology and methods change resulting in changes to routines.		It's true because before,—we're high tech now. It's different from before. We used to—when we give meds before, when I started in this building—in this building, in this hospital, we used to uh mix our antibiotics. I'd come home smelling of penicillin because I have to mix ALL of them.
		34L. You must adapt and keep up with changes. 34LL. Adapt to change	I just adapt to that, like you know? I said, All this because I'm a nurse, you're a nurse and you have to keep up with your works. So you have to keep up with what is now and compared to before, like you know.
11k. So do you think about that everyday?	35L. It is healthy and effective to separate work and home lives.	36L. When at work, I think about work, but I don't take work home with me.	Yeah I think about that like you know—but when I go home, I don't think about work. I leave my work. That's what I told the girls. Like you know? When I go home, I don't—I don't bring home my work. When I come back I just face it—oh I am at work now.
12k. Did you go to a lot of conferences?	37L. Attending learning events is challenging when working full time.		Not—not much you know because I have a limit of my conferences because I—because I'm working all the time. I'm working 8 hours a day. That's why.

		38L. At times, learning events are social opportunities.	The girls say, come on auntie, we have to go and we'll go somewhere after—and I said OK I'll go!
			Yah, because if I'm off, I'm going out. I won't say no, I always go with them. Like you know, I said. Like I'm off, I'm free.
		39L. Attending learning events depends on staffing schedules.	Oh but I don't have staff—Nobody will work on the evenings. You can't go. There I am. I'm left.
		40L. I will stay behind on the unit to allow someone else attend the event.	You go, all young ones. You can go. Just leave me. I say just leave me. I tell them. Well, just leave me. Just give me all the floats.
13k. Did anybody mentor you?	41L. I taught myself.	41LL. Teach self	I just teached myself.
	42L. Options were available to move from unit to unit to match personal circumstances and lifestyles.		In the 80's we moved here. And then I wanted to have an evening position because I.. my kids were still small. So I said, Can I have a permanent evening, like you know in my unit on urology? And they said, no Sarah, there is another already on a permanent evenings so I can't get you.. I can't give you a permanent position. So I said OK so can I just transfer to another unit to have an evening position? The next unit was an ENT—so from urology to ENT. I don't have much—I don't have much experience in that ENT but I said I will work for it. I will know it. I said to myself, as long as I have my evenings. So she just took me and I said, Can I apply, and I asked her, the unit supervisor next door, and I said, Do you have a permanent evenings? And she said Yes! I have a permanent evenings position but it's ENT. And I say, can I apply on that position? And she said, Oh I will take you! Just said, Sarah,

			Just transfer! You can transfer. You can start on Monday! And I said, I have to ask permission first to my supervisor and they were friends. So anyways, I said, can I, I was wanting to transfer to ENT. There's a position in ENT so can I just go to ENT. Like transfer my position there so I can have permanent evenings? She said Sure Sarah. It was Ok before. It was easy to do that, like now you—it's hard now. You have to apply. You have to be interviewed. Blah, blah blah. Anyway at that time, she just took me and said OK when do you want to start? And I said oh I have to ask permission first and then—and so I talked to my supervisor and then she said, Oh OK I will talk to her and what ever is feasible and just—just like that! Just right there. So I can transfer to evenings so I said to her What can I do I said, OK I'm the evening unit, the evening nurse.
		43L. Learning the skills and knowledge from unit to another built upon prior experience and positions held. 43LL. New clinical skills	So I said this is easy—I said to myself … because I know my background in the Philippians, before leaving my country, I worked as an OR nurse. So my ah—my—I scrubbed in the ENT—the ENT cases. So I know the parts that were they're operating, like you know? I know the mastoid,—all this laryngectomy, I know what part they're doing it. On my unit, was doing it all this minor surgeries. I do that everyday at home. Like I assisted so I can know which part. I said, Oh this is easy. I said—I said this is easy so—so I said I will learn, like you know. The tracheostomy, you know it's like—it's just like

			you know I say Oh I fit with this like you know
	44L. I taught myself the specialized skills and knowledge on the units and set up my own routine.	44LL. New medications	So while I was working evenings I teached my own things in the evenings in there, in that time. I had 32 patients on that unit. We had admissions galore because it's kind of short surgery. They go home the following day or the next day so like now they're doing that in the day—the day surgery now. On just days. The people here, they stay in the hospital for two or three days. So I make my own—my own routine on evenings so because I'm the one giving the medications to the patients so I almost memorized their medications. And it's kind of routine, also learning medications, like you know?
	45L. I set up systems to make it easier to process orders and expedite patient treatments.		This is what I'm going to do in evenings. I have ah parameters for extra sedations, this is it's not very strict like before where you have to have doctor's orders like you know? But I just do orders and go sign the doctor's name because we already agreed. The doctors feel like great like, Ok Sarah you can do this. This is what you're going to do Ok. If you want Gravol unless the patient is not allergic to it, you can give Gravol for this age and you can give other antiemetic's if it's not like you know—if it's not effective like that.
	46L. I established communications in the team so there is clarity, especially in emergency situations.		Don't just call you for a dramatic call, but if I call you, that's an emergency, OK? This is what you're going to do, like, I said, OK, well I have count and blow outs. What you going to do? Of course that's an emergency. You have to come! Like you know. I have trick an miss you flying! Of

			course Sarah has to put back that tracheostomy because, I can't find a respiratory tech.
	47L. I have learned many skills in my work throughout my career.	47LL. Advanced skills	I have to do installations and everything! Like you know. If the patient's—if the tracheostomy is fine, did you have a look at it? You have to put it back, like you know? Sarah know how to insert a tracheostomy tube. I learned that at that time. I learn it and I say, Oh my God, this is something! I learned lots of these things!
14k. How did you learn it all? How did you do that?	48L. When I learned new things, I had to ask someone to show me how.	48LL. Teach each other	I have to learn myself and have to ask them, like—tell them what to do, like you know? So I said this is what you're going to do. If it is like this, you have to put it on, I said, Oh OK then they put the ties on. We do that before—we do installations, and like deep installations because there's no respiratory tech. Our ENT staff people they don't need technicians. They're respiratory — the nurses have to do it. We're not taught how to do it! They taught us then.
	49L. When I had to learn new things, I had to look it up and research it.	49LL. Patient research	What I did was mastoidectomy, so I did a little bit of research like—what do you do with mastoidectomy? What's hard, like you know? What's his nursing care and post-op care?
	50L. When I learned new skills or knowledge, I shared it with my unit team by logging it on a clipboard.	50LL. Refresher	I have a small, ah—small ah—this ah—what do you call that—clipboard. You know I put it—I put it in a—in a envelope or something. Where we can just look with my co-worker. You can just refresh yourself. What you're going to do.
15k. Oh you mean a workbook?	51L. I created a workbook reference for my team to refer to		A workbook, yeah. Like that yeah. Yeah—yeah. Because I always see them like you know. So I said, Ok just look

	when they have to research their patient.		at in there, like you know. You know what you have to reference.
	52L. Supporting the team learning is valued and rewarded.	52LL. Supervisor commendation.	I say, just look at it—it's in there—and you can see that. So I guess my supervisor appreciated. She really loves me, like you know. She gave me a good recommendation. She gave me a good letter—ah ah—to the administration. Uh Ok, I said thank you for that but I'm fine with whatever.
	53L. Administrative changes result in staff layoffs and having to move from one position to another against their wishes.		All the nurses in maternity are all older people and when they came out, they looked at ENT. It's not—it's not heavy. There's no lifting. So they all fought for ENT. OK they fought for the ENT so of course Sarah is out. So, OK, so it was really hard for the doctors that I was out. It was hard for them and they keep on—they say.. Sarah, I'll take you back. I say, don't worry! I'm here already—I set up the surgery.
		54L. At times of lay-offs, you must go where there is an opening and hope they will accept you.	I said, because you have to apply. I said, OK I'll go for surgery. Because it is almost the same as ENT. Urology is surgery. I don't want to go to medicine, myself. I said, Ok I'll go to surgery. And the supervisor of the surgery said, Sarah I'll take you right now! And I said, Are you sure? And she said yea, you start on Monday.
		55L. Staffing and learning requirements may not be met in times of layoffs when having to adhere to union rules.	Doesn't matter if you write it because it is according to seniority. That's the union rules and they say… They say, Sarah they all, for sure write that but it's because it is according to seniority. Why are you taking me back? The nurses say nobody know ENT and nobody will teach them!

		56L. There is a need for more ways to provide training for nurses new to the unit instead of relying on experienced nurses.	I said, I'm going to retire soon. I says, I said Oh I said I still like you to come back, and I said well, It's OK just train your nurses to look at it. It's different and [indiscernible]. They'll learn. They're lots of them.
16k. Like so what do you think nurses have to do to keep up with those sorts of changes?	57L. Experience is the best teacher, so don't stay in one place for too long.	57LL. New experiences	Don't get stuck to one place. It's better for them… yea better for them. Like you know. Just like my supervisor says I only stay here Sarah for a few years. Really? I say, because she was just hard like you know. I said really? I'm not like you that you will stay forever! I said, I said Oh don't worry about me because I know because I'm leaving soon so let me just stay here. Like you know. I don't want to go somewhere else now and she said, Ah, me? I just go from one to another get experience and go wherever.
		58L. When moving from one area to another, you bring with you skills and knowledge from where you were and add new. 58LL. Career change	Like you know if you are stuck already in 3G, at least you know already what surgery looks like. And then, If you are in surgery, I'm sure it's easy to go to medicine. Because surgery is fast like you know. The patients are turning over—it's really fast and medicine is very slow. I'm sure you will just go with medicine—if you will go to medicine, it's won't be hard for you. Because you have always skills (sic) in surgery. You can bring it to medicine but it's not much skills in medicine. But anyway. There's—it's not hard like you know. If you want to change
17k. One last thought. I just want to ask you what do you think it takes to be	59L. You must make sure you know what you are doing.		Well I guess, to be competent like you have to make sure that if you are in your job, you have to help yourself in what you're doing.

competent in nursing? Not just from yourself, but what do you think nurses need to do to be competent in their nursing?			
	60L. You must focus on your work when you are at work and don't bring your problems to work.		Not—as I said—don't bring your problems that you have at home and bring them to work. Because it bothers you like you know. You just have to focus on your work. After work you can face what you have at home like you know.
		61L. While at work, you have to be focused and calm and take care of patients.	I said, if I have yeah of course all of us have problems like you know—like there are problems. But it doesn't come to work like you know. You just have to set it aside like you know. Be calm, like you know you have to focus and we just take care of our patients.
		62L. Rely on the team and ask questions when you need.	So we can ask one another what's good and we just have to help each other. I said, We are teams here like you know. So we can ask someone—and we can ask for help to do this or do that.
		63L. Ask questions and ask for mentorship from senior nurses but you have to try and practice yourself.	Now girls, I said, you have—it's your chance to try! Like you know? How about if I'll be gone, who will do it? Like you know? I can't do it—you know, if I'll be gone. You have to do it, like you know. Give yourself a chance to do it.
		64L. It is important for experienced nurses to mentor and allow others to practice.	I said OK OK I'll do it. Just watch me so they say, How did you do that?? And I say it's an experience. [laughing]. It's just an experience. I've been doing this for a long time. That's right. You don't have to worry because every time there is something to be done, I will let you do it so you will know.

			I said, I'm not bragging myself, but anyway, I've been doing this for awhile. So it's time for you to do it. Like you know. I'll just watch you. Oh my God.
18k. That's a great comment. Do you have anything else you want to tell me? How do you think CARNA—does CARNA have a say in anything? Or UNA? Or Alberta Health Services? Do they have a say in anything? In terms of how you keep up, how you stay competent?	65L. CARNA sets rules and limits for what you have to do and that you have to be competent.		Well CARNA usually tell us, You have to do this. You have to be competent, you have to—How many you have.. you have limits like how many you have to attend for the blah blah blah education. That's what my co-worker—my co-worker just said We have to do this because it's time for our license to be—
		66L. You will learn what you need to learn based on your practice.	Oh good for you because you're going already. I said, well I think yea yea You can say that— That's good for them going but you will learn like you know what you're doing. You will still learn. Like you know. If that's what we're assigned to do it like you know. So that we can —you know—learn more on what we have—like what we have now.
		67L. You will learn new technologies as you need to. 67LL. New technologies	You want us to have more experience in what to learn you know. New technologies and all those things like you know. So let's get up on that. You have to do it.
19k. You told me your story about what motivated you to learn and how you.. how you learned from the doctors. And how you just needed to and you dove right it.			Yea. You have to because there's no other way. You have to learn like you know.

		68L. You learn because you have to so you can provide safe patient care.	Like somebody like you know, How did you do that?? And I said, I have to do that like, our adrenalin is pretty fast. I have to do it. There was no doctor in the house. I said, like you know. So what you're going to do. You have to do it. Like you know. Just to save the patient. And you have to learn like you know.
	69L. Nurses may lose their license if they make mistakes, but the patient is the most important reason to learn and perform nursing correctly.		And also I will tell you I have a co-worker who was ah—fired because of me because – I—because I'm mean. I just scared of my last—being taken up I said to her, OK when I—I went to the patient's room—the patient stopped talking. Like you know. Talking to me, so I have the medications so I was talking to the patient— it was OK. So I went out and then all of a sudden, when I went, she was at the bedside, and then she must have seen that the patient is not right. Did you not tell me anything about it. Like your assessment or whatever. And then when she came out, and then she said, ah—ah—so when I go back to the bedside, I noticed something on the patient! I said, What's going on? I said, Hello, what are you doing… how are you doing, like you know? So when I opened the patient and the patient was unresponsive. When I opened, she was already blue and she was—I said, How does this happen so quick like you know. You were here… and she says, hey did you do that? No, I was just in … I was just—Oh my God. I can't—I can't—myself. You are going to take my license away from this. Like you know if I will make an incident report and I

			will have to do this. And I — my God, I was almost — almost in tears. But we have to save the patient like you know. I said, What kind—I was— I told her if—in a separate way. What kind of assessment that you did? Well I was there, and I mean you did not tell me anything. Like what did you do—did you do your assessment of your patient? Like—So I coded her and they were able to save the patient. They saved the patient.
	70L. Nurses must rely on each other but also there is a duty to report unsafe practice.		And then they said, Oh Sarah you did it like you know. What you did was right. Well I said, Well I have to—what else can I do? We have to save the patient. And then I did not know what happened to her but there were investigations. The nurses are something in here. And I said, Oh my goodness, I did not do that on purpose! Why did I say anything, you know? But I was just saying, Don't take my license away because of that like you know.
	71L. You must learn what to do in each nursing situation or you risk patient safety.		I said, Oh like you know—you know how to do your assessment. You know if the patient is not right. You have to tell me… You have to look at the body! You just looked at their face? And you do not look at the thing? When I opened, he looked mottled, I said Oh my goodness!
	72L. You are at risk for losing your nursing license if you do not know what to do or you make preventable mistakes.		You know. And I said What happened. I said. But she got upset. She said Oh my God, they're going to take my license! I don't want my license off yet. Because I still… I still want to work. I said to her (in discernible)… two days after. I said, I did not report her but everybody

			knows what happened like you know.
20k. I'm sure that's not the only patient you saved! [Laughing]… That's a good story… Yup, you're asking all the right questions.	73L. You must understand your own knowledge level in each situation and ask questions when you need to.	73LL. Adverse event	I answered my own questions. I questioned and then I answered my own question. Did I do the right thing? Yea I think so. Because I said to the nurse, if you are not sure, don't be sure that you know what you are doing. You ask questions and ask auntie. Like don't just go right through it. I know this and I know this. You have to ask Am I right to do this? Is this the right… If you're in doubt, please don't. Ask!
	74L. Even after many years of nursing, you have to constantly question and lean on your team.	74LL. Med computation	Even now, I even ask, Is this the right computation that I did? Especially , I don't carry all those um.. phones like that. So I do my own thing and then I said, Auntie Sarah just do that in computer. I ..I don't have those things that you're bringing. OK we'll do that in your thing. Can you do this? Is this right? They say, Oh that is right! I'm still in the old school.

Appendix 4G-Craig Second Level Analysis

Table 35. Craig-Second level of analysis

First level analysis	Second level analysis
1Q. MyCCP is left to the last minute and is not thought of until then. 12Q. It is difficult to keep the MyCCP program in mind throughout the year. 2Q. MyCCP is not something to keep front of mind.	1R. MyCCP is not important until permit renewal time.
3Q. You must prove what you enter into MyCCP. 4Q. Goals and objectives must be concrete and verifiable. 7Q. Proof of learning is required in MyCCP 6Q. The nursing practice standards indicators are difficult to prove in practice. 11Q. Goals and objectives must be verifiable to be valid. 13Q. I try to ensure MyCCP entries relate directly to my learning activities at work. 22Q. MyCCP program requires specific dates of informal feedback otherwise there is a risk of failing an audit. 23Q. It is cumbersome to track informal feedback. 29Q. What I write in MyCCP profile is an honest account of what I do. 34Q. As a reporting mechanism, I try to articulate my learning activities so they fit the online form.	2R. Reporting in MyCCP must be valid and verifiable.
5Q. The MyCCP computer software is difficult to use. 27Q. It is very stressful that I don't know what is required in the MyCCP program. 8QThe activity in MyCCP is set up to guide learning but it is too open-ended to work. 15Q. The MyCCP program does not require anything specific enough for it to be meaningful to nurses. 16Q. The MyCCP program is too ambiguous to be effective. 25Q. I do the best I can filling out the MyCCP program but I am not clear on what is needed. 32Q. MyCCP would be better if it were more structured, less ambiguous and specific. It is too open-ended. 33Q. Since concrete, quantifiable proof of learning is required, then the format of MyCCP should enable recording of this instead of free text which is ambiguous.	3R. The MyCCP ambiguity is stressful.
9Q. MyCCP does not work as it is supposed to.	4R. MyCCP does not achieve its goals.

14Q. The MyCCP program does not work as it is intended to work. 30Q. I pick a practice standard indicator that matches what I want in my learning plan though this is not the intention of the MyCCP program. 31Q. The nursing practice standards indicators are intended to be a guide to the learning plan but they are actually pointless and something to put up with. 35Q. Defining objectives for the year does not work well in practice.	
10Q. The CCP program is not negative. 21Q. MyCCP helps as a guide to evaluate practice. 19Q. The MyCCP program is helpful when it provides guidance and direction.	5R. The MyCCP may guide practice evaluation.
18Q. Competent practice and a sense of comfort are indications you are getting better at your job. 17Q. Continuing competence improves with work experience and related courses. 37Q. My learning objectives relate to the current position I hold and what I need to do to be competent there and for my future ambitions. 38Q. The workplace influences learning when there is something new impacting my work. 51Q. Learning opportunities at work increase awareness of different methods of working. 47Q. Professional development is always present in practice and not necessarily a planned process.	6R. Competence increases with experience and comfort.
61Q. Online course are more available and focused learning but they do not suit all learning styles. 42Q. Learning activities are generally selected according to personal learning styles. 39Q. I am self-directed in my learning and I learn as I need, as I go. 36Q. Competency is personal and intrinsically driven by my personal goals. 52Q. Formal learning in courses add to the professional profile.	7R. Accessing learning activities is a personal choice.
20Q. Formal feedback is uncommon, so most feedback is informal. 41Q. Though it is difficult to attend conferences because of work, I continue to look for interesting ones and do my best to attend. 44Q. In order to attend learning events, I need time off from work, access to paid education days and the personal availability to go. 46Q. It is not desirable to access vacation days and other paid time off for education events.	8R. Learning activities are not feasible.

62Q. Courses are difficult to access due to high demand. 59Q. Learning events are expensive and out of pocket with limited reimbursement from employers. 60Q. Conferences are not always good use of time.	
24Q. The threat of an audit is not something anyone wants. 26Q. Getting audited could end your career as a nurse. 28Q. The MyCCP profile is for CARNA, not for members.	9R. CARNA audits are a career-limiting threat.
43Q. I am motivated by others' suggestions for learning. 48Q. Work colleagues are supportive in providing recommendations and opening talking about learning activities. 49Q. Organization management promotes and enables professional development opportunities. 40Q. Opportunities to advance in the workplace provides new formal and informal learning opportunities. 50Q. Unit educators make personalized recommendations about learning opportunities. 63Q. Nurse educators are excellent resources to help set up education opportunities and provide guidance. 64Q. Nurse educators are visible on the units and are involved in education for staff. 65Q. Nurse educators promote several activities. 66Q. Nurse educators support nurses in their first year in the profession and remain available when requested.	10R. Some learning supports are effective in the workplace.
45Q. The three paid education days are beneficial for taking mandatory and non-mandatory learning. 53Q. UNA regards education as very important because they negotiated paid education days. 54Q. It is the role of UNA and CARNA to support and guide registered nurses to progress as a group. 55Q. RNs need to take more of a leadership role so leadership learning is promoted.	11R. UNA supports learning through contract negotiation.
56Q. CARNA does not influence what I choose to develop, though they are supportive. 57Q. CARNA is present at conferences. 58Q. CARNA does promote learning events but not enough to reach many people	12R. CARNA has a minimal influence on learning.

Appendix 4H Craig-First Level Analysis

Table 36. Craig-First level of analysis

1P. So tell me about your process with regards to the MyCCP, learning plan. And basically the intention of this program I think is- is for you to record your learning throughout the year, according to the uh, uh, practice standard indicators and such.	1Q. MyCCP is left to the last minute and is not thought of until then.	1QQ. Do all at once 1QQQ. Don't think about it much.	Yeah. Um, I'm definitely not very good at keeping it updated throughout the year. I kind of do it all at once. Uh, it's kind of ... I don't know. I just do it when it's due to be renewed. It's one of those things that I don't actually think about that much.
2P. Meagan: I'm interested to know, you know, where did your thoughts originate? What influenced you to make the decisions that you did in here? Craig: About what? Goals and that kind of stuff? Meagan: Yeah.	2Q. MyCCP is not something to keep front of mind.	2QQ. Forget immediately	Yeah, okay. Um ... oh, yeah. I just did it and I already forgot.
	3Q. You must prove what you enter into MyCCP.	4Q. Goals and objectives must be concrete and verifiable. 4QQ. Choose verifiable goals	I think the point I was trying to get across in this question is that I tend to choose goals and learning objectives that have easily verifiable outcomes as opposed to more abstract types that could be difficult to prove.
	5Q. The MyCCP computer software is difficult to use.		No, I think it's 'cause I picked on that. That's— Okay, this one's done already so I don't think I can change anything. Yeah. That's not what I want. The program's not the easiest to use, that's for sure.
	6Q. The nursing practice standards indicators are difficult to prove in practice.	7Q. Proof of learning is required in MyCCP	Uh, yeah, indicators. So you like— Some of them, like— The nurse is accountable at all times for their own actions. Unless I do something that I need to be

			accountable for, there's no real way to say I did it there.
	8Q. The activity in MyCCP is set up to guide learning but it is too open-ended to work.	9Q. MyCCP does not work as it is supposed to.	Or like, how do you prove it? How is that even learning? I don't know. That's—I feel like they make it really, like, way too open-ended in my opinion. Yeah.
	10Q. The CCP program is not negative.	10QQ. Select verifiable indicator	I'm not sure what I was doing in this section but it comes across like I'm ranting about the program which I don't think was my intent.
3P. What kinds of indicators have you selected in the past and how did you, how did you uh, work with it?		11Q. Goals and objectives must be verifiable to be valid.	It looks like I'm just reiterating what I said in the first response about selecting goals that are easily verifiable, and pertinent to what I'm doing at any given time.
	12Q. It is difficult to keep the MyCCP program in mind throughout the year.	12QQ. Ensure completion	That's my one thing. I feel like the way that's set up is—you don't necessarily keep it in mind all the time. It's not like it's—I don't know. It's something that I almost have to remind myself when it's due and what my plan was for the year, and make sure I did everything.
		13Q. I try to ensure MyCCP entries relate directly to my learning activities at work. 13QQ. Select wound care 13QQQ. Wound care courses	I picked something specific again, like assess the practice. So I chose wound care, and like that was pertinent to what I was doing. That's something that I can show fairly easily that I'm taking steps to improve. Um, so and that one at the end of last year was leadership, 'cause I did the um, unit quality lead for my unit. So I went to a bunch of courses for that, so it's pretty easy to say. It's not even that it's—Like I don't want—It's not that it's easy

			to do, it's just that it's something that I'm actively involved in, so I don't want to pick something that's really unrelated to what I'm doing. That's kind of how I approach that.
4P. Um, overall just kind of speaking to this continuing competence program with this being part of the program, how do you feel that that influences your continuing professional development?	14Q. The MyCCP program does not work as it is intended to work.	14QQ. One entry per year	The program itself—I- I don't want to come across as too hard on it, but I don't know if it does a whole lot, 'cause I mean, it's not like—Like I said, it's not like something that I'm thinking about all the time, so it's not something that I'm constantly referring back to. I know that's probably what their intention is, but just the way it's developed doesn't really—There's no push to like, go back and continually keep making sure I'm doing what I need to do.
	15Q. The MyCCP program does not require anything specific enough for it to be meaningful to nurses.	16QQ. Must prove you achieved your goal.	It'll probably make things harder for everyone, but it doesn't have like, a set amount of things you need to do to show you achieved your goal. You just kind of have to show you did it at some point. So I mean, without any real push to make you do anything, it's hard to like—As long as you kind of make an effort, it seems like it's good enough.
		16Q. The MyCCP program is too ambiguous to be effective.	I don't know if the program itself does much, but maybe that's just 'cause I just don't, I don't really like things that are that open-ended. Maybe that's just how ... At least in this kind of ... I find it's a little bit too ambiguous as to what I need to do to continue my competency, I guess, if that makes sense.

5P. Um, how do you see your own competence with respect to uh, your continuing professional development?	17Q. Continuing competence improves with work experience and related courses.	17QQ Day to day experience	I feel like it's always improving, 'cause ... I don't know how much of that is just a matter of like, experience and just things that you do in your day to day or even through like, courses and whatnot that you end up taking. I feel like it's improving and I think that's having a positive effect on my professional development I guess, but ... yeah, so I mean I guess they go hand in hand, for sure.
	18Q. Competent practice and a sense of comfort are indications you are getting better at your job.		I feel like as you're more comfortable and competent with things in your profession, you're getting better at your job, but I don't know how much of that is due to this kind of stuff that— versus just how my career is going at this point. Yeah.
6P. Um, and, is there anything else that influences what you enter into this program and how you interact with it?	19Q. The MyCCP program is helpful when it provides guidance and direction.		Um, there's a few spots where it's like ... has a couple suggestions for what they ... areas they think you should do. So that's, I do find that helpful. It kind of guides me what I put down
			um, feedback is helpful 'cause I mean, when you go to enter it, there's definitely sections like this type of feedback and people who it would be good from, that kind of stuff. So I find that helpful.
7P. What do you find helpful about the feedback that you've entered in here?			I mean, it's helpful 'cause it makes you think back to it.
	20Q. Formal feedback is uncommon, so most feedback is informal.	20QQ. Informal	A lot of feedback is very— Most of what we get is informal. I mean, just like our managers are so busy that we don't get much in the way of like, formal feedback. Like it's like

			yearly, and even then it's a little
		21Q. MyCCP helps as a guide to evaluate practice. 21QQ. Manager	—But it does help you think, which is kind of nice. Like it makes you think back to what we both said. I guess it helps you evaluate what you're doing, which is good. So I don't mind that part of it actually.
	22Q. MyCCP program requires specific dates of informal feedback otherwise there is a risk of failing an audit.	22QQ. Dates not accurate	I find it asks for like, specific dates and times. And you're like, I think it was in November that they said this. I didn't write it down 'cause I didn't make a note of it, but—So that's always a little bit tough, but then I'm always a little bit worried 'cause what if you get audited? They ask for proof of like, informal feedback.
	23Q. It is cumbersome to track informal feedback.	23QQ. Verbal not recorded	I'm like, how do I give proof of that? Somebody just talked to me. So I—That's a little bit tough, but especially verbal. I didn't write down my conversation. I didn't record it, so, but—
8P. You mentioned auditing, and I'm curious to know how uh, you think about auditing in relation to your um, in relation to your thinking of your continuing competence?	24Q. The threat of an audit is not something anyone wants.		Oh, it's always a fairly significant factor, 'cause I mean, I've never been audited. But like, nobody wants to have to deal with that.
	25Q. I do the best I can filling out the MyCCP program but I am not clear on what is needed.		I am fairly consistent with what I'm putting, what I'm putting down as being accurate, but even then I'm like— Still it's having to prove you did all these things. It can be—I don't know. It's definitely something that you think about.
	26Q. Getting audited could end your career as a nurse.		If you get audited and it doesn't go well, then there goes your career, so yeah.

	I27Q. t is very stressful that I don’t know what is required in the MyCCP program.		I did all these things, but like, how picky are they gonna be? Are they gonna care that I took this course a week off when I said I did? 'Cause I just ... I think I said I don't always write down dates and stuff, so it's a little bit— I wouldn't say stress-inducing, but it's definitely a component of it.
9P. Who would you say you're writing your plan for?	28Q. The MyCCP profile is for CARNA, not for members.		Um, CARNA. Not really me. Yeah, I'd say more CARNA, more. Yeah.
10P. If you were writing your own learning plan with no other audience except for yourself, would it be very different?	29Q. What I write in MyCCP profile is an honest account of what I do.	29QQ. Write for audience	I think subject would probably be similar. I mean like, there's—The things I put in this, I do tend to pick things that I actually am fairly—I would like to work on. Um, so I think that side of it's probably similar. It's probably just like how I word it, that kind of thing. I mean, yeah. A lot of it is just, you have to— I feel like I have to write it out for your audience I guess, a lot more than I would otherwise. But it's just I'd like to improve this versus—And then you have to think about all the other stuff that goes with it. So I think the subject matter would be similar.
11P. What about the practice standards indicators? Do those—How- how do you view those? In terms of your continuing competence?	30Q. I pick a practice standard indicator that matches what I want in my learning plan though this is not the intention of the MyCCP program.	31QQ. Pick what is closest.	Yeah, so I'm more so trying to pick a practice standard that fits what I want to do versus the other way around. I think it's just kind of like I have to pick one, so this one's closest to what I want to do. So I'll pick that.
	31Q. The nursing practice standards indicators are intended to be a guide to the learning plan but they are actually pointless	31QQQ. Selection doesn’t reflect goal.	I don't think that they're ... They don't really guide anything, for me at least. Like they're more of a pain than anything else. Yeah. They were like that when I was at school, too. You

	and something to put up with.		always had to like, choose as many indicators as you can. What difference does it make? This isn't my goal. Why do I have to like ... I guess that's just how it is
12P. Um, do you have anything else you'd like to add about your MyCCP learning plan and related to your own experience and- and your own um, your own learning?	32Q. MyCCP would be better if it were more structured, less ambiguous and specific. It is too open-ended.		Um, I don't think so. Like I said, it's just ... I just find it more ... I'd like if it was more structured, I think. Like it's structured, but it's very ambiguous to what they want you to do. I think sometimes it would be nicer if they ... Or even just get more like ... Go to this. Like, I don't want to say like ... I know, I know people in other professions who it's like you need 500 hours of whatever like to do the competency stuff. I don't necessarily think you need to do that, but it would be like ... Go within the certain categories of things at least throughout the year. At least then I think it would guide people to doing actual learning versus trying to show they did a goal. That's just how I take it, I think.
		33Q. Since concrete, quantifiable proof of learning is required, then the format of MyCCP should enable recording of this instead of free text which is ambiguous.	Here I am once again talking to the difficulties I personally have with the more abstract elements of the learning plan, and how difficult it can be to say you did something without necessarily speaking to concrete, quantifiable proof.
13P. Just- just a curious question actually. Uh, kind of leading off of some of the things you said, do you, do	34Q. As a reporting mechanism, I try to articulate my learning		Reporting. 100%...I would do these things either way. That's just—I like, I like learning and gaining

you find this is a- a driver for you to learn or do you find it's more of a reporting-	activities so they fit the online form.		competency and I find that I'm just like— Every year you kind of have to make sure, fit everything you did throughout the year into this. It's not like I'm doing things because of it. So yeah, definitely reporting.
	35Q. Defining objectives for the year does not work well in practice.		I think I was attempting to make the point, and I think I touch on this later, is that the CARNA learning plan really is a tool that allows me to show what I have done as opposed to directing my learning. It seems as though the intent of the plan is to provide a structured outline for our learning for the year but it really doesn't work that well in practice unless you're the type of person who really needs defined objectives in advance to do anything.
14P. I- I'd like you to think about your- your contin- your continuing professional development and related to your continuing competence because that- that's legislation saying you have to do this. So think about that, but relate it to your own world, you know, your own personal life, your own um, ambitions and goals and- and where you'd like to see yourself. But also relate it to your manager, your employer. AHS is a big entity you work in, CARNA, UNA, all those things that are sitting on the outside of- of an RNs life— And the world that RNs have to live in. And if you could just speak to me openly about	36Q. Competency is personal and intrinsically driven by my personal goals.		Um, I feel like as far as continuing competency, it's —I don't know if a lot of the outside influence is— Like those outsiders really influence me that much. I feel like when, as far as what I'd like to gain competency, it's more just for myself and like, what I would like to do in the future.

what- what all those influences are like for you.			
	37Q. My learning objectives relate to the current position I hold and what I need to do to be competent there and for my future ambitions.	37QQ. Career progression	I mean like, if you look back even when I was first starting, a lot of it was just like, trying to gain competency in my current role, which was like a new nurse on my floor. And as I've kind of gone on and like, I've taken on different roles like doing the unit lead and that kind of stuff, now I think I'm leaning towards more like leadership, that kind of stuff.
	38Q. The workplace influences learning when there is something new impacting my work.		So I find that like that area really does, but I don't know —I wouldn't say like, AHS or management or any of that really has any kind of impact on what I'm doing. I mean, I guess like if we add something new at work, then I'll work to gain competence in that, but that's more just as like uh, I want to make sure I'm practicing safely versus ... Yeah.
	39Q. I am self-directed in my learning and I learn as I need, as I go.	39QQ. Self-directed learning	My point here I believe is that I tend to be quite self-directed in my learning, whether that is due to me being a new hire and trying to gain competence in that respect or as I have progressed in my career and trying to learn new things as I go.
15P. The last time that you um, took a course or- or advanced yourself with some continuing competence- activity, think back to that time and- and I'd like to know what your process was in thinking about what you wanted to do	40Q. Opportunities to advance in the workplace provides new formal and informal learning opportunities.	40QQ. Leadership courses	Um, for me it was definitely —It was all the uh, all the leadership courses. Um, I had just been approached to do the unit lead and there's a whole leadership course component to it that they were asking us to do. So that was kind of— They would let us know when the

and what- what gave you that idea?			courses were and which would work.
	41Q. Though it is difficult to attend conferences because of work, I continue to look for interesting ones and do my best to attend.		Um, I don't tend to like, seek out conferences and that kind of thing. I don't know if it's ... A lot of them sound interesting, but I'm either working. I don't, so I don't tend to do that kind of stuff, but um, yeah… Having never been, I guess I just don't, but it's probably something I'll do at some point in the future. I just, at this point, I haven't had a chance.
			I think I had been a little down on conferences when I replied to this question and I think I came across as a little bit more passive in my learning than I actually am. I think I was trying to make the point that I don't aggressively seek out all the possible conferences being offered in a year but I do look for those that are of relevance to me and do my best to attend.
16P. Tell me more about um, what- what makes you want to do some activities over others.	42Q. Learning activities are generally selected according to personal learning styles.		It's a little hard to understand what I said here, but I was attempting to get across the point that I choose certain activities over others largely based on what works for my own personal learning style. I spoke to the difficulties I have sometimes with online courses as I tend to read and move on rather than internalize the information that they're presenting.
17P. And so if um, if there was a conference opportunity that a manager approached you with then	43Q. I am motivated by others' suggestions for learning.		Probably the only thing would be if it- if I was busy. If somebody offers to me I'll usually do it, 'cause

and uh, and you ended up declining that opportunity, what were you thinking that would lead you to decline?			it might be that somebody else feels it would benefit me and I attempt to take their advice on that one. I mean, if I was out of the country or something, that's probably the only reason I would decline. I wouldn't decline out of like, lack of interest or anything 'cause—but I do enjoy learning new things. Yeah, I would ... Yeah, that's pretty much it.
18P. When you say um, that you're busy, are you referring to your personal life- Or your, or your professional life?	44Q. In order to attend learning events, I need time off from work, access to paid education days and the personal availability to go.		No, personal life. I mean, unless I was —Yeah, like if I was on vacation or had other like, whatever reason I couldn't go, but I would —I'm more than willing to take time off at work or whatever if it's available. Yeah, take advantage of those education days.
19P. And do you think uh, for yourself that having those education days are —give you an advantage or- or disadvantage, or—	45Q. The three paid education days are beneficial for taking mandatory and non-mandatory learning.		Oh yeah. I think it's an advantage. I mean, it's always helpful to be able to take time off to go to a course. I don't have to use vacation or whatever you've had to use before. I think it's definitely beneficial. I mean even I've used a couple of just going to the leadership courses and whatnot, which has been helpful.
	46Q. It is not desirable to access vacation days and other paid time off for education events.		I don't think —I don't know that I would go to them if I didn't have those, 'cause vacation days or stat or whatever, are in short supply. You don't really want to burn through that 'cause— They definitely have been helpful for that.
20P. How- how- how much are- are your daily thoughts or your regular thoughts involve um, your continuing competence? Sorry,	47Q. Professional development is always present in practice and not necessarily a planned process.	47QQ Daily basis	My point here I think was that when we talk about thinking about professional development it’s not always a conscious thing, it’s something that’s always

continuing professional development.			present in your practice but I do not on a daily basis think “How I can a develop today?” it’s more just an ongoing process of bettering myself professionally.
21P. How does it work for your peers and yourself in terms of continuing your professional development?	48Q. Work colleagues are supportive in providing recommendations and opening talking about learning activities.		Um, people tend to —They do talk about it quite a bit. Like, if somebody's going to a course, they'll see if anybody else wants to go and that kind of stuff, 'cause it's always better to do things with people you work with. So I find — Actually, we have a pretty supportive unit as far as that kind of thing. Everybody's always really open about what they're doing and recommending it to people or not if it's not good, so. Yeah, and it's helpful that way.
22P. What about um, what about your managers and senior managers and kind of up that… The chain? I should say across the chain.	49Q. Organization management promotes and enables professional development opportunities.		I’d like to come back on certain elements of this response. Particularly the part where I wrote that “I don’t know how much they promote it” as since the time of this interview there has been a significant push within our program to help promote professional development; our program has developed a large conference that we offer to our employees as well as those from other sites. We have also begun offering learning opportunities for our staff to attend conferences and courses that they can they bring back to the unit and help educate others. So now I would say that the promotion of professional

			development has become very present on the unit and in our practices. I think at the time of the interview I may not have been as aware of the background work going on in this area and it came across in my response.
	50Q. Unit educators make personalized recommendations about learning opportunities.		Our educators are quite good about it and I guess that is kind of their role. So they're very ... They tend to be very upfront about when there's this. They give you a little time about courses or stuff like that. So that's pretty helpful, but yeah. I don't know how much they necessarily promote opportunities like that, although I guess they did get me ... They did recommend the whole unit lead. So in that respect, they have been. So maybe that's just for me. Everybody's a little different.
23P. And what has your — How have you been with your learning in the, in the leadership?	51Q. Learning opportunities at work increase awareness of different methods of working.		That's been actually quite helpful um, even just the like leadership styles or all that in different courses we've done. It's definitely opened- opened me up to different styles of leading, I guess. I tend to —In the past, I always had a different approach and then as you learn that not everybody works the same way, so you kind of have to take different- different views. It's been helpful and good also. Yeah.
	52Q. Formal learning in courses add to the professional profile.		Yeah. Especially if I haven't done it before, it's always helpful to try something new. I mean it always —I don't want to say it looks

			good on a resume, but it does and it also —Like I said, it is growing development. So yeah.
24P. What do you think the viewpoint is of the union, UNA, with regards to continuing professional development?	53Q. UNA regards education as very important because they negotiated paid education days.		Probably fairly important to them. Um, they get us the education days I assume. But no, I mean I feel like that's something that they would be fairly —like they would promote quite strongly. I don't know how much I necessarily see that, but maybe that's just 'cause I'm not paying attention. I don't know.
25P. Tell me a little bit more as to why you think they would view it as important.	54Q. It is the role of UNA and CARNA to support and guide registered nurses to progress as a group.		I, well —I guess their role is to like, support us and kind of help guide us as a —well, I guess as CARNA. They want, they want what's best for us as a group and even if you look at like, the current —how things are going, LPNs increase roles and all that kind of stuff. If you want to maintain a positive environment for RNs, you have to keep growing as a group. So I feel like they would be quite strongly in support of that. I can't really stagnate 'cause that's their role at that point.
26P. With regards to the role of the LPN, the- the health teams that work there, do you see any particular influence on your continuing professional development from that point of view?	55Q. RNs need to take more of a leadership role so leadership learning is promoted.		I guess for my- myself maybe, because I have been doing more of like, leadership that side of things, which is kind of where I think they want RNs as a whole to go and take on more responsibility in that respect, but I don't know how much that would affect other people.
27P. Tell me about CARNA, the influence that CARNA has. I know we talked a lot about MyCCP, but I guess as- as a whole, how do you	56Q. CARNA does not influence what I choose to develop, though they are supportive.		Um, I mean they do help. I believe they support a lot of the different opportunities that are out there. So in that way, they're actively

see them influencing your continuing professional development?			promoting it. I don't know as like, an organization how much they're directly influencing what I'm choosing to develop, but I mean, I think by a lot of —I guess any conference, they're usually involved in some way.
	57Q. CARNA is present at conferences.	57QQ. Ortho conference	We had an ortho conference here and they were there. So I mean like, in that respect they are.
	58Q. CARNA does promote learning events but not enough to reach many people.		I think this may have been a case of me not necessarily paying attention to all the things that CARNA does to promote continuing professional development. I've since been keeping an eye out for the different things they do to promote it and it's far more present than I had initially realized. This may speak to the efficacy of their efforts in reaching staff but I think it may also be the case that I had previously been focused on establishing myself on the unit and now that I think I've done that I'm starting to look for other opportunities that are out there.
28P. Do you find um, challenges?	59Q. Learning events are expensive and out of pocket with limited reimbursement from employers.		. I mean, any kind of conference can be, I mean even just logistically can be tough. Uh, they can be expensive for sure. Sometimes it can be a little daunting. I know you get money from the union and whatnot, but it still costs like four or $500 and you're like, I'm already paying 600 and some to get my

			registration. So with that, I guess that's a challenge.
	60Q. Conferences are not always good use of time.		The other thing is sometimes it might be one aspect of the conference that's interesting to you, and then but the rest of the day isn't. And you don't really want to go for nine hours to hear an hour long on care or something.
	61Q. Online course are more available and focused learning but they do not suit all learning styles.		So I mean, I guess then, that kind of thing would be better approached with online courses. But I don't always learn as well from them.
	62Q. Courses are difficult to access due to high demand.		Logistically, it can be a little tough. I mean, especially like with those leadership courses. There was way more people than courses, so it was always a little tough to get in and then you go away and then you miss a course. So it was kind of tough that way.
29P. Tell me about that. Tell me about this infrastructure.	63Q. Nurse educators are excellent resources to help set up education opportunities and provide guidance.	63QQ. Educator resources	It's just, I guess our educators are pretty good at if you have any questions, if you want to do a course, they can help you out with it. They can direct you to the resources you need. So I find that really helpful. Um, I guess but you have to know that they're there. A lot of people I think only use them when it's like, "I need help with this," versus like, "What can I do?" So that's helpful. Yeah, I guess that's kind of what I mean. Yeah.
30P. And the- the educators, do they have quite a bit of involvement, then?	64Q. Nurse educators are visible on the units and are involved in education for staff.		Yeah. I mean, we have one for two units, so we do see her or whoever's covering quite frequently, especially— Yeah. So I think they're fairly involved.

	65Q. Nurse educators promote several activities.		This has certainly changed over the last year or so with the educators taking an increased role in promoting professional development with things such as the ortho conference, lunch and learns, nurse rounds, etc all being heavily promoted within our program by the educators.
	66Q. Nurse educators support nurses in their first year in the profession and remain available when requested.		They're very heavily involved when you're new, but then later on they kind of —They might send you an email about what's coming up. So they're not actively doing it. But they're there if you ask.

Appendix 4I Heather-Second Level Analysis

Table 37. Heather-Second level of analysis

First level analysis	Second level analysis
1u. I do CCP only when necessary. 8u. MyCCP reporting is a task to endure. 10u. Fear of CARNA repercussions guide MyCCP entries. 19u. Fear of CARNA repercussions lead to incongruous learning goals. 20u. Learning goals are simplistic because of fear of CARNA. 21u. Make sure goals are concrete and clear so CARNA does not misinterpret them.	1V. Fear of CARNA repercussions influence MyCCP reporting.
3u. CCP does not reflect my learning accomplishments. 9u. Learning goals relate to my nursing practice. 24u. Learning goals do not fit into the practice standards indicators. 5u. CCP does not motivate me to learn or plan learning. 48u. MyCCP keeps learning plans on track but I don't use it that way. 24u. Learning goals relate to my nursing practice rather than practice standards indicators. 64u. Setting up a learning plan at the beginning of the year is not effective or accurate. 66u. It becomes a work-around when reporting at the end. 65u. Often the learning goal changes. 63u. Knowledge-based goals take more time. 67u. MyCCP does not reflect the actual learning. 61u. It is important to get credit for the learning accomplishments. 49u. t is too difficult to keep up with entering information into MyCCP as it happens so details are forgotten. 59u. The ambiguity of MyCCP program wastes my time.	2V. MyCCP does not work as intended.
12u. New colleagues can create workload stress. 14u. Workload imbalances lead to frustration. 28u. If feedback is not provided appropriately and timely, then bad situations continue to escalate. 39u. The morale at the workplace is impacted by the workload. 37u. Culture and work colleagues create barriers. 38u. Integrating new knowledge or skills is met with resistance from work colleagues. 36u. There are many barriers to learning that must be overcome.	3V. Workload and work culture are stressful.

44u. Executive level influences workload and stress levels. 41u. Workplace happiness has a cascading affect on the quality of work and patient care in particular. 45u. Funding impacts the nurse-patient ratio where there is not enough patient care time. 47u. When it is very busy at work, learning goals are set aside.	
16u. Learning goals tied to improving self and the team. 23u. Learning goals are tied to team conflict. 27u. Learning goals include strategies to improve teamwork and communication. 26u. Learning goals evolve over time and are tied to work-context experiences.	4V. Learning goals to improve conflict.
22u. Managers provide opportunities to increase competence. 32u. Managers recommend courses and provide resources. 33u. When managers are involved in learning, the learning experience is more rewarding. 40u. Managers try to improve morale with social events.	5V. Nurse managers are a positive learning influence.
29u. Learning is influenced by the work context and career goals that arise. 30u. Learning involves developing new knowledge and skills while also refining current knowledge and skills. 34u. Personal growth weighs heavily in determining learning goals. 25u. Learning goals are personal and intrinsically driven. 46u. Learning goals are tied to career advancement. 35u. The new knowledge and skills acquired in the workplace transfer to personal life. 69u. Developing yourself is learning through experience and not from reading and classroom. 68u. Learning about yourself and learning new skills are the most important aspects of learning. 17u. Knowledge-based goals are easiest to do.	6V. Learning goals are personal and intrinsically driven.
31u. UNA does not influence learning	7V. UNA is not influential.
51u. Continuing competence in one nurse has a ripple effect on the continuing competence of other nurses. 52u. Continuing competence advances the nursing profession. 53u. Advancing continuing competence improves productivity at work and at home. 54u. If you are motivated, you are more productive. 57u. Being busy is motivating and productive.	8V. Continuing competence improves motivation and productivity.

50u. I work on my learning goals informally but MyCCP formalizes my plan. 62u. It gets faster and easier to fill out MyCCP after doing it a few years in a row.	
55u. Active, purposeful learning comes to a standstill once in the profession. 56u. It becomes difficult to concentrate on long periods of reading and writing because of the nature of the career. 58u. MyCCP requires typing out what has been accomplished. 60u. Most people can 'quickly' complete their MyCCP record in 45 minutes to a couple of hours. 42u. Nurses must learn constantly to adapt to change. 43u. Learning as you go ensures the minimum learning requirements for patient safety are met.	9V. Learning formally is not natural in a busy profession.
70u. Reflection usually happens after the work hours and more on difficulties. 71u. Reflection ensures learning is applied to practice.	10V. Reflection is essential in learning.

Appendix 4J Heather-First Level Analysis

Table 38. Heather-First level of analysis

1x. Alright, so, it's kind of that time of year anyway, where we're starting to look at the, um-	1u. I do CCP only when necessary.	2u. I wait until I absolutely have to before completing MYCCP. 2uu. Only when necessary	Yeah, no I think I have one in there but I don't typically put everything in, like I'll do learning activities throughout the year, but I don't technically sit down and actually put them in the computer until the end of the year. Until the bare end!
2x. That's— and you know, as you're going through this, tell me your thoughts. Everything that you're thinking and—And everything is very, very helpful as you-	3u. CCP does not reflect my learning accomplishments.	4u. There is a wide variety of learning that takes place unrelated to MyCCP. 4uu. Self study	Yeah. I personally think with this process, like I find throughout the year as an RN?, you do a lot of self-study, et cetera, in regards to things you need to know for your job, or like, for example, I do different leadership things, or you know, new positions, so there's different learning that you need to do that's associated to that
	5u. CCP does not motivate me to learn or plan learning.	6u. MyCCP does not drive my learning activities. 6uu. Just put something down	You don't really take on learning, just for the purpose of putting it into a system, um ... so I honestly feel this whole ... um ... you know, the whole input, I find there's a lot more things that you do do during the year, um, and then you just kind of input something, you know, your initial goals.
		7u. What goes into MyCCP does not reflect everything learned.	but I don't really feel like it's actually reflective of um ... what, the learning that does happen over the year.
	8u. MyCCP reporting is a task to endure.	8uu. Initial goals that inevitably change. 8uuu. Actual learning unacknowledged.	RN's do a lot of learning every year, that isn't captured in the my CPP record. The CPP is more of a task, I don't feel it reflects an RN's year of learning accurately.

	9u. Learning goals relate to my nursing practice.		Yeah, so my goal was to, um, learn constructive feedback techniques.
	10u. Fear of CARNA repercussions guide MyCCP entries.	11u. Modifications of MyCCP entries due to fear of CARNA judgement.	Um, I didn't want to put that directly into the system because I didn't wanna think, you know what I mean, you don't want the CARNA to think you're only focusing on that one or that there's lots of conflict, but what I felt was the reason I wanted to learn about constructive feedback was because um, I previously worked on the floor as an RN for many years, um, and I am a hard worker, so I find ... you don't necessarily get taken advantage of, but a lot of times, when you're on the floor, you end up taking on more and your counterpart, we work in team nursing on the units where I was working before, they don't always necessarily reciprocate the workload
			I geared my learning goal towards constructive feedback techniques rather than conflict management out of fear that CARNA would think I cause lots of conflict, which I do not. What is really wanted to learn was conflict management techniques.
	12u. New colleagues can create workload stress.	13u. New grads create additional stress and work related to their work capabilities.	When new grads that have yet to develop effective time management skills it can lead to an increased work load for senior nurses although the new nurses are putting in 100% effort. This can lead to frustration overtime if time

			management does not improve.
	14u. Workload imbalances lead to frustration.	15u. There can be conflict within teams.	When other nurses take advantage of the hard work of a team member, it can also lead to frustration. This can occur with any team member new or old.
	16u. Learning goals tied to improving self and the team.	16uu. Application level goals	So, um, that's kind of where I was going with this goal, so it was kinda nice because um, previously most of my goals that I had done, um, were strictly knowledge based, where you applied the information, but it was kind of just more in your thinking, whereas this is something that I was able to pull the information to, and then I kind of actively trying to—um, use it and it kind of betters your team, I think, as opposed to just helping yourself.
	17u. Knowledge-based goals are easiest to do.	18u. CARNA encourages "S.M.A.R.T." goals that do not apply to goals that increase knowledge. 18uu. Knowledge level goal	But I do find lots of times with some, just the way that the CARNA, the learning setup, and even the way that you need to input your goals, so it needs to be this smart goal—I find, it's always just been easier to do a knowledge-based thing where you read some information or read an article or this or that, because um, I personally, I'm very by the book, um.
	19u. Fear of CARNA repercussions lead to incongruous learning goals.	19uu. Goal not authentic	So I'm always worried that, um, if my goal isn't super concrete, you know, lines in the sand, um, that there is more room, um, for interpretation and just because CARNA just used this information to um, audit people or make sure

			that they're up to par, I always have just, um, maybe chosen a goal that necessarily isn't something that I want, that is my primary focus on what I'd want to learn.
	20u. Learning goals are simplistic because of fear of CARNA.	20uu. Pick something simple	Um, and that doesn't necessarily mean that outside of the box, in my own time, that I don't learn that, but I've just always found what I input and show to CARNA, um, the learning that I do in that aspect, I ... it's always just very simple, linear ... a very linear goal that's easy to achieve, you know, through learning and through information, um, as opposed to more um, you know, more ... dynamic goals, which I do do on my own.
	21u. Make sure goals are concrete and clear so CARNA does not misinterpret them.		But I ... I personally feel that the way you need to set up your smart goal, et cetera, it does lead to a lot of, um, interpretation and that. Because of that, I always stray away from putting that into the system, 'cause yeah.
3x. What ... uh, what about, um, what about the uh, the notion of competence? This whole program… Is the continuing competence, can you tell me about your view points of ... of how you see your competence, maybe in general or in relation…To this?	22u. Managers provide opportunities to increase competence.		Well, I feel my competence, I feel it's always growing, um, I ... I feel moreso, um, it's through like managers, et cetera, who give you different opportunities. Um, I feel that's what's ... so, moreso fires um, like my personal learning? Um, as well as my personal interests, um, whereas this is just kind of a guide, um ... you know.
4x. Um, excellent. Is there anything more you want to ... to tell me about	23u. Learning goals are tied to team conflict.	23uu. To resolve conflict	Well, for example, even like this year, um, I wanted to do, um ... you know,

this process? Um, in terms of deciding on a ... on the indicator or ... or any of the ways uh, that you've selected your goals?			looking at ways to resolve conflict, but it's not necessarily conflict, but it was moreso internal frustration.
	24u. Learning goals do not fit into the practice standards indicators.	25u. Learning goals are personal and intrinsically driven. 25uu. Adjust goals to fit system	Um, but I found that was kind of hard because you have all these options so it needs to fit in a specific category, and I, at times, I find um, that that kind of causes um, the system to direct your learning maybe in a different way than you would see in your head and ultimately, you're the one who's responsible for your learning and you know what you —how you'd want to cater your learning, but sometimes I find I do adjust my goals, et cetera, to fit the system.
5x. K, that's interesting. And, um, when you were talking about how you came up with your goal and um, like where were you? Were you, uh, at work when you were thinking about it?	26u. Learning goals evolve over time and are tied to work-context experiences.	26uu. Stress induced	I think it's just something over time, um, I think, um, working on the unit where I work too, it was —it was a heavy unit, and you know, the morale was going down and people were stressed, so it seemed just as an obvious thing to me, that was important, um, especially to have effective, um, relationships with your coworkers, um.
	27u. Learning goals include strategies to improve teamwork and communication.	27uu. To improve work life	I just tried to kind of shift my view and say, you know, it's —things aren't really going to change that much, so then what I need to do is rather than, you know, having these things on my mind and feeling frustrated and stressed with them, maybe people who aren't pulling their weight, et cetera, I need to find a way to kind of do myself justice to let them know,

			you know, to try to move things forward as opposed to just sitting back and complaining or feeling frustrating and then being —you know, feeling negative about going to work, so I just found it was a good way to kind of make that adjustment.
6x. Tell me more about the feedback.	28u. If feedback is not provided appropriately and timely, then bad situations continue to escalate.	28uu. Give with caution 28uuu. Sounds like complaining	I find, if uh um, the feedback isn't dealt with appropriately and things go on over time, then it just, that one staff member ends up getting a negative, kind of a negative image, and then it just becomes a thing that they're that person that people complain about, et cetera, rather than giving them the benefit of the doubt and trying to integrate them, right?
7x. Can you talk to um, some of the other ... some of the other things that may influence, and um, help you to determine your ... your continuing competence- Your professional development.	29u. Learning is influenced by the work context and career goals that arise.	29uu. Leadership training	Typically, for me, well that's always um, it's always related to the area I work and so um, if new opportunities have arose for example, on my old unit, um, I got like a pain leadership role, so then that involved lots of extra study and um, going to different seminars, et cetera. Reading different uh, research articles, and then also disseminating that information to the staff and kind of being a support for staff when they needed, um, assistance in that area, um.
		30u. Learning involves developing new knowledge and skills while also refining current knowledge and skills.	And then recently, I switched roles from —I was a floor nurse for three years, and then I switched to more of an independent leadership role, um, where I'm directing a new program, so through that,

		30uu. New job roles	um, you know, there's a wh- it's more all-encompassing, there's leadership, um, lots of different things that I'm dealing with, so through that, there was a lot of—there was a lot of learning to continual learning, so, because of that, um, not only I —did I have to gain the knowledge base in regards to, um, the new job, um, but also to, um, you know, kind of try to refine your leadership skills and work with the new team and um, just kind of find what's best for the functioning .
8x. Um, what about other um, outside influences, and I'm thinking union or employer, and you already to spoke to CARNA, but feel free to ... To talk even further.	31u. UNA does not influence learning	31uu. Orthopedic journal	Union, to be honest, I don't think the union really influences me that much, um, in regards to ... to my learning, um. I do feel there is a strong influence from managers, like often my manager will, um, direct certain courses or um, different things to me, um, that she feels was relevant. Even like this morning, she had an orthopedic journal on our desk that she had asked us to photocopy, just to read certain articles, so it's nice 'cause she does direct, um, some things that she sees helpful, too.
	32u. Managers recommend courses and provide resources.		And I also kind of feel it's nice, 'cause I find she kind of, um, she kind of helps you grow in your role. Um, she gives you lots of different learning opportunities, that you can either decline or take, but ultimately I see it, that she's trying ... she's giving me the opportunities to benefit

			me as opposed to increase the workload
		33u. When managers are involved in learning, the learning experience is more rewarding.	Um, so I often, um, when timing permits, I often try to take those, um, learning opportunities, um, because I see them as a part of greater growth, as opposed to just um, bogging down my time.
9x. Um, yeah, um, I'm quite interested to know about your —the influence in your personal life, too- You know, I just, positive and negative, there are always, um, different forces on you in terms of how you view your learning, and um-	34u. Personal growth weighs heavily in determining learning goals.	34uu. Self-development	I think that definitely correlates to my —my personal life, like before I was in nursing, I was a more shy person and then, you know, when I started nursing, um, you know, you didn't have the same leadership and assertion skills, et cetera, and over time, I've developed those, but I think um, I've developed them in a professional manner, which is respected by my peers. Um, so I have effective delivery techniques.
		35u. The new knowledge and skills acquired in the workplace transfer to personal life.	—so I feel that's helped me in my personal life, um, just to kind of better direct it, and that's good to because then you have the work-life balance, but I do feel kind of those um, leadership skills and, you know, standing up for yourself and your friends and your family, um.
10x. What— what challenges do you, um, have challenges in terms of your continuing professional development?	36u. There are many barriers to learning that must be overcome.	37u. Culture and work colleagues create barriers. 37uu. Develop culture	Um, oh well even, for example, in my new position, um, it's a new program so we're slowly building it, and there's, you know, there's different culture and um, so you're constantly meeting um, you know, nothing is really a straight path, you're constantly meeting, um, barriers and um, then you need to develop techniques

			to try to overcome them and they're not always so direct and um, the other thing within that is, it's not only a one person um, you might have an idea of how you want to go about it, but because of other people's views and, you know, culture, um.
	38u. Integrating new knowledge or skills is met with resistance from work colleagues.		You also have to learn techniques to kind of integrate that learning into other peoples' realm because, just because you have an idea of how you coordinate things, um, everybody might not see it the same and you also might not, you know, not necessarily not be right, but you might wanna— I might wanna change um, how I go about some —delivering things, 'cause if other people aren't receiving it, perhaps on my end, it needs to be altered.
11x. Can you tell me about the culture, in terms of-	39u. The morale at the workplace is impacted by the workload.		Um. Well, I think on the units, at times, you know, it is busier, so that can, um, that can definitely affect the culture and the morale, um, the morale on the nursing floors, um, so I think everybody means well, but, you know, when it gets busy and stressful, um, them—it's hard to keep the morale up at times.
		40u. Managers try to improve morale with social events.	the managers do different things to try to, um, try to improve that. Be it, bring in things or have, you know, an out —out of work event or something, um, our program is also doing like a barbecue for all the staff, um. Yeah.

12x. And how —how do those things benefit you?	41u. Workplace happiness has a cascading affect on the quality of work and patient care in particular.		I think in general, if everybody's happier with your workplace, so are you. And then everybody has more energy to put towards the work, so it makes the workplace a better place, and then it —it also benefits the patients more, so.
13x. Um, so in terms of ... of your obligations- In your continuing professional development, I guess, what are your viewpoints on —on that?	42u. Nurses must learn constantly to adapt to change.	42uu. Career driven	I think it's definitely important, um, especially being in a career where things are constantly changing, I think it's definitely important, um, for nurses to continually, um, you know, learn new things, um.
	43u. Learning as you go ensures the minimum learning requirements for patient safety are met.	43uu. Keep up with the minimum	Maybe just learning as you go, often, too, um, but as long as you're ... you're keeping up at least the minimum ... I think you should do more than the minimum, but I think you should at least, um, you know, you need to be doing at least the minimum to keep your patients safe, um, and I think ... it would be impossible to go through a year of nursing without looking anything up. Yeah.
14x. Um, do ... do uh, you spoke a little about your managers. Do ... can you speak to the executive level managers? Like the managers all the way up, in terms of their influence on your-	44u. Executive level influences workload and stress levels.		Not —not personally, um, really I think the only way that that would really affect, um, at a lower level, would just be the funding. Obviously, um, different levels of funding are going to correlate with different workloads and different morale's and stress levels and —so.
15x. How does the funding work?	45u. Funding impacts the nurse-patient ratio where there is not enough patient care time.		I don't know exactly how the funding works, but um, I do know it ... it can be quite busy, not always, but um, uh, in general, I think

			worldwide healthcare is in a crunch for nurses, and so um, nurses are always quite busy and um, I guess we always wish we could have more one-on-one time with our patients and um, but instead, you just, you prioritize and do what you can do to, um, keep everybody safe and as healthy as they can be.
16x. And how do you see yourself in the future? And ... and do you have a particular way of viewing yourself and your trajectory?	46u. Learning goals are tied to career advancement.		Um, I hope to continue to grow, um, and— in kind of a leadership role, and be in —kind of a role similar to what —what I'm in now, but maybe something maybe a little bit more dynamic, um, where you're more, so in managing or directing um —'Cause now, I realize from working on the floor, I feel like I've had a lot of self-development in just the — even the past few months in this job, so I wanna continue to move that way in the future. So.
17x. Great. And so, do you, in terms of you ... in terms of that thought process, do you feel that, on a daily basis that ... that, um, influences how you, you know ... what steps you'll take next or what, um, you'll learn next and that sort of thing?	47u. When it is very busy at work, learning goals are set aside.	43uu. Keep up with the minimum	Yeah, I think so. Um, I think you just learn through time, um, what's working well and what's not and how you could better yourself. There are some days where, you know, you're swamped and it's more of a [laughs] a freeze and you're just focusing on your work and your mind's not really thinking of those, um, kind of higher level uh functionings, but um, yeah. I do think so, mm-hmm [affirmative].
18x. That's wonderful. Um. Do you have anything more you would like to talk about with	48u. MyCCP keeps learning plans on track but I don't use it that way.	48uu. A tool to stay on track	Yeah, no, I find —it is — it is a good tool, I think, to keep people on track. I personally feel I end up ... I end up just kind of working

regards to your MyCCP learning plan?			on things through the year, but then it's not really —it's not something I actively use and maybe it would be nice if I did use it more actively, 'cause there are a lot of things that I do do during the year that I don't, um, necessarily put in here, um, because it only has you put in the one learning plan, and then, that's kinda your focus on as to what to input into the computer as opposed to thinking about actively entering it throughout the year, so—
	49u. It is too difficult to keep up with entering information into MyCCP as it happens so details are forgotten.	49uu. Save wrong articles.	It might even be a good idea if they had a reminder, like an email, you know, that goes out to you to say, you know, enter your learning activity, because you do a lot of stuff and you don't necessarily forget it, um, but you'll read things and then, you'll get the information but you don't necessarily always, if it's not the one that's in your learning plan, you might not save those articles and then ... and then you never put them in the system, because you don't have the proper references saved to input.
19x. And with your goal that you setup there, do you think that it's something that you would have worked on anyway, or is ... was this um, the impetus for you to- To think of that?	50u. I work on my learning goals informally but MyCCP formalizes my plan.	50uu. Receive lots of feedback	I think, like, I'm always constantly working on it, um, for sure. But maybe in a more of an indirect way. I think lots of people give feedback, but I think it's hard to give, um, you know, really construct-direct feedback. Um, so, I had and would be continuously working on constructive feedback, um, but I kind of wanted to use this goal to kind of, not

			really push me over, but um, make me be able to provide that really direct, um, specific feedback, um. Yeah, so ... and in a little bit of a different way, it did push me to kind of, um, meet something.
20x. Um, and do you have any other thoughts about ... just continuing professional development, you continuing competence in general? With respect to just your ... your whole world! Your whole life, your personal life, your work life, your every day life, your ... and then, you know, all the outside things. Your union, and everything else.	51u. Continuing competence in one nurse has a ripple effect on the continuing competence of other nurses.	52u. Continuing competence advances the nursing profession.	I think —I think it is um, good, um, obviously, continuing competency is gonna impact nurses, and then, um, the more knowledge nurses have, the more they can share with each other, and— and then it creates kind of, you know, role model nurses, where um, you see them looking things up so other ones in turn, and then it builds on that, some —so there is more knowledge, um.
	53u. Advancing continuing competence improves productivity at work and at home.		—you actively decide to put more on your plate and learn more, I think in general, it keeps you, um, you know, you get things done, um, and in your personal life, it ... it pushes you to, um, you know, be more active and be more dynamic and get more things done in a day.
		54u. f you are motivated, you are more productive.	I think that hard working motivated people accomplish more, and can take on more tasks. I feel that the more tasks one completes, the more initiative it gives them to complete additional tasks.
	55u. Active, purposeful learning comes to a standstill once in the profession.		Um, I think it's similar to, 'cause I felt when I graduated from university, you're used to doing lots of papers on — constantly

			having things on your plate, and then, you go into the workforce, and, you know, initially you're bogged down by the graduate nurse process and all that learning, but then it kind of comes to a standstill point where, you know, earlier on in my nursing career, I found, you know, there's days where, even with doing your continuing competency, it's because you're not used to actively throughout the year having to sit down and write a paper, and sit down and a lot five or so hours to something, so, I did find that, um.
		56u. It becomes difficult to concentrate on long periods of reading and writing because of the nature of the career.	Once one passes the graduate nurse phase and is comfortable working as a nurse there are smaller knowledge gaps to fill. This gives the nurse more time for personal stuff outside of work. I found that once I was comfortable working on the floor, it was hard to sit at a computer to do my CPP for hours as I was not used to sitting down an writing at a computer as my nursing job doesn't entail much writing.
			I hadn't edited or written a paper since university. So although willing to help, I felt this task was cumbersome after years of being out of university.
	57u. Being busy is motivating and productive.		Same idea as above, being busy causes one to be able to successfully

			complete an additional workload as work is motivating. I feel that when I am not busy and not using my time effectively, I get less done.
21x. Go ahead and log out of the MyCCP system.	58u. MyCCP requires typing out what has been accomplished.		She said, "oh, you have to have it done, um, soon here", so not necessarily that we don't have the stuff to put into the system, but it's just a matter of sitting down and typing it out.
	59u. The ambiguity of MyCCP program wastes my time.	59uu. 300 word max	When I first inputted my initial my CPP record as a new grad, I didn't know what the system entailed. I spent lots of time preparing and organizing my thoughts for my record, to find out I could only input 300 words. I found that to be a big waste of my time.
22x. What's— what's it like, uh, at renewal time when— when the crunch is on and –and— what's ... what do you feel like—	60u. Most people can 'quickly' complete their MyCCP record in 45 minutes to a couple of hours.	60uu. Last minute 60uuu. Get credit for what I do 60uuuu. A couple hours at computer	I've just been one usually to leave it til more of the last minute (laughs). I do find lots of people —lots of people treat it really casually, like "oh, it doesn't take that long, I just sat down and did it in a, you know, a quick hour or so" whereas, I have a more, not necessarily thorough, but, you know, a very —more particular personality so, I don't like just to sit down for 45 minutes and write one thing, and if there are a lot of things that pertain to my goal, I like to get them all in so that at times, I could take a little bit more ... more time, but I wanna get credit for what I've done, so. Sometimes, I do need to tackle down and just have a couple of hours at the computer.

	61u. It is important to get credit for the learning accomplishments.		
	62u. It gets faster and easier to fill out MyCCP after doing it a few years in a row.		I feel that over time, um, now that I'm doing it, um, I've been able to refine my goals in a way too, that to know, but not necessarily easier to evaluate, but, um. It's —it's probably a more direct thing that you can evaluate pretty quickly.
		63u. Knowledge-based goals take more time.	I feel the knowledge based ones do take a lot more time to input into the system—Depending on how much, um, how many learning activities you do and pertaining to it.
23x. So, um, just uh — just kinda more curious actually, but when — when you're writing things out, do you feel that you're writing it for yourself, or uh, or do you feel like you're writing it for an audience?	64u. Setting up a learning plan at the beginning of the year is not effective or accurate.	64uu. Learning goal changes. 64uuu. Create goal under pressure	My goal often changes after it's initial input into my CPP as when entering the goal I often just put something simple in as I've just spent hours working on my CPP evaluation for the prior year. I am focused on submitting my CPP evaluation, rather than constructing a goal under pressure. This results in me often changing my goal to something I am more interested in once I come up with a new goal.
		65u. Often the learning goal changes.	
		66u. It becomes a work-around when reporting at the end.	And at times, I still will do other learning, but just fill in the one that I did at the beginning of the year, just because — It's there and I probably created a goal that was relatively straight forward. So at times, when you're just doing it, it's — it's just easier to um, do it in that way.

		67u. MyCCP does not reflect the actual learning. 67uu. Does not reflect actual	Yeah, I don't think it really reflects the learning that goes on.
24x. What learning is meaningful to you?	68u. Learning about yourself and learning new skills are the most important aspects of learning.		Um, I think —well, I think it's important to have a knowledge base, but it's also important to kinda learn about yourself and kind of gain different skills, um, I think the skills are what are really important.
		69u. Developing yourself is learning through experience and not from reading and classroom.	Um, um, just kind of internal and our interpersonal skills, um, which you don't necessarily always learn, as well, through, um, through, you know, documents and teachings. Sometimes, that's just something you learn over time from being in different situations.
	70u. Reflection usually happens after the work hours and more on difficulties.	70uu. Too busy for reflection 71uu. Reflect on difficulties 71uuu. Come to a different solution	And then, even with reflection, I find you reflect on things, but you don't always have time to reflect or you might reflect after, but I find it's —it's moreso on the hard days that you reflect, or you know, the busier days where it's really obvious that you need to come to a different solution, but um. In the middle ground, there's not always lots of time for reflection when things are just so busy all the time.
25x. Where does reflection —how does that work in, uh, in continuing competence and professional development?	71u. Reflection ensures learning is applied to practice.	71uuuu. A realization	Um, well I always just think whatever you learn, um, you— it just kind of puts an importance on it, kind of a weight, um, and makes you realize if it's an important thing for yourself or for the workforce, why you should bring it forward, um, as

			opposed to just, um, getting the information and not applying it anywhere.

Appendix 4K Victor-Second Level Analysis

Table 39. Victor- Second level of analysis

First level analysis	Second level analysis
1z. MyCCP is additional work. 4z. MyCCP is a required task. 29z. Additional demands on nurses cause burnout and attrition. 41z. MyCCP requirements are minimal. 59z. MyCCP is a chore. 56z. Just endure the MyCCP process to renew practice permit.	1zz. MyCCP is a required chore.
2z. CARNA just wants your money for renewal. 14z. The purpose of CCP is to detect nurses who are inadequate. 22z. If we don't do MyCCP, CARNA will revoke nursing license. 23z. MyCCP must be completed correctly or risk losing license. 60z. MyCCP could be easier. 52z. CARNA's efforts to support learning are not helpful.	2zz. CARNA is suspicious and punitive.
3z. The purpose of MyCCP is unclear. 8z. MyCCP does not improve learning. 27z. MyCCP does not do enough to encourage learning. 53z. CARNA's resources are not helpful. 71z. MyCCP does not represent the learning that occurs. 62z. CARNA doesn't know what is reported in MyCCP. 13z. MyCCP reporting compares nurses on the lowest level of knowledge and skills. 102z. Learning is not always purposeful or conscious. 45z. Learning requirements determined by individuals are discordant from CARNA's determination of required learning.	3zz. MyCCP does not fulfill its function.
5z. I am learning regardless of CARNA requirements. 17z. MyCCP is unnecessary because nurses are responsible and accountable. 66z. It is the nurses accountability to know what is needed to learn. 70z. Nurses have their own accountability to learn. 99z. Learning addresses the knowledge gaps.	4zz. Learning is a nurses' accountability.
10z. Learning is required for work. 19z. Continuing professional development happens naturally while working. 28z. Learning in nursing is inexhaustible. 98z. Learning for interest is spontaneous and natural. 83z. Learning is spontaneous in meeting challenges. 88z. Learning is mandatory to advance with changes in technology. 96z. The greatest learning are work challenges. 104z. Learning comes from where it needs to come from.	5zz. Learning solves daily challenges.

11z. MyCCP is a necessary reporting formality unrelated to continuing professional development. 6z. MyCCP prescribes CPD reporting. 16z. CARNA preselects information to be recorded in MyCCP. 25z. You must summarize the main points of learning in MyCCP. 47z. CARNA reporting requirements are unspecific. 55z. The nursing practice standards are a reminder to be accountable and responsible. 50z. Nurses select practice standards indicators that are appropriate to their context.	6zz. MyCCP is prescriptive reporting.
20z. Nurse educators ensure continuing professional development so MyCCP is redundant. 73z. Assessment of continuing competence is unnecessary. 39z. Nursing credentials should be enough. 18z. It is unnecessary to manage nurses continuing professional development. 49z. Nurses learn more than what they report to CARNA.	7zz. MyCCP is unnecessary.
31z. The demands on the unit are constant. 33z. Work demands overwhelms learning. 37z. Learning after work is unrewarded. 68z. Some people do not have time to learn. 87z. Learning is twenty-four hours per day because of constant change.	8zz. Work demands challenge learning.
43z. Intrinsic drive to know more about my work. 26z. Individual nurses know what they need to improve 105z. Learning requires motivation. 100z. Learning may be for personal reasons. 51z. Most learning is self-directed. 57z. Learning entails building on experience and knowledge. 69z. There are a variety of ways to learn. 72z. Learning needs are very diverse.	9zz. Learning is intrinsically motivated.
63z. Competence is awareness of own weaknesses. 67z. Competence is becoming realizing and becoming aware of what is needed to learn. 64z. Competence is a sense of comfort. 77z. I am intrinsically motivated to learn, especially when I am uncomfortable in my work.	10zz. Competence is self-awareness.
75z. My view of nursing is from an international perspective. 76z. An international perspective is an expanded viewpoint including systems perspective. 85z. An international perspective includes systems.	11zz. International viewpoints include system perspective.
78z. The union sponsors time off work to learn which is good. 79z. The union negotiates a fair salary.	12zz. UNA is a positive learning influence.
80z. Work colleagues are role models and exemplars. 101z. Learning increases competence in your team.	13zz. Work colleagues model competence.

81z. The unit routine is the first learning requirement.	14zz. The unit routine is the competence building block.
89z. Feedback among colleagues is risky to relationships. 91z. Providing effective feedback requires empathy. 93z. Feedback requires knowledge of personal circumstances. 95z. Making suggestions and teaching others may offend them.	15zz. Feedback requires empathy.

Appendix 4L Victor-First Level Analysis

Table 40. Victor-First level of analysis

1y. So anyway, tell me, tell me right from the start… Uh, when you need to go into this program [MyCCP]- Tell me your thoughts about it.	1z. MyCCP is additional work.		Um, of course you don't want to go, but —because, it's like additional —additional work for you.
	2z. CARNA just wants your money for renewal.		Okay, they want money, you're ready to pay money to renew your license.
	3z. The purpose of MyCCP is unclear.		Okay, that's fine. But why are they asking you to do continuing competence program?
	4z. MyCCP is a required task.	4zz. Just have to do it.	It's really, it's —it's just like .—you just have to do it. Like in-and-outs you have to just sign up, like.—And sometime you have to pick up. Do you really need it? Do you really have time to pay attention to that?
	5z. I am learning regardless of CARNA requirements.	5zz. Read med-surg text	I'm learning like med-surg book everything, so really I'm doing continuing.
	6z. MyCCP prescribes CPD reporting.	7z. I cannot record my learning because I cannot fit it into CARNA's prescribed format. 7zz. Not applicable to me.	But I cannot put it here in record, because I have to pick up something what they have.
	8z. MyCCP does not improve learning.	9z. MyCCP does not help me improve. 9zz. A formality	And really, do I really need ... I used to think, okay maybe I would like to improve. But it just like formality.
	10z. Learning is required for work.		But you are improving every day, because you have you le-learn, like somebody does not [indiscernible] 02:01] so they have to learn

			because they need it to work.
	11z. MyCCP is a necessary reporting formality unrelated to continuing professional development.	12z. MyCCP is not necessary for my learning but I am required to comply once per year. 12zz. Review once per year.	And maybe they need it more than they mentioned it here, in the file. So, it just — just some formality they want, we are doing it of course. So we will review it, we will have time so it's good that they are not requesting us to do it every week. So, that's why they do it once in a year, so it's fine —we can accept it—
	13z. MyCCP reporting compares nurses on the lowest level of knowledge and skills.	13zz. Low expectations.	But, it's not really as much helpful, even if we are reviewing somebody's background can be way higher, but they just reviewing these small things like say, equaling everybody like— like the same.
	14z. The purpose of CCP is to detect nurses who are inadequate.	15z. CARNA is looking for inadequate nurses and they don't have time to look for the strong ones	Maybe that they're looking for weakness, but not always person will pick up weakness. Sometimes person will pick up, in what they are strong, because they just don't have time to look for it.
	16z. CARNA preselects information to be recorded in MyCCP.	16zz. Simply pick out something	And they [2:52], they will have like a user file they will talking about because they know it. So that yes, I learned —I learned that, because you not ask something else. They will ask what you picked out. Which one? They will just pick it out.
	17z. MyCCP is unnecessary because		And, I understand, sometimes, safe, ethical practice is

	nurses are responsible and accountable.		important to be accountable, but it's like —so, you don't have to ask anyone, it's just everybody's— everybody's responsibility what they are doing.
	18z. It is unnecessary to manage nurses continuing professional development.		So, it's up to the people. They have to —it's their work, so — I don't think they have to mention but just —I don't know, it's just additional time to managing people that they have to continue learning.
	19z. Continuing professional development happens naturally while working.	19zz. Daily experiential learning	Okay —but this is continue learning, when you are coming to work. Every time you are dealing with different patient the same, like, when clinical symptoms in different patient different, so — as long as you're working the better you're getting experience where you are getting better, so —
	20z. Nurse educators ensure continuing professional development so MyCCP is redundant.	21z. MyCCP is unnecessary because there are accountability processes for learning at work. Redundant. 21zz. CNE led learning 21zzz. Study, take exams	Even at work, when we are learning, like, CNEs. Sometimes they expect it from us to do it— to do more, but we just don't have time to finish, uh, everything what they want. We already doing it work, but just to catch a CNE, show what you know, and —it's the same, you know it-how to do it in practice, but you still have to do exam or whatever, so you,

			again, have to go and study.
	22z. If we don't do MyCCP, CARNA will revoke nursing license.		Yeah, so, I don't think it's as much helpful from CARNA, but it's a requirement so we, as you will see, will not get license.
2y. One thing you said a little bit earlier on was, um, "This is just one small thing in—in the realm of what you learned." Um, like, tell me more about that… What you said was ... you-you put something in but it was just a small thing in-in the realm of what you learned.	23z. MyCCP must be completed correctly or risk losing license.	24z. MyCCP is like an exam; you have to answer everything correctly or risk failing an audit. 24zz. Like high-stakes exam	Um, because —like, you want to know, like, if you are picking up a topic, like, I would like to admission. So, and, you just put some sentence. It's okay, I'll learn that, that, that, that —because you — you prepare in case you will have a review. So, it has to be a written right. And, uh, but— on practice, it's a bit different. So, it's just like — like an exam. You just answer everything, that's it.
3y. Tell me more about how you have to write things a certain way.	25z. You must summarize the main points of learning in MyCCP.	25zz. Capture main ideas	So, if you —if you interest, you will go, you will read literature, so if you have more time you will write more. But, if not, you just have to write at least main —what — main what you would like and what you learn, already learn, and just, like, main thesis.
	26z. Individual nurses know what they need to improve.		Anyway— everybody knows their weaknesses so they have to improve it.
	27z. MyCCP does not do enough to encourage learning.	27zz. Not enough to help	But, maybe it, what, it can be helpful to just push them a little bit, but it's so small, it's just —it's not enough

	28z. Learning in nursing is inexhaustible.		Even just picking up – even— you will have, if you have five lives, it won't be enough for your practice.
	29z. Additional demands on nurses cause burnout and attrition.	30z. If CARNA demands any more than they do, nurses will burn out and leave the profession.	Because it's just a bit —but they will start giving us, like, exams, like, to read books. Everybody will drop just nursing and go somewhere else, whereas they don't — because you are burn out at work.
	31z. The demands on the unit are constant.	32z. Even leaving for this short period for an interview is too much to ask.	Like, I came yesterday and couldn't come because I was so busy and here, I just left my LPNs to do my stuff.
	33z. Work demands overwhelms learning.	34z. It is very difficult to plan learning when working such long hours.	So, just because — you are busy at work all the time so —but, it depends, because some people are working full time, some people are picking up even more shifts. They are working two wards, so somebody's working just point five, so they have time to pay more attention what they want to learn. So, it's individual.
4y. So, for yourself, um, on a day like today, you just said-That you had to leave your patients and for the LPNs to complete their care?		35z. It is very difficult to leave the unit for any length of time.	Yeah, because some in and outs are not done. I just came. So, it's time to do it. So even a good LPNs was I told no problem. Yeah, but you have to, you have to be on the unit because all the time, there is demand.
5y. So, it's, you have to take time away from your regular work that you want to do.		36z. You can sometimes leave the unit to attend a	If you, if you want to learn at work, if you're on, it depends. Sometimes, slowing

		learning event if it is slow, but that is rare.	down. So, you have time. Like weekends, evening, overtime. But if you're, usually you're busy.
	37z. Learning after work is unrewarded.	38z. When you are off work, you are not getting paid to learn so you shouldn't have to.	And not everybody at home has time, like, because you're not getting paid for it.
	39z. Nursing credentials should be enough.	40z. CARNA makes you record your learning each year, even though you have finished your education and you have your registration.	You already have your diplomas, everything. So, you have your license. You're eligible to get it. So, it's still here you have to learn.
	41z. MyCCP requirements are minimal.	42z. Completing the MyCCP requirements is not too much to ask. 42zz. One topic is doable.	That's fine. Just not always people have because it's not mine. Just one topic. So, it's okay. We can, we can do it.
6y. Something you said earlier on was "if you're coming to work, you're learning." I'd I'd like to know more about that.	43z. Intrinsic drive to know more about my work.	44z. Learning is interesting because I want deeper knowledge about my daily work.	It's just, it depends also for everybody. Like for me, I want to know. Like, if I don't know something, for me it's interesting why it's like that. Why this medication is given to this patient. So, why is not given? Maybe next time, I will have to know.
7y. More than the question that CARNA asks you?	45z. Learning requirements determined by individuals are discordant from CARNA's determination of required learning.	46z. CARNA doesn't ask me about what is interesting to me.	So, they don't have this question. But it's interesting for me. More than their question.
	47z. CARNA reporting requirements are unspecific.	48z. CARNA must ask very general questions about learning because of the diversity of nursing practice.	Yeah, so, but it's also, they cannot ask it because here, they have management, here they have rounds in clinical areas, in hospitals, and long

			terms. So, they cannot ask this question in long term care. Does he care about insulin drip? You'll never see it in his life. And they will change it maybe next time. And be that they implement it. And it still get have it, and it doesn't have it. But we have to know, so.
	49z. Nurses learn more than what they report to CARNA.		So, we have to learn, you're learning more at work than with CARNA. CARNA is just formality. It's just for show. Not formality. I don't know. But it's not what we need really at work. Maybe we need, but you have picking up like additional, on top of what we have already because every area is different.
	50z. Nurses select practice standards indicators that are appropriate to their context.		So, maybe, but also, maybe from all these topics, everybody can pick up what is good for them, what say they really need. So, I don't know. Maybe, because you're looking okay. This I don't need. I'm not working this area. I'm not. This item, okay. This most familiar, what I'd like to know.
	51z. Most learning is self-directed.		So, in this case, yeah, you can become on this topic and just do some researching internet or some. But if you are reading some magazines or internet, you're reading it. So, you don't have to pick it up from here.

	52z. CARNA's efforts to support learning are not helpful.		Yeah, so it's just, it's enough. It's better if they do like they are issuing magazine, and they send it to everybody. Just try something. Some interesting article, like really what is important. Some people don't read it. And not read like somebody awarded witih some like, I don't know. You just looking, and you just look. Half magazine's useless, just waste of paper.
	53z. CARNA's resources are not helpful.	54z. CARNA needs to develop useful and interesting resources to support nurses.	So, they can put there this topic so people choose it, and they're thinking it's very important. You know, let us read. But make it interesting.
8y. What about, um, the nursing practice standards? Because, you know how you always have to select an indicator? What do you, what goes through your mind when you have to do that part of it?	55z. The nursing practice standards are a reminder to be accountable and responsible.	55zz. Accountable	Okay. So, nursing standard. Okay, it's, everything is obvious here, so every nurse has to have these qualities. So, I don't think it's, okay, you're just going through it like, next reminder, okay. You have to be accountable what you're doing. You have to be responsible.
			That's okay. I don't know. Just one time more mentions it. You have to think if you are doing something, if you're giving medication, whatever you're doing. And the way you're organized. You, it's obvious, so, really.

9y. Well, it does ask about you know, feedback and learning activities. Um, how, how do you go about filling this in and, like, what, what are you thinking when you go through these particular sections?	56z. Just endure the MyCCP process to renew practice permit.	56zz. Try to make sense of it and submit	I have to do it. That's it. I think. I have to finish it to submit. I have to submit it. So, you just think okay. How to submit it, how to write, how to pick a topic and give answer that makes sense.
	57z. Learning entails building on experience and knowledge.	58z. It is helpful to build on what you know.	So, you just picking up where you know, a little bit, a little bit. You want to increase your knowledge.
			Yeah, so. Well, it's hard to tell because every time's different. Next one you have is new. Just you have to do it.
	59z. MyCCP is a chore.		You have to do it, and of course, nobody's very happy about it.
	60z. MyCCP could be easier.	61z. The MyCCP process could be easier similar to other professions.	I think they won't eliminate it, I don't think. So, because everybody has LPN has it also. LPN you have to write, or pen you have to just click. So, it's easier there. Just click, click. And they wrote how they did. And if they have a review. So, they will just write from where, like what from, what resources they used to improve their knowledge in that certain areas.
	62z. CARNA doesn't know what is reported in MyCCP.		I don't even think somebody's reading. Because so many nurses in the background, it's hard to review everything. And they even know that if they want to pick up somebody to

			review, no problem. People will be ready.
10y. So, what I'd love to, for you to speak to is how do you know your own competence?	63z. Competence is awareness of own weaknesses.	63zz. Insight to weakness	Your own, you just know your a little bit weakness in that area of what you're feeling. If you're at work, "okay, I have this task, I don't know here how to do it."
	64z. Competence is a sense of comfort.	65z. Competence is a feeling of comfort with accomplishing work tasks. 65zz. Level of comfort	I am not feeling comfortable when I'm filling out the documentation, or when I'm doing somebody assessment or whatever, or I'm giving some type of medication.
	66z. It is the nurses accountability to know what is needed to learn.	66zz. Must feel it	So, they need, they need to learn about it because how you can work and don't know. But it's up to you. CARNA doesn't have to ask you. They have to learn by self, they have to know if there's a gap. They have to feel it, if they knew.
	67z. Competence is becoming realizing and becoming aware of what is needed to learn.		They have to have like, um, a realization. Now, people think they understand if they just, I know, if they really aware.
	68z. Some people do not have time to learn.		Everybody's aware, but does he want to? Does he have time to learn? So, it's different.
	69z. There are a variety of ways to learn.		There are people who like to learn. There are people who don't and who don't have time. But continue learning and taking learning on the break, you know? Just Google everything. It's really not bad. They have policies. They have

			hours. Ask friends or coworkers. Managers who already know.
11y. What else influences you? So, let's go onto the second part here. Um, thank you for helping me understand your thought process around this, continuing competence.	70z. Nurses have their own accountability to learn.		It's good. It's good. But I don't… CARNA doesn't have the push. I understand, but they don't because it's everybody's own responsibility to have continued competency.
	71z. MyCCP does not represent the learning that occurs.		So, because really, we have to learn more than here, they imagine.
	72z. Learning needs are very diverse.		But everybody has different knowledge. Everybody has different interests. So, and feeling the level of responsibility and accountability different also for every different people. So, the approach is different.
	73z. Assessment of continuing competence is unnecessary.	74z. There is no need to assess continuing competence because learning is required in nursing. 74zz. New medicine 74zzz. New policy 74zzzz. New approaches 74zzzzz. New technology	But of course, people have to have continuing competence. Not assessment, just continuing learning because it's changing. New medication. New policies. New approach to medicine completely. Electronic everything will come. So, it's competence. You don't know computer, you have to increase your competence otherwise…at you're at work. Yeah.
12y. No, you mentioned a couple things there. And what I'm hearing you say is that some of the influences on you, in particular is, um, when a question comes up at work. A new medication or a new, something new is	75z. My view of nursing is from an international perspective.	75zz. Non-nursing	No, I like to learn. I like to learn, because I learn all my life. From moment I moved to Canada, I downgraded my style, so in nursing, so, that's a big. But I work in a bit different

happening with your patient… And just the constant changes. One of the drivers for you is that's kind of what I heard… I'm wondering about what else in your life influences your learning. I'm talking really big and broad… You know, UNA. You already talked about CARNA. What about you're employer, Alberta Health Services? What about your home life? Your personal life? What about some of those things?			area there. So, I have to learn for me because even I'm coming here from different side. Not even from nursing sometimes.
	76z. An international perspective is an expanded viewpoint including systems perspective.		So, if when I'm working, so I see it from different perspective. Even notice all nurses see. Not even many doctors notice it. So, you'll see. So, I'm still learning as a nurse because for me, many, many issues are interesting, like what CARNA is expansion is, and how's approach to treatment in Canada. It's ways, it's organize. So, I am still observing in that. That's the reason for me wants to come to Canada, to see how health care system is working or what is different.
	77z. I am intrinsically motivated to learn, especially when I am uncomfortable in my work.	77zz. Ways to improve	And I like to improve myself. I like to know what I'm doing. And my coworker are asking, I feel comfortable when I know. So, if don't know, I will look, and I will know. Right? Because if I don't know, I don't know. So, I, that's fine. I can

			find it right away. Yeah, so.
13y. What about the union and some of these systems that you work in? How do they influence?	78z. The union sponsors time off work to learn which is good.		What union is doing good if they are sponsoring people for some learning activities. So, it's, it's not bad, but I don't think what else. I don't know so much about union because I am not long here in these unions. But I know what can really help. It's also some parts of bureaucracy, I think. So, I don't think so here.
	79z. The union negotiates a fair salary.		But because of union agreement, people are getting minimum. So, from this side, union is good. So, I know. Really it's hard to tell.
14y. What about your team, your work team, like, right on the unit? How does that, your peers, how does that influence your continuing professional development?	80z. Work colleagues are role models and exemplars.		Hmm. You see how people are working. Like, you take as example people who really know something, who are working well. So, and you want to notice, like, to be fast like that. At least, to be able to, like I'm telling because I just started.
	81z. The unit routine is the first learning requirement.	82z. You must understand the unit routine before increasing competency. 82zz. Learn unit routine	And after that, you will work on improving yourself. Like, to be comfortable. On the unit, to be comfortable to do this routine because they know it's routine mostly. But you have to catch it. Because first, it's not

			even part of your knowledge or routine. Get into routine, and after that, you can increase your knowledge, your competency, whatever you need.
	83z. Learning is spontaneous in meeting challenges.	84z. You must be ready to learn spontaneously to be ready for challenges that come your way.	Whatever challenge you are facing, you have to be ready for it. Or if you are ready at this moment, you have to learn, because you don't know what patient you'll get tomorrow. So, it's a problem. Or even any other that you have to learn.
	85z. An international perspective includes systems.	86z. Because I am internationally educated, I must learn more about health care and systems. 86zz. New cultural systems	For me, I have a lot because Canada for me completely different system. So, medicine's so different. Many things are new, so everyday you're learning.
	87z. Learning is twenty-four hours per day because of constant change.		I think even for people that already work long time, they still have to learn now. Because so many new implementation, we even cannot go in places. If you want to learn, you will have to learn, like, 24 hours.
	88z. Learning is mandatory to advance with changes in technology.		Yeah, so, it's good. But it's obvious as I continue where it's, everybody has to do it. It's even, you don't even to question. To question. It's not luck that you have to learn. Otherwise, you don't learn how to change TV channels if you, because it's different than it was 10 years

			ago. It's not on TV anymore. Yes, I know.
15y. Do you find there are any challenges to your continuing professional development? Do those challenges impact or influence your learning in any way?	89z. Feedback among colleagues is risky to relationships.	90z. Giving feedback and suggestions to peers may be taken the wrong way. 90zz. Feedback invades personal space. 90zzz. Impacts confidence	So, you have to consider, it's very personal. And sometimes, to suggest to somebody's not a good idea because what if you didn't suggest for right person. Maybe they're not ready for that. Because suggesting's also judgment, because you're influencing people. So, they might be mad at you because of why they taught me. Maybe they have high self esteem. Maybe they have lower self esteem. And they say that you are pushing.
16y. What works best for you?	91z. Providing effective feedback requires empathy.	92z. Providing feedback is tricky because you don't know where the other person is coming from. 92zz. Only if asked	For me? Uh, you mean in suggestion or? If people even ask me, I, if they want to ask me advice, I can tell them, but I will tell them, I don't know if it will work for you. Because you're always when you're suggesting, you don't know person real background what's going on. You can know, okay, where they started. That's not enough.
	93z. Feedback requires knowledge of personal circumstances.	94z. You can't assume another person's situation at work because they have their own goals, family and other influences in their lives. 94zz. Not necessarily meaningful.	And what is for this person first, you don't know. Is it career or is it family? So, you know, if they want to work here, maybe they want to work somewhere else. So, what is their real goal? They will never tell you.

	95z. Making suggestions and teaching others may offend them.		So, if they will ask you some information, okay, you will just tell them. But if you want to teach, to suggest, you just have to be very careful what really suggest because you can might get problem, even from that. I know.
17y. Do you have any further thoughts about the things that really influenced your professional development and competence?	96z. The greatest learning are work challenges.	97z. Daily challenges in the job are the greatest influences in continuing professional development.	Um, it's every day's challenges that influences.
	98z. Learning for interest is spontaneous and natural.	98zz. Medical journal	And when you have free time, you just reading some medical literature. So, just for this interesting for you. What area you are speaking of. It's coming spontaneously.
	99z. Learning addresses the knowledge gaps.	99zz. Solve a problem	It's not like, oh, I want to learn. It's just, okay, I feel okay today. I had this problem. I have here a gap I want to learn.
	100z. Learning may be for personal reasons.		Tomorrow, I have something else. I want to learn that. It cannot be a light at two ends, but even it will not be related to nursing.
	101z. Learning increases competence in your team.		But later, [inaudible 00:30:54] information, you know, be more competent than your colleagues.
	102z. Learning is not always purposeful or conscious.	103z. The more you learn, the more you build your knowledge and the more you continue to learn. It is not necessarily conscious or purposeful or planned.	And you will pick up information for nursing faster. It will just see, okay, you know. Just from different, from different sites. So, I don't think it has to be, oh, okay, I'm learning that, I'm learning that.

			It has to become from difference had after you built it, from that together [inaudible 00:31:17].
	104z. Learning comes from where it needs to come from.		It will come the shelf where it has to come. It will be recognized.
	105z. Learning requires motivation.		Just everybody has to be, like, hungry to learn, like, yeah. Yeah.

Appendix 4M Marie-Second Level Analysis

Table 41. Marie-Second level of analysis

First level analysis	Second level analysis
2ac. MyCCP compiles education offerings throughout the year. 3ac. Work initiatives are relevant to MyCCP 23ac. I record workshops in MyCCP. 26ac. Workshops include experts who present case examples. 6ac. Navigating MyCCP is an accomplishment. 12ac. It is surprising what I can learn and do. 14ac. I record learning into MyCCP that makes me feel proud.	1ad. MyCCP records formal learning activities.
4ac. Changes in the workplace take getting used to. 8ac. It takes effort to implement new policy. 43ac. Staying on my toes every shift 44ac. Avoiding mistakes 45ac. Changes in the workplace are challenging	2ad. Daily workplace changes requires adapting to avoid mistakes.
69ac. CARNA ensures I maintain my license. 70ac. CARNA does not motivate learning. 72ac. CARNA and AHS enforce learning. 40ac. CARNA does not encourage learning, it mandates it.	3ad. CARNA enforces not motivates learning.
5ac. The online format of MyCCP is challenging. 19ac. Select nursing practice standards indicator after careful thought. 24ac. Select the nursing practice standard indicator that is the closest. 7ac. I do more than what it shows in MyCCP.	4ad. The MyCCP plan does not reflect my true, lived learning.
11ac. Staying informed about patient conditions is my accountability. 16ac. I stay accountable in my scope of practice. 17ac. I am accountable to keep patients safe from harm. 20ac. Building on knowledge and skills maintains accountability. 1ac. It is important to stay up to date. 15ac. I investigate what is allowed in my scope of practice when there are changes. 18ac. Competence is practice within the legal scope.	5ad. Competent is accountable learning. (staying up to date, ensuring I am practicing within scope, maintaining skills to keep patients safe)
27ac. There is valuable learning in workshops. 28ac. UNA provides free learning opportunities. 29ac. UNA provides needed learning topics. 30ac. New learning topics are enhancements. 32ac. Elearning is available at work. 33ac. Private workshops are available.	6ad. UNA, CARNA and AHS provide accessible learning opportunities.

36ac. Paid education days cover the time away from the unit at a learning event. 37ac. Learning events are valuable even if not paid. 38ac. Friends and socializing are motivating. 41ac. CARNA offers mandated learning, licensing, and learning for interest. 22ac. I select workshops to enhance my skills. 49ac. Online resources provide information	
31ac. Pay out of pocket. 34ac. Paying out of pocket is necessary at times. 35ac. Attending learning events depends on day off request approval. 42ac. Daily challenges 21ac. To learn, you step out of your comfort zone.	7ad. Learning may be troublesome and expensive.
39ac. Nurse educators encourage policy implementation. 66ac. The system determines the practice. 67ac. I adjust my practice to accomplish tasks as designed by the organization instead of making my own choices in my practice. 68ac. Standardized practices ensure steps in the process are completed. 9ac. Policies dictate the unit routine. 25ac. Learning activities must match the indicator in MyCCP.	8ad. Policies, workplace change, and system structures determine the learning plan.
46ac. Daily studying for effective patient care 47ac. Complex medical cases drive learning 51ac. Must be knowledgeable before providing patient care. 52ac. Being knowledgeable protects patients and staff. 71ac. I am motivated to learn to deliver safe, effective nursing care. 10ac. I need to understand my patients' conditions. 13ac. Learning more helps me to be more involved.	9ad. My accountability intrinsically motivates learning.
48ac. The first step in learning is asking your colleagues 53ac. Always ask your colleagues. 50ac. The nurse educator assists nurses to study their patient cases. 54ac. Managers, internet, nurse educators and colleagues are the most important knowledge resources. 55ac. Nurse educators "show how" and "do for" in terms of researching patient care information 56ac. Nurse educators provide moral support and boost confidence. 57ac. Nurse educators ensure safety.	10ad. Nurse educators, managers are formal and valued learning supports.

60ac. Showing is best learning.	
58ac. Nurses stand by to support each other 59ac. Every nurse is a learner and a teacher 59ac. Senior nurses have valuable knowledge to share 62ac. Senior nurses teach improved methods of nursing care. 63ac. Nurses model effective techniques 64ac. Nurses improve on each others' practices	11ad. Workplace colleagues model and share nursing knowledge and experience.
65ac. International nursing is very different from Canadian nursing.	12ad. International experience provides a unique perspective.

Appendix 4N Marie-First Level Analysis

Table 42. Marie-First level of analysis

1ab. So so yeah the whole point of this is just tell me everything you're thinking about when you when you go in to do this um on a yearly basis so.	1ac. It is important to stay up to date.		Okay so um since it's needed ... I mean it's we have to like be keeping up with what is the latest in the healthcare system, which is just right for us to do, right? We have to be um always updated to that.
	2ac. MyCCP compiles education offerings throughout the year.		So since it's required and we have lots of workshops that's been like offered to us all year round so we have the options to take whatever workshops or whatever reading that that we need to do, which is related to what we put in our MyCCP
	3ac. Work initiatives are relevant to MyCCP	3aca. Learn new policy	so if my target like last year they want us to like keep up with a new system the COACT so that's what I put in MyCCP that I am um putting my service, my knowledge, and my skills in line with what the COACTis asking us to do so the the coverage is like wider.
		3acac. New rules and regulations	so I attended I read some of the rules and regulations that's gonna come up that we had a dry run and later on become implemented. And I work with uh there's a representative for the COACT so I work hand in hand with her.
		4ac. Changes in the workplace take getting used to.	You have to update your boards every now and then so we kept up with that. It was hard on

		4aca. People I spoke with 4acac. The team I spoke with	the first time, but we kinda get used to it. And then I uh renewed my MyCCP then, and I updated all the things I learned, the people I spoke with, the the team that I work with.
	5ac. The online format of MyCCP is challenging.	5aca. Work around computer issues	So yeah sometimes the computer itself I need to help to like go around it, right? Especially if they change uh the the the how it looks. Change the uh icons. They change some of this. It becomes like oops something that I need to learn again.
	6ac. Navigating MyCCP is an accomplishment.	6aca. Keeping it updated	I have to keep up again, right? So at least I'm up to it, and I'm learning it. And I'm updating it, which is good. Which is good.
	7ac. I do more than what it shows in MyCCP.	7aca. Workshop unrelated to MyCCP	And I um take workshop that is not even related to what I put in my MyCCP. Well if I'm interested through it I go to that workshop. So I do more than what I write in my MyCCP. If it's given, I'll take it. If it's new to me, I'll take it. That that's how I— so this is the one. My record right there.
2ab. So you used you used COACT as .. As your learning objective. And uh where did COACT come from? And now my understanding of COACT is it's a new way of team uh based health-care, right?	8ac. It takes effort to implement new policy.	9ac. Policies dictate the unit routine.	Yeah, it's a collaboration. It's a collaborative system now in in the unit. Before you have your own patients, you take care of your own patients when half of the staff is on break. They give report to someone, and it will just be everywhere. You can have a patient on your

			right, on your left, on the end of the unit, everywhere. It could be everywhere, and when you give report. Let's say some some nurses give me report like two of them going for break they will both of them be giving me report like that would be too much. My patient last year, two patients that I will end up with like 12 patients. And that will be too much so to make the system more organized there's two team. In every team there will be one going for break, two staying, or one going to break, one staying. You give report to your team. You give report to your te ... that way two is like keeping an eye on one side, both sides, right? So it's just really nice. None of the nurse can just say "Oh I'm busy. I can't take that one". No, you're on your team. You should listen to your team.
3ab. So um using that as an example I guess, when that came in and you first heard of it, what tell me about what your your thoughts in in how that led to your learning plan. Like what what were the triggers that and and the things that came to you that that made you think "This is	10ac. I need to understand my patients' conditions.	10aca. Rapid patient deterioration.	Well one thing is um I should know more of of the of my unit, of my one side. Before I just focus on my four four patients, and someone responsibility is their responsibility, right?…I don't just know their their medication, I know what's going to happen to them, what are the procedures today, um what are the tests that

what's going to go in this learning plan".			need to be done, and if patient is like kind of like uh getting sour then I'm getting informed and I'm getting involved.
	11ac. Staying informed about patient conditions is my accountability.	11aca. Research patient conditions	Right now it's because I'm in one side, and I'm the team lead. I have to make sure I'm up to all the patients in my side… And I should be up to my reading and you know educating myself with all the patients I have in one site
	12ac. It is surprising what I can learn and do.	12aca. Patient care	So it means it it's like more knowing more, involving more, and knowing my patients more. I'm not just like focusing four. Like that's a good— and I didn't realize I can I can do that.
	13ac. Learning more helps me to be more involved.		I can be like yeah uh I know the patient, I know the patient. I can tell them with uh even without the nurse around, and uh yeah. It keeps me more, you know, it opens up my mind that hm I can handle all this.
	14ac. I record learning into MyCCP that makes me feel proud.		And I should be involved more, and I learn more of my patients. I get into it more. That's good thing for me. That's why it in my MyCCP.
4ab. I'm I'm curious to as to how you view your own competence related to this learning.	15ac. I investigate what is allowed in my scope of practice when there are changes.		Um actually— how do I view it —uh I would say before since I was just focused on on on a limited number I am now focused on more than what I have so I should be like

			browsing more on what I am allowed and not allowed to do, and I have to be more uh focus and you know,
	16ac. I stay accountable in my scope of practice.	16aca. Ensuring within scope	I like I should I should keep an eye on my accountability on my patients, even not my patients. I have to make sure what I'm doing is like covered but is what is the nursing duty supposed to be so I keep that in mind always, that I'm not going beyond it, I'm not going under it.
	17ac. I am accountable to keep patients safe from harm.	17aca. Accountability to avoid mistakes. 17acaa. Respecting patient rights	Have to make sure I'm into it, and I'm not violating any any of my patients' rights and not doing overdosing and I I mean accountability. I keep I keep track on that.
		18ac. Competence is practice within the legal scope. 18aca. Scope of practice	I make sure what I'm doing is within my scope of my my license. That's how think that's how I think it's affecting me
5ab. I was just wondering what were you thinking when you had to select a nursing practice standard?	19ac. Select nursing practice standards indicator after careful thought.	19aca. Forget what I chose	Oh. What to select ... there is like a list of nursing practice, right? And I always want uh ... I always uh I think twice or three times I choose the uh um ... oh I mentioned it earlier ... about uh accountability I think and uh ... I forget what I choose ... it's about uh enhancing our skills and knowledge and getting up to to whatever is the latest in healthcare system. I think this is the one I choose.

	20ac. Building on knowledge and skills maintains accountability.	20aca. Select workshops	Um number one, there's like uh um more of the workshop being offered to us and and I don't want to be stuck in just one uh knowledge, like just in surgery, okay? So whenever there's like a trauma, there's emerg, there's cardio workshop that's coming, I don't just uh I want make sure I attend to that workshop just to give me more extra knowledge added on my surgery skills. That's that's how I choose it my my accountability I think, just the last one I choose. I I base it on that.
	21ac. To learn, you step out of your comfort zone.	21aca. Learn beyond comfort zone.	Cause I want to learn more. I want to hear more cause if you are just listening and thinking only workshop related to surgery, you know that already. What about if you step out of your comfort zone? Can you can you face it? Can you do accountabilities on that if you don't know that, right?
	22ac. I select workshops to enhance my skills.		So I kind of like do that. Make sure that I I attend some of the workshop, and that's I always choose that is related to that, enhancing my skills.
	23ac. I record workshops in MyCCP.		Cause that's I'm going to put in there anyway. I attended a workshop on

			this, on this, on this, on this.
	24ac. Select the nursing practice standard indicator that is the closest.	24aca. Pick the closest.	And there's a lot of choices in there, and that's the closest.
6ab. Okay so you choose— you've often selected the closest one then?	25ac. Learning activities must match the indicator in MyCCP.		Cause uh the only uh this is what I say the workshop is my way of learning other than the uh one I'm learning from the unit so it's always the workshop I go to.
7ab. And when you say "workshop" what what describe to me what a workshop is.	26ac. Workshops include experts who present case examples.		Okay. Uh they offer a workshop. It means we they invite a speaker. We go attend to that workshop. They will explain. There's a couple of speakers in one workshop. It's it covers the trauma. There's a doctor that covers trauma. There's the nurses that um share experience in trauma, and they will discuss cases. And how it uh deals how they deal with it nowadays compared to before. And how they use like the COACT, how they do it in the in their unit.
	27ac. There is valuable learning in workshops.		Those are two studies so yeah so in every workshop I attend uh some some of it related to surgery some of it not, but I'm learning from it. I'm learning from it so yeah. That's how I uh do it.
8ab. Tell me about um how you attend the workshops. Are they like how do you hear about them and what… What sparks your interest in one	28ac. UNA provides free learning opportunities.		Oh okay. For the workshop um number one source my number one source is the UNA cause they give it for free number one all the members of UNA they

versus another? Um how does it work around your work life, your home life? Like that kind of stuff.			uh offer workshops, and it's free come and attend
	29ac. UNA provides needed learning topics.		So in every posting we attend cause yeah and they kinda give us um the latest kinda education that we need, right?
	30ac. New learning topics are enhancements.		The next is there's other they're other units, the trauma, the EMERG, the cardio uh they send flyers. They put in our unit, and it's the latest that we kinda like it's new to our thing. And if you don't know anything about it or probably we need to enhance, we go to it.
	31ac. Pay out of pocket.		We pay and then we book that kind of workshop.
	32ac. Elearning is available at work.	32aca. Read employer newsletter.	Another thing is we have we are member of uh uh in —whatcha call this one— CARNA, and there is like my learning link something uh so we can go there and explore and study what the latest are that is our computer, right? The my learning link. So in there we go and then whatever is the update, and then we also receive email from from AHS on what is the latest so I if they select it I'll read it we receive newsletter. We dig into it, and then there's a a link that we can go if we want to study more than what we are seeing on the on the email.

	33ac. Private workshops are available.		And there's also private ones that conducts workshop. They send uh brochure to our my my place to my address, and there's a couple for the entire year so I flip and check whatever I want to study there.
	34ac. Paying out of pocket is necessary at times.		It's costly, but [laughter] if I'm interested I go I go to it cause I need to have something to learn, right?
	35ac. Attending learning events depends on day off request approval.		So that's how I that's how the resource, and how it affects my um daily living you said? I always booked it if I'm working, let's say it the date is I'm working I request for a day off and it becomes a study study day.
	36ac. Paid education days cover the time away from the unit at a learning event.		And if I'm off that day, even if I'm off, I go. And if you register it — because we are given three days of education. If I go for my during my day off it will be paid because it's eduation day,
	37ac. Learning events are valuable even if not paid.		but if I run out of education day that will be no pay… But I still go…
	38ac. Friends and socializing are motivating.		Yeah, if I'm interested I still go, especially with my friends [laughter] cause after the workshop it's shopping time [laughter]
9ab. So so how would you say uh, because you mentioned Alberta Health Services and CARNA and UNA and how they have different courses, but tell me	39ac. Nurse educators encourage policy implementation.		Oh uh um for Alberta Health, we have educators that always come to the unit and remind us that there's a new stuff, there's a new thing so uh it keeps us updated, always,

how each of those things really influenced your continuing professional development. Like let's start with um Alberta Health Services, how did they really influence your continuing professional development?			especially if it's uh if it will affect the unit's uh protocols so we are always updated.
	40ac. CARNA does not encourage learning, it mandates it.	40aca. Attend manatory CARNA learning	Um for CARNA uh how it affects if I'm interested, I'm going. They just give us flyers, and since it's since for CARNA uh their requirement is for us to study we have we can't say no. We have at least one of two, right? So we have to go and study. It's part of my license, and for the other part uh it makes me encourage me to attend if I find it like oh I don't know that topic myself on that, especially I'm old school so yea
	41ac. CARNA offers mandated learning, licensing, and learning for interest.		If the topic is interesting, I go attend so those three kinds: the one must learn, the other it's part of my licensing, the other we're not interested by going —
10ab. Do you find any challenges in particular with um with your continuing professional development and your continuing competency?	42ac. Daily challenges	43ac. Staying on my toes every shift	Let's say if you want if you are moving to another unit, it's just another challenge, right? That's a challenge I that's how I thought the challenges to me. Um when you're in a unit, I'm always challenged with the different cases, different

			patients. That that's my challenge so like the day is not the same like every time you go there's I have to be like on my toes and be challenge —I know it's the same day, and I don't want any problem, any mistake that I do today so that's a challenge already to me. That's yeah. I have to be up on my toes every every shift that I go.
		44ac. Avoiding mistakes	
		45ac. Changes in the workplace are challenging	
11ab. And um can you tell me a little bit more about when you're on the unit and and you have something new that comes about can you can you tell me what that's like in terms of what are you thinking when that new thing happens and you know you need to do some you know professional development to become competent or increase your competence or however you view that?	46ac. Daily studying for effective patient care		Every time I'm given an assignment and I see a patient that has something I don't know and something that I um I have to study this what is let's say a different kind of a comorbidity I think for surgery. So this patient has this. Okay what is that?
		47ac. Complex medical cases drive learning	
	48ac. The first step in learning is asking your colleagues	49ac. Online resources provide information 49aca. Ask colleagues 49acac. Internet search	Um my resource is I ask any one of you like my colleagues have they encountered this? If none of them knows they say "no, never". Best resource is I go straight to Google just

			to get an idea, "okay, what is this? What is that?"
	50ac. The nurse educator assists nurses to study their patient cases.	50aca. Educator provided	And then I go to medical some —you know in the computer to medical thing uh I ask the educator just to know what it is, and sometimes there is an order to do something and I don't know how to do it. I always call the educator, and I have to search what it is and then we always have to protocols you know the AHS protocols go through it, study it, cause I'm not going to do things something that I don't know. I have to dig into it before I do it.
	51ac. Must be knowledgeable before providing patient care.		
	52ac. Being knowledgeable protects patients and staff.		And if it's even if I'm not going to do it —it's just uh the patient has it. I have to know what it is. It might be contagious. You don't know, right? So study it. I read into the uh internet and our protocols too and sometimes the uh manager they encountered it before too. So I ask I I search my resources. I have to make sure I know —
		53ac. Always ask your colleagues.	
	54ac. Managers, internet, nurse educators and colleagues are the most important knowledge resources.		
	55ac. Nurse educators “show how” and “do for” in terms of		If if the nursing educator, let's say my last resource is my

	researching patient care information		nursing educator and they said oh that's something new let's search on that and now my nurse educator is the one searching for it and making sure I got the answer —
	56ac. Nurse educators provide moral support and boost confidence.	57ac. Nurse educators ensure safety.	Cause if I don't know it how am I gonna do it? So they'll be helping you with the search on it, and then they make sure that they present it to you, you understand, you know what to do. And then if you're not confident doing it they will stay and help you stay with you and doing it.
	58ac. Nurses stand by to support each other		And then the next time that thing happen, I will be the next resource.
	59ac. Every nurse is a learner and a teacher	59aca. Peer colleagues	Let's say there's another nurse: "Oh I have this thing and uh I don't know how to do it" "Oh, I've done that with Linda". Let's say I with Linda, the educator. "I've done it with Linda, and this is how we did it", and then I'm gonna be a resource. And then I teach them. and it's always nice that you learn something, and then you pass it on. You know you're gonna gonna come. It might not be tomorrow or the next day, but it will come in the next coming days, right? So yeah—
12ab. Do you find that that's like what what's the best learning situation for you?	60ac. Showing is best learning.	60aca. Observe and try	Uh for me, my my best learning is to show it to me. Show it to me, and it will print in my mind like a Xerox copy [laughter]. It's in there,

			but if you like explain it to me blah blah blah I'm not taking the picture.
			Yeah while you're saying it, show it to me, and the less you talk, the more you do, the more I understand. That that's my learning.
	61ac. Senior nurses have valuable knowledge to share	61aca. Senior nurses teach	This is some techniques also, you know? When they say that insert NG. Okay, it's easy to insert NG, but some nurses they have their own technique. How to insert really easy, less painful for the patient, less discomfort. That's what you want to learn, the skills of the senior nurses, the skills of the other nurses cause you might be doing it differently that's why the patient is "Ah it's all bleeding now".
	62ac. Senior nurses teach improved methods of nursing care.		
	63ac. Nurses model effective techniques	63aca. New clinical techniques. 63acac. Building new knowledge/skills	Like I must be doing wrong something wrong so if someone can show it to me and I learn how they do it and the patient is comfortable I'll start doing what the other nurses do. It's more of techniques, right? And that's what I learn want to learn from the other nurses.
	64ac. Nurses improve on each others' practices		
13ab. Have you noticed that that there's been a lot of change in your in your work? Um in	65ac. International nursing is very different from Canadian nursing.		Uh I been nursing for it's hard to compare because I work back home for five years, and

particular and like how do you think you have been able to cope with all the learning related to that change to this point?			it's totally different from here, okay?
	66ac. The system determines the practice.		But since there's a new system I have to follow the system so I have to do the system. Not my way, but the system way.
14ab. Like how did—what was that [change] process like. Do you remember?	67ac. I adjust my practice to accomplish tasks as designed by the organization instead of making my own choices in my practice.	67aca. Unit resources	Yeah, be-before they would say "Oh, discharge your patient. It's up to you how to discharge your patient". Um there were even no no pamphlets to give before. You just do your own verbal, and what where where I get my information I go to the uh my learning link and let's say the patient is post-op uh laparotomy I I pop up the laparotomy, I read whatever teaching I need to read, I put in my head, and I go to the patient and I explain to the patient. Um I think or probably there's already been lingo I was not using because I was not I was not given uh a step by step. I do it on my my my own my own way so and on my own way I explain, I give the uh prescription, I I give the followup, and I ask I have followup patient if he understands, he knows where to go if in case of uh infection or something um That's how it's all verbal, right? And now then they said, "Oh we

			have a new protocol in discharging patient. You have this list that you need to follow and let them sign, you sign, we're documented". Uh okay. So now in every discharge we have a form that we need to sign, we have to follow step by step by step and we have to make sure all the papers that they need all together clip in and discharge summary, our teaching pamphlets, our uh the prescription and the followup, and everything that I explained. There's a take chart, there's a know take box, and make sure that they will it be good for them and they understand. They sign, I sign.
	68ac. Standardized practices ensure steps in the process are completed.		Yes, it is. So the discharge is not a rush rush. Before when the patient knows that they're going home they're like right away "I want to go home now" *clap hands*. You have to rush and there's uh I think I believe there's a lot of like left behind something and then when they're they already home they realize "Oh I don't know what to do with blah blah". And they start calling uh unit. They're already discharged. I can give you a help teaching over the phone. So you eradicate all that. That's an additional. That right now I would say none

			of my our patients calling back, having problem when reaching home in how to manage their surgery, which is really nice. It's really nice.
15ab. So just tell me, any last thoughts on on what you feel really influences you in in terms of your personal life, your own self, uh your own drives um Alberta Health Services, your employer, UNA, CARNA, anything in terms of final thoughts in terms of what do you think influences your continuing professional development learning?	69ac. CARNA ensures I maintain my license.	70ac. CARNA does not motivate learning.	Um how they influence me ... I ... I think I am more influenced by my patient than by CARNA and it's it's yes it is part of my license. Yes, it is part of my unit's uh requirement, but it's more on uh what I can deliver to my patient.
	71ac. I am motivated to learn to deliver safe, effective nursing care.	71aca. Patient care driven	Sometimes the patient's like showing me a different kind of problem. That that's the one encouraging to study more. Let's say this patient has this and sometimes it pops it in my head, "Oh, how am I gonna avoid this kind of thing? Okay, I need to learn all this".
	72ac. CARNA and AHS enforce learning.	72aca. Filling knowledge gaps for patient care. 72acac. It is a robot thing. 72acaca. Learning activities for the sake of reporting. 73ac. Personal goals drive learning rather than CARNA.	Uh the CARNA and AHS is kind of like a kind of like a robot thing. It's right there in your head that you have to do it, right? So yeah I have to get a workshop, yes I have to follow the what educator's telling me that I will learn. But it's an automatic thing that I need to do, but more behind behind my my head is if I encounter a patient and it catch my interest,

			that's the one that encourage me to like "Okay. I need to further study this. Interesting. How I will avoid this, or um how are they managing this? How did she get this?". That's that's the one that you know is influencing me more cause CARNA it's there. It's just take a workshop you you have to learn this kind of thing. The the unit you have to learn this kind of thing, right? It's it's in there. You have to do it. Like it or not you have to do it, right?

Appendix 4O Miss M.-Second Level Analysis

Table 43. Miss M.-Second level of analysis

First level analysis	Second level analysis
1bc. MyCCP learning goals correlate to health issues occurring in society. 2bc. Seeking learning sources must match learning goals 3bc. MyCCP records learning activities related to the learning objectives.	1bd. MyCCP directs learning goals.
4bc. Patients and families provide feedback 5bc. Managers do not provide evaluations or formal feedback unless asked to. 6bc. Thank-you cards provide feedback. 7bc. Constructive feedback is desirable. 8bc. Feedback from colleagues and employers is important.	2bd. Inadequate feedback.
9bc. Self-reflection may be a kind of feedback. 16bc. Learning provides new perspectives. 17bc. Self-reflection reveals weaknesses. 20bc. Creating a learning plan requires reflection. 34bc. Reflection on practice informs where to improve	3bd. Reflection is a learning starting point.
10bc. UNA workshops may be informative 13bc. AHS provides free elearning. 30bc. UNA supports learning. 31bc. UNA arranges funding and paid time off for learning.	4bd. UNA provides and supports learning.
11bc. Paperwork for funding is a burden. 12bc. Waiting for funding	5bd. Funding is an obstacle.
14bc. AHS promotes learning topics 27bc. AHS data informs learning requirements. 28bc. Learning to improve quality improves patient outcomes.	6bd. AHS directs learning topics
15bc. Colleagues model good practice. 33bc. Learning from others' mistakes 26bc. Continuing professional development is generally regarded as necessary and valuable.	7bd. Colleagues motivate learning though positive and negative modeling
19bc. Practice standards indicators are straightforward. 22bc. Practice standards indicators apply to nursing scope of practice. 36bc. The practice standards are ingrained from undergraduate learning.	8bd. Practice standards indicators are fundamental knowledge.
21bc. Changes in career motivate learning plans. 18bc. Professional development preferences change year over year. 23bc. Full scope of practice goes beyond bedside nursing care. 24bc. Nurses are challenged to become leaders.	9bd. Career progressions drives learning.

25bc. Leadership requires complex skills and knowledge.	
32bc. Day to day activities are the motivation for professional development.	10bd. Daily work necessitates learning.
35bc. Regulation is important to ensure standards of practice are met. 37bc. CARNA publishes reprimands of members. 38bc. Conduct matters are sometimes ridiculous. 29bc. CARNA does not influence learning.	11bd. CARNA enforces rather than inspires learning.

Appendix 4P Miss M.-First Level Analysis

Table 44. Miss M.-First level of analysis

1ba. Explain to me, you know, what you, what made you, ahh, input the different things that are in there and, and what were you thinking at the time and, and how does this correlate to your actual work.	1bc. MyCCP learning goals correlate to health issues occurring in society.	1bcb. Pain management goal. 1bcbc. Noticing affects of patient care. 1bcbcb. Make relevant to practice.	Uhhhmm…just see…I think my…goal was…pain management…pain control in patients with opioid dependency or tolerancy. So, obviously it's, it's, it's a big issue, like, ahhh, we get so many people that have abused or misused narcotics. And once, once they get to hospital, ummm you know, sometime the hospitalists or the residents they just, you know, do Dilaudid two mg, or something, for their pain control, which is obviously… not sufficient. So, umm, as well they're a little bit more hyper-sensitive to a lot of things, so they experience more pain
2ba. What, what would be your plan in, in, umm, filling out your profile?	2bc. Seeking learning sources must match learning goals	2bcb. Review articles 2bcbc. Required to add more.	So, so far, umm, all I've done is review a couple articles, uhmm, I might, I might check on "my learning link", to see if there's any more, uhmm, modules to kind of, directed at, like, clinical staff, to see, ahh… to see if there's anything more but, like, this year there wasn't a whole lot workshop-wise for pain control, so that's not included.
3ba. Yeah, exactly, how, how would you, umm, complete this profile?	3bc. MyCCP records learning activities related to the learning objectives.	3bcb. Summarize learning activities.	Complete this profile? Yeah, umm, I'd probably just look at, ahhh, a

		3bcbc. Gained insights from learning activities.	couple more articles, maybe do another online module and just kinda summarize, kinda, what I've learned and… what kind of insights I've gained from, from everything and what I can take forward into the next year.
4ba. Yeah, umm, so what would you put in, in that [feedback] area?	4bc. Patients and families provide feedback	4bcb. Patient 4bcbc. Family	Uhmm, a lot of, a lot of years I just do patient or family feedback
	5bc. Managers do not provide evaluations or formal feedback unless asked to.	5bcb. Manager	I don't think I've ever had a official evaluation by any of my managers, which does make it a little bit more difficult to do manager input but if, uhmm, like you know, a manag, a manager has pulled me aside and just, you know, said, you know, you're doing good at this or, you know, umm, you know, we've had really good feedback about you then I'll put it in, or
	6bc. Thank you cards provide feedback.	6bcb. Thank you card	if I get a, umm, card or something from a patient I'll include that. Yeah, so… this year I must just have to ask one of the managers to provide some feedback, since I don't have anything written… I'll just have to just ask.
5ba. What are... can you tell me a little bit more about feedback and, and, uhh, how that intersects with your, your learning?	7bc. Constructive feedback is desirable.		Hmm, ah, well, most of the time it is constructive, hopefully it is for everyone.

	8bc. Feedback from colleagues and employers is important.	8bcb. Colleagues	Uhmm, I, I think feedback, umm, it does, it does matter, ahhh, from colleagues and… patient and managers and such.
	9bc. Self-reflection may be a kind of feedback.		Umm, I think a lot of people… they, they do self-reflection too, umm, based on their interactions with patients and umm… kind of their reactions and, uhh, whaa, what kind of relationship you're building with your patient, so I think a lot of people just do self-reflection and kind of go on that just to, umm, refine their performance.
6ba. And umm, other learning activities, do you generally find that you add to this section … And if you, you did, what would you think you'd put there?	10bc. UNA workshops may be informative	10bcb. UNA workshop	Umm well, this year, umm, this one was a free UNA workshop, umm, by Barb Bancroft, umm, so I always go to those ones…umm… 'cause they're always quite informative…
	11bc. Paperwork for funding is a burden.		Umm, a lot, a lot of times the paperwork it involves to get funding for education is quite cumbersome…
	12bc. Waiting for funding		… and it takes a couple of weeks to to get paid for it umm, when you apply for it. So that's obviously a barrier sometimes.
	13bc. AHS provides free elearning.		Ahumm, yeah, but besides that, umm, a lot of this is, umm, through "my learning link".
	14bc. AHS promotes learning topics	14bcb. Quality improvement	This year, umm, a lot of emphasis had been put on quality improvement (banging on table)…so I kind of…focused on that.

7ba. So what you, you mentioned that you were thinking of process improvement as one of the corporate kind of initiatives, were, what, what other, umm, motivations were there in selecting some of these other ones?			Umm, ahh, well, right now I have patient and family-centered care, um, I think, ahh, it, it, that is kind of like an AHS initiative as well, I suppose, right.
8ba. Your own initiative versus where, where else do you think you may have been influenced from?	15bc. Colleagues model good practice.	16bc. Learning provides new perspectives. 16bcb. Insight from other perspectives	Well you know, I've, I've seen some really good examples of people… out, out there on the floor that have had really good, umm, communication skills, especially when it comes to, like, conflict management and stuff like that, that's, like, that's an area that everyone struggles with, right? But, umm, I think, uhh, yeah I think as, umm, I, I think when you go through these courses you kind of… get a different perspective, right, on these things so it does make it easier for me to deal with these situations as well.
	17bc. Self-reflection reveals weaknesses.	17bcb. Identify weak point	I think coming out of university, that was, umm, that was yeah, seven years ago, that was one area that was really difficult for me just 'cause I was really introverted and mmm, you know, had a, had a difficult time connecting with patients. So, you know, it's something that I've kind of always been… umm... I've,

			I've kind of identified it as a, a weak point in… umm… personality I guess.
	18bc. Professional development preferences change year over year.	18bcb. Understand learning trajectory.	I probably, the last couple of years it's been more, kind of like, clinical, medical perspectives that I've been making learning objectives. I think I've had enough of that for now, and I think I'll kind of focus on this ki…, this sort of…umm… this kin…this sort of, like, nurse, nursing patient communication issue.
9ba. Indicator and such. Umm, if we can't get in to there, that's ok, I was just wondering how would you have selected a practice indicator and, or maybe you can even speak to, umm, how you've previously selected that sort of thing.	19bc. Practice standards indicators are straightforward.	19bcb. Basic	I don't remember what all the indicator are anymore…so…these ones are all pretty straight forward, hey?
	20bc. Creating a learning plan requires reflection.	20bcb. Making learning plan meaningful 20bcbc. Extract meaning from simplistic indicators.	Umm… what I would do… mmmm (long pause) most of them are kind of… a given, mmm (long pause). I feel like a lot of things, like, and little things you can work on… but I don't know if I would make a, like… a learning plan on anything in particular (chair moving). Like, I could make a plan on quality improvement, I could make a learning plan on, umm… on collaborating with clients and stuff.

			Yeah. Hmmm, but I think those are, kind of, minor refinements. (long pause). Hmm. (long pause) I'll have to think about it. Is that ok?
	21bc. Changes in career motivate learning plans.	21bcb. Based on career progression.	Umm, like, right now since I've entered into a new role, umm, it, I'll probably, it, it was, it's been a, quite a learning curve, so whatever indicator I select it'll probably be something relating to, umm, going from bedside maybe to more full scope nursing. Umm, before I was, umm, pretty much causal and floating, so it's, it's been a, it's been a big leap. Umm, so I, I would, if there was something to, kind of, reflect that inda, indicator I would probably select that, kind of, working within full scope of practice or transitioning, umm, something that kind of reflects that.
	22bc. Practice standards indicators apply to nursing scope of practice.	22bcb. Full scope of practice.	Umm, so I, I would, if there was something to, kind of, reflect that inda, indicator I would probably select that, kind of, working within full scope of practice or transitioning, umm, something that kind of reflects that.
10ba. Tell me more about what you mean by full scope, scope nursing.	23bc. Full scope of practice goes beyond bedside nursing care.		Umm, so, right now, I think, umm, well in the orthopedics department anyway, they're, they want to move nurses away from, well, what they have traditionally done into more

			leadership roles. So, umm, instead of just doing, just doing bedside nursing, umm, I think which they believe, uhh, umm, well it's important too but they also want, instead of having a charge nurse at the desk they want us to be, umm, you know, making all the discharge planning, talking with the doctors, umm, organizing everything in that way but, everything that a charge nurse does but while working, umm, directly at the bedside with the patient.
	24bc. Nurses are challenged to become leaders.	24bcb. Leadership initiatives	Yeah, I think the main thing is bringing RNs up a level into leadership roles… I think it will be a, a big challenge for, for a lot of people.
11ba. Yeah. Umm, and so… what do you mean by challenge, can you tell me a little bit more about that?	25bc. Leadership requires complex skills and knowledge.		Umm, a lot of people, uhhhm, I think they'll have time, difficulties with, ahh, organization, umm, continuity of care, umm, the communication, that sort of thing. Um, a lot of people are not used to that role, umm, usually a select number of people on the unit, ahh, more experience staff, umm, end up in the charge nurse role so they're, they're used to doing that organizing all that, umm, and when only one person is doing all the organizing and discharging, well it

			ensures that… ahh, every, everything is done and they know exactly what's going on. Umm, but, if you have multiple people on multiple shifts, kind of, trying to organizing everything for the patient, umm, I think, I think it would, ahh, be a little bit more difficult. The straight forward case is probably ok but you know, when you need more complex social services or long term care or the referrals, I think it would be, ahh, more of a challenge.
12ba. Hmm. Hmm. Umm, in what you've just told me, do you, do you feel that there is going to be… or there is influence on continuing professional development, and, and, umm, what, what do you think your view point is on.	26bc. Continuing professional development is generally regarded as necessary and valuable.		Umm, well, continuing development, I, uhh, I think there always has been an emphasis on it, umm, I don't know if people partake in it enthusiastically on the most part, umm… ahh… but I think, I think it's something that peoples will kind of view as necessary as they start, they'll probably have to do a lot of… upgrading in a lot of areas, so, umm, I think they'll see it, see it as a valuable tool definitely.
13ba. And, umm, I was wondering if you could just talk a little bit more about how your employer, uh, influences your continuing professional development.	27bc. AHS data informs learning requirements.	28bc. Learning to improve quality improves patient outcomes. 28bcb. Data driven	Uhh, well, I think, umm, AHS does collect a lot of data regarding, umm, readmission rates, infection rates, umm, patient satisfaction and based on that… they, umm, they identify areas that we could potentially improve on, umm, specifically right now it's, it's patient experience and, umm, ahh, you know, emergency room times, readmission rates and such like that. Umm… not, not

			only to reduce costs but to improve patient care outcomes. So… umm, I, I think, base, based on the data and the analysis they come up with, ahh, these… these focus points.
14ba. And, and, what about, umm, the union, and how does that play in, union, CARNA some of those other entities in your life.	29bc. CARNA does not influence learning.		Aaah, ooh, CARNA, ehh, not so much [laugh].
	30bc. UNA supports learning.		But, umm, UNA, UNA does provide quite a supportive role.
	31bc. UNA arranges funding and paid time off for learning.		They, they, ensure that we, we, umm, we, uhaa, that we are ent…they make us know that we are, we are, enti…entitled to, umm, ahh, funding for education, umm, en, en, entitled to days off for it and what not. And they do provide some, some funding as well, if you attend the union meetings they'll, umm, they'll fund a workshop in, out of the city, or out of the province somewhere, so, it's, it's helpful. I've never attended myself, but yeah. They make it known.
15ba. Good! Good, and so, umm, how have your interactions with UNA, like, I, I guess I'm trying to see where the intersection is that, that helps you to feel motivated or encouraged, or, or even just plants that seed in you to, to,	32bc. Day to day activities are the motivation for professional development.	15bab. Daily activities.	I think it's based on [long pause] kind of—day to day activities really.

umm, pursue a particular type of education			
	33bc. Learning from others' mistakes	33bcb. Observe others' mistakes	Umm. A lot of times it's, it's when you see people doing things that (laugh) they really shouldn't be.
	34bc. Reflection on practice informs where to improve	34bcb. How I could have done better.	And you, you think that, oh this could be done better or I could probably have done that a little bit better, umm, stuff like that, umm… ahh… especially when it comes to patient safety and stuff like that, so—
16ba. Umm, and tell me more about CARNA. I know that you, your, you kinda said well they're [cross-talk].	35bc. Regulation is important to ensure standards of practice are met.		They're, they're, they… well, we need regulation, obviously, umm, because, like, we take care of vulnerable people and they want to make sure that... we, like, we have certain standards of practice, so that's, that's all very important.
	36bc. The practice standards are ingrained from undergraduate learning.		Uhh, day to day practice I don't think I'm influenced by them so much. Umm, I think it's ingrained in us when we're students of what's expected and what's appropriate behaviour, umm, and we probably go through all the manuals and standards and ethics… that CARNA, ahh, outlines, so, I mean, it's like, we all know that.
	37bc. CARNA publishes reprimands of members.	37bcb. Read CARNA magazine.	Umm, I mean, when you read the CARNA magan, magazines you kind of see what people are, kind of, being reprimanded for.

	38bc. Conduct matters are sometimes ridiculous.		Umm, some of it's quite ridiculous (laugh)… ahh, or outrageous, ahh.

Appendix 4Q Focus Group One-Second Level Analysis

Table 45. Focus Group 1-Second level of analysis

First level analysis	Second level analysis
58y. Nurses can enter nonsensical information into MyCCP. 1a. Pick an indicator randomly and make it fit. 3a. The practice standard indicator is not memorable. 6y. CARNA reporting processes are necessary but not relevant to nurses. 69y. Nurses can and often do misinform their MyCCP reports. 17y. Some nurses will report their certification learning as their continuing competence which is not correct. 62y. Reflection cannot be easily expressed in MyCCP reports. 85y. Nurses fulfill their obligations to CARNA only when they have to. 86y. Nurses band together to bemoan their experience of MyCCP reporting.	1d. Nurses do not report their continuing competence auther
117y. MyCCP reporting should be avoided until absolutely necessary. 1y. CARNA processes are agonizing and unnecessary. 123y. There is absolutely no one who thinks positively of CARNA. 122y. Even community health nurses do not see value in CARNA. 108y. CARNA is not required nor wanted. 87y. MyCCP is a “headache” and nothing more. 109y. CARNA should simply be eliminated. 67y. CARNA reporting is a burden and meaningless. 124y. It would be shocking to think of anyone positively approving of CARNA.	2d. CARNA is a negative presence.
110y. CARNA is not successful in protecting patients. 114y. CARNA inconveniently charges membership money. 115y. CARNA membership fees are a hardship for families.	3d. CARNA causes hardship.
116y. Paying the membership fee is not as bad as the MyCCP reporting. 119y. MyCCP reporting does not detect incompetence.	4d. CARNA is incompetent.

113y. CARNA's reporting systems are unstable. 4y. You don't learn anything related to practice standard indicator selection and learning activity selection. 2a. The associated learning activities are not meaningful. 111y. CARNA processes are ineffective to fulfill their mandate. 57y. CARNA does not use the data that nurses are mandated to enter. 120y. CARNA processes were contrived by people who do not know nursing or patient care.	
5y. It would be easier to allow learning to occur naturally and report it after. 5a. A retroactive reporting process avoids faking or inadequate learning choices. 7y. A points system of monitoring learning would make nursing capabilities more homogenous. 118y. MyCCP should be quick and easy. 112y. CARNA would be more meaningful if they were an advocate for nurses.	5d. MyCCP design doesn't consider experiential learning.
8y. Meeting MyCCP reporting requirements gives the wrong message of learning requirements. 3y. Proof of education could be more meaningful if it had more structure. 6a. The MyCCP learning requirements do not reflect what learning is actually needed in nursing practice. 53y. CARNA MyCCP is asinine considering the reality of actual learning.	6d. MyCCP could be made more meaningful.
9y. Social interactions are important learning influences. 10y. Peers encourage learning. 11y. Nurses will pay out of pocket to attend learning events recommended by their peers. 12y. Peer pressure is not a factor to influence learning initiatives.	7d. Peers encourage learning.
7a. Nurses are motivated to learn for their own reasons. 13y. Some nurses are internally driven and others are not. 16y. Some nurses never go to learning events and are plainly not interested. 22y. Regardless of the incentive, nurses are either motivated or they are not.	8d. The motivation to learn varies greatly.

14y. Managers encourage learning through posters promotions. 33y. Promotion of learning events is part of the managers' job and part of the normal unit routine.	9d. It is part of the managers' job to promote learning.
25y. Managers are responsible for ensuring nurses receive their paid education days. 30y. If there is a high-demand for access to an activity, Managers may deny requests. 31y. Frequency and numbers of requests for education support varies but could be up to 3 requests per month. 10a. There are new structured learning opportunities monthly. 2y. Managers monitor learning activities.	10d. Managers are responsible for providing access to educa
15y. Managers make difficult decisions to decline approvals when numbers are at maximum. 26y. Nurses select the activity they want to attend and seek approval from the manager. 8a. Managers could face grievances. 27y. It is rare for nurses to grieve the manager's decision to deny education leave. 70y. Managers are responsible for competence and incompetence.	11d. Managers are the gatekeepers of learning.
18y. Financial support and paid time off is an incentive. 29y. Fees associated with learning events are covered out of pocket or by application to the union. 19y. The employer does not have a role in promoting learning, rather it is the union. 24y. RNs are entitled-if they choose- to three paid days off for learning. 23y. RNs are lucky to have union-negotiated benefits for learning unlike other nursing professions. 101y. The paid time off is a value-add to CARNA learning plans.	12d. UNA is a key supporter of nurse education.
21y. Essential clinical learning in the workplace is popular but difficult to let people go from the unit. 20y. It is a hassle for managers to send nurses to learning events due to scheduling constraints.	13d. Managers must prioritize operations.

28y. Nurses are encouraged to attend learning events on their days off and they get reimbursed for their time attending. 9a. It is preferred that nurses attend when it does not interrupt the work schedule. 32y. The primary concern of the manager regarding education requests is ensuring they have enough staff to cover the unit. 34y. Operational requirements are priority. 94y. Scheduling learning sessions is the greatest challenge. 95y. Scheduling learning events is highly complex considering unit coverage, numbers of nurses and shifts.	
41y. Quality huddles are group discussions to address errors and issues. 38y. Nurses are accountable to meet other health disciplines' requirements. 39y. Interdisciplinary experts may speak to nurses during 10-minute huddles on the unit.	14d. Quick, frequent, in situ meetings help disseminate new
35y. Nurses rely on interdisciplinary expertise. 11a. Nurses apply interdisciplinary expertise into their practice. 36y. Nurses learn from experts in other health disciplines. 37y. Interdisciplinary learning is often spontaneous and informal on the units.	15d. Learning opportunities are interdisciplinary.
42y. Huddles do not reach all nursing staff. 40y. Ten-minute required daily huddles depends on workload. 43y. Reliance on peer to peer information dissemination. 12a. Nursing staff do not receive new information together due to complex scheduling. 44y. Managers hope to reach 80% of nurses with new information. 13a. It is impossible to catch everyone. 74y. It is impossible for Managers to understand the competence of 30 nurse team members. 96y. Managers have difficulty tracking the various clinical skills of the nurses in their teams. 97y. It is an onerous amount of work to monitor nurses clinical competencies.	16d. Managers are overwhelmed with numbers of staff to monitor and support competence.

45y. Administrative schemes are not informed by front-line nurses. 47y. Administrative schemes add complexity to previously functioning workflows. 48y. Structured communication designed by administration adds demands to the workload. 15a. Constant new processes and policies drive learning. 88y. New legislation will be another struggle to add to the pile. 89y. New policy and skills implementation requires significant resources and effort. 91y. Increasing nursing scope has a heavy impact on workload and scheduling.	17d. Administrative implementations add to workload.
49y. Managers are accountable to administrative schemes/strategies. 14a. Managers must learn, disseminate, and teach new administrative schemes/strategies. 72y. Managers must ensure new policies and procedures are well-understood and followed.	18d. Nurse managers accountable for change management.
50y. Nurses are resistant to changes in clinical care and routines. 46y. Administrative schemes/strategies impact work culture.	19d. Change increases nurse resistance.
51y. CARNA processes are moot because learning is continuous. 52y. Nurses must constantly learn to be effective. 1y. Proving learning is unnecessary.	20d. Learning is ingrained in nursing practice.
54y. MyCCP is not understandable especially for internationally educated nurses. 55y. Nurses do not report appropriately in MyCCP because they do not understand the language. 56y. Many nurses would benefit from plain language in CARNA processes.	21d. CARNA's processes are not understood.
59y. CARNA's requirements for one learning activity is not an indication of competence when they must learn far more than that on a daily basis. 61y. A once-per-year reflection and a single learning plan does not indicate competence. 63y. CARNA's view of competence is not realistic.	22d. CARNA insidiously undermines the meaning of compe

64y. Competence is the common sense, skills, thought process, critical thinking and ongoing practice. 18a. Reading articles do not make a nurse competent. 17a. Practice indicators do not indicate competence.	
66y. Reflection is reflexive in the learning process. 16a. Reflection is ongoing in practice. 68y. Staying competent is constantly questioning practice. 65y. Peer to peer learning and feedback advances competence.	23d. Reflection is embedded in the process of learning.
77y. Incompetence is evidenced by poor nursing practice 71y. Managers must recognize incompetence and correct safety concerns. 76y. Incompetence is difficult to hide. 80y. Managers are well aware of those who are incompetent 60y. Competency problems are fixed by managers and educators, not CARNA. 81y. Nurses are honest and admit their errors. 82y. Most nurses are honest about reporting errors.	24d. Incompetence is hidden in plain sight. (not addressed but everyone knows it is there) knowingly tolerated. Collusion.
73y. Managers provide the initial education and resources and nurses are accountable following. 19a. Managers activate peer to peer learning. 75y. Peer to peer learning works well and managers monitor. 78y. Peers note incompetence. 79y. Nursing team members take accountability for competence of their peers. 83y. Nurses are committed to help each other rather than influenced by CARNA.	25d. Competence is a shared accountability. (peers, managers, co-workers maintain the competence of ea
92y. Managers must monitor particular clinical skills that must be recertified yearly. 93y. Skills are specific to the area of nursing and competency in these are monitored by managers. 90y. It is advantageous to increase nursing scope. 84y. There are diverse learning needs. 121y. Different areas of nursing have different education requirements.	26d. Learning requirements are unique to each nurse.

98y. Individuals must be accountable for themselves.	
102y. Nurses have personal reasons but are more motivated if it is a social event. 103y. Nurses pursue learning for their personal, professional and social needs. 107y. Nurses mostly think of professional development as personal growth. 104y. Nurses learn in order to advance their careers. 99y. The nurses who are focused on improving patient care are the ones driven to continually learn. 100y. Personal interest in the learning topic is a motivator	27d. Nurses have personal reasons for learning.
105y. Managers look for ongoing professional development and learning when screening and interviewing candidates. 106y. Showing you are motivated to learn is a desired nurse quality in recruitment.	28d. Managers value nurses who are motivated to learn.

Appendix 4R-Focus Group 1 First Level Analysis

Table 46. Focus group 1-First level of analysis

Questions	Major Theme	Sub Themes	Key Comments
1x. Recording started mid conversation.	1y. CARNA processes are agonizing and unnecessary.		LADY IMPORT…the process and especially the senior nurses who are not computer savvy, it's painful for these poor people to try and get through that process and complete that indicator when I know they're going to four in-services this year.
	2y. Managers monitor learning activities.		LADY IMPORT And we know, we know which staff haven't taken any in-services, we know which haven't gone to any conferences…Cause we have to approve… So it's, as a manager you're able to track that, as a manager as well.
	3y. Proof of education could be more meaningful if it had more structure.		BABY DOLL: I feel like, have you guys ever looked into the CNA certification? BABY DOLL: That process I agree with, maybe not the amount of hours that the you have to get in the five years, but you have to have a certain amount of hours to prove that you've furthered your education in order to keep your CNA certification after you've passed the exam or whatever. Umm, that I could see being beneficial because it forces people to actually seek out educational opportunities and actually go to these things rather than just picking a random goal of what you think you're gonna—
	4y. You don't learn anything related to practice standard indicator selection and	1a. Pick an indicator randomly and make it fit.	BABY DOLL: I have no idea of what mine is for this year. MR J.: Yeah, me neither.

	learning activity selection.	2a. The associated learning activities are not meaningful. 3a. The practice standard indicator is not memorable.	LADY IMPORT: (cross talk) I can't remember. BABY DOLL: (cross talk) I don't remember what I picked last September. MR J.: Nope. BABY DOLL: (cross talk, laughing) And I have not been working towards it BABY DOLL: because I don't remember it BABY DOLL: 'cause I just picked a, a… item out of a list and I said I'll make it fit later. LADY IMPORT: Exactly. LADY IMPORT: Or, or you say you're going to read a certain article. Well if I read that in September I'm not gonna remember it by January, chances are. LADY IMPORT: So, you're not, I don't, you're not really learning anything [inaudible] (chair creaking). BABY DOLL: No.
	5y. It would be easier to allow learning to occur naturally and report it after.	4a. Let me tell you what I did instead of report on what I planned to do. It is a set up for a broken promise.	LADY IMPORT: 'Cause you don't know what's gonna come up throughout the year, you don't know what conferences are gonna come up, you don't know what new skills you're (overhead page) going to have to learn for your area. ML: Right. LADY IMPORT: So that comes up later, so it's LADY IMPORT: almost instead of having me pick an indicator, just have me tell you what I did. ML: Right. BABY DOLL: (cross talk) Have it be a requirement. LADY IMPORT: 'cause then I know, Ok I did this, this and

			this this year, here's the proof, thank you very much. LADY IMPORT: It just makes more sense LADY IMPORT: to me to do it that way.
2x. ML: So the CARNA, it's what I'm hearing, just, ah, to put it all together is the CARNA influence is, is relatively minor, the, the, the, ahh, getting through the process of the online, umm, program is just a matter of I've gotta get to my registration and LADY IMPORT: Mhmm. ML: I've gotta pick an indicator just 'cause I gotta get through this but MR J.: Mhmm. ML: not, umm, if, if, correct me if I'm wrong, but it's not necessarily meaningful in terms of what they actually feel, ah, about their education.	6y. CARNA reporting processes are necessary but not relevant to nurses.		MR J.: Correct. ML: Is that what you were sa, what you were [inaudible] saying? MR J.: That's exactly [inaudible] BABY DOLL: Ya, you do it because you want to keep your license and this is what you have to do. MR J.: Ya. BABY DOLL: That's it. ML: Right, right. LADY IMPORT: And it's not where your passion is, it's not where your drive is LADY IMPORT: 'cause you'll figure that out throughout the year LADY IMPORT: as to what you need. LADY IMPORT: So.
	7y. A points system of monitoring learning would make nursing capabilities more homogenous.	5a. A retroactive reporting process avoids faking or inadequate learning choices.	BABY DOLL: And I feel like if it was based on amount of hours, like the CNA, then people like long-term care, if they work in long-term care or other facilities, would be… more… forced to actually further their education 'cause we get them here and they're (long pause)

			ML: Hmm. BABY DOLL: not as advanced. (laugh) ML: I see, yeah. BABY DOLL: Because they're just kind of stagnant in their… MR J.: Lack of opportunities, and, yeah. ML: Right. Right. LADY IMPORT: But again, if they were forced to just prove oh I went to this and I learned this this year. LADY IMPORT: This is what I did, it just makes more sense than saying oh, I'm going to read this article and then I'm done.
	8y. Meeting MyCCP reporting requirements gives the wrong message of learning requirements.	6a. The MyCCP learning requirements do not reflect what learning is actually needed in nursing practice.	LADY IMPORT: It may, almost give them a false sense of security in a way, maybe. LADY IMPORT: In that, yeah, yeah, yeah, that's good, I've read LADY IMPORT: this and I'm done now for the year. ML: Met the regulatory. LADY IMPORT: Instead of actually having to go to a conference or take a class or… LADY IMPORT: complete something.
3x. ML: Right. Umm, well what about other, other influences, do you feel that there is a peer or colleague, kind of, influence on their learning, on their continuing professional development?	9y. Social interactions are important learning influences.		LADY IMPORT: I think conferences are good too because if you have people that you work with that you are friends with that are going it forces you to want to go as well, you, 'cause it's a social situation MR J.: Yeah. BABY DOLL: but it's also educational. Like, I've gone too a few because a bunch of people I knew were going, and I'm like, yeah sure sounds fun

			and it gets you out of the hospital and… MR J.: Yeah. BABY DOLL: you do learn something new and while BABY DOLL: you're there but… BABY DOLL: Ummm… MR J.: It's still a social event.
	10y. Peers encourage learning.		BABY DOLL: Yeah. And it is influential from other people or if you're never even heard of it and someone mentions it, but… MR J.: Yeah. It's a good reputation of a good in-service. BABY DOLL: Yeah. MR J.: And that kind of gets people interested as well, the trauma symposium. BABY DOLL: I peer pressure people to come to my conference but… (laugh) (group laughter)
	11y. Nurses will pay out of pocket to attend learning events recommended by their peers.		BABY DOLL: Yeah, like, Barb, Barb Bancroft, everybody knows… MR J.: Yeah. MR J.: (cross talk) There's a few key ones people… LADY IMPORT: (cross talk) Everyone know her and how much fun her sessions are. BABY DOLL: Yeah, and they'll pay three hundred dollars for her LADY IMPORT: Yeah. BABY DOLL: session just to see her because people have just said she's amazing. MR J.: Umhmm. ML: Hmm. Excellent. BABY DOLL: (cross talk) [inaudible].
	12y. Peer pressure is not a factor to	7a. Nurses are motivated to learn	LADY IMPORT: (cross talk) I don't know if there's any peer

	influence learning initiatives.	for their own reasons.	pressure involved (cross talk) [inaudible] MR J.: No, (cross talk) [inaudible] LADY IMPORT: I think it's more…yeah, comradery and that (cross talk) [inaudible] BABY DOLL: Yeah, it's not peer pressure, it just, you know. LADY IMPORT: I think it's, yeah, I think it's just… and just respect for themselves and their drive to be good RNs or LPNs… LADY IMPORT: It's just a… MR J.: Internal [inaudible], external pressure. LADY IMPORT: Yeah, I think it's an internal drive rather than anything else. ML: Right.
	13y. Some nurses are internally driven and others are not.		LADY IMPORT: No, I mean, I think, yeah, no, I, I do think it's more an internal drive then any exterior influence. (cross talk) BABY DOLL: (cross talk) Oh, 'cause if you don't want to go, you won't go.
	14y. Managers encourage learning through posters promotions.		MR J.: [inaudible] LADY IMPORT: Yeah. And we all put, we all put posters up, you know, LADY IMPORT: we get the notification that something's coming up. The poster's get put up.
	15y. Managers make difficult decisions to decline approvals when numbers are at maximum.		LADY IMPORT: And then you, quite often, you're actually declining 'cause you've got some many people wanting to go. LADY IMPORT: And it's a first come, first serve, so if you get to go

			LADY IMPORT: and you say sorry I can't let anyone else go, and ML: Yep. LADY IMPORT: you know, so, it, that happens frequently MR J.: Mhmm. LADY IMPORT: and it's all self driven.
	16y. Some nurses never go to learning events and are plainly not interested.		BABY DOLL: We all know the nurses that have never gone to one, and that will not no matter what you say, so it's nothing to do with peer pressure, it's… MR J.: Yeah. BABY DOLL: They, just, are not interested LADY IMPORT: Not interested. BABY DOLL: in… furthering their knowledge or whatever. LADY IMPORT: [inaudible] MR J.: No.
	17y. Some nurses will report their certification learning as their continuing competence which is not correct.		BABY DOLL: Yeah, they're just here to do it. LADY IMPORT: And they use their recertification's and things within the hospital as their education. MR J.: Yep. LADY IMPORT: There's a few that will do that. LADY IMPORT: But I think, not many.
	18y. Financial support and paid time off is an incentive.		LADY IMPORT: And there's also the little bit of a thing that if your part-time you get paid an extra day to go to education. MR J.: Yeah. Bit more of an incentive. LADY IMPORT: There's a little bit of that too. LADY IMPORT: As a financial aspect LADY IMPORT: or a day off.

4x. ML: Yeah, so, and (scratching noise) actually I think you've touched on something fairly important there too with regards to the, em, the, the system, the employer, umm, you know, offering a day off and that kind of thing. Is there anything else that could possible impact an RN in a, in such a way that they would pursue their contin, their continuing professional development?	19y. The employer does not have a role in promoting learning, rather it is the union.		MR J.: I don't know if so much employer as, as per union contact. (chair creaking) BABY DOLL: yeah. MR J.: It's not so much that we're promoting it, it's more that it's what their entitled to and…
	20y. It is a hassle for managers to send nurses to learning events due to scheduling constraints.		LADY IMPORT: 'cause quite often it's an absolute hassle because then you have to find replacement staff, so as much as we encourage then to do it LADY IMPORT: it's, it is a hassle for us as managers to work around so they can do it.
	21y. Essential clinical learning in the workplace is popular but difficult to let people go from the unit.		LADY IMPORT: You know we do a trauma day, so every single member of staff wants to go to that. LADY IMPORT: So, it's a nightmare. And all the casual staff that work with us want to go and the ortho ones are probably the same, so it's a headache LADY IMPORT: as a manger but you want as many to go as you can.
	22y. Regardless of the incentive, nurses are either		LADY IMPORT: So, I don't know, other than them getting paid and getting a day off I'm

	motivated or they are not.		not sure that there's any other incentives that we could add. LADY IMPORT: 'cause again, it's for their own personal growth and their own personal interests LADY IMPORT: and they're got that drive themselves or they don't.
	23y. RNs are lucky to have union-negotiated benefits for learning unlike other nursing professions.		BABY DOLL: As RNs, we can, we can request for the, the UNA funding and once people find out about that they're a little more inclined to go 'cause then you get paid for the day and you can get reimburse for the conference. But for LPNs there's no incentive.
5x. ML: Right. Umm, so you talked also a little bit about the union and I'm kind of interested to know more about the union and how that they plan into the, umm, professional development situation.	24y. RNs are entitled-if they choose- to three paid days off for learning.		MR J.: Well as per the contract they're entitled to x amount of educational days per year. And it's (chair creaking) up to that individual RN to… BABY DOLL: Use them. MR J.: Use them, yeah, utilize all of them if they want. BABY DOLL: They don't accumulate [inaudible], you don't use them you lose them. BABY DOLL: (cross talk) You get paid.
	25y. Managers are responsible for ensuring nurses receive their paid education days.	8a. Managers could face grievances.	LADY IMPORT: And then when you could run into trouble is if you declined a couple for somebody and they didn't get their allotted allowance [inaudible] and you could have issues with that. ML: Right. LADY IMPORT: So if operationally you can't give them the time off for them, then I have one that comes [whispers, inaudible] grieve that. ML: Is that right?

			MR J.: That a pretty rare situation I think though too. I know, like, we don't have anything like that. LADY IMPORT: Yeah. MR J.: There's potential of course, but… LADY IMPORT: There's the potential.
6x. ML: So in, in other words, they can select a, ahh, a learning activity and, and they'll bring it to you for your permission? ML: And then if, if you can find coverage and if there's, umm, opportunity then you'll, you'll grant that request? MR J.: Correct, yeah. ML: But if you can't grant that request they could go to the union. LADY IMPORT: Potentially. MR J.: Yeah. ML: Potentially.	26y. Nurses select the activity they want to attend and seek approval from the manager.		LADY IMPORT: So usually there's enough opportunity for them to do it.
	27y. It is rare for nurses to grieve the manager's decision to deny education leave.		BABY DOLL: Yeah, I don't know, I don't know when in what situation the union would be, the union would be on their side. LADY IMPORT: Well I think if they if they didn't get, for some reason didn't get their allotted allowance that they're allowed to have, they could potentially [inaudible]. MR J.: Yeah, if you denied them every single time. (cross talk) [inaudible]. But, yeah.

			LADY IMPORT: (cross talk) ‘cause you entitle by contact to have that many days. LADY IMPORT: You know, it’s just that it’s a possibility MR J.: (clears throat) yeah. LADY IMPORT: I just have one that I could see doing that but I think it’s a rare thing. MR J.: Yeah.
	28y. Nurses are encouraged to attend learning events on their days off and they get reimbursed for their time attending.	9a. It is preferred that nurses attend when it does not interrupt the work schedule.	LADY IMPORT: And if they’re on a day off and the opportunities on a day off, then we approve it and they get paid for it. MR J.: Mhmm. ML: Mhmm. Hmm. I see. LADY IMPORT: Yeah. MR J.: That’s what we prefer. LADY IMPORT: Yeah. (laugh) That’s easy. MR J.: Do it on a day you’re not scheduled to work. ML: Yeah. MR J.: Then you’ll get it no questions ask. LADY IMPORT: Yep. ML: Yeah. Umm, does it include, umm, money for the activity itself or just the, the ti… MR J.: Eight hours. ML: Right. MR J.: Yeah.
	29y. Fees associated with learning events are covered out of pocket or by application to the union.		LADY IMPORT: Well if there’s a fee for the conference their responsible [inaudible] (cross talk) BABY DOLL: (cross talk) That’s where they can go through UNA. LADY IMPORT: potentially get refunded from the union ML: I see. LADY IMPORT: for the cost of the conference.

			ML: Oh, I see. So they would apply to the union LADY IMPORT: They'd apply. BABY DOLL: Yeah. They have five hundred dollars… ML: and then the union has funding. BABY DOLL: or four hundred dollars a year per staff.
7x. ML: How, how frequently do you find that your, (sigh), having to, umm, you know because of your own constraints with staffing or other things, how frequently do you find you have to turn down an educational request. Is it fairly frequent or… infrequent?	30y. If there is a high-demand for access to an activity, Managers may deny requests.		MR J.: That's usually only ever time you'll have to decline is, is something program specific to your area that everybody wants to go to. That's really the only time I can think of. ML: Yeah. MR J.: Very rare, otherwise that's, everybody's interests [inaudible] random, educational opportunity.
8x. ML: Right. Ahh, from your perspective, I'm trying to, kind of, get a sense of how often and how frequently you, you have to deal with, um, requests from staff that want to go, from RNs in particular I guess, umm, who want to go for an educational opportunity.	31y. Frequency and numbers of requests for education support varies but could be up to 3 requests per month.	10a. There are new structured learning opportunities monthly.	LADY IMPORT: Well I think than, ahh, rather than summer months, I think it would be monthly that (cross talk) [inaudible]. BABY DOLL: (cross talk) There's al, there's, there's a conference (cross talk) [inaudible]. LADY IMPORT: (cross talk) [inaudible] and it might only one or two people wanting to go or it could be ten. ML: Right. LADY IMPORT: But I think, I think there's always something, whether it's the Ann Bancroft, or there's ML: Right. LADY IMPORT: always some opportunity for them to go to something.

			MR J.: Yeah, seems like. BABY DOLL: Like I think up until May this year there was probably about… three conferences everyone ML: (whisper) wow. BABY DOLL: that, I think everybody just wanted to go, everybody had their conferences set up between February and April, so it was really busy during that time. Summer not so much but and then again in the spring or fall.
9x. ML: How do, how do you, umm, feel that that impacts your own workload. Do you find it challenging or is it, well, it's part of it and…	32y. The primary concern of the manager regarding education requests is ensuring they have enough staff to cover the unit.		MR J.: It's just treated it the same as a vacation… request, really. Like from our point of, from manger, you gotta book somebody off to get somebody else in, so it depends on how many people are already off that day... how many other people requested the same education day. So it's treated the same as a vacation or a stat request. ML: Right. MR J.: Really, because… from our point of view, all we're concerned about from that aspect is, umm, filling that spot back on the floor for that shift. That's my primary concern.
10x. ML: Right. Good. And do you feel supported as well in your role in, in, umm, you know, providing these opportunities, and, your, your intersection with the RN continuing professional development.	33y. Promotion of learning events is part of the managers' job and part of the normal unit routine.		MR J.: I mean, the educational opportunities come out, they get printed out, (chair creaking) educators help us set all that up, it gets put on the back clipboard so information is easily accessible for everybody, and it's there for them to have a look and decide if it's of interest to them or not. ML: Hmm. Mhmm. LADY IMPORT: (cross talk) [inaudible] It just is, it's just, I

			think it's just a part of what we do. ML: Mhmm. LADY IMPORT: I think it's just accepted that it's just part of what goes ML: Yeah. LADY IMPORT: on in acute care ML: Mhmm. LADY IMPORT: it's just another thing to be dealt with. ML: Hmm.
	34y. Operational requirements are priority.		BABY DOLL: Like, I think everybody supports… as much as they can… until it starts to affect your operational… ML: Yeah. MR J.: Yeah. BABY DOLL: There's only so much you can do and only so much they can do.
11x. ML: Yeah. Fair enough. Umm, what about interprofessional teams because the, the team aspect is, the health care team is getting… its evolving (laugh) and so what, what do you think, umm, are there any influences from that perspective, umm, that you see from your vantage point?	35y. Nurses rely on interdisciplinary expertise.	11a. Nurses apply interdisciplinary expertise into their practice.	LADY IMPORT: for our team to go to, I don't remember seeing, sort of a, (chair creaking)…dietician's conference or anything that, and honestly it would be so much above our heads. MR J.: Yeah, that's (cross talk) [inaudible]. LADY IMPORT: You know, I mean, it's just such a specialized area that to go to one of their conferences and have them talk about nutrition it would be just like soosh, soosh. ML: (laughs) MR J.: Yeah. BABY DOLL: [inaudible] a lot of them going to a lot of our conferences LADY IMPORT: Yeah, yeah. BABY DOLL: just 'cause it's, it broader topics and… MR J.: Mhm.

			BABY DOLL: like, areas that concern in their… LADY IMPORT: Yeah. BABY DOLL: area of expertise as well. But. MR J.: Yeah. BABY DOLL: (cross talk) [inaudible]. LADY IMPORT: (cross talk) Or the other way around, when they get into the logistics of what they do for PT/OT I just…[inaudible]. BABY DOLL: (laugh) MR J.: That's why they're there, so we ask [inaudible] (cross talk) (laugh) LADY IMPORT: Yeah, they're experts and that… BABY DOLL: So that we don't have to. (laugh) ML: (laugh) LADY IMPORT: (laugh) hey, help…yeah. (tapping sound)
12x. ML: Umm, ok, so, that…er… I, I was sort of thinking there, there could be particular pressures because of the way that teamwork is going and everything, but, um, it's sounding like, like, it's, the, there's still the educational opportunities are still very particular to each area and… nursing is still really very focused more on the nursing, and…	36y. Nurses learn from experts in other health disciplines.		BABY DOLL: I don't have to be particularly knowledgably in mobilizing my patient BABY DOLL: 'cause that's what physio's for. BABY DOLL: Or dietary, like, I can know the basics but when it comes to expertise, that's what they're for. BABY DOLL: Right, so, they're not pressuring us to know everything because BABY DOLL: that's their job
	37y. Interdisciplinary		LADY IMPORT: (cross talk) day by day on the unit, like,

	learning is often spontaneous and informal on the units.		OT will come out and they'll explain something to us and then the staff will learn from that during a shift. LADY IMPORT: It's nothing official, it's just, oh by the way blah, blah, blah, blah, blah LADY IMPORT: you don't want that splint because MR J.: Yeah. LADY IMPORT: you want this, you want that, you want the other. LADY IMPORT: And so that goes on all day.
	38y. Nurses are accountable to meet other health disciplines' requirements.		LADY IMPORT: Kin, it's a kin, or el, dietary will (bang noise) come and say, well we need to do this, we need this, we need this, LADY IMPORT: we need this and you go, oh ok, that makes sense. LADY IMPORT: So that an ongoing learning process LADY IMPORT: but it's not a formal…
	39y. Interdisciplinary experts may speak to nurses during 10-minute huddles on the unit.		LADY IMPORT: thing, I think with the huddles and with the little education things, the sort of, the ten minute things on the unit, that's another time LADY IMPORT: that's an opportunity for a different team to come in and speak to the nursing staff. LADY IMPORT: So that's, but again, it's not an official thing, it's just an LADY IMPORT: ongoing process LADY IMPORT: that occurs.
13x. ML: Tell me more about what, umm, the huddle is and, and, that,	40y. Ten-minute required daily huddles depends on workload.		LADY IMPORT: What some of us are supposed to be doing on a… weekly basis… BABY DOLL: you guys aren't? (laugh)

um, situation. That's, that's quite interesting.			LADY IMPORT: Well, we're, we're not every week, no, it's summer, we don't... we, we try to keep our head above water. BABY DOLL: So the staff probably huddles twice…well, we do it twice a week. MR J.: With ortho, yeah, everybody's a little different on theirs. BABY DOLL: Yeah. MR J.: And it's more… the title of it… than anything 'cause we do like a little mini quality huddle in the morning for our AM bed round as… LADY IMPORT: Yeah.
	41y. Quality huddles are group discussions to address errors and issues.		LADY IMPORT: It, it, it's quality. MR J.: Yeah. ML: Right. LADY IMPORT: Rather than, but it, it is sort of an education component too ML: Right. LADY IMPORT: as well as the quality, so if somethings happened on the floor, so, I don't know, a med error or something, then you'll talk what happened, how it happened, why did LADY IMPORT: it happen and what (bang noise) can we do differently kind of thing LADY IMPORT: and it's just a very brief BABY DOLL: Yeah. LADY IMPORT: synopsis almost… LADY IMPORT: of what can we do, what do we need to work on. BABY DOLL: And you're only capturing who's on that day, right.

	42y. Huddles do not reach all nursing staff.		BABY DOLL: So… I, and I usually change my topics… every other day or every other BABY DOLL: huddle so you're only capturing a handful of people ML: Right. BABY DOLL: to talk about, unless I'm gonna say the same BABY DOLL: thing for a month then BABY DOLL: I might capture everybody BABY DOLL: but with shift work it's impossible.
	43y. Reliance on peer to peer information dissemination.	12a. Nursing staff do not receive new information together due to complex scheduling.	BABY DOLL: So you're just, you're hoping that they kind of talk about it, they'll be like ohh she mentioned this today BABY DOLL: (chair creaking) and that probably didn't happen but, you're hoping it spreads if you just hit like a handful of people. ML: Sure. ML: (cross talk) Where did the idea… LADY IMPORT: (cross talk) We don't work in an area where you can get everyone together. LADY IMPORT: It's just impossible. LADY IMPORT: So, you know, you got, say thirty employees… ML: Right. LADY IMPORT: well they all work different shifts. MR J.: Mhmm. LADY IMPORT: So, exactly what you're saying, you capture maybe seven people. MR J.: Mhmm. LADY IMPORT: Each time.

	44y. Managers hope to reach 80% of nurses with new information.	13a. It is impossible to catch everyone.	BABY DOLL: Our goal, for any ne, new roll out our goal is eighty percent BABY DOLL: 'cause then everybody else will teach everybody else BABY DOLL: because it's impossible to catch everybody, but…
14x. ML: Yeah. Umm, so that, the team huddle evolved out of COACT and, oh, COACT came from… the government, is that right?	45y. Administrative schemes are not informed by front-line nurses.		LADY IMPORT: Well it come from something that a computer program spat out of [inaudible]. (group laugher) LADY IMPORT: I don't know where it came from. BABY DOLL: Someone who's never worked on the floor. LADY IMPORT: Yeah. It's not very popular.
	46y. Administrative schemes/strategies impact work culture.		BABY DOLL: Is has good aspects but… MR J.: Yeah. BABY DOLL: It's, it's a huge culture shift.
15x. ML: It has really impacted continuing professional development though, it sound like, umm you're having to kind of, cross, ehh, provide cross information and, ahh, and so on.	47y. Administrative schemes add complexity to previously functioning workflows.		MR J.: Well it was, it's just, we were doing cross information previous to this, it just wasn't structured and defined… MR J.: the way (cross talk) COACT's kind of dictated it to be. So that's kind of where people struggle a little bit, it's now there's a rigid framework for this…fluid… communication style that we do. MR J.: And now it's, it's their asking it to be a bit more structured whereas before it happened, before, it was just… at its own pace and time. ML: Right. MR J.: When it was (background chatter) convenient for staff.

			MR J.: Now it's just a little bit more… rigidity to, to this model. (cross talk) MR J.: I think that's what people struggle with (door closing). Yeah.
16x. ML: So in, ahh, in it becoming more formalized, you actually have to record your events and things like that? Or is it more just…	48y. Structured communication designed by administration adds demands to the workload.		MR J.: Yeah. More of a timeline kind of a structure throughout the shift. ML: I see. MR J.: Designated times that… they're supposed to be attempted to… to communicate and have these huddles and… BABY DOLL: Yeah, like, you have huddles, you have rapid rounds, you have comfort rounds, you have, and all these are supposed to have specific times and if you're doing something, you drop and you do it. … BABY DOLL: Not to mention report and safety checks… that's all just… that's all very…(bang on table)
17x. ML: And so those are all things that you have to coordinate and organize?	49y. Managers are accountable to administrative schemes/strategies.	14a. Managers must learn, disseminate, and teach new administrative schemes/strategies.	MR J.: Attempt. LADY IMPORT: Attempt, yeah, and it's yeah. And it's all things that have been thrown from… in a ver, very, short period of time. MR J.: Mhmm. LADY IMPORT: So it's been a huge shift. LADY IMPORT: And part of the problem is that the schools weren't teaching that, so then you get the new grad who LADY IMPORT: haven't been taught to do it that way and suddenly so they, they've gone to school, they're learnt things and then then come onto the floor and it's totally different to what they're done as a student.

			LADY IMPORT: So it's been a big learning curve for everybody.
	50y. Nurses are resistant to changes in clinical care and routines.		LADY IMPORT: And, ahh, resistance 'cause nurses don't like change… we all know that. Umm, so I think there's been a certain amount of resistance to it, and just a lot, uh, and, and different policies with, ah, diabetes management and different forms for this and LADY IMPORT: different forms for that. So it's been LADY IMPORT: a slew LADY IMPORT: of LADY IMPORT: new information, new rollouts LADY IMPORT: within the last two years? MR J.: Mhmm. BABY DOLL: Yeah.
	51y. CARNA processes are moot because learning is continuous.	15a. Constant new processes and policies drive learning.	LADY IMPORT: You know, for CARNA to say we have to pick an indicator and that's what we're gonna do this year (banging noise) it just, it almost a moot point. We (chair sliding) we're doing this every single day. LADY IMPORT: There's always something new coming up. LADY IMPORT: And, even if it's a change in (bang noise) policy and procedure, it's always happening, there's always something new.
	52y. Nurses must constantly learn to be effective.		LADY IMPORT: So it's never fluid, their knowledge is not fluid, they don't just LADY IMPORT: plod along with their knowledge LADY IMPORT: if they do, they don't… do very well.
	53y. CARNA MyCCP is asinine		LADY IMPORT: So, you know, I think it's, it, it just

	considering the reality of actual learning.		seems, you know, asinine to, for them to have to, for all of us to have to pick something, do it, prove we did it, LADY IMPORT: remember what we said we were gonna do LADY IMPORT: and complete it, pay for the next year and come up with a new one.
	54y. MyCCP is not understandable especially for internationally educated nurses.		LADY IMPORT: And, you know, even the site… it's written in gobbledegook BABY DOLL: (laughing) LADY IMPORT: like, write those indicators in real English, with, peo, the people can understand…ohh this is what I can do for this. Because sometimes you'll read those indicators and you go, I end up going what can, how can, what can I attached that to, what does that mean, what… MR J.: Yeah. (cross talk)
	55y. Nurses do not report appropriately in MyCCP because they do not understand the language.		LADY IMPORT: (cross talk) What do I, what am I going to do to meet this indicator. MR J.: (cross talk) not that one, not that one, not that one. BABY DOLL: (cross talk) If I can't understand it I'm not doing that one. LADY IMPORT: [inaudible] use the same indicator and just do something different. MR J.: Oh, rotate [inaudible] BABY DOLL: Mhmm. LADY IMPORT: Because you don't really know what those damned indicators mean in the first place. LADY IMPORT: And I think a lot of people struggle with that.
	56y. Many nurses would benefit from plain		LADY IMPORT: So you know, just keep it a little more

	language in CARNA processes.		basic and not quite so [inaudible]. LADY IMPORT: And just make it easy. Someone where English is a second language, I don't know how they, I don't know how the do it. MR J.: (cross talk) [inaudible] a struggle. LADY IMPORT: I honestly don't know. MR J.: That's a significant percentage of the nursing population.
	57y. CARNA does not use the data that nurses are mandated to enter.		BABY DOLL: I don't know how much CARNA actually reads it.
	58y. Nurses can enter nonsensical information to MyCCP.		BABY DOLL: A lot of them don't make a lot of sense. Not by the end, I'm just like blahhh, blahh. (group laughter, cross talk) [inaudible]
18x. ML: So, I, I had a look at the legislation and the legislation just simple says… RNs have to continue their professional development on a yearly basis, and they have to use reflective practice in order to maintain their competence. And so I was wondering if you had any thoughts on, on those statements… related to, umm, all of the influences that we're talked about, I guess I'm, I'm curious about	59y. CARNA's requirements for one learning activity is not an indication of competence when they must learn far more than that on a daily basis.		BABY DOLL: That's the thing, like, you keep saying, we've, I can think of at least in the last two years, we've probably implemented and taught nurses about twenty different things. Never mind having this one little question that they had to answer, or two, in the last two years for CARNA. So they're obviously, they're…the question if someone were competent is still up in the air but. (group laughter)

the, the concept of competence in all of this.			
	60y. Competency problems are fixed by managers and educators, not CARNA.		BABY DOLL: Umm, they're all, they all graduated, they're all keeping up their competency and if they're not that's where the managers and educators step in and see where the problem is, and, learning plan and fix it. Not, CARNA'S not gonna fix it. A little reflection that they gonna write, be like, (drumming fingers on table as if typing) oh I might have made an error, a med error.
	62y. Reflection cannot be easily expressed in MyCCP reports.	16a. Reflection is ongoing in practice.	BABY DOLL: Like it's, and the reflection part… I, I hate that word LADY IMPORT: I hate it. BABY DOLL: because I… LADY IMPORT: How did it affect your practice? BABY DOLL: (laugh) Like… LADY IMPORT: [inaudible] all through the day. BABY DOLL: Yeah, like, I learned how to not do that or how to do something differently or, like, I, it's just, you're always reflecting it's just hard to verbalize it.
	63y. CARNA's view of competence is not realistic.	17a. Practice indicators do not indicate competence.	LADY IMPORT: But CARNA does force you to do this… these indicators does not make a competent nurse. BABY DOLL: Oh God no. LADY IMPORT: (cross talk) Going to a conference, reading a book does not make a competent nurse. BABY DOLL: (cross talk) School doesn't make a competent nurse.
	64y. Competence is the common	18a. Reading articles do not	MR J.: Yeah.

	sense, skills, thought process, critical thinking and ongoing practice.	make a nurse competent.	LADY IMPORT: Competency is… common sense, skills, thought process, critical thinking BABY DOLL: And practice. LADY IMPORT: it's not how many articles I've read.
	65y. Peer to peer learning and feedback advances competence.		LADY IMPORT: And so, and learning from my peers, that's, that's what makes me a competent nurse. So for you to sa, for CARNA to say well good, you've done this so you're competent, (bang noise) no not necessarily. MR J.: No.
	66y. Reflection is reflexive in the learning process.		LADY IMPORT: And reflecting, well I reflect after I've done all that (chair creaking). Yeah, it's way easier now I've learned how to do it. LADY IMPORT: That's my reflection. MR J.: Yeah. (group laughter)
	67y. CARNA reporting is a burden and meaningless.		LADY IMPORT: but what hap, you know, really for me to go and then have to write a paragraph on what, ughh, it's, it's painful to be honest, I mean, I think nurses reflect every day when they leave the unit… a good nurse reflects on what they did well that day and what they didn't do well. BABY DOLL: And what they can do different. MR J.: Yeah and what worked.
	68y. Staying competent is constantly questioning practice.		BABY DOLL: It's, it's part of it, how can I do that or when you walk into the room… yikes. LADY IMPORT: You know or…(cross talk) BABY DOLL: (cross talk) [inaudible]

			LADY IMPORT: Or you did a really good job of it, that's your reflection of your practice and that's how LADY IMPORT: you stay competent is questioning yourself.
	69y. Nurses can and often do misinform their MyCCP reports.		MR J.: No. To be honest, the CARNA registration, like, to… anyone can BS their way through that. LADY IMPORT: Yeah. MR J.: Anyone can. It's very easy. LADY IMPORT: Yeah. LADY IMPORT: And most do.
19x. ML: No, as, as manager in, in, talking about competence and RN competence and things like that because you could mentioned it a couple of things there that, umm, sometimes you'll notice, ahh, something and, and you'll, you'll bring them aside and create a learning plan, I think I think it was you who said that Sue.	70y. Managers are responsible for competence and incompetence. 71y. Managers must recognize incompetence and correct safety concerns. 72y. Managers must ensure new policies and procedures are well-understood and followed.		LADY IMPORT: Yeah, I think that's what we all do on a regular basis. MR J.: Yeah, it's always real time mentoring and if there is a major issue with something that, you know, is gonna put the patient in jeopardy or, or safety at risk, then it's, you know, a bit more of an in-depth discussion, perhaps a chat with a clinical nurse educator for your, for your area just to make sure that they're LADY IMPORT: understanding the policy and procedure for that after a quick review of what's immediately available and… MR J.: And so you use your co-workers… BABY DOLL: (cross talk) Yeah, and the, we, we give them… MR J.: (cross talk) to help kinda shape the way that goes.
	73y. Managers provide the initial education and resources and		BABY DOLL: We give them resources, we show them… where they can find the resources if they have

	nurses are accountable following.		questions and then we always do an evaluation and follow-up. BABY DOLL: Like, just to make sure that this is happening and… MR J.: Mhmm. LADY IMPORT: It's an individual professional responsibility. LADY IMPORT: To ensure they know what they're doing.
	74y. It is impossible for Managers to understand the competence of 30 nurse team members.	19a. Managers activate peer to peer learning.	LADY IMPORT: You know, and, at, at some point we have to [inaudible] we can't know what thirty people are necessarily doing every minute so I think that has to be on their shoulders too and it's when you either see someone doing something really well and you say oh can you show us how you did that. LADY IMPORT: Or meet me we need to talk. You know, so I think it is, it's a day by day process that the educators or the manager or their colleagues.
	75y. Peer to peer learning works well and managers monitor.		LADY IMPORT: They, I think, nurses are good at…pulling someone aside too and saying, you know, I did it this way and it was really easy. LADY IMPORT: Or, hey, show me what did you do (chair creaking). LADY IMPORT: So, I, I, it's, that's just… LADY IMPORT: That's, they've got to do that themselves. LADY IMPORT: You police it maybe in one word.
	76y. Incompetence is difficult to hide.		BABY DOLL: I think competency eventually because as much as some people try

	77y. Incompetence is evidenced by poor nursing practice. 78y. Peers note incompetence.		and hide it, and that's why people didn't like COACT, 'cause (laugh) it's harder to find your, harder to hide you incompetency with COACT, umm, as much as you try to hide it in certain situations eventually it comes forward. BABY DOLL: In one way or another, you either see it yourself and your like, why did you just do it that way or why did you do that or somebody else notices or a patient suffers because of it. BABY DOLL: Somehow, eventually, if they do it enough times, it catches up with them and it does come out and then we deal with it. Nobody goes… under the radar for their entire career being completely incompetent.
	79y. Nursing team members take accountability for competence of their peers.		LADY IMPORT: Other RNs won't allow it. BABY DOLL: No, because then their picking up the slack, or like I said there's an adverse event and a patient suffers and someone definitely notices that. BABY DOLL: Or they actually own up to it or someone BABY DOLL: fills out an RLS, like somehow
	80y. Managers are well aware of those who are incompetent		BABY DOLL: it comes out. There's no way that there's incompetent nurses on the floors that we don't know about. BABY DOLL: Trust me, we know them all (laugh). MR J.: Mhmm. BABY DOLL: We know who they are.

	81y. Nurses are honest and admit their errors.		LADY IMPORT: And they [inaudible] this is, this is the good thing about the RLS process is… their so honest about putting those RLS reports in. BABY DOLL: Mhmm. LADY IMPORT: So they make (cross talk) [inaudible] it's not swept under the rug. BABY DOLL: (cross talk) It actually does [inaudible]. LADY IMPORT: They, they do an RLS, they know it's a no brain thing. (chair creaking)
	82y. Most nurses are honest about reporting errors.		LADY IMPORT: But they do it because they want to improve the process. And so, I, I, I just, I, I don't know, I think most of the people in the surgery program are very committed and very dedicated and want to give the best care they can give, and of course you got a few that are just there for the paycheque but… BABY DOLL: Mhmm. LADY IMPORT: I think it's a few.
	83y. Nurses are committed to help each other rather than influenced by CARNA.		LADY IMPORT: And I think that's why they're… entrusted in education, I think that's why they help each other, I think that's why they teach each other is 'cause of that commitment. And CARNA's… insistence on these… indicators doesn't influence them. MR J.: No. LADY IMPORT: Not at all. MR J.: No.
	84y. There are diverse learning needs.		BABY DOLL: I do think it's different unless you're in an acute care facility at all, 'cause I can just, I can see the nurses in long term care.

			LADY IMPORT: It's a whole different ballgame.
	85y. Nurses fulfill their obligations to CARNA only when they have to. 86y. Nurses band together to bemoan their experience of MyCCP reporting. 87y. MyCCP is a "headache" and nothing more.		LADY IMPORT: But don't you find no one ever even talks about the CARNA and their indicators til September (laugh). MR J.: No. LADY IMPORT: And then (cross talk) [inaudible] BABY DOLL: (cross talk) I got the email the other day and I was like, arggggh. (group laughter) LADY IMPORT: And everyone starts complaining about it. (cross talk) BABY DOLL: (cross talk) Registration is up in… LADY IMPORT: (cross talk) Oh my God, what are you going to do this year? MR J.: Yeah. LADY IMPORT: And so that's the only time (cross talk) BABY DOLL: (cross talk) 'cause no one [inaudible]. LADY IMPORT: they talk about it, it's never discussed throughout the year except (cross talk) [inaudible]. BABY DOLL: (cross talk) April, September or April, August, September. LADY IMPORT: So it, it doesn't have that much of an influence on their practice, at all, I don't think. It's just a headache.
20x. ML: So, uhm, in the sense of CARNA is, is now looking at new legislation that will expand the scope of practice for registered nurses,	88y. New legislation will be another struggle to add to the pile.		MR J.: Just another round of learning (cross talk) BABY DOLL: (cross talk) Just add to the list. MR J.: that's all it is, it's just the next thing. That's all it is.

so then there's gonna be this big impact once again, umm, how will you experience that in your roles… because… (door closes) it would be now another round of… RNs learning about what, what it is they.			
	89y. New policy and skills implementation requires significant resources and effort.		LADY IMPORT: Honestly, that, 'cause, we've just increased… some of the skills. We have some [inaudible] so we've increased some of the skills and to try and teach it to everybody. BABY DOLL: Oiya. LADY IMPORT: Was a huge amount of work for Joyce, our educator, but it was also a huge cost because you have to bring all these people in, on extra days, for the learning.
	90y. It is advantageous to increase nursing scope. 91y. Increasing nursing scope has a heavy impact on workload and scheduling.		LADY IMPORT: So that, it, it would be more of an impact for us trying to schedule people to take it, and then for the educators to do… (keys clanking) do those skills and perform those skills and certify people, so it's, it'll be a huge increase in workload but at the same time, to protect an RNs job. ML: Mhmm, yeah, yeah. LADY IMPORT: I'm glad to hear CARNA's actually doing that.
	92y. Managers must monitor particular clinical skills that must be recertified yearly.		BABY DOLL: (cross talk) And even in acute care, we already have special clinical competencies… well you can call them that MR J.: Mhmm.

	93y. Skills are specific to the area of nursing and competency in these are monitored by managers.		BABY DOLL: that we make all the RNs including managers go through because there's certain skills at this site that they don't practice often enough for them to be super familiar with. BABY DOLL: So we've identified which ones and we do it every single year. BABY DOLL: Same thing. (laugh) ML: Wow. BABY DOLL: Over and over, so they're doing, it's, it's I guess, the sim, similar skills… BABY DOLL: but they're relearning them every year, just making sure that they're up to date if anything BABY DOLL: new has come out with that specific BABY DOLL: skill 'cause it's something they don't do on a regular basis. BABY DOLL: It's not like regular med admin. ML: Right. BABY DOLL: Its things that rarely come up, that they don't see so that their… once it does come up… oh, like, I just did this. BABY DOLL: Or I did this last year, like, it's not like, oh it's been five years since I've done this. MR J.: Mhmm. BABY DOLL: Right. So we're making sure they're, at least with certain things, are staying on top of their competency.
21x. ML: I see. So you have, really, umm, ingrained processes it sound like for, it, it, is	94y. Scheduling learning sessions is the greatest challenge.		LADY IMPORT: It takes quite a bit of time. MR J.: The scheduling is the biggest thing.

there a lot of monitoring involved and a lot of paperwork, and, and I'm just curious to know what kind of time it takes out of your, your roles.	95y. Scheduling learning events is highly complex considering unit coverage, numbers of nurses and shifts.		LADY IMPORT: The scheduling for us as managers trying to get everyone into those sessions, right, 'cause what are they now? They're about… BABY DOLL: They're four hours. Four hours. LADY IMPORT: Four hours. BABY DOLL: So it's even more annoying 'cause you only have half a shift. LADY IMPORT: Yeah. So for us as managers it's a, it's a huge undertaking for the educators. MR J.: Mhmm. BABY DOLL: 'cause we have to do LADY IMPORT: Huge. BABY DOLL: what did we say…we covered… 'cause we have a float staff as well, I think it was… roughly… three hundred and some odd nurses to rotate through these four hour classes. ML: Wow. BABY DOLL: So we're teaching, and we can only take about twelve a class. BABY DOLL: So twelve for three hundred and some divided by twelve, that's a lot of sessions. And then that doesn't even, umm, count the skills, so when someone's first hired… we give 'em the package of these clinical competencies that they need to read, do an exam, we mark the exam, pass or fail, talk to them about it and then they have to do the skill with us, every single one of them before they can do it on their own.

	96y. Managers have difficulty tracking the various clinical skills of the nurses in their teams. 97y. It is an onerous amount of work to monitor nurses clinical competencies.		BABY DOLL: So that's… as well. So I have nurses, we have nurses on the floor that have done the exams that have never actually done the skill. BABY DOLL: Because it just hasn't come up. But there's weeks where you do it, like, six times a day, so… it really varies…but… it's all the work…
22x. What, what do you, what are your view points, from your vantage point what, what do you feel are the impacts on, on them, or the influences of their continuing professional development.	98y. Individuals must be accountable for themselves.		LADY IMPORT: I just think it's very (cross talk) [inaudible]. BABY DOLL: (cross talk) Individualized. MR J.: (cross talk) [inaudible] LADY IMPORT: To them it's just part of their… job. ML: Right. LADY IMPORT: It's just something they do (chair creaking), it's something that's… they feel they need to do, is to continue educating themselves.
	99y. The nurses who are focused on improving patient care are the ones driven to continually learn.		BABY DOLL: Well most of them went into it to actually, to care for patient and to… see… that they get better and, like, most nurses went into it for that reason. I feel like if that's their mentality then we're inclined to do educational and to keep up their practice. But if the ones that are here just for, for the money.
	100y. Personal interest in the learning topic is a motivator. 101y. The paid time off is a value-add to CARNA learning plans.		MR J.: Not so inclined, unless they're… BABY DOLL: Yeah. MR J.: personally interested and like we said before… education opportunity comes up, or you heard it through the grapevine, like we said, that somebody's heard of this particular in-service is very

			interesting, and you know, you get the day's paid for anyway, soo… BABY DOLL: Yeah. MR J.: you may as well go for something, use it for your indicator.
	102y. Nurses have personal reasons but are more motivated if it is a social event.		MR J.: So, I think it's just a personal… I don't think their influenced by… if their friends are going, like we said, it a social event. LADY IMPORT: Yes.
	103y. Nurses pursue learning for their personal, professional and social needs.		MR J.: If you're very interested in a specific topic for your own personal growth, or if you've had a recent experience that's, it's applicable too, then they'd be interested in it, but other than that… I can't say… what goes through their head… retirement, maybe some of [inaudible] (group laughter) MR J.: very interesting for them too, it's planning for their… for their own personal lives. MR J.: And professional lives I guess.
	104y. Nurses learn in order to advance their careers.		LADY IMPORT: And if they want to move on to a different area, you know, especially the young ones, they want [inaudible] ICU. MR J.: Yeah. (cross talk) Or test the waters a little bit too [inaudible]. LADY IMPORT: (cross talk) So, you know, and go… Yeah, they, they don't want to want to work in the same area for twenty years.
	105y. Managers look for ongoing professional development and		LADY IMPORT: Interview question is what level of education, what in-services have you done. (chair creaking,

	learning when screening and interviewing candidates. 106y. Showing you are motivated to learn is a desired nurse quality in recruitment.		band noise) And so, 'cause to me, that's an indicator, if you graduated six years ago and you've not gone to a conference still I am going to go… hmmmm… MR J.: Yeah. LADY IMPORT: Right, you, you, it sets off little alarm bells as to how driven you are.
	107y. Nurses mostly think of professional development as personal growth.		LADY IMPORT: And so, but I don't, they don't think of that… I think it purely is… a, a personal growth thing for them… honestly.
23x. ML: Mhmm. Any other further thoughts on this? I can't tell you how valuable… your perspectives are.	108y. CARNA is not required nor wanted. 109y. CARNA should simply be eliminated.		BABY DOLL: I just want CARNA to read this and go… ok let's get rid of it (laughing). LADY IMPORT: I don't know how many people does it employ [inaudible]. BABY DOLL: Yeah, can you imagine? (chair creaking) MR J.: Yeah, it seems like it's a pure… government… (laugh) LADY IMPORT: (cross talk) You know, considering… MR J.: (cross talk) model LADY IMPORT: (cross talk) Yeah, 'cause MR J.: (cross talk) of registration.
	110y. CARNA is not successful in protecting patients. 111y. CARNA processes are ineffective to fulfill their mandate.		LADY IMPORT: (cross talk) considering CARNA's there for protection of the patient, I don't think it's doing that. MR J.: Nope.
	112y. CARNA would be more meaningful if they were an advocate for nurses.		LADY IMPORT: I don't think having nurses choose an indicator protects the public… at all. And so if that's their role they need to come up with a different role, like, being public about cutting back on

			RNs, or there's other areas they can be involved in… LADY IMPORT: to protect the public than having nurses jump through hoops every August/September.
	113y. CARNA's reporting systems are unstable.		BABY DOLL: And there's a reason the system crashes the week before deadline every year… BABY DOLL: 'cause people wait till the last possible second to do it.
	114y. CARNA inconveniently charges membership money.		LADY IMPORT: Well, and that five hundred and forty dollars too. BABY DOLL: Uhhaa. LADY IMPORT: None of us have that sitting in our back pocket just to [inaudible] BABY DOLL: Right after summer. ML: No. MR J.: No. BABY DOLL: And then it increases by a hundred if you wait a month.
	115y. CARNA membership fees are a hardship for families.		LADY IMPORT: Yeah. And September everyone is taking their kids back to school and all that cost too. MR J.: Exactly what I was going to say, and the sports season starts for all the youngsters too. LADY IMPORT: Yeah, so, I mean, that's why everyone wait for payday, that last payday, before… MR J.: Yeah. LADY IMPORT: God, registrations up… but, and then it just throws it in 'cause it takes three times longer, you're not just paid, done, yayy paid for another year. MR J.: Yeah.

	116y. Paying the membership fee is not as bad as the MyCCP reporting. 117y. MyCCP reporting should be avoided until absolutely necessary. 118y. MyCCP should be quick and easy.		BABY DOLL: Like I don't, I, I, ehh, it sucks to pay don't get me wrong 'cause it's a big chunk of money but if I had to pay and not fill it out, that would be fantastic. ML: (laugh) MR J.: Let's be honest we all spend the least amount of time possible on that website. (group laughter) MR J.: They make it thirty seconds to get it done, you would to be, in and out in thirty seconds. BABY DOLL: Just take it out of my account every… whatever month. LADY IMPORT: Just take it and I'll fax, I'll, I'll scan you (cross talk) BABY DOLL: (cross talk) Yeah, direct deposit. LADY IMPORT: my certificates for the year (cross talk) MR J.: (cross talk) Yeah. LADY IMPORT: and then I'm done. (quiet group laughter) BABY DOLL: Honestly.
	119y. MyCCP reporting does not detect incompetence. 120y. CARNA processes were contrived by people who do not know nursing or patient care.		LADY IMPORT: It, it's the way it's done, and the process, and it just, how their doing it makes no sense 'cause (chair creaking) it's not capturing the people who are incompetent. BABY DOLL: Again, it was made by people BABY DOLL: that don't work in health care or LADY IMPORT: yeah. BABY DOLL: bedside or acute care or in any kind of, kind of health-care sy, sy… system at all.

	121y. Different areas of nursing have different education requirements.		LADY IMPORT: you know, how much can you increase your, your education working in a clinic. MR J.: Exactly, how many, (cross talk) it'd be different to see. LADY IMPORT: (cross talk) It's the same thing [inaudible].
	122y. Even community health nurses do not see value in CARNA.		BABY DOLL: (cross talk) But for them… but for them they're not gonna view CARNA as valuable either. MR J.: No. BABY DOLL: 'Cause they're, like… yeah, same thing, it's a… silly little goal that they… picked… LADY IMPORT: Yeah. BABY DOLL: and… it has nothing to do with the job every day.

Appendix 4S-Focus Group 2 Second Level Analysis

Table 47. Focus group 2-Second level of analysis

First level analysis	Second level analysis
1h. Learning is constant. 2h. Staying competent requires constant learning. 50h. Continuous learning is inherent in nursing and for accountability. 67h. Informal education is ubiquitous and more effective. 66h. Both formal and informal education are important for competence.	1i. Nurses consistently gain competence through formal and informal learning.
3h. Fear of audit. 4h. Every renewal is fear of audit.	2i. Nurses are highly anxious about engaging with CARNA.
5h. Difficult to record learning at risk for audit. 19h. CARNA reporting is frustrating and intimidating. 52h. Nurses do not log their accolades to report to CARNA. 54h. Nurses make up information in CARNA reports.	2ii. Nurses cannot report authentically in MyCCP.
7h. Formal events are impossible to attend. 9h. Workload too heavy for learning sessions. 46h. The organization needs to recognize nurses' untenable workload. 56h. CARNA requirements add to workload. 8h. Breaks not long enough to attend one-hour events. 48h. CARNA is oblivious to the challenges of their requirements. 6h. Informal learning not recognized increases pressure for formal learning.	3i. UNA, AHS and CARNA each, individually impose conditions separately but simultaneously, that culminate to an onerous demand on nurses. Are oblivious to the culminated demand on nurses.
101h. UNA complains of low turn-out without understanding the complexity of the nursing situation. 100h. UNA negotiates staff breaks and education days but without consideration of staffing issues or scheduling constraints. 102h. UNA promotes education events. 99h. UNA does not keep track of education day utilization. 103h. Not everyone gets to access valuable learning sessions.	3ii. UNA benefits are not realistic in context.
10h. Learning in short on-unit sessions is ineffective. 107h. Nurses need education where they can focus on learning and not be worried about their unit work. 31h. Learning is scant and superficial and not safe.	4i. Short, in situ learning events are not effective, meaningful learning.

32h. Too few nurses engage in learning sessions. 36h. Educators attempt to provide education on the fly. 37h. Education on the fly is ineffective. 47h. It is impossible to focus on learning when worried about the unit. 101h. Nurses are focused on their patients and their tasks making it difficult to learn on the unit.	
11h. Managers require specialized education but cannot be away from the unit. 13h. Managers are too busy to take time away from the unit for learning. 14h. It is too risky for managers to leave unit. 18h. Even with so much to learn, managers cannot attend learning sessions. 45h. Meetings are lengthy and take away support from the front line.	5i. Managers cannot access education due to their work obligations.
15h. Managers do their best to accommodate staff learning. 76h. Managers help identify nurse learning needs. 77h. Managers recognize opportunities to enhance strengths.	6i. Managers identify nurses' learning needs and provide opportunities to learn.
17h. Managers must navigate human resources with CARNA disciplinary actions. 16h. Managers must check permit status'.	7i. CARNA requirements are an additional layer of work for managers.
20h. It is a rush and additional work to finish MyCCP. 21h. Nurses only complete MyCCP when necessary. 22h. CARNA systems are unstable. 52h. Nurses do not log their accolades to report to CARNA. 54h. Nurses make up information in CARNA reports.	8i. Completing the unstable MyCCP is onerous.
23h. Nurses do not need CARNA to be motivated to learn. 79h. Some are eager to learn and others resist. 85h. Nurses are reluctant to give up their personal time for learning. 86h. Nurses are skeptical of learning programs implementations. 91h. Registered nurses are less motivated than other nursing groups. 88h. Nurses will not go over and above what is required of them. 89h. Nurses need leadership training to inspire and motivate them.	9i. Nurses are not motivated to exceed minimum expectations.
90h. Registered nurses are not motivated to practice with an increased scope. 94h. Nursing has become more restricted in scope.	9ii. Nursing scope is stagnant.

24h. Nurses need support in their learning. 106h. It is unknown how to get more support for nurses. 25h. The organization is decreasing support for learning. 27h. Withdrawal of an 8-hour day for CPR and mandatory modules is additional stress for nurses. 29h. Educators try their best but are overworked. 34h. Education offered at the convenience of the employer. 42h. Allocated learning time is getting less and less. 60h. Education sessions should be for everyone but are offered fleetingly. 87h. Learning opportunities are not equally accessible to all nurses who require it.	10i. The employer is reducing support for nurses' learning.
26h. Managers know it is impossible for nurses to fulfill mandatory modules during their shifts. 104h. Opportunities to increase accessibility to learning should be explored. 30h. The expectation is to stay current, but do it all on your own time.	10ii. Nurses bear responsibility for their learning on their own time.
35h. Scheduling is a very complex, time-consuming problem. 33h. Shift work makes it impossible for some nurses to attend sessions. 59h. Scheduling and staffing prevent attendance at learning sessions despite high demands. 98h. Managers must accommodate the UNA education days.	11i. Managers must prioritize adequate staffing but are obligated to promote learning.
53h. Managers must maintain logs of staff mandatory learning (organizational). 105h. Managers have no way of knowing if nurses actually attend approved day off learning sessions. 28h. Managers have accountability to ensure learning but without organizational support.	11ii. Managers cannot accurately monitor nurses' learning.
38h. Managers fall behind on clinical skills. 39h. Managers cannot be relied on to be a resource. 40h. Managers cannot keep up their own learning for clinical competence. 41. Managers are expected to be a "go-to" resource. 43h. Managers feel less clinically competent with less education available. 44h. Managers require additional education. 12h. Managers love more education.	12i. Managers require both clinical and leadership learning and there is a lack of both formal and informal- contributes to deteriorating skills.
49h. CARNA is disconnected. 51h. CARNA does not recognize the depth and breadth of nurses' learning.	13i. CARNA is detached and unsupportive.

55h. The CARNA expectations to work on one thing is unrealistic. 74h. CARNA does not provide support for competence. 80h. The CARNA CC program does not influence yearly learning.	
57h. Nurses are too exhausted to journal for CARNA requirements. 58h. Nurses lack the personal resources to journal appropriately.	14i. Nurses lack the resources necessary to fulfill CARNA reporting requirements.
78h. Education is motivating if relevant to the nurses' practice context. 75h. Nurses do not understand the relevance of some mandatory learning.	14ii. Nurses are motivated if they understand the relevance of mandatory learning.
61h. Knowledge dissemination depends on colleagues sharing. 62h. Knowledge sharing is not reliable. 81h. Formal learning is best when it is social. 82h. Nurses learn effectively when it is collaborative.	15i. Knowledge dissemination is reliant on social collaborations in learning.
65h. Competence does not mean complying with rules. 68h. Critical thinking and sound decision-making is competence versus following policy and rules. 69h. "Booksmart" nurses can be incompetent in practice. 70h. Managers do not have confidence in nurses without clinical proficiency. 71h. Competence depends on the nursing context. 73h. Personal circumstances impact competence. 62h. Education does not make a nurse competent.	16i. Competence is critical thinking, sound decisions, and proficient clinical skills.
72h. Comfort is a factor in competence. 84h. Nurse feel competent when they are comfortable in their practice but then they lose motivation to learn further. 83h. Nurses strive to be comfortable at work but then they lose motivation to continue advancing themselves. 63h. Education increases confidence but not necessarily competence.	17i. Comfort and confidence are ways of knowing own competence.
93h. Despite CARNA's apathy, nurses need to be accountable to their scope of practice. 92h. Nurses should be proud of their title. 95h. Registered nurses are very capable. 96h. Nurses are knowledgeable but this isn't recognized or respected by members of the interdisciplinary team. 97h. Nurses are intimidated by other professionals who look down on them.	18i. Nursing capabilities are under recognized in general.

Appendix 4T-Focus Group 2 First Level Analysis

Table 48. Focus group 2-First level of analysis

Question	Major theme	Sub-theme	Statements
1g. Yeah. How, um, from your point of view how does Carna influence you? Or in what ways do they influence you? Or, or… Yeah in terms of professional learning. Carna is uh, they enact the legislation, which is where kind of my grounding point… Um, so in what ways do you think Carna has an influence on professional development? And continual learning?	1h. Learning is constant.		DAWN I think in, in our setting, whether in my position or there's the position of the staff, we're constantly learning new things.
	2h.Staying competent requires constant learning.		DAWN Things change daily, every week, everything changes on a regular basis, so the continued competency portion of it, we're doing it, but having to actually do a work plan and focus on one thing when ... if the legislation says that we have to make sure we have educational hours that we're keeping up to date with the current ... I think in our setting, we're already doing that.
	3h. Fear of audit.		DAWN My competencies yearly they're like, ugh, what am I going to do, and am I going to ... The biggest thing is am I going to get audited. Am I going to push that button and get audited.
	4h.Every renewal is fear of audit.		DEBBIE And from my point of view, same thing. Like, when I open up my e-mail from them I ... Oh good this year I'm going to be audited 'cause I think I'm more worried about that ... Because I

			have, the, I, I keep up to date. Like I have to, I have no choice.
	5h. Difficult-to-record learning at risk for audit.		DAWN Although, I, and, you know, in keeping with that, um, the issue is yes, we're doing ongoing learning and doing things on the unit in the area, but it isn't necessarily formally and stamped on a piece of paper but I have the ability to identify it to Carna that I've actually done this learning. Um, you know, 'cause not every e- every opportunity, you know what, a new procedure, a new wound back, you're doing that education. But it isn't so formalized that it's actually coming with a piece of paper that you sign off of to be able to present to Carna if you are in a position of being audited. Um, so that is, um, that's a challenge-
	6h. Informal learning not recognized increases pressure for formal learning.		DAWN To be able to do that. So, Carna's supportive, you know perhaps the informal formal learning sessions isn't necessarily being, um, captured in a way that helps to relieve some of the staffs pressure. I think they feel pressured to ensure that they're doing certain things despite the fact that they don't recognize that they are learning throughout ...
	7h. Formal events are impossible to attend.		DAWN Um, as far as other, you know, how we're supported in other ways, um, you know there are opportunities that arise for educational, so practice wise, that supported, um, with [inaudible 00:04:34] usually, but is done at a time that's impossible for pretty much the staff to participate.
	8h. Breaks not long enough to attend one-hour events.		DAWN You know, they'll do a practice wise on a Thursday afternoon from noon 'til 1:00. Um, that's not where our break schedules lie. Um, so a staff member might be able to take in part of it, but can't take in all of it.
	9h. Workload too heavy for learning sessions.		DAWN So that, that creates issues in that regard. Um, you know, not being to necessarily leave the unit to be able to take in a lot of the education sessions becomes an issue for, I feel, from our management team because we're ... we're trying to compress so much of our work into our eight hour day, which isn't, isn't contained to an eight hour day and often exceeds, overflows in the front end or the

			back end that taking, having, um, those opportunities to kind of take in some of those sessions is a bit of a challenge.
	10h. Learning in short on-unit sessions is ineffective.		DAWN Um, you know to a point where we ... The only time that we can really do it is we actually physically have to book ourselves off of the unit for a period of time to be able participate in some of the education. Which is good, um, because then you can stay completely focused on the education that you're at.
	11h. Managers require specialized education but cannot be away from the unit.		DAWN But at the same time, you know, I'm a fairly new manager, so I would love to have the opportunity to do more educational, learn more about my position, learn different things, but to do that I would literally wind up being off the unit a great deal more than, um, what I am right now. And that's not good for my unit either. Being away for extended periods of time.
	12h. Managers love more education.		DAWN But, you know, I'd love to have the opportunity to be in more education sessions.
	13h. Managers are too busy to take time away from the unit for learning.		DEBBIE Anyway, we've been in management almost the same time and ... pulling yourself off the unit to go to these educational sessions ... Great idea, they're offered, but can we get away? Can we get out, we can- we could book ourselves off but can we really truly get away without all these other things, e-mails coming in, or deadlines, or we want answer now.
	14h. It is too risky for managers to leave unit.		DEBBIE And the other thing's if we do pull ourselves away it impacts everything, everything from how the unit is run, what's happening on that day, the staffing levels, to the budget. Like, that's a huge thing.
	15h. Managers do their best to accommodate staff learning.		DEBBIE You know, I- I in every attempt I do when staff come up to you and they put requests in for educational sessions, absolutely. You know, we try to accommodate those as much as we can. Um, in two years I've been I think I have, I haven't denied one yet. Which every, you know, you're an RN or you're an LPN, um, but as an RN it's like a minimum of three in ... I- I try to accommodate as best as I can.

	16h. Managers must check permit status'.		DEBBIE The only time that I think with Carna that I- when it comes to the employees and ... is the only connection I have with them is, um ... at the end of September, October, come October first do they have their license. We get that little e-mail saying, "Double check that their license is not current."
	17h. Managers must navigate human resources with CARNA disciplinary actions.		DEBBIE That's the only contact that we have with Carna because a lot of the staff if there are any ... disciplinaries backed or anything like that, that has to go through Carna. It's ... we always go through HR and get their advice and most of the times, they kind of te- tell us, okay, no you can't do that. We can't do that. So, you know that's ... that would be the only contact I've had with Carna, but for educational-wise, there's lots out there.
	18h. Even with so much to learn, managers cannot attend learning sessions.		DEBBIE Can I personally take it? I would love to. Can I get it into my schedule? Ninety percent of the time is no, which is kinda sad because, you know, there is ... the position that we're in is such a steep learning curve. And, there's so much to learn. Everyday, there's something new and there ... There's so much more. It's like being introduced to you on a regular basis, that I think we're already keeping up with our education, keeping up with the requirements and the legislations that have been set forward. DAWN Yep
	19h. CARNA reporting is frustrating and intimidating.		DEBBIE And, and feeling that you have to have it documented on a piece of paper on a yearly basis, I- in, in this area I find it to be, ah, just another deadline that you're regretting and then you'll, you know, the whole thing about am I gonna get audited? What's ... What are the consequences? And, it's just ... it's frustrating at times. DAWN Yep
	20h. It is a rush and additional work to finish MyCCP.		DAWN You're rushing to complete and meet that deadline. Every- this, this time of year the crunch is on. Cause, everybody knows that their registrations

			due and they need to get that competency in.
	21h. Nurses only complete MyCCP when necessary.		DAWN It's not something that, kind of, they work on throughout the year and, and are completing. I find for the most part, they're often always jamming it in within the last, you know, few weeks trying to go, okay, well I'll get all my data in.
	22h. CARNA systems are unstable.		DEBBIE And, you're willing to do it before the day of, because if not, then the computer system will shut you out. (laughs) DAWN Yeah. It's not a very receptive system.
	23h. Nurses do not need CARNA to be motivated to learn.		DAWN You know, [inaudible 00:10:07], um, I think definitely put on the professionals themselves. Their, you know, their responsibility to, you know, take on their own learning themselves.
	24h. Nurses need support in their learning.		DAWN Which, is fine, but it needs to be equally supported in allowing them to do it.
	25h. The organization is decreasing support for learning.		DAWN So, for example, when it comes to just simple education, um, like their CPR. They do their CPR, um, but their modules related to policies, procedures, different things, you know, uh, codes, and different types of things that they have to do. That's over eleven hours worth of modules, that they're expected to either do on their own, at home, unpaid. Or, try and fit in, while they're here at work, while you're trying to look after a full load of patients?
	26h. Managers know it is impossible for nurses to fulfill mandatory modules during their shifts.		DAWN It's a challenge, I mean, you know, for weeks I- I've, personally, just come back from a vacation, so I won't speak for the last couple week. But, I can definitely say for the months preceding, you know, all of my beds, all of my stretchers have been completely full. My staff have been working at the fullest of capacity. How yo have an expectation that they can find half an hour to an hour for some of these modules ... to sit down and actually look at them and get them done is, um, I think a little unrealistic.
	27h. Withdrawal of an 8-hour day for CPR and		DAWN And, that is something that they actually moved away from. Because, at one point in time, that time used to be

	mandatory modules is additional stress for nurses.		covered. They used to be able to get their eight hour day in over at the learning center, be able to get their CPR done, be able to do their modules, and they pulled off the module component. So, that's an extra stressor that the staff is then under.
	28h. Managers have accountability to ensure learning but without organizational support.		DAWN Um, and you know, and then it's ... It falls, befalls us as management to try and ensure that they get it done. Otherwise, now it's a grievance with the union saying, you know, why didn't you give them the time or why, why wasn't this allowed?
2g. Meagan: So they have to do it on their own time? DAWN Yes. DEBBIE It's required by AHS, the site. DAWN Yep. Meagan: So why aren't you paying them to do it?	29h. Educators try their best but are overworked.		DAWN Yeah. So that ... that's a bit of a challenge. Um, I feel that, perhaps, our educators, and they are wonderful educators in our particular area ... try their hardest, but I don't feel that they're necessarily as available to everyone as they possibly could be to help support that formal component of their education. Whether it be, you know, being able to come into the unit and do some in servicing where it could be signed off as a potential learning moment. Um, they don't have the time for that either because of their work load. Um, but they, they try very hard.
	30h. The expectation is to stay current, but do it all on your own time.		DAWN They are, like I said, an exceptional group of educators that do try very hard. But, they don't have the time in their schedule, just like all the rest of us who were pulled very thin. And I don't feel that ... the work is expected to be done and your expected to say current, but you basically are expected to do it in as much of your own time as you possibly can, and that is unfortunate.
	31h. Learning is scant and superficial and not safe.		DAWN It's ... because, you are going to wind up, I feel, getting, um, you're not going to be getting quality learning. You're going to be getting shoestring learning. And, that isn't safe for anybody.
	32h. Too few nurses engage in learning sessions.		DAWN Number one, it's only touching a small group of people that are willing to put in the effort and the time when it should be actually something that is offered.
	33h. Shift work makes is impossible for		DAWN So, um, sometimes the education sessions aren't offered in a way where the staff can ... can get there. I mean, We

	some nurses to attend sessions.		work in a facility that's a twenty-four hour seven day a week facility and yet the night staff is never considered when it comes to education. They often have to pull themselves off onto a day shift or on a day off to come in and do education. Um, or they have to stay after a night shift has been done.
	34h. Education offered at the convenience of the employer.		DAWN Or, you know, they're not ... I don't feel that those ... they're given the same opportunities. Um, so it's, it's ... I feel that education is often at the convenience of the employer verses the ... DEBBIE When they're willing to offer it?
	35h. Scheduling is a very complex, time-consuming problem.		DAWN ... And, and then, to be able to pull them off, um, what I find is that, I have ... when there's an education session for a period of a month or so, so many of these are being given ... I have to book people then, and then I do it consecutively. And then, what I do, is I bring an extra person in. That way, I know that when they're in that session, they're patients aren't assigned to somebody else or increases somebody else's workload. So, that's also challenging because, in a program, in the surgeon program, there's so many staff that ha- and only so many physicians. I could have two people up. Dawn could have two people up. And then, the other units can have some people up. But, finding enough of th- the casual staff that are available to fill those vacant spots — that's another, that's another challenge…Um—Because the casual staff also have to have time off to be able to be able to go to those education sessions as well. So, that just depletes [inaudible 00:15:31] a little bit more.
	36h. Educators attempt to provide education on the fly.	37h. Education on the fly is ineffective.	DEBBIE And then, you have no coverage for sick calls or personal leaves you have not covered. And like Dawn said, it's like the ... and sometimes the education that the educators do, they do a fantastic job, it's on the spot. Okay, you guys are here, let's do this. Okay, I have today, you're here, okay, I'm going to touch base with you. But, your mind is not really focused on what is being taught. You touched

			base with it. You're like, okay, when it rolls out, you know, we'll give you support. But, your minds not fully focused on that, that session. Where ... cause if you have five, six patients on your, on your slate and you have to have all these discharges and you're getting all these admissions, your ... your mind is not on the education.
	38h. Managers fall behind on clinical skills.	39h. Managers cannot be relied on to be a resource. 40h. Managers cannot keep up their own learning for clinical competence. 41. Managers are expected to be a "go-to" resource.	DEBBIE I think we try our hardest and in the position that I am in, I can speak for myself, I have a clinical component to my job where I'm on the unit. I understand the workflow, I understand the, you know, patient load, I ... and I have the right staff on the unit. But, because I lack the hands on on certain things, I've done my, my clinical competencies. I do them every year. But, because I don't have the hands on, when I see something I'm like, okay, I'll help you guys. I need help so that I can remember how to do it, which is sad. Certain things, no problem, they're just a given. But other stuff, like with our new tap- tap machines, before the, uh, rectal sheaths taps catheter. I know what it does. I understand the concept. I understand, you know, the side effects. I understand that the ... the assessment and everything. But, if the machine is beeping and I'm like, it's beeping everybody's busy. I'm going to go in the room like, you know what, I'm going to go help over there. You go fix that machine. Because, I don't remember how to do it, so no hands on my, my position. It kinda ... it's effecting my ability to do what I learned to do. DAWN Uh huh. Absolutely. And, since we're looked at as that, um, level of people that can assist and help and that should ... we should be that go-to individual that our staff should be able to come to to be able to answer questions and troubleshoot and do things with.
	42h. Allocated learning time is getting less and less.		DEBBIE I feel like I'm slipping further and further away from my ability to do that too. And the, the sessions are getting smaller and smaller. You know, it used to be two days worth of ... you know, day or two worth of, you know, um, retraining

	43h. Managers feel less clinically competent with less education available.		every year to be able to walk you through this stuff and how do you expect in fifteen minutes for me to remember that pump for the next year when I'm not touching it ... is a different story, but now it's down to four hours, uh, worth of training. And so, it's even less time. That when you're running stuff through it's, you know, it's ... it becomes too difficult.
	44h. Managers require additional education.		DEBBIE Um, and then there's a lot of time when our education session are ... and it's not necessarily even just an education session, but it could be something related to a management component of something that we have to do.
	45h. Meetings are lengthy and take away support from the front line.		DEBBIE And, it's tossed into our calendar an hour in advance. And, the expectation is that we're moved away from ... again, perhaps, that clinical component and support, because, we're part of the count of our nursing staff. And, being pulled away for a meeting that's an hour, two, sometimes three hours long, without leaving the back up and support on the unit.
	46h. The organization needs to recognize nurses' untenable workload.		DEBBIE There seems to be a little bit of lack of recognition that, you know, all those staff, they're all down one staff member, but they're all still trying to rotate through and get in their breaks or get out of the, you know, the patient assignments done or doing whatever. And, so you disadvantaged that core group of people that is supposed to be focused on patient care and you're impacting patient care because you're not scheduling thing appropriately to allow us to come to ...
	47h. It is impossible to focus on learning when worried about the unit.		DEBBIE And then, again, it puts us in a situation where I'm not focused on what's going on in that meeting or in that education session. I'm focused on what's going on in my unit and whether, you know, things have been addressed properly. Or, I'll be texting or doing something to try and maintain some sort of contact and flow with what's happening over there. So, that can be incredibly challenging.

	48h. CARNA is oblivious to the challenges of their requirements.		DEBBIE Um, so, I don't know that ... Ca- I feel as though Carna might be disconnected. In the ways from how, you know, how that formal education is occurring, but how, you know, the expectation again that you're doing, you know, reading. Or, that you have these goals and that you've ... you getting these feedbacks and doing certain things, but there's limitations and restrictions that are kind of tossed in there.
	49h. CARNA is disconnected.		DAWN I think with, with Carna I think they're a bit disconnected with what reality is. Like nothings stays static.
	50h. Continuous learning is inherent in nursing and for accountability.		DAWN Nothing stays the same. Every day something's changing. Every day a new procedure is done. Every day of a new medication. Every day of a new staff giving this medication for the first time. And, legally, I'm responsible. You're supposed to look it up and they look it up. It's a continuous ... it for continuous ...
	51h. CARNA does not recognize the depth and breadth of nurses' learning.		DEBBIE: Shh. DAWN: ... monitoring above the unit. DEBBIE: Mm-hmm (affirmative). DAWN: Whether it's ... DEBBIE: But, how do you document that. DAWN: Exactly. DEBBIE: And, ho- how is it recognized?
	52h. Nurses do not log their accolades to report to CARNA.		DAWN And, keeping a track of that is like when somebody gives you the one question in Carna with the- with the ... continuing competence. Uh, a date when somebody gave you a kudos. Like, you did a good job. And, the people are like, well, I get them but I don't write them down. I don't keep a log of what I do.
	53h. Managers must maintain		DAWN Um, some people might, the logs that I keep of staff are ... Your special

	logs of staff mandatory learning (organizational).		clinical competencies. Those I keep, because every year they're expired. There's CPR, I keep a log of that because they're very strict now with the view of ex- let it expire. You gotta go to the community. So, there's certain things that I will keep logged for them, but even at my, where I'm at, and they're asking, well, did someone give you some kudos? I'm like, jeez, what day was that? And then, and guarantee, you know, most people will say, well, how am I doing today? Good, okay. So, yesterday this is what she said to me. DEBBIE Yep.
	54h. Nurses make up information in CARNA reports.		DAWN Or, quite honestly, I did feel that the staff, probably ... No. And, I'm only speaking because I honestly believe that this is what they wind up doing. They, they know that they're getting that recognition. Or, they know that they're doing certain things. Or, they know they've done an informal session. But, they haven't taken the time to write it in their log books, so I think they make up dates. And, they'll get as close as they possibly can to things. And, I don't understand how doing that makes everything good with Carna, because, you know, we've been talk as nursing staff, never falsify things. And yet, I'm fairly certain that, you know, ho- how do you, how do yo do that? Like, how do you, you know, write down those things? I, I'm highly suspicious that the staff probably are just you know, I'll just write that date down. Because, in the event that I do wind up getting audited, I wanna make sure that I've got it there. But, at the same time, you know, who docks it up?
	55h. The CARNA expectations to work on one thing is unrealistic.		DEBBIE And, it's not. And, with Carna expecting you to do work on one thing for the whole year? It'll come down to crunch time.

	56h. CARNA requirements add to workload. 57h. Nurses are too exhausted to journal for CARNA requirements.		DAWN . And, yet, that's almost what it feels like, um, [inaudible 00:23:37] the patient is from Carna, is that rather than focusing on what we're supposed to be doing and doing our nursing care and doing the things ... and, and I, you know, education incredibly important and we're doing it every single day, but it almost feels like you're asking me to sit down and record that and take time away from what I'm actually supposed to be doing. Cause, by the end of the day, I'm not going to sit down with my journal and write everything down. Because, I'm tired by the end of the day. I am ... I done.
	58h. Nurses lack the personal resources to journal appropriately.		DAWN So, you know, then it winds up being a case of yeah. So, for me, when it comes to my education, thank goodness I have a computer and a calendar that tells me when I attended an education sessions. Cause, it's the only way I can go back and remember what day something happened. But, the poor nursing staff doesn't have that. Unless, they're keeping a journal or something. There's nothing that they have.
	59h. Scheduling and staffing prevent attendance at learning sessions despite high demands.		DAWN And, I don't know that there's, you know, I think the f- informal ... Again, there's these small little sessions that they're, you know, try to attend, try to attend. And, I agree with you, I try to give education off to, to people. And, I- I think I've refused one invitation a day and it was because everyone on the night shift wanted it off to be able to attend. I can't do that. I have to have somebody left. Um, because ... why? Because, there aren't enough people to cover charge in the [inaudible 00:25:01] to be able to do that. Or, you know, are familiar enough with the unit to be able to take on that role. So, it's like, you know, I know a lot of the staff would really like to be able to attend some of these education sessions that come up and it's an awesome session and they all wanna go to it. So, I get twenty applications to, to go to one education session and I grap for all the people that are off ... on th- they're on their days off and grap for the couple that

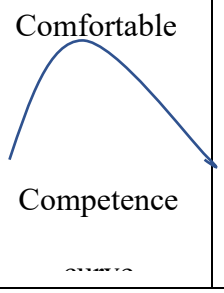
			are on their days ... uh, that are actually working.
	60h. Education sessions should be for everyone but are offered fleetingly.		DAWN But, at the same time, it winds up being a really hard place to be in, because, you know, that ... you don't know if that education sessions ever gonna be seen again. It could be one that they saw in a magazine or whatever and wanted to attend, but it only comes up once and you never see it again.
	61h. Knowledge dissemination depends on colleagues sharing.	62h. Knowledge sharing is not reliable.	DAWN So then, they have to rely upon each others exchange of information, relaying information. And, again, it's not the same as having been there and done it and learned it because everyone learns something a little bit different and, you know, even in a room full of conversation, you'll have picked out something different than I will have picked up from that. And, so that information that might have been most relevant to you, you haven't heard because that wasn't what that individual that heard it and relayed it to you was focused on.
3g. Can you tell me some of your thoughts on the notion of education in relation to competence?	62h. Education does not make a nurse competent.		DAWN: Like, what education does, it keeps you up to date. With, but ... the changes that are happening. DEBBIE: Agreed. DAWN: Um ... DEBBIE: But it doesn't necessarily make you competent. DAWN: No, because, you know, in- initially it does. We do see so many error initially until, you know, we work with them. DEBBIE: For practice [inaudible 00:27:34]. DAWN: Yeah. DEBBIE: Absolutely.

			DAWN: So, and it also takes the communication between staff and asking each other questions between what did that mean or seeking the, the clinical nurse educator for support and just for clarification. Does education make you more competent? I mean, I say yes, to a degree where it's leading in that way. Once, you fully grasp the new concept of education?
	63h. Education increases confidence but not necessarily competence.		DAWN Education, I think definitely has to contribute to confidence. But, we have also been witness to education to certain individuals, not helping to establish safety or a feeling of, uh, safe to practice. Therefore, confident practice, I would say. Um, you know, not being allowed to be independent because, um, despite the education people still don't get it. Um, you know, or choose to disregard it.
	64h. Some nurses choose not to comply to organizational policy but are not incompetent.		DAWN One of the things the staff has to do is they're supposed to being doing [inaudible 00:29:02] assessments on a patient to identify, you know, skin break down and, and things like that. They all have the education. They know how to fill out the paperwork. But, they choose not to necessarily do it, because they don't see a reason for it. Or, they don't understand how relevant it is. Or, they don't understand that when they do certain things ... Well, I keep filling this out but it doesn't seem to do anything, or it doesn't get anywhere, so why do I continue to fill it out? So ...
	65h. Competence does not mean complying with rules.		DAWN But, the reality is, is that there is not truly a reason or purpose behind it. So, does it make their practice in-, you know, are they, are they not competent based on that? They know how to do it. They just choose not to do it. So, you can have the education and still choose to do things differently, or off the books, or against policy or procedure, because you

			feel that your way of doing it is different. But that, you know ... And, it doesn't necessarily mean that your, your method of doing things is incorrect. It just might not match policy and procedure. I wouldn't necessarily say every single time somebody is not competent when they do it, cause they could be very competent. But, it maybe doesn't align with policy and procedure practice that is maybe considered best practice.
	66h. Both formal and informal education are important for competence.	67h. Informal education is ubiquitous and more effective.	DAWN But what do you both encounter? Individuals that are very competent and others that are less competent. Um, and, sometimes it makes a difference in regards to what level of education that they've had. Um, I've worked with some individuals who have less degrees of education than others and whose practice is more competent than others that have greater educations. You know, I think if we looked at, um, you know, sometimes it's street smarts verses book smarts that get us in ... that they can learn some of these so ... the formal education? Or, is it the informal education?
	68h. Critical thinking and sound decision-making is competence versus following policy and rules.		DEBBIE: And, because they're very, they feel very ... you guys are really good [inaudible 00:31:37] and you acknowledge that. I think they use their own ... well, I'm not filling out that because I know the patients fine. DAWN: Yeah. (laughs) DEBBIE: They're up and around, moving around. Why am I doing that? DAWN: It's just an extra paperwork. Why am I, why do I have to do another checklist. DEBBIE: Yeah. DAWN: Why do I have to do another score when

			they're up and around [inaudible 00:31:52]. Um, they are very competent, but because I'm not one that paper doesn't mean that they're incompetent.
	69h. “Booksmart” nurses can be incompetent in practice.	70h. Managers do not have confidence in nurses without clinical proficiency. 71h. Competence depends on the nursing context.	DEBBIE I've also worked with a very highly educated individual, who had no clue how to do different things. And, was it because, you know, they had this education based on a certain ... let's just say book smart that they never put into practice any of those components or it never physically worked with it. So, am I gonna unleash this individual with all the book smarts onto somebody? Absolutely not. I'm sorry, you're not competent to practice that with ... unsupervised at this moment. So, there is a, there is a relationship between education and competence, but I don't know that it's a direct link to the ability to be competent at working in a certain setting. I wouldn't be competent walking in ... I, please, I've been nursing for a really long time, but don't unleash me in ICU. I'm sorry, that's a little too serious. That's, that's a different animal. You give me the appropriate support and, and, um, you know, and again, education. I might be there, but at the same time, it just might not be my area of, of ...
	72h. Comfort is a factor in competence.		DEBBIE ... of expertise or comfort. And, comfort, I think, has a big factor in competence as well. So, I don't know. (laughs)
	73h. Personal circumstances impact competence.	74h. CARNA does not provide support for competence.	DEBBIE But, we've also noticed, actually in recent years maybe, noticed that other factors are impacting competence. Whether it be, uh, outside factors such as home life, uh, mental health issues, stress, um ... So, these can be highly educated individuals who these outside factors are not necessarily practiced in the most competent way. So, how do you capture that, you know, competency. A card of competency. And, you know, if you ask Carna to support

			you or help you in certain situations, all they have to go on is a piece of paper that somebody else's completed or that individual's completed. But, is it accurate? I don't know. How accurate is it? So ...
4g. Um, tell me about how you think the RNs are personally influenced.	75h. Nurses do not understand the relevance of some mandatory learning.		DEBBIE Well, I think that they, um, for example, when you look at just the education from, from my staff. When we look at the education opportunities that are out there, they don't, they seem to want to, obviously, focus on the things that are most relevant to their current practice. Um, and they, if they can't sometimes see how it's relevant, they don't necessarily want to ... don't, don't take the initiative to engage in it.
	76h. Managers help identify nurse learning needs.		DEBBIE . Um, but I think that they could benefit from other opportunities that I know that the employer necessarily isn't offering to them. So, for example, um, we had been designated a couple of, of staff members. One to two per unit that were to take additional leadership training with us while we were going through, um, the [inaudible 00:36:08] program. And, they were considered quality leads on our units because of this additional leadership. But, as we ourselves, as management, went through these particular classes as well, I can speak for myself in saying that there were several of them that I recognized that I felt several of my staff might benefit from actually attending. But those particular programs aren't offered to everyone on the staff.
	77h. Managers recognize opportunities to enhance strengths.		DEBBIE It's a limited crew of people, or, and it again, it came down to finances. It's too expensive for them to take or do whatever. Um, but, I felt that was actually holding back people that I think could ... who don't necessarily see in themselves their leadership qualities, or could learn things and, um, access these things. Cause I would like to put them into it. But, they themselves either don't have the opportunity to access it, or wouldn't think about doing it.
	78h. Education is motivating if		DEBBIE So, um, you know I think most of them do look at education being

	relevant to the nurses' practice context.		helpful. But, it, this, and, but it's ... When it's relevant to their current practice. I don't see too many of them wanting to go and do, um, ACLS when it's not something that they practice on the unit. Why would they do that? But, if it's on my particular unit, um, something related to the GI track. I'm there. If it's something, you know, related to insulin training ... If it's related to the things current in their practice, then they want to know.
	79h. Some are eager to learn and others resist.		DEBBIE They are often eager to wanna learn. There's some that are resistors. But, um, and don't actually want to participate. But, I think that's really worth it.
	80h. The CARNA CC program does not influence yearly learning.		DAWN Yeah, I think the, the insulin's ... I don't think the clinical competency portion of Carna influences their learning in terms of, okay, I'm due at the end of August. I don't think that influences them on their yearly plan of education. I think the influence a lot is program specific, or having on my unit urology days it's once a year, everybody wants to go.
	81h. Formal learning is best when it is social.	82h. Nurses learn effectively when it is collaborative.	DAWN It's, it's things that they can go with their friends, with their coworkers, or surgery day is another big one. DEBBIE It's very social. DAWN It's a very social thing. So, they go in groups and they learn together. And, the, I've sat with them and they all talk about it like, oh, we didn't know that, oh look what they're doing there. So, it's, it's that communication between [inaudible 00:38:58] and then, in a different environment outside the hospital that actually influences them to seek further learning.
	83h. Nurses strive to be comfortable at work but then they lose motivation to continue advancing themselves.	84h. Nurse feel competent when they are  	DAWN Um, D***, you know, she said that we identify, uh, either needs or things that we can actually ... it's like, you know, you're doing really well at that. You know, maybe we should take it to the next level. And, one of them's like no, I'm comfortable where I'm at. This, I'm comfortable at my job, I know my days off, I don't need that extra, extra responsibility under my plate, on my plate. I don't need that. I'm comfortable where I'm at. I come here, I do my job,

		comfortable in their practice but then they lose motivation to learn further.	go home. And, I don't hav- and I don't have to worry about work.
	85h. Nurses are reluctant to give up their personal time for learning.		DAWN I think that's another influence why they don't wanna go out there. We ... I've identified things on staff. I'm like, you there's this course, maybe you should do it, and they're like no. Um, that's my day off, I'd rather be doing something that I wanna do. I'm, you know, this is my job. I do my job and I go home and I have my private life. I don't need to be stuck to my job twenty-four hours a day.
	86h. Nurses are skeptical of learning programs implementations.		DAWN Or, the other thing is, you know, we've identified later is, we've ... They went through us with the leadership course and once they're in that they're like, oh, you bought into that program. They're not, you know, that individuals like, oh, you, you're a ... what is it Luke said? Anyway, you're ... you bought out. It's like, you don't believe in what we're all going through. It's not that, it's like, we're trying to make it better. You know, it's, it takes time. Or, you're a sellout. That's the other thing.
	87h. Learning opportunities are not equally accessible to all nurses who require it.		DEBBIE Well, that real- the reality is, on our end, each one of them should ... are to certain degrees, leaders. And, they just, they're at maybe differing or varying stages of it. But, they are all leaders in their own rank, but they're not being offered the same opportunities. Um, you know, to kind of help with that. T
	88h. Nurses will not go over and above what is required of them.		DEBBIE They definitely, um, you know, they'll go to their education days, but none of the ... you know, they might talk about, you know, how the day was or some of the things that they learned, but none of them ever create a presentation and bring it back for the group if they were ... They won't independently do it. They would have to be asked to do it, before they would typically bring something like that back to the unit.
	89h. Nurses need leadership training to inspire		DEBBIE Um, which, again, if they had more opportunities to learn, you know, maybe some of those leadership lessons, it would be something that they would

	and motivate them.		want to bring back and want to put forward. Unless, unless I'm physically saying, oh, would you write something up for the crew, or would you do something. They don't take those individual initiatives to do it.
	90h. Registered nurses are not motivated to practice with an increased scope.		DAWN You know, I also find that with our end it's like, they work until their full scope. They're fine there. They don't wanna go above. Whereas, you've got the LPNs that are slowly moving up, and th- I find that the LPNs are more ambitious. DEBBIE Yes.
	91h. Registered nurses are less motivated than other nursing groups.	92h. Nurses should be proud of their title.	DAWN In terms of education, in LPNs are more proactive. And, okay, you know, I can do that now. And, they go ahead. Whereas, if you've got an RN it's like, you guys can do that too, like, verifying orders. Even though, we, we, you know, the way it's set up now. If you have the LPNs working to their full scope, they do e- they will be the first one to do everything they can to their full scope. Whereas, the RNs are like, you know, they're kind of laid back. Like okay, it's like they don't take that initiative to make themselves better or promote their profession anymore. Just like, [inaudible 00:42:42]. Just identify either yourself as an RN. There's absolutely nothing wrong ... You should be proud of who you are. You went to four years of education, maybe even more or less, depending on what program you went through. But, you should be very proud of your title
	93h. Despite CARNA's apathy, nurses need to be accountable to their scope of practice.		DAWN And they're like, well Carna's not doing anything for us, well ... There's a whole separate story, you know. But, it's like. If, if you RN, there is that leadership component, you have to seek it out. You have to make yourself better. You have to be able to promote yourself even better, you know, because, you know, the scopes are getting closer and closer together.
	94h. Nursing has become more restricted in scope.	95h. Registered nurses are very capable.	DEBBIE Yep. They are. Absolutely. I think that, you know, they don't recognize that we're not working as an RN to their fullest scope practice. They, they've kind of compartmentalized

			themselves a little bit. Cause I sure know when I went through nursing school, things that we looked at, what we could potentially do and how, all of a sudden, it's like nope you can't do that. You can't do that. Nope, you can't do that. No, you can't do that. And yet, you look at the NPs and it's like, well I learned that while I was in nursing school. Why are you allowed to do it as an NP and I can't do it right now, but it's in my school to practice to be able to do it. Wh- What? It's like, I don't understand, and you know, they ... we do have some really strong RNs that could move forward. I mean, they have no problems being able to say when they're speaking to their colleagues, this is going on with the patient, or I think this is going on with the patient.
	96h. Nurses are knowledgeable but this isn't recognized or respected by members of the interdisciplinary team.	97h. Nurses are intimidated by other professionals who look down on them.	DEBBIE They know their stuff. They know exactly what they're doing. Uh, they know they're education. They've learned something new. But, they won't take something that they've learned new and take it back to a physician or say, have you heard about this or done this. It's like it's ... it's, it's like the totem pole. I'm on my level on my totem pole and I'm not happy to make a motion outside of that. I'm content being right where I am. I'm not going to make waves. I'm not going to do anything. And, sometimes, however, when they do, they feel backlash from other people and so, they often aren't. You know, they might have the knowledge, which might be different from education. They have the knowledge, but at the same time, it's not necessarily, uh, received, by all the members of the interdisciplinary team.
5g. Uh, okay, one last thing I'll ask you about and that's, um, the union. You- You've mentioned a couple times about Una. Just, sort of, um ...	98h. Managers must accommodate the UNA education days.		DEBBIE The first one is professional development days. We, according to the [inaudible 00:46:14], we have to give them three, minimum of three, a year.

They do have some type of role in professional development. Could, could you just tell me a little bit about that?			
	99h. UNA does not keep track of education day utilization.		DEBBIE: So, that's one thing. In their professional development ... DAWN: However, they're ... we have to give them three a year ... Meagan: Do they take ... DAWN: ...but, they don't actually keep track of the fact that they aren't utilizing them. DEBBIE: Yep. DAWN: So, even though they are instructed, they're, that ... you ha- you were entitled to have three a year. Una never comes back to us and says, they only used one. Una never comes back to us and says, they didn't do any at all. DEBBIE: It, it, it's ... it's only when we deny one and then we'll get it.
	100h. UNA negotiates staff breaks and education days but without consideration of staffing issues or scheduling constraints.	101h. UNA complains of low turn-out without understanding the complexity of the nursing situation.	DAWN It's like they're not as equally engaged in trying to make those opportunities and again, you know, Una's heavily involved with some of the things that are happening in the facility in regards to the way we do breaks, and when we do breaks, and yet, they set up, they set up education systems despite our ongoing ... this isn't a great time. They still continue to run them. It's like, well how can you expect ... then, and then they turn around and they come back to

			us and say, well nobody shows up. Well, that's because you're not setting it up at a time that's convenient.
	101h. Nurses are focused on their patients and their tasks making it difficult to learn on the unit.		DAWN And, then, they're like, every once in a while, you know what I'll do. Oh, well, maybe it would be better if we do them on the unit in a backroom meeting. No, because my nurses are not going to focus on that. They're still focused on their patients. If the call bell rings, they know that they're supposed to answer it. They're gonna leave what you're doing and they're gonna go. They're not ... they're gonna be focused on what's going on out there and trying to sport.
	102h. UNA promotes education events.		DEBBIE The union does put our bulletins where they actually do promote development in terms of, they have either monthly, or every other month, or every three months, they do posts.
	103h. Not everyone gets to access valuable learning sessions.		DEBBIE: Those are very well attended. She's a great speaker. So those, I will get requests for professional development days for those. DAWN: But, again, once that one's up, you don't see it again. DEBBIE: Yeah. DAWN: So, accessing it, where everybody has the potential to access to ...
	104h. Opportunities to increase accessibility to learning should be explored.		DAWN ... like, I would prefer to see them doing things like, um, and this might be an infringement on, you know, [inaudible 00:48:30] or who their presenter is. Being able to videotape or record, do whatever, so that it's accessible to the staff beyond those days once it's presented. Or, have a way to be able to access the site to be able to get to it. Um, but again, it's a social event, right? They go with their friends, they ...
	105h. Managers have no way of		DAWN ... you know, sometimes, sometimes you wonder whether or not,

	knowing if nurses actually attend approved day off learning sessions.		uh, they've attended or not. But, again, there's another thing is that, we have no means of actually identifying truly, whether these people have attended when we give them the opportunity. Because, you know, there's, there's nothing. They- yeah. Sure. The sessions at West [inaudible 00:49:07] Mall. Um, but do I know that you didn't go shopping for the day verses sitting in there? I don't know.
	106h. It is unknown how to get more support for nurses.	107h. Nurses need education where they can focus on learning and not be worried about their unit work.	DEBBIE: Yeah. But, again, I think that, I think that the nurses could potentially be more supported in more ways. It's just how we go about getting it, you know? DAWN: Yeah. And, you know, being able to take them off the floor and get them the proper education with ... where their focus is just on that item. Oh, Okay.

Appendix 4U-Executive Focus Group Second Level Analysis

Table 49. Executive focus group-Second level of analysis

First level analysis	Second level analysis
27L. Nurses may justify their personal time given to learning if there is no cost associated. 22L. Interested nurses will take learning opportunities on their own time. 38L. Nurses want balance and part of that is to learn at home on their personal time. 28L. Investing in personal time to learn is justified if it is relevant.	1M. Nurses justify learning on their personal time.
2L. Professional development depends on available opportunities. 9L. Nurses are concerned and anxious about the mandatory education they must do on their own time. 8L. There are barriers to mandatory organizational learning. 10L. The time required for mandatory education should be paid for. 21L. Nurses should be paid for their time to do mandatory learning. 25L. Three paid education days are not enough for some nurses who are motivated. 17L. The reality is that staffing and shift work are challenges to accessing learning.	2M. Mandatory learning *should* be provided and funded.
107L. AHS hopes for ways to improve clinical practice. 108L. AHS desires to support nurses' career development. 6L. Learning opportunities more abundant in urban centres. 29L. Over the years, there are decreasing on-site learning opportunities. 30L. Case studies are an example of where spontaneous learning could occur in the system years ago but not in current day circumstances. 106L. AHS is exploring ideas for continuing nurse education. 57L. It is a bonus if the employer provides necessary education.	3M. AHS provide waning support for nursing CPD.
3L. Nurses must be able to afford time and money for learning. 7L. Nurses must afford costs of education. 26L. Motivation is key to choosing education and overcomes the cost barrier.	4M. Nurses pay for the learning they require.
4L. UNA complies with nurses' solicitation for learning benefits. 5L. UNA reduces barriers.	5M. UNA reduces barriers to learning.

11L. Education must be relevant. 23L. Nurses will take education that is relevant to their practice 109L. Relevancy to the nurse is the driving force in continuing competence. 110L. Relevancy is a selling point for education initiatives. 115L. Mandatory education must be relevant to be effective learning. 113L. The educator should make learning relevant.	6M. Nurses are motivated when education is relevant.
12L. New grads are provided more educational opportunities to support their entry into professional practice. 15L. New nurses require more general education versus experienced nurses who require more depth and specific education. 1L.Education requirements vary with nursing experience. 37L. Learning may be meaningful at different points in a nurses experience.	7M. Education requirements vary with professional experience.
13L. Technology increases access to education. 20L. Online learning increases flexibility to access learning. 24L. AHS arranges elearning opportunities. 14L. Elearning supports access but interrupts personal time.	8M. Online learning increases access to education.
16L. Nurses acknowledge their need to grow and seek learning. 45L. The most valuable and relevant learning is that spontaneous decision to attend a conference or workshop. 54L. Nurses' accountability for their own competency drives them to seek learning opportunities. 55L. New skills, interventions or procedures relevant to nurses' individual practice are highly important to them to learn. 56L. Nurses are motivated and seek opportunities to learn new policies or implementations. 111L. Nurses explore what they need currently and in the future.	9M. Nurses seek the education they know they need.
31L. Nurses would rather learn in smaller chunks. 35L. Many nurses would rather be mentored and instructed one-on-one. 36L. Learning style is important to the efficacy of learning. 34L. Learning with technology is not the best way to learn for everyone.	10M. Learning styles and preferences influence learning.
33L. Busy lives are the reason for high attrition at learning events.	11M. Nurses have busy personal lives.

18L. “Just-in-time staffing” reduces time for vacations and time to learn. 32L. Nurses lives are complex and busy. 48L. Lifestyles are a factor in learning choices.	
40L. “Mandatory learning” is both what the employer deems mandatory and also the annual learning nurses must do for regulation. 39L. Mandatory education is repetitive and boring because it is taken year over year. 47L. Mandatory learning are often certifications required for certain nursing positions.	12M. Nurses must learn rote, yearly education in most nursing positions.
46L. Mandatory learning is not always what is needed for the nurses’ specific role. 77L. Completion of the mandatory education requirements does not mean a person is competent. 117L. Mandatory learning does not necessarily target areas of incompetence. 116L. Incompetent nurses can still competently complete mandatory education.	13M. Completion of mandatory learning does not indicate competence.
41L. Strong nursing leaders increase awareness of, and encourage learning opportunities. 42L. Nurse leaders arrange scheduling for learning sessions. 43L. Strong nurse leaders encourage and positively reinforce staff nurses to seek additional education. 112L. The educator can make or break learning motivation and/or efficacy.	14M. Nurse leaders/managers are learning motivators and gatekeepers.
98L. “Continuing competence” is a state of change. 44L. Unstructured learning is also continuing professional development. 49L. Continuing competency is difficult to measure because learning on the job is elusive. 68L. Informal learning includes modeling competent care. 80L. Experiential learning is more efficacious than education programs. 58L. Learning something every day is an enhancement to nursing practice. 53L. Mistakes are learning moments that improve nursing practice. 59L. Enhancing practice doesn’t mean introducing new skills or knowledge. 105L. Patient conditions are learning opportunities.	15M. Unmeasurable, experiential learning helps to continue competence.
60L. Nurses overcomplicate the MyCCP learning objective. 61L. The MyCCP learning objective is what nurses are doing in their daily practice.	16M. Nurses should apply experiential learning to their MyCCP learning objective.

50L. Nurses accept that they must demonstrate their continuing competency.	
51L. The assumption is that nurses are competent. 73L. Nurses should know what competent practice should be and whether they can deliver it. 52L. Nurses should question how they have enhanced their competency. 79L. Rural nurses have more challenges with continuing competence.	17M. Nurses must know how to continue their own competence.
62L. Nurses know they are competent because of feedback they receive from patients. 64L. Peer feedback is critical to nurses knowing their own competence. 65L. Nurses constantly receive feedback from many sources. 74L. Nurses determine their competence from feedback from peers and leaders.	18M. Nurses know their competence from peer, manager and patient feedback.
70L. Nurse managers must detect incompetence related to poor health. 71L. It is up to nursing peers and leaders to detect incompetence. 75L. The greatest challenge to nurse leaders are those staff nurses who are unconsciously incompetent. 76L. Nurse leaders must determine the various reasons for incompetence. 118L. Nurse leaders have the responsibility to determine competence gaps. 119L. More nurse leaders are needed to determine learning gaps.	19M. Nurse managers are accountable for detecting and managing staff nurses' competence.
99L. "Incompetent" is unsafe practice. 63L. Some nurses do not know whether they are competent or incompetent. 72L. Loss of competency may be related to physical or mental illness. 95L. Professional competencies are nursing core concepts and principles. 114L. It is a struggle to determine undermines nurses' competence. 94L. Competencies for professional nursing practice are too complex to generalize. 97L. "Competence" should be viewed as varying in degrees. 104L. Some nurses are more competent than others.	20M. Loss of nursing competence is convoluted and challenging to pinpoint.
66L. Coaching is the way leaders help nurses become competent. 67L. Senior nurses coach younger nurses on skills, tasks, and interpersonal skills. 69L. It is up to nurse leaders to coach nurses who are unconsciously incompetent.	21M. Nurse managers, educators, and senior nurses must provide coaching to increase competence in staff nurses.

78L. “Strong” nurse leaders infuse a positive informal learning environment when they coach and mentor nursing staff.	
82L. Constant change should not be overwhelming because it is the norm. 83L. Patient expectations and new technologies are steering nursing in new directions. 87L. Technology removes nurses from touching patients. 89L. Critical decision-making will soon involve computer-generated information. 90L. The new interface of technology will increase the need for critical thinking. 91L. Nurses will need to consider an understanding of quality in future continuing competence. 103L. There will be varying difficulties in learning new technology.	22M. Upcoming changes will increase the need for nursing critical thinking and adaptation.
84L. Organizational leaders need to be resilient, thoughtful and collaborative in educational approaches. 85L. Organizational leaders decide what is learning priorities. 86L. Lack of communication and collaboration alienates organizational leaders from each other. 88L. Organizational leaders recognize the importance of reaching a collaborative understanding of strategies. 96L. Organizational leaders must consider all nursing contexts in the province. 81L. Organizational unification decreases redundancies and increases efficiencies.	23M. Organizations do not, but should communicate and collaborate for unified approaches to education and implementations.
92L. New expectations of nursing competencies should be considered in undergraduate programs. 93L. Knowledge translation and application needs to be incorporated into nursing programs.	24M. Elements of continuing competence approaches should be included in undergraduate programs.
100L. Nurses are compelled to execute organizational changes. 101L. Nurses must adjust quickly to changes and return to their patient care. 102L. Nurses “work around” new implementations if it doesn’t benefit patient care. 19L. Patient care is a priority over staff education.	25M. Nurses must learn and adapt quickly while prioritizing patient care.

Appendix 4V Executive Focus Group First Level Analysis

Table 50. Executive focus group-First level analysis

Question	Major Theme	Sub Theme	Statements

1Q. Okay, so the topic then is the influences on, on Registered Nurse Continuing Professional Development and you as managers, what your ... and what y- your view is of those, of their influences and continuing professional development. So, um n- not your, your personal experience, but your experience of their continuing professional development. Does that make sense? But for example, CARNA, UNA, the employer, um, peers, colleagues, um, how leaders influence. Um, workplace influences, scheduling, um, busy work, um, any of that. Technology, um, maybe you have a perspective of their personal influences. And um, anything else you can think of. Interprofessional teams, um, anything that comes to mind.	1L.Education requirements vary with nursing experience.		Alice. Well, from my perspective, there's a, there's different stages, uh, in terms of professional development. The needs and desires perhaps of a new grad may be different than somebody who is well-established in a- a practice setting.
	2L. Professional development depends on		Alice. Um, certainly in terms of what influences um, con- continuing professional development, I think there are a couple of significant things to do. Uh, one

	available opportunities.		is, what is even available? How, what opportunities exist in areas that may be of interest to the individual? Not so good.
	3L. Nurses must be able to afford time and money for learning.		Alice. That alone, and um, I would say, cost and ability to attend.
	4L. UNA complies with nurses' solicitation for learning benefits.	5L. UNA reduces barriers.	Alice. Certainly that has been identified, uh, over the course of years with uh, the members of UNA, where we have been repeatedly asked to um, and we have negotiated things like professional development days, where every nurse, whether they're casual employee or, a full-time employee is entitled to three professional paid professional development days a year. Uh, that was ... I think that reduces the barri- some of the barriers in terms of access
	6L. Learning opportunities more abundant in urban centres.		Alice. it's really related to opportunities, but uh, somebody in a rural setting uh, will have a much greater uh, a higher threshold to, to leap in terms of uh, even being able to attend. Because it generally, uh, the farther away you are from a major center like Edmonton and Calgary, the more likely that you're going to require additional time off, additional travel.
	7L. Nurses must afford costs of education.		Alice. Um, so the- the costs become a factor as well. Um, that's in terms of, of what I see as education that nurses want to um, or want to access to for their own uh, reasons.
	8L. There are barriers to mandatory organizational learning.		Alice And then of course there's the whole area of mandatory in-service. Which, interestingly enough does have some of its own barriers in terms of when. Mandatory in-service, mandatory education is most, I think, most readily responded to, or addressed.
	9L. Nurses are concerned and anxious about the mandatory education they must do on their own time.	10L. The time required for mandatory education should be paid for.	Alice. There is the ... I know there is a lot of concern or, some angst around um, what is stated to be mandatory, but expected to be done on the nurse's own personal time. And, the on- the whole online education stuff that uh, has evolved and then the modules- um, the modules, I mean, we actually have proposals that there should be a funded day in addition to the, the days where uh, three days of stuff I want to pursue, um, per year that there's an

			additional day where I am uh, recognized and paid to do just the required online, in-service of employers.
	11L. Education must be relevant.		Alice. So, um, I think the relevancy of it, uh, is a factor as well. But uh, access and, and uh and cost, that kind of stuff I- I think are significant.
	12L. New grads are provided more educational opportunities to support their entry into professional practice.		Alice. And it depends too, what kind of um, entry supports are provided in terms of how much in- individuals need to pursue uh, additional uh, continuing educational development on their own. I think individuals who perhaps come into practice settings new graduates in a supported way like the uh, uh transitional grad nurse where, currently it's nine months, but uh, they have up to nine months in the supernumerary position to acclimatize themselves and actually spend perhaps more time uh, doing some clinical uh, education as well. Um, I think their needs may perhaps be lesser or there may be a sense of: I have sort of less panic about getting stuff, because they, before they're actually fully, uh, flung into the work environment they've had a, uh, a supported entry, so I think those, from my perspective, those are things that, that influence.
	13L. Technology increases access to education.	14L. Elearning supports access but interrupts personal time.	Grace. Yeah. The first thing that flew into my head, um, Alice you called it access, but I was thinking timing. Es- especially in a profession where so many people work shift-work. And, so having the ability to do things online or, in different through the use of technology is really important. Um, but then I do agree with your comment. Sometimes that flow between, well I could do it then but it's my personal time and how do I feel about that, versus time specific for it.
	15L. New nurses require more general education versus experienced nurses who require more depth and specific education.		Grace. Um, so access and I think the other thing is, and, and, Alice you said it as well, but just a little bit of a different twist for me, is there seems to be continuing education needs that differ along the career path, so those that, and you, you said similar, so those that are new and entering the profession, seem to have learning needs that are broader in nature and they're quite comfortable with that. You know, talking

			about social media, or documentation principles, or those kinds of things whereas when I talk to nurses um, that are at different points along their experience curve. The more experienced they get, the more specialized and the more focused and the more right down into the depth of what they want and what they need,
	16L. Nurses acknowledge their need to grow and seek learning.		Grace. and sometimes it's both, it's that mix of I need to- to grow more, but I'm also required to grow more and where could I go to get that?
	17L. The reality is that staffing and shift work are challenges to accessing learning.		Christine. And I would agree to, I think it is access and timing and shift-work and, from an employer's perspective, an ability to free up staff to attend, so you have somebody plan to attend something and someone is ill, and then you can't leave your patients without care. You know what I mean? So there's there is- always the challenges around staffing and freeing people up for education. That's what managers would say, I know that for a fact. I'm not saying that's right or wrong,) I'm speaking to the reality of the workplace.
	18L. "Just-in-time staffing" reduces time for vacations and time to learn.		Alice. We've gone to, so close to just in time staffing that eliminating any peaks in rotations so that you don't have days where people can be encouraged to go and do something because they don't have them anymore. Which, I mean, that's why people don't get vacation. Christine: Right, so, now- now. Alice: I'm not saying- Christine: She just came out of negotiations, can you tell? (laughs) Alice: I'm not saying that in ... I'm just saying that we don't have a lot of uh, free, free time.
	19L. Patient care is a priority over staff education.		Christine. No, we don't, yeah I agree with you. And so, and that's exactly why I brought it up. Because I think there's, there's an inability sometimes to release staff for education, that's what it is. Because, priority always is patient care.

			And regardless of how we schedule, or what we do with our schedules, there is always variation..
	20L. Online learning increases flexibility to access learning.		Christine. I totally agree with Deb about different levels of learning, at different times in the organization. it's interesting about online learning because you— it is the way of the future. People talk to us about wanting that flexibility and needing that flexibility
	21L. Nurses should be paid for their time to do mandatory learning.		Christine. There will always be a some requirements for mandatory education and staff should be paid to complete that if the organization requires it.
	22L. Interested nurses will take learning opportunities on their own time.	23L. Nurses will take education that is relevant to their practice. 24L. AHS arranges elearning opportunities.	Christine. We do however, have nurses who are keenly interested in some education and take it on their own time simply out of interest because ... And I'll give you an example, we just initiated a partnership with the de Souza Institute, I don't know if you're familiar with it, but it's a leading authority in oncology care and education.We have a partnership with them around some fundamentals of cancer care education. And we have a license with them and they've done some beautiful education work, and as part of our contract agreement with us for a period of six months, they agreed to release us an unlimited amount of licenses for any health care provider, including nurss who is interested in the learning the fundamentals of oncology. So, if you signed up, and you have an AHS email address, you can get a license to take this, I think its 16 hours of learning, online. Well, we're already at 1300 people who've accessed the education at and 800 of those have completed it. So that's pretty impressive, and this is people that are interested and what we're finding is, what we're hearing is that these are people are working on units that are not oncology units, but they're dealing with oncology patients. And they just need to know more about it, because it will support their practice. So there is, and I think will always be nurses who are just invested in nursing practice and in education, and will take that time to do it. We-will always, find that if

			it's relevant for their practice they'll carve out time.	
	25L. Three paid education days are not enough for some nurses who are motivated.		Christine: Christine: Alice: Christine:	Well the three, three professional development days a year is perhaps for some, too much, and for- Others not near enough. (laughs) Others not near enough is the reality, right? Yeah, yeah, yeah.
	26L. Motivation is key to choosing education and overcomes the cost barrier.		Alice: Christine: Alice: Christine:	I mean, self-mo- personal motivation is, is a big element of- Yeah. Whether people choose to partici- and I agree um, I mean if you're really interested in doing something, and especially if you don't have the cost barrier- Yeah, that's right.
	27L. Nurses may justify their personal time given to learning if there is no cost associated.	28L. Investing in personal time to learn is justified if it is relevant.	Alice: Christine: Alice:	Then it's a matter of your own personal time and it's, I would suggest that for most of the oncology stuff, if you're- if it's not directly related to your employment, the job you're in right now, it wouldn't have been, it wouldn't have been free, right? Generally, that's, so that's great. I mean, I think that what it says is, is-is that making it available at no cost to the individual, then the individual sees the value- That's right. In investing their own time, even whether it's

			related to their practice setting, now we're in the future. I mean, oncology, I don't know anybody whose family is- Christine: Doesn't have some experience- Alice: Hasn't been touched at one point or another, so I think the relevance is, is certainly a factor in, in uptake of it as well.
	29L. Over the years, there are decreasing on-site learning opportunities.		Grace. …Significant factors from that system level, so it's not just staffing, but it's the way that I look at capacity within the system, so when I first started as a nurse, we didn't always run at 150% (laughs) and people had babies, and they were there in the hospital for a period of time, so those system shifts have pushed other shifts in the way that not only do we work and practice, but in the way that we have opportunities to learn.
	30L. Case studies are an example of where spontaneous learning could occur in the system years ago but not in current day circumstances.		Grace. Um, so that the idea of um, I'm gonna call them case studies, but you know when there was a quieter time on the unit, maybe somebody presented an interesting case, or there was some of the more experienced individuals who took time to share with others, that was kinda serendipitous, that was just in time education and all those kinds of things and the system doesn't have the capacity, I don't think to do that kind of thing. Not that any of the teams wouldn't like that, it's just really hard to get away.
	31L. Nurses would rather learn in smaller chunks.	32L. Nurses lives are complex and busy.	Grace. The other thing I've heard is um, the influence of the rest of our busy lives, so technology is a blessing and a curse in that, you know, a lot of people extremely multitask on a lot of different levels, so I've heard from people they like the ability to do small bits, don't have to do it all at once, and I got interrupted and I had to stop, can I come back and finish it? So, um, you know, I- my son was sick, or I had to- I had to take him to hockey, or her to hockey, and whatever, and can I do it at another time and

	33L. Busy lives are the reason for high attrition at learning events.		Christine. I- I think sometimes when I see the amount of interest in people that sign up for things, they have good intentions, then you look at who actually participates and you go, wow. I lost about 80% of the people that said they were coming, so what happened. And I think it's that busy-ness and so if we can look at repeating the same thing a whole bunch of different times-
	34L. Learning with technology is not the best way to learn for everyone.	35L. Many nurses would rather be mentored and instructed one-on-one.	Grace. Yeah, and- and coming and going. Right? Then you- you talked just a little bit about that opportunity um, and the other thing I wanted to say is um, technology is not always the right fit for everybody. So, there have been people that have called me and they flat out say, I don't want to be self-directed learning, I don't want to do it online, I want someone to come and talk to me, or to show me, or hands-on, so I think we really have to take a step back and look at how different people learn. And, and uh, cause they're telling us that. There's a large number, and- and I guess I sometimes stereotype groups and think oh, the younger ones: technology. I need to take a step back cause it's not always so.
	36L. Learning style is important to the efficacy of learning.	37L. Learning may be meaningful at different points in a nurses experience.	Grace. Right? Or vice versa. Those that are at the more experienced end of their career, it's not all that they don't necessarily want all face-to-face. So it's, what is their learning style, and how best do they learn, and- and then one other thought, is that um, it's not once and done, either. So some, some learners have said they'll come back again um, it's kind of that old saying where you don't, until somebody you know is pregnant, you don't notice all the pregnant people, and then suddenly you go, where did all these pregnant people come from? So, so with learning, they just, they may have been at the session, then sometimes seems to happen in their practice setting and they go oh, and then they want to go back and look at that topic again cause they're, they're ready to absorb it a different way.
	38L. Nurses want balance and part of that is to learn at home on their personal time.		Christine. Yeah, I think you're right. I think flexibility's really key. I think that people are looking for different things in terms of the pressures of their life and work-life balance and how do you fit it all in? , They

			work very hard at work, and- and sometimes when they come home-, they're done, right, they're tired.? And they want to focus on different things, but we have heard from people they like flexibility. They like to be able to work evenings and do something online while they're having coffee in the morning.in their jammies.
	39L. Mandatory education is repetitive and boring because it is taken year over year.		Christine. And, as Deb said not everybody is the same, so. And mandatory education is a whole different kettle of fish. It presents the same kind of barriers in some ways, but mandatory education I know for nurses sometimes feels very repetitive and I did it last year and I did the same thing and it sounds the same, and it looks the same, and we can't seem to make it more interesting. I think it's a challenge for them to want to engage in learning that they feel like know hands down they could probably teach the course themselves..
	40L. “Mandatory learning” is both what the employer deems mandatory and also the annual learning nurses must do for regulation.		Alice. Well and I mean, some of the mandatory, and there's two different types of mandatory, there's man- what the employer might determine to be mandatory. And then there's stuff that the employees have actually determined to be mandatory and in terms of things of like annuals, that kind of stuff, which they've asked to have put into a contract, because it's so important that they want to make sure they get it. Um, but I- I do agree with the flexibility and the whole, lots of different ways. When it's provided, how it's provided, um, that kind of stuff.
	41L. Strong nursing leaders increase awareness of, and encourage learning opportunities.	42L. Nurse leaders arrange scheduling for learning sessions.	Alice. I also think a factor that influences continuing education is nursing leadership. And if they- they ... if you're working in an environment where y- you have strong leaders who encourage um, undertaking education uh, make you aware of opportunities in your area that you're currently working in, or generally, I think that does play a factor, you know in terms of uh, willingness to you know, achieve time-off or make- ... cause some of these things happen with you know, I'll trade, I'd like to go, I'll trade, it's not all just about the paid time, it's, it's can you make arrangements, you know.

	43L. Strong nurse leaders encourage and positively reinforce staff nurses to seek additional education.		Alice. And uh, I think that where you have a strong nursing leader in a program or, or unit who encourages their staff and you know, positively reinforces their staff for taking on and seeking out additional education, I think, I think there is a big difference in terms of both what the staff do, and- and what they bring back.
	44L. Unstructured learning is also continuing professional development.		Grace. What, what a really powerful comment, cause I sat here and I thought, wow you know, my comments may have unintentionally been more focused on you know, structured learning. But I think it's really important that we talk about unstructured learning. Which is still continuing professional developments.
	45L. The most valuable and relevant learning is that spontaneous decision to attend a conference or workshop.	46L. Mandatory learning is not always what is needed for the nurses' specific role.	Grace. So, so and, and, and we talk about optional and mandatory, but, but structured and unstructured is another way too. So some of the learning that can happen that is the most valuable, the most relevant is what I call that just in time, where someone who has the capacity and capability to say, had you thought about or, I have learned that and then that spikes their interest. And they'll go often do some reading about it, or they'll suddenly hear about a conference, or they'll say I heard there was a skills day on such and such, I'd like to go to that. And I think that we need to be very cautious in looking at what is, what's the right fit. Mandatory just always, makes me just stop and think for a bit, because are we putting some assumptions on individuals that this is what they need for their role and both of you talked about oncology, COPD, chronic disease management, and those kind of, everywhere. They're not just on a [inaudible 00:23:16] unit or-
	47L. Mandatory learning are often certifications required for certain nursing positions.		Alice: And I wasn't talking about mandatory in terms of, you must take this. Grace: No, no. Alice: There's some positions have mandatory- Grace: Certifications.

			Alice: Applicants, yeah. So, that, if you're wanting to go into that kind of practice setting, even if the employer doesn't identify it as manda- as a mandatory thing to have, some people will say I don't wanna go in there unless I have that, that background education right, so whether or not PALS are being provided um, by the employer, uh or whether or not the job posting says it's preferred or required. That will influence some of how, what people seek out in terms of ongoing education, right, if they want to make a, a, a- Christine: Yeah, if they want to make a- Alice: A career change- Grace: Yeah, yeah.
	48L. Lifestyles are a factor in learning choices.		Alice. Into an area, they will build their skill level and knowledge in that area, so it's again, it's about what people want, and that can be driven by a whole bunch of things. It may be individuals and that goes back to your comment in terms of uh, personal lifestyles. Somebody who is looking at uh, a family and wants a, a job that more closely will align with child care, or whatever, you know may look at specific education for a specific kind of setting because that's what, what drives them on in terms of-
2Q. I'm gonna just jump in for a second, and because one of the drivers in thinking about my research question was, was the continuing education is	49L. Continuing competency is difficult to measure because learning on the job is elusive.		Alice. I mean, people are always learning, I mean there's, there's some s- there used to be [inaudible 00:25:26] in terms of continuing competency, um, and you know, how do you measure that? I don't know anybody who can practice in this profession and not continue to, to learn cause every day ... no two days are alike in terms of, of care.

mandatory for continuing competence. I'd just like to throw that out there, and get some of your thoughts on continuing competence in relation to continuing professional education.			
	50L. Nurses accept that they must demonstrate their continuing competency.		Alice. Um, so if you're not learning, there's something wrong in my view, but yes I mean, I- I think people accept the, the change that was made in terms of the, the legislation and the expectations around being able to demonstrate or prove that you have uh, continued to you know, demonstrate your competency or enhance your competence.
	51L. The assumption is that nurses are competent.		Alice. Cause I think that's really what it's all about, I mean um, is what have you done to enhance your practice as a, w- w- something's happened we should presume that people are competent at the practice.
	52L. Nurses should question how they have enhanced their competency.	53L. Mistakes are learning moments that improve nursing practice.	Alice. But what have you done to enhance your, your personal competency or, I think it's just accepted that we all, you know the self-reflection and all that kind of stuff, that even if there is a mistake, you don't look at it in terms of the mistake, but what did I learn, what did I learn? What does that, what does that mean to me in terms of tomorrow when I go to work?
	54L. Nurses' accountability for their own competency drives them to seek learning opportunities.	55L. New skills, interventions or procedures relevant to nurses' individual practice are highly important to them to learn.	Christine. Mm-hmm (affirmative), yep. So you know that tweaked something for me and that was around how we think about scope of practice. I always think about it with the CARNA pyramid that has the legislation on the bottom and then college standards, and then employer policy, and then individual competence,, and then does your patient needs. And, and like Alice says, it's so fundamental to who nurses are that in my mind, they, they've owned that competency. And they, they seek opportunity, especially if it's a new skill or a new activity, or a new intervention that they're using on the unit, they really want

			to understand and learn that, because it is relevant to their practice and they need to learn it to maintain competency. That's very important to nurses.
	56L. Nurses are motivated and seek opportunities to learn new policies or implementations.	57L. It is a bonus if the employer provides necessary education.	Christine. And I thinking terms of supporting competency, I think employers support that that learning and if we have a new policy we roll or an implementation plan or education, I think lots of nurses really seek that continuing education to support their practice. If the employer has it available for them, that's a bonus. But if they need it, they'll look for it, they'll find it. That's my sense.
	58L. Learning something every day is an enhancement to nursing practice.		Grace. But, I think that one of the um, things that I was thinking about is for, we've come a long way, and I think that a lot of nurses across the country have started to use a different, different words to think about continuing competence. But if I think about some of the discussions I've had with nurses that were educated 30, 35, 40 years ago, um, it really is that ongoing evaluation piece. So, it- it's like every day you learn something different. So it's not, it's an, it's an enhancement. You're right, it's an enhancement.
	59L. Enhancing practice doesn't mean introducing new skills or knowledge.		Grace. Um, I think that we live in an environment within health care right now that technology is just so prevalent and that there are new things that we're learning every day. But we might forget about continuing competence is that continual quality improvement based on, what have I evaluated, and what worked well, and maybe I'm gonna continue to do that because it worked well. But that's an enhancement, recognizing that it worked well. So, um, some of the discussions that I have with nurses where they think they have to come up with something new every year, I will talk to them about well maybe not.
	60L. Nurses overcomplicate the MyCCP learning objective.	61L. The MyCCP learning objective is what nurses are doing in their daily practice.	Grace. And why are you trying to make it so complicated? Describe for me what you do every day, and maybe we can get an objective out of that (laughs) instead of creating some new one, or the other thing, trying to develop seven, where you have a really solid good one.

3Q. Let me ask you a little bit more about what you're saying there, and where you're going with that. How do you think RN's know their competence?	62L. Nurses know they are competent because of feedback they receive from patients.		Grace. I think the majority know, I think the majority know from a variety of sources, by their self-satisfaction of the job well done, by patients immediate feedback verbally or physically or by body language.
	63L. Some nurses do not know whether they are competent or incompetent.	64L. Peer feedback is critical to nurses knowing their own competence.	Grace. Um, unfortunately the, I- I think some don't. I- I do believe that's a very small number though and I think that peers and good working teams, so whose ever in that team, if, if it's a solid interprofessional team where there's a good amount of trust and good communication, you're gonna get that feedback too. In lots of positive ways, or in constructive ways around, "had you thought about".
	65L. Nurses constantly receive feedback from many sources.		Christine. Yeah, and I- agree with you. I think that nurses live in a world of immediate feedback. They're always getting it, constantly from patients, from family, from team members, and I think the more we engage our patients in the work and make them part of our care, nurses are going to get even more feedback.
	66L. Coaching is the way leaders help nurses become competent.	67L. Senior nurses coach younger nurses on skills, tasks, and interpersonal skills.	Christine. But I want to go back to what you said earlier because I think you didn't use the word coaching. But I think it's coaching. I think that is a way that we help people become competent and I think that more senior nurses supporting our younger nurses and it's not always about a skill or a task, it's watching them talk to patients. For example if I am a new nurse and Alice's explaining something to a patient that really involves the patient, the patient feels heard and I listen to that, and I understand that is the way it is done.
	68L. Informal learning includes modeling competent care.		Christine. So it's not about formal learning, I think that is De's point too, is that lots of competency is witnessing the best in care. And we see lots of that. Experts in care.
	69L. It is up to nurse leaders to coach nurses who are unconsciously incompetent.		Alice: I'm trying to think about it from a, in terms of people who clearly are not competent. Because, certainly our organizations all run into people who-

			Grace: Thank goodness they're smaller numbers. Alice: Yeah, that's true but I'm trying to think, wh- what do they, how do they proceed their practice, do they honestly perceive that they are, they are good and they are, I don't know. I mean I, so there's that whole, I just- Christine: So if they're unaware, then Alice it comes back to that whole l- leadership piece, right? Alice: Yes. Christine: And the responsibility of a leader. Alice: Absolutely. Christine: Yes, to work with them and coach them and support them because if you're oblivious-
	70L. Nurse managers must detect incompetence related to poor health.		Alice. Yeah, and I mean if you don't, I mean that's, if you don't have strong present leadership to be able to, say this is, I think maybe it's because in circumstances where there isn't and then people just slide. And because, it doesn't, but it is a some, I mean we do, we do face that, some of it is, is, is health-related, right?
	71L. It is up to nursing peers and leaders to detect incompetence.	72L. Loss of competency may be related to physical or mental illness.	Alice. Some people lose th- their competence uh, competency deteriorates for, for physical or other reasons, but I have to say that in terms of knowing you're competent, I do think a lot of it comes back to people around you. Your peers, your leaders, um, and you know, there's, I mean that's the thing about nursing, that direct contact. You get immediate gratification. (laughs) Right? I mean, and the jobs that we do, there's, I mean that's the thing I miss most is that, you never know.

	73L. Nurses should know what competent practice should be and whether they can deliver it.		Alice. Nothing goes fast, and I mean you know when you, you know when you've done both. You know when you've done a good job, and you know when for whatever reason, somebody won't get into what constricts or, w- when you haven't. Right, and um, I think that's a real dilemma for some nurses is that they know, what, what competent practice should be, and it's whether or not they are able to, to deliver it.
	74L. Nurses determine their competence from feedback from peers and leaders.		Alice. Um, so you know I think there's this "do you know what best practice is" or, most of the time should know what best practice is and you know, what is competent practice, and, and strive for it, it's very disheartening when they don't achieve it, but I think it's the immediacy, the feedback, and having that, that reaffirmation basically on a, almost on a daily basis, about whether you're practicing well or you're not.
	75L. The greatest challenge to nurse leaders are those staff nurses who are unconsciously incompetent.		Grace. I think um, it's always positive to think about the greatest cohort being those that do recognize and understand um, but if we're looking at mandatory uh, continuing competence, and I think that was your question you wanted us to think about is, the greatest challenges with those individuals when I have been in management positions that are unconsciously incompetent and so, you look at that and you think, what is happening.
	76L. Nurse leaders must determine the various reasons for incompetence.		Grace. Is it a lack of skill? Is it a different education that come f- is there, what's the gap? What's happening? Is it health? Is it social, psychosocial, what, what's going on?
	77L. Completion of the mandatory education requirements does not mean a person is competent.		Grace. Um, there are a- a laundry lists of reasons, and those individuals in, in some senses can complete mandatory education requirements and succeed, but I question their continuing competence. Is that, is that fair? You know, that they seem to be able to do the "x", and then you watch them in practice, again that leadership, that coaching, that mentoring piece, you go wow. They're not connecting what they learned in practice.
	78L. "Strong" nurse leaders		Grace. So, just another twist on the whole idea of mandatory and continuing com-

	infuse a positive informal learning environment when they coach and mentor nursing staff.		cause they're a small number, but they can create as individuals, great distress for those that they're working with, and those that are providing supervision to them. And, um, it takes a lot of resources. And I don't know where it comes from, I have seen it. I do think some of it is mitigated when I've looked and been in different places that I've worked over the years, if you do have strong leadership and if you do have a culture of coaching. It seems to mitigate some of that. Because even, the individuals are stimulated and enthusiastic about learning because it's not, it's informal and it's just integrated into work every day. It's not like, okay I have to go learn this. It just happens.
	79L. Rural nurses have more challenges with continuing competence.		Grace. Yeah. It's tougher in some places, because of system problems, you know. For some of rural and remote, and it's really, I'll give you a concrete example. It's really hard for some nurses who work in more rurally located facilities who don't have a lot of births to keep up their continuing competence in labor and deliveries, so we've looked at education that's available through Stork or Moral-B or those kinds of things, but it's not the same as having the experience with a mom and a baby right in front of you, it's different.
	80L. Experiential learning is more efficacious than education programs.		Grace. Yes, to maintain your continuing competence, right? It is, they're very sound education programs, please don't get me wrong, but it's not the same as real life. Just, like we could all think of examples. You can do CPR until someone codes in front of you, and then everything, you do go into automatic, but they're not all, not all codes are the same.
4Q. Just one last thing to, to throw out. Um, there are big things coming down the pipe, there's new technology that's coming in, there's new legislation perhaps, there's things that we are	81L. Organizational unification decreases redundancies and increases efficiencies.		Christine. Um, so I think that um, there's ways to minimize the amount of education or documents or things that we put on people by being more collaborative and we've seen some efforts, with the union, and with the regulatory bodies, where regulatory bodies are coming together and agreeing on things like medical assistance and dying, and things to help you with your practice. You don't have three different documents from three different nursing

concerned about in particular, um, and relating, relating it back to the connection between competency and continuing professional development, what are your, um, what are your thoughts or do you have any sort of plans in mind, or strategies or anything like that that you could share along those lines? Given how critically important um, it is that they, that they, come to work and they learn it, and that they can do it.			organizations. I think collaboration is the key. I think that any time we can minimize and get together on something that's meaningful education, we should try,
	82L. Constant change should not be overwhelming because it is the norm.		Christine. I think we have to try and feel hopeful instead of overwhelmed. Really, I think we have to change our mindset a little bit. Because change is not going to go away. There's constant change and ever since I started in nursing, which is many, many years ago, , we'd say there's always something changing even way back then.
	83L. Patient expectations and new technologies are steering nursing in new directions.		Christine. Well, there's even more new, and there's a couple things that are totally driving us and one is what patients expect of us, and the other is technology.
	84L. Organizational leaders need to be resilient, thoughtful and collaborative in educational approaches.		Christine.. And so, we just have to be hopeful and remain resilient that we can solidify our education approaches and not try and duplicate our efforts, prioritize.
	85L. Organizational		Christine. Prioritize what we have to put in front of people. And, focus on what's really

	leaders decide what is learning priorities.		important. So I would suggest to you with big things coming down the pipe, that we all have to hold hands around the CIS and what that's going to mean for practice, like we have to-
	86L. Lack of communication and collaboration alienates organizational leaders from each other.	87L. Technology removes nurses from touching patients.	Alice: CIS? Christine.: Sorry, information system. Our new information system. It's going to have a lot of influence on practice, right? Alice: In what way? Christine.: Oh, Alice, it's, can, do you want to talk about it now? Or do you want to talk about it- Alice: Well, because, the one word I wrote down, and I'm curious, when you asked, one of the words was touch. Because fundamentals to nursing is touching people. Christine.: Well, I'm not suggesting- Alice No, no, no, no, no. I'm just, what, what will this do, and will it create more, make more information available or is it about charting and, and patient records, or?
	88L. Organizational leaders recognize the importance of reaching a collaborative understanding of strategies.		Christine.. Okay, so we need to talk to you. I think that one of the areas where there's a growing body of knowledge is around nursing informatics. And we recognize that nurses need to understand informatics more and what that means in their practice, and so we're starting to see competencies in those areas. So what I would suggest is that in the coming years, when you talk about these big trends Meagan, that will be a coming trend, I think is that nurses will need to understand informatics, they'll need to understand how it will impact their practice. They'll need to understand,

			because we need nursing actually to, to drive the tool, not the tool to drive nursing, right? That- that's how we need to see it, right?
	89L. Critical decision-making will soon involve computer-generated information.		Grace: And that's what you were saying too, it's, it is wh- where's the finite point between using my judgment and my critical thinking, because whether it's computer generated or paper generated, or generated by my unit manager saying, have you done that? Um, there has to be some critical decision making, whether it's relevant based on what I've seen and heard, right? Christine.: Yeah, absolutely.
	90L. The new interface of technology will increase the need for critical thinking.		Christine.. I don't think it's going to decrease critical thinking, in fact I think it will increase critical thinking and how we interface with technology, and how we interface with the patient, including patient [inaudible 00:49:33], so that's going to be one big trend.
	91L. Nurses will need to consider an understanding of quality in future continuing competence.		Christine.. The other big trend I think around continuing competency is going to be quality of literacy and you've talked about that How do nurses understand quality? What it means in their practice setting..
	92L. New expectations of nursing competencies should be considered in undergraduate programs.		Grace. I think my addition to that comment is I think we need to go downstream a little, and that if I think about nursing education, there needs to be thought and, and regulatory colleges play a role in that too, that when we look at competencies and what is, what is it that we see as the competencies for entry to the profession, how do we create that learning environment for students to um, embrace enhancing quality changing, change management all those kinds of things and…
	93L. Knowledge translation and application needs to be incorporated into nursing programs.		Grace. I'm really comfortable with learning this, even though it's not directly related to something here, but I can translate that. And that's knowledge translation too, right? I can learn this, but take it over and apply it there. So I think we have to look at education for nursing students, we need to work together, practitioners, everyone, not just nursing practitioners, but multi-stakeholders on what are the competencies.

	94L. Competencies for professional nursing practice are too complex to generalize.		Grace. But that's only the beginning. That's just for entry. I mean, where it gets really complicated is when we look at someone saying what are all the competencies for registered nurse practice? Well I don't have that list. (laughs)
	95L. Professional competencies are nursing core concepts and principles.		Grace. We have a competency profile. We do have a profile. Fair enough, yes we do. But, it still doesn't list all of the interventions and so forth that would fall under that profile, right? That was my thought as we were talking. Cause you can't just keep, it can't just be in my personal opinion, increase, increase, increase for those in practice. We need to continue to go back and look at um, what is it, what are the principles, what are the concepts? Because, what I learned today about intervenous therapy pumps, is not gonna be applicable, in a very short period of time.
	96L. Organizational leaders must consider all nursing contexts in the province.		Christine. That's right, that's right. And we do have, you know thinking about the CIS. We've already got nurses working in the systems in Edmonton and Calgary. So it's not like this is going to be a foreign concept for lots of our urban areas, it's going to be a bigger adjustment, I think, like many things are for some of our rural settings and it's creating a provincial system that's going to be a significant change.
5Q. Okay, this one ... and then you can always add to this, cause I know it's 5:16 now, I- I don't, I- I- I mean I have water, I could be here for three days and still survive, right? So, um but, you can always add to this after this but given your situation with CIS and how big it is, end of the day you need the	97L. "Competence" should be viewed as varying in degrees.	98L. "Continuing competence" is a state of change. 99L. "Incompetent" is unsafe practice.	Grace. I'm pondering, you know sometimes we use the words competence and continuing competence in the same sentence and I, I don't, I guess it's my belief, or my working definition, some people think of competence as you are or you aren't and it's finite. And I think that competence has degrees of competence. But because I'm comfortable with learning and so maybe my model in my head is that we are always in a constant state of continuing competence. I seem to be able to have a clearer understanding when somebody's incompetent because that's a safety bar for me, or harm, or hurt, or something. Right? But, the rest seems to be a life-long career of continuing competence, not competence.

nurse to, the RN to come in… And log in, use it, and still have excellent nursing care… Yeah, and you've got A over here where we're talking about rolling it out and Z over here, where that happens. And I guess, my interest is that point where the RN says I've gotta learn this.			
	100L. Nurses are compelled t to execute organizational change.		Alice. But nurses are going to do whatever they have to do, whatever if it's, if it's a- an information system that, that they have to learn, they're gonna do it, right? They, they have no choice.
	101L. Nurses must adjust quickly to changes and return to their patient care.		Alice. So that they can get back to doing what they want to do, which is touching and caring, right? So um, I mean, the, it's a, n- nursing i- is always changing, right? It's always, since the day I started nursing school. Every, it's a constant evolution of who does what, what needs to be done, uh how it's done, it's been continually evolving. Um, but wasn't ... what really hasn't changed is, hopefully, is that the patient is at the center of the, of what you do and why you do it, right?
	102L. Nurses "work around" new implementations if it doesn't benefit patient care.		Alice. Um, but I mean, if you have to learn a new system to get the best outcomes, whether that's clean linen, or a bath, or a, treat- treatment, you do what you do. I mean, nurses are the best work around people I know, right? In terms of they do what they have to do to get it done for a person they're responsible for.
	103L. There will be varying difficulties in learning new technology.		Alice. So, I mean it's, I don't think, I mean I think people will take it in their strides. Some people will obviously have more difficulty learning it the same way some people had more difficulty learning how to use a smart phone, or how to use a computer. Period.

	104L. Some nurses are more competent than others.		Alice. But, uh, and I agree, I think the competence and competency is on a continuum. Cause even on a single unit where you might have the best factors in terms of supportive um, environments, supportive leaders, there will still be people who are better. Or more competent. Um, more insightful, more whatever. I- I mean it's, not that the other people, others are incompetent, but they just may not have the same degree of, of skill and competency, or whatever.
	105L. Patient conditions are learning opportunities.		Grace. Just one addition to that, I was just gonna say the other thing as you were talking I thought, opportunity, so you can have all the insight in the world, but it could be just sparked by that one contact with a patient that comes with something that's just unique. Um, and unique good, unique not so good, just unique. And, you learn, because of that encounter. Because of that situation, because of that context. Um, and so the more things that you, the more opportunities that you have in your career to let that happen, cause it doesn't just happen in big urban centers.
	106L. AHS is exploring ideas for continuing nurse education.		Christine. We've toyed with something in Alberta Health Services but I don't think we're very intentional about it. It's the idea of, providing learning not only in terms of continuing competence but also creating streams learning. Do you know what I mean? For example if you were interested in being a nurse educator and you were sparked by that there would be a pathways you could undertake and you'd move along this trajectory of learning, and I'm not saying you couldn't be a nurse educator without getting it all. But this series of learning would prepare you for that.
	107L. AHS hopes for ways to improve clinical practice.	108L. AHS desires to support nurses' career development.	Christine. And I think we've done a good job in some areas about leadership, but I don't think we've done a good job in terms of clinical practice and laddering that learning to build clinical expertise. I think there could be a real opportunity there, because the registered nursing role is clinical expertise and how do we intentionally build on that clinical expertise in an intentional way, instead of it being a little bit half-hazard. I'll grab a course here,

			and I'll grab a course there. Maybe there's an opportunity to think about laddering continual- continuing education with an area of focus that you as an individual nurse are interested in moving towards. Have you ever talked about that, or thought about that, or heard about it?
	109L. Relevancy to the nurse is the driving force in continuing competence.		Alice. Yeah, as, as you were talking I remember as, as a relatively new grad and the director of the medical program at the hospital I worked, um, who was not my unit manager, my head nurse, or whatever you want to call it but, coming up and saying, suggesting that you know, you should consider going and getting your degree, and you should uh, which I- I saw as, as nursing, uh, leadership. Um, in terms of that it wasn't, I mean she didn't really know me, except she knew of my practice on my unit and whatever, but um that kind of that support. And I guess in some ways, skill development, or, what I wrote down as you were talking though is, is, in terms of what factors, what goes back to, you going back to your why people seek out additional or want to enhance their competency. I think a big factor that influences that is the relevancy. The relevancy of it to them, to their personal life, and that kind of stuff, but also the relevancy of patient.
	110L. Relevancy is a selling point for education initiatives.		Alice. I think the more relevant people perceive it to be, whether that's for patient safety or your own personal safety, particularly patient safety and outcomes, the more people want it and will eat it up and, and consume it, right? So, I think relevancy of opportunities is also very important.
	111L. Nurses explore what they need currently and in the future.		Christine. But, and not just as I said, you know talked earlier about, it may not just be what they're doing today, but what they might aspire to do in the future or went over that kind of stuff.
	112L. The educator can make or break learning motivation and/or efficacy.		Grace. You know, when you were talking, um, the other thing that came to mind for me, for continuing competence with relevancy, which was critical, because I remember personally and with students when I was an educator and, it is relevancy, but you can quickly have that spark put out,

			that fire if you don't have the right educator.
	113L. The educator should make learning relevant.		Grace. Right? (laughs) So it can be so relevant and then you either go online and go away, and work on other things, or you go to a classroom and you think, oh man, they're not making it relevant for me. Cause they're, it just not, so th- that is so important. Um, so all of those factors we've talked about, they're just so, in a big ball, connected, right? Cause its access, and it's timely, and it's relevance, it's that leadership component, the coaching, the style of learning, cause you may, you might have someone who, other, 99 people say that was fantastic. You're sitting there and you think, really? (laughs) Because it wasn't for me.
	114L. It is a struggle to determine undermines nurses' competence.		Grace. So, it's, it's complex. It's very complex. Very complex. And that's why I think we struggle so hard in trying to help people find their way through that because we don't know all the, you try to get out some of the factors by your conversation with them and sometimes they don't even know as the learner, what's all impacting them, right? They might say well, it's the day of the week. But it's really, yeah, it's that, but there's a whole bunch else behind that, so. Um, we didn't get a lot into the mandatory part.
	115L. Mandatory education must be relevant to be effective learning.		Grace: If it's mandated, it's not relevant to me, I'm not gonna buy into it. Alice: Who is it mandatory to? Grace: And for what, right?
	116L. Incompetent nurses can still competently complete mandatory education.	117L. Mandatory learning does not necessarily target areas of incompetence.	Grace. Yeah, and then we don't even, we didn't even hit the surface at all around, so what's the outcome of that mandatory continuing competence? Because I did say a little bit, is even those who are unconsciously incompetent can successfully complete some things. But it does not mean that they're competent in practice, or safe sometimes. It depends. So it, cause it depends,Alice you said, it depends on mandatory what for who and why.

	118L. Nurse leaders have the responsibility to determine competence gaps.	119L. More nurse leaders are needed to determine learning gaps.	Grace. So if it's that I'm mandated to take this, but really I have a huge gap in this, (laughs) we're out of sync. And that's where I think that we really do need to, all three of us, is that the importance of leadership. And that's where, that's the other thing I think we really need to look at within the system, is who are those leaders. I think registered nurses need to be those leaders and step up and do those things.

Appendix 4W-MyCCP Analysis

Table 51. Full analysis of MyCCP Systemization

MyCCP Record Page Title/type	Clicks	Prompts/coding	Options	Description
Sign in to MyCARNA from CARNA website	1	Orange button/tab?		Sign in button
Click MyCCP link	1	Orange button		Sign in to MyCCP record
View list of records	1	1 orange button to view current record. 4 blue buttons to view past records.	Select orange to view and complete current record and/or view previous years.	View list of previous and current records-select current year record.
Current record	1	• Faded lettering indicating requirements complete. • Bolded font meaning requirements needing to be completed. • Grey check marks meaning need to be done but "not right now" • Green check marks means they need to be completed.	Click to select	MyCCP progress list: Show two lists indicating parts of the report: practice reflection and professional development
Introduction to MyCCP	2	Orange button + icon to expand instructions page	Option to expand but must select orange button.	Provides instructions. Expand button provides a full pop-up page of detailed instructions.
Privacy Policy	2	Orange button + icon to expand page	Orange button mandatory Expand page optional	Explains privacy policy
Review Privacy Policy window.	1	Green button		Agree to privacy policy after reading detailed policy pop-up page.
Privacy policy complete	1	Gear icon	May select undue or delete if click gear icon.	Confirm and progress.
My Nursing practice	2	+ icon to expand more instructions blue button	May read more instructions Must click blue button	Purpose to click identify practice.

Select nursing role	1	Multiple blue buttons		Select from a menu of nursing role descriptions.
Select employment status	1	Orange button green button	Choose one button	Select employed to move to next step in record and select unemployed to go back and terminate the process.
Practice setting	3	1 fill in the blank 2 drop down fields green button blue button	• Fill in practice setting • Choose from selection in 2 drop-down menus. • Select from two buttons: complete (green) or update employment status (blue)	Describe and select practice setting information.
Other option (optional)	3	1 fill in the blank 2 drop down fields green button blue button	• Fill in practice setting • Choose from selection in 2 drop-down menus. Select from two buttons: complete (green) or update employment status (blue)	Describe and select practice setting information if an additional practice setting is identified.
My nursing role	2	+ icon for expandable instructions blue button		Shows what was selected from previous pages. May add further information if there is additional roles.
My RN learning plan	2	+ icon for expandable instructions blue button	Based on self-assessment and feedback received, you must analyze your practice and select an indicator to focus on.	Select an indicator.
List of indicators with expandable explanations.	10+	Blue buttons + icon to expand each indicator selection to full page pop up of explanation of indicator.	**View indicators and select *only one*** that best fits as above.	Analyze indicators that would best fit self-reflection in the previous step.
Enter learning objective	3	2 open text box fields Orange button Grey button	Open writing.	Describe the selected indicator and write the **relevance of the indicator** to the **learning objective.** SMART approach
Practice reflection completed	1	Blue button		Submit completed practice reflection.

Enter Continuing Professional Development	1	Blue button	Practice standard indicator shows up as previously chosen. Click select learning activity to expand selection of activity options.	Select learning activity
Enter learning activity	5	• One drop down • 300 word text box • enter date • 3000 word text box • one green button • two blue buttons	• **type** of activity from dropdown • **topic** of activity from text box • completion **date** • Enter text of how the learning activity helped you **meet your learning objective** • Select learning activity completed or • Not completed yet, or • Did not complete	Enter **learning activity** information.
Evaluate the influence of learning.	1	Display of previously selected information Orange button	Review selected material and press button to open window to evaluate learning.	Review and progress.
Evaluate influence of learning.	1	One orange button Two blue buttons	Select from the following: • Evaluate influence of learning •did not implement plan •change objective	Attest to **evaluation of learning.**
Evaluate influence of learning.	2	One text box-3000 words Orange button Blue button	Enter how has your professional development activities for this indicator influenced your nursing practice.	Enter and review the implementation of learning. Attest to review.
Review learning plan	1	Pre-selected information selected. Green button Blue button	Review and select the green button if complete or blue button if changes need to be made.	Review and attest to the learning plan.
My feedback	4	Two + expandable icons Two blue buttons	Select buttons to add feedback information	Review feedback requirements.
Select feedback type	1	Two blue buttons Two + expandable icons	Review requirements and definitions of verbal or written feedback and select either the verbal or written feedback option.	Review types of feedback and select type of feedback that applies.
Written feedback	4	One dropdown One open text box 3000 word	Enter required feedback into fields.	Enter source (verbal or written), **feedback** received,

		One date entry Green button		and the date the feedback received.
My other learning activities (optional)	1	Blue button	Select this option if extra learning activities occurred NOT related to learning objective.	Optional entries if more learning activities occurred.
Other learning activities (optional)	5	• One drop down • 300 word text box • enter date • 3000 word text box • one green button two blue buttons	• type of activity from dropdown • topic of activity from text box • completion date • Enter text of how the learning activity helped you meet your learning objective • Select learning activity completed or • Not completed yet, or Did not complete	Enter learning activity information.
Summary: Current status of continuing professional development in progress.	1	One green button One blue button	Select green if record is complete Select blue if record is incomplete.	Attest and submit completed or incomplete record.
MyCCP Record Page	**Clicks**	**Prompts/coding**	**Options**	**Description**
Totals: includes optional pages Some totals are approximate	59 clicks	44 blue buttons 9 green buttons 10 orange buttons 4 text boxes 3000 words 2 text boxes 300 words 3 date entries 7 dropdown menus 8 +expandable windows 1 grey button 1 area of faded lettering 1 area of bolded lettering 1 area of green check boxes 1 area of grey check boxes 3 short answer fill in the blanks 2 gear icons	7 windows to advance to the next 5 attestations 7 open, written fields 5 full pages of instructions/information 4 areas of analysis and/or evaluation	8 sections of required entries. 23 pages not relevant to requirements.

		Red field highlighting if required information not entered Asterisks indicating mandatory fields		

Appendix 4X-Unreported Professional Development

Table 52. Unreported Professional Development

Descriptions of Unreported Professional Development								
	Darren	**Jim**	**Sarah**	**Craig**	**Heather**	**Victor**	**Marie**	**Miss M.**
Leadership training	3bb Leadership course			40QQ. Leadership courses	29uu. Leadership training			24bcb. Leadership initiatives
Clinical training	36bb. New skills	61ee. Adapt to new clinical approaches.	43LL. New clinical skills 44LL. New medications 47LL. Advanced skills	13QQQ. Wound care courses 57QQ. Ortho conference		74zz. New medicine 74zzzz. New approaches	63aca. New clinical techniques.	
Summary	99a. Specific education: 14 mentions of specific new knowledge or clinical skill education.							
Career progression	29bb. Constant training	53ee. Move career forward.	58LL. Career change		30uu. New job roles 42uu. Career driven			22bcb. Full scope of practice.
Daily experiential learning	76bb. Experiential	47ee. Constant change.	34LL. Adapt to change	47QQ Daily basis 17QQ. Day to day experiences		19zz. Daily experiential learning	10aca. Rapid patient deterioration. 12aca. Patient care	15bab. Daily activities.
Keep up	69bb. Survival. 78bb. Adapting to change.	55ee. Stay updated.			43uu. Keep up with the minimum	82zz. Learn unit routine		
New policy	73bb. New implementations.	25ee. Discharge processes.				74zzz. New policy	3acac. New rules and regulations	

							3aca. Learn new policy	
Innovations	48bb. New innovations 32bb. New technology	57ee. Adapt to new technology.	67LL. New technologies			74zzzzz. New technology		
Summary	99b. Change and Adapting: 28 mentions of experiential learning in response to workplace change.							
Independent research	82bb. Research study.	23ee. Healthcare system.	6LL. Read books 49LL. Patient research		31uu. Orthopedic journal	98zz. Medical journal	11aca. Research patient conditions	2bcb. Review articles
Self-study	101bb. New patient conditions.	39ee. Constant questioning. 8ee. New culture.	41LL. Teach self	39QQ. Self-directed learning.	4uu. Self-study	5zz. Read med-surg text		
Summary	99c. Self-study: 15 mentions of self-study.							
Negative experiences	88bb. Negative experience.						17aca. Accountability to avoid mistakes.	
Summary	99d. Negative experiences: 2 mentions of negative work experiences as a point of learning.							
Outside of profession.	98bb. Learn outside of profession.				34uu. Self-development	86zz. New cultural systems 75zz. Non-nursing	7aca. Workshop unrelated to MyCCP	
	80bb. CPR						40aca. Attend mandatory CARNA learning	
Others	80bbb. Code training							

	80bbbb. Research Day							
	81bb. UNA course							
Summary	99e. Non-nursing or regular recertification training: 10 mentions							

Appendix 5A-Cross Quadrant Analysis

Table 53. Cross-quadrant analysis

Quadrant Theme	**Associated Themes**	**Associated Quadrants**
Diversity adds to collective wisdom	Nursing is culturally hostile.	UL
	CARNA is threatening and irrelevant.	LL
	Report fields filled with anything.	UR
	Competence reporting inaccurate.	LL
	Stated expressions of frustration.	UR
	Authentic learning underreported.	UR
	Report anything.	LR
Nurses are responsible for their practice.	Unstructured learning is entrenched in their practice.	UL
	UNA is the only visible advocate	UL
	Nursing practice blighted by workload.	UL
	Quixotic CCP begets inaccurate reporting.	UL
	Relevant education motivates nurses.	LL
	Nurse managers experience moral distress.	LL
	CARNA does not recognize learning that advances competence.	LL
	Competence not addressed.	LL
	Authentic learning underreported	UR
	Practice Standards Indicators not individually applied to learning	UR
	The indicator does not align with the learning goal	UR
	Report fields filled with anything	UR

	Minimal effort and thought to meet minimum requirements	UR
	Abandonment	LR
	Simplistic task setting	LR
UNA is the only visible advocate	Unrealistic learning requirements are uncompensated.	LL
	Incongruous organizations hinder learning.	LL
	UNA an advocate	LL
	CARNA is meaningless and threatening.	UL
	Quixotic CCP begets inaccurate reporting.	UL
	CARNA is meaningless and threatening.	UL
	Stated expressions of frustration.	UR
	Feedback from patients, managers, and colleagues.	UR
	Abandonment	LR
	Bait and switch	LR
	Over-reliance on whistle-blowing	LR
Unstructured learning entrenched in practice	Nursing practice blighted by workload.	UL
	Constant change diminishes competence.	UL
	Quixotic CCP begets inaccurate reporting	UL
	Relevant education motivates nurses.	LL
	Unrealistic learning requirements are uncompensated.	LL
	CARNA does not recognize learning that advances competence.	LL
	Incongruous organizations hinder learning.	LL
	Competence reporting inaccurate.	LL

	Practice Standards Indicators not individually applied to learning.	UR
	Developed learning goals attempt to achieve compliance	UR
	Report fields filled with anything.	UR
	Non-specific learning.	UR
	Minimal effort and thought to meet minimum requirements.	UR
	Authentic learning underreported.	UR
	Report anything.	LR
	Predict the required learning.	LR
	Unnecessary demand for learning activities.	LR
	Forced a one-year plan	LR
	Time burden.	LR
Nursing practice blighted by workload	Nurses are responsible for their practice.	UL
	UNA is the only visible advocate.	UL
	Unstructured learning is entrenched in practice.	UL
	Constant change diminishes competence.	UL
	Nurse managers experience moral distress.	LL
	Relevant education motivates nurses.	LL
	Unrealistic learning requirements are uncompensated.	LL
	Incongruous organizations hinder learning.	LL
	CARNA does not recognize learning that advances competence	LL
	Competence reporting inaccurate.	LL
	UNA an advocate	LL

	Competence not addressed	LL
	Minimal effort and thought to meet minimum requirements.	UR
	Practice standards indicators not individually applied to learning	UR
	The indicator does not align with the learning goal	UR
	Report fields filled with anything	UR
	Non-specific learning.	UR
	Abandonment	LR
	Unnecessary demand for learning activities.	LR
	Undue stress	LR
	Time burden	LR
Nursing is culturally hostile	Diversity adds to collective wisdom.	UL
	Nursing practice blighted by workload.	UL
	UNA is the only visible advocate.	UL
	Constant change diminishes competence.	UL
	CARNA is meaningless and threatening	UL
	Nurse managers experience moral distress.	LL
	Unrealistic learning requirements are uncompensated.	LL
	Incongruous organizations hinder learning.	LL
	CARNA threatening and irrelevant.	LL
	UNA an advocate.	LL
	Collect feedback from patients, managers and colleagues.	UR
	Stated expressions of frustration.	UR

	Unnecessary demand for learning activities.	LR
	A Forced one-year plan.	LR
	Undue stress.	LR
	Bait and switch.	LR
	Feedback degrading teams.	LR
	Over-reliance on whistle-blowing.	LR
	Choose code of ethics versus getting caught.	LR
Constant change diminishes competence	Unstructured learning is entrenched in practice.	UL
	Nursing is culturally hostile.	UL
	Nursing practice blighted by workload.	UL
	Relevant education motivates nurses.	LL
	Nurse managers experience moral distress.	LL
	CARNA does not recognize learning that advances competence	LL
	Competence is not addressed.	LL
	The indicator does not align with the learning goal	UR
	Non-specific learning.	UR
	Reported data are irrelevant to legislation.	UR
	Underreported authentic learning.	UR
	Simplistic task setting.	LR
	Feedback degrading teams.	LR
	Choose code of ethics versus getting caught.	LR
	A Forced one-year plan.	
Quixotic CCP begets inaccurate reporting	Nurses are responsible for their practice.	UL
	CARNA is meaningless and threatening.	UL

	Nursing is culturally hostile.	UL
	Relevant education motivates nurses.	LL
	CARNA is threatening and irrelevant.	LL
	Incongruous organizations hinder learning.	LL
	CARNA does not recognize learning that advances competence.	LL
	Competence reporting inaccurate.	LL
	Competence reporting not authentic.	LL
	Practice Standards Indicators not individually applied to learning.	UR
	Developed learning goals attempt to achieve compliance.	UR
	The indicator does not align with the learning goal.	UR
	Non-specific learning.	UR
	Report fields filled with anything.	UR
	Minimal effort and thought to meet minimum requirements.	UR
	Authentic learning underreported.	UR
	Report anything.	LR
	Unnecessary demand for learning activities.	LR
	A forced one-year plan.	LR
	Predict the required learning.	LR
	Simplistic task setting.	LR
	Choose code of ethics versus getting caught.	LR
	UNA is the only visible advocate.	UL

CARNA is meaningless and threatening.	Nursing is culturally hostile.	UL
	Quixotic CCP begets inaccurate reporting	UL
	Unrealistic learning requirements are uncompensated.	LL
	Incongruous organizations hinder learning.	LL
	CARNA is threatening and irrelevant.	LL
	CARNA does not recognize learning that advances competence.	LL
	UNA an advocate.	LL
	Competence is not addressed.	LL
	Competence reporting inaccurate.	LL
	Developed learning goals attempt to achieve compliance.	UR
	The indicator does not align with the learning goal.	UR
	Feedback from patients, managers and colleagues.	UR
	Non-specific learning.	UR
	Report fields filled with anything.	UR
	Minimal effort and thought to meet minimum requirements.	UR
	Stated expressions of frustration.	UR
	Authentic learning underreported.	UR
	Abandonment.	LR
	Report anything.	LR
	Unnecessary demand for learning activities.	LR
	A forced one-year plan.	LR
	Predict the required learning.	LR

	Undue stress.	LR
	Time burden.	LR
	Bait and switch.	LR
	Simplistic task setting.	LR
	Choose code of ethics versus getting caught.	LR
Relevant education motivates nurses	Unrealistic learning requirements are uncompensated.	LL
	UNA is the only visible advocate.	LL
	Incongruous organizations hinder learning.	LL
	Nurse managers experience moral distress.	LL
	Nurses responsible for their practice.	UL
	UNA the only visible advocate.	UL
	Nursing practice blighted by workload.	UL
	Quixotic CCP begets inaccurate reporting.	UL
	Practice Standards Indicators not individually applied to learning.	UR
	Developed learning goals attempt to achieve compliance.	UR
	The indicator does not align with the learning goal.	UR
	Non-specific learning.	UR
	Report fields filled with anything.	UR
	Stated expressions of frustration.	UR
	Reported data are irrelevant to legislation.	UR
	Authentic learning underreported.	UR
	Report anything.	LR
	A Forced one-year plan.	LR

	Unnecessary demand for learning activities.	LR
	Undue stress	LR
	Predict the required learning	LR
	Simplistic task-setting.	LR
Nurse managers experience moral distress	Nurses are responsible in their practice.	UL
	UNA is the only visible advocate.	UL
	Nursing practice blighted by workload.	UL
	Constant change diminishes competence.	UL
	Relevant education motivates nurses.	LL
	Unrealistic learning requirements are uncompensated.	LL
	Incongruous organizations hinder learning.	LL
	CARNA is threatening and irrelevant.	LL
	Feedback from patients, managers, and colleagues.	UR
	Developed learning goals attempt to achieve compliance.	UR
	Minimal effort and thought to meet minimum requirements.	UR
	Authentic learning underreported.	UR
	Abandonment	LR
	Choose the code of ethics versus getting caught.	LR
	Feedback degrading teams.	LR
	Over-reliance on whistle-blowing.	LR
	Time burden.	LR
	Undue stress.	LR
	Unnecessary demand for learning requirements.	LR

Unrealistic learning requirements are uncompensated	Incongruous organizations hinder learning.	LL
	CARNA does not recognize learning that advances competence.	LL
	UNA is an advocate.	LL
	Nurses are responsible for their practice.	UL
	Nursing practice blighted by workload.	UL
	CARNA is meaningless and threatening.	UL
	Relevant education motivates nurses.	LL
	Nurse managers experience moral distress.	LL
	Incongruous organizations hinder learning.	LL
	CARNA is threatening and irrelevant.	LL
	Competence not addressed.	LL
	Competence reporting inaccurate.	LL
	Competence reporting not authentic.	LL
	Practice Standards Indicators not individually applied to learning.	UR
	Developed learning goals attempt to achieve compliance.	UR
	The indicator does not align with the learning goal.	UR
	Non-specific learning.	UR
	Report fields filled with anything.	UR
	Stated expressions of frustration.	UR
	Reported data are irrelevant to legislation.	UR
	Authentic learning underreported.	UR
	Abandonment.	LR

	Report anything.	LR
	Unnecessary demand for learning activities.	LR
	A Forced one-year plan.	LR
	Predict the required learning.	LR
	Time burden.	LR
	Undue stress.	LR
	Bait and switch.	LR
	Choose code of ethics versus getting caught.	LR
Incongruous organizations hinder learning	UNA is the only visible advocate.	UL
	Unstructured learning is entrenched in practice.	UL
	Nursing practice is blighted by workload.	UL
	Nursing is culturally hostile.	UL
	Constant change diminishes competence.	UL
	Quixotic CCP begets inaccurate reporting.	UL
	CARNA is meaningless and threatening.	UL
	Nurse managers experience moral distress.	LL
	Unrealistic learning requirements are uncompensated.	LL
	CARNA is threatening and irrelevant.	LL
	CARNA does not recognize learning that advances competence.	LL
	UNA an advocate	LL
	CARNA does not recognize learning that advances competence.	LL
	Competence reporting inaccurate.	LL
	Competence reporting not authentic.	LL

	Minimal effort and thought to meet minimum requirements.	UR
	Stated expressions of frustration.	UR
	Reported data are irrelevant to legislation.	UR
	Feedback from patients, managers, colleagues.	UR
	Unnecessary demand for learning activities.	LR
	A Forced one-year plan.	LR
	Predict the required learning.	LR
	Undue stress	LR
	Time burden	LR
	Simplistic task setting	LR
	Feedback degrading teams	LR
CARNA is threatening and irrelevant	CARNA does not recognize learning that advances competence.	LL
	UNA an advocate.	LL
	Competence not addressed.	LL
	Competence reporting not authentic.	LL
	Nurse managers experience moral distress.	LL
	Unrealistic learning requirements uncompensated.	LL
	Diversity adds to collective wisdom.	UL
	UNA is the only visible advocate.	UL
	Nursing is culturally hostile.	UL
	Quixotic CCP begets inaccurate reporting.	UL
	CARNA is meaningless and threatening.	UL
	Feedback from patients, managers and colleagues.	UR

	Report fields filled with anything.	UR
	Stated expressions of frustration.	UR
	Abandonment	LR
	Report anything	LR
	Unnecessary demand for learning	LR
	Forced a one-year plan	LR
	Undue stress	LR
	Time burden	LR
	Simplistic task setting	LR
	Bait and switch	LR
	Over-reliance on whistle-blowing.	LR
	Choose the code of ethics versus getting caught.	LR
CARNA does not recognize learning that advances competence	Nurses are responsible for their practice.	UL
	Unstructured learning is entrenched in practice.	UL
	Nursing is culturally hostile.	UL
	Quixotic CCP begets inaccurate reporting.	UL
	CARNA is meaningless and threatening.	UL
	Relevant education motivates nurses.	LL
	Unrealistic learning requirements are uncompensated.	LL
	Incongruous organizations hinder learning.	LL
	CARNA is threatening and irrelevant.	LL
	Competence is not addressed.	LL
	Competence reporting inaccurate.	LL
	Competence reporting not authentic.	LL

	Practice Standards Indicators not individually applied to learning.	UR
	Developed learning goals attempt to achieve compliance.	UR
	The indicator does not align with the learning goal.	UR
	Feedback from patients, managers and colleagues.	UR
	Non-specific learning.	UR
	Stated expressions of frustration.	UR
	Reported data are irrelevant to legislation.	UR
	Authentic learning underreported.	UR
	Abandonment.	LR
	Report anything.	LR
	Unnecessary demand for learning activities.	LR
	A forced one-year plan.	LR
	Predict the required learning.	LR
	Undue stress	LR
	Simplistic task setting	LR
	Feedback degrading teams	LR
	Over-reliance on whistle-blowing.	LR
	Code of ethics versus getting caught	LR
UNA an advocate	Diversity adds to collective wisdom.	UL
	UNA is the only visible advocate.	UL
	Nursing practice blighted by workload.	UL
	Constant change diminishes competence.	UL
	Relevant education motivates nurses.	LL

	Unrealistic learning requirements are uncompensated.	LL
	CARNA does not recognize learning that advances competence.	LL
	Competence not addressed.	LL
	Non-specific learning	UR
	Feedback from patients, managers and colleagues.	UR
	Minimal effort and thought to meet minimum requirements.	UR
	Reported data are irrelevant to legislation.	UR
	Authentic learning underreported.	UR
	Time burden	LR
	Unnecessary demand for learning activities.	LR
	Abandonment	LR
Competence not addressed	Relevant education motivates nurses.	LL
	Nurse managers experience moral distress.	LL
	Unrealistic learning requirements are uncompensated.	LL
	Incongruous organizations hinder learning.	LL
	CARNA does not recognize learning that advances competence.	LL
	Competence reporting inaccurate	LL
	Competence reporting not authentic	LL
	Diversity adds to collective wisdom.	UL
	Nurses are responsible for their practice.	UL
	Unstructured learning entrenched in practice.	UL
	Nursing practice blighted by workload.	UL

	Constant change diminishes competence.	UL
	Quixotic CCP begets inaccurate reporting.	UL
	CARNA is meaningless and threatening.	UL
	Practice Standards Indicators not individually applied to learning.	UR
	Developed learning goals attempt to achieve compliance.	UR
	The indicator does not align with the learning goal.	UR
	Feedback from patients, managers and colleagues.	UR
	Report fields filled with anything.	UR
	Stated expressions of frustration.	UR
	Reported data are irrelevant to legislation.	UR
	Authentic learning underreported.	UR
	Report anything	LR
	Unnecessary demand for learning activities.	LR
	Predict the required learning	LR
	Undue stress	LR
	Time burden	LR
	Feedback degrading teams.	LR
	Choose code of ethics versus getting caught.	LR
Competence reporting inaccurate	Diversity adds to collective wisdom.	UL
	Nurses are responsible for their practice.	UL
	Unstructured learning entrenched in the workplace.	UL
	Quixotic CCP begets inaccurate reporting.	UL
	CARNA is meaningless and threatening.	UL

	Unrealistic learning requirements are uncompensated.	LL
	Incongruous organizations hinder learning.	LL
	CARNA is threatening and irrelevant.	LL
	CARNA does not recognize learning that advances competence.	LL
	Competence is not addressed.	LL
	Competence reporting not authentic.	LL
	Practice Standards indicators not individually applied to learning.	UR
	Developed learning goals attempt to achieve compliance.	UR
	The indicator does not align with the learning goal.	UR
	Feedback from patients, managers, and colleagues.	UR
	Report fields filled with anything.	UR
	Stated expressions of frustration.	UR
	Reported data are irrelevant to legislation.	UR
	Authentic learning underreported.	UR
	Report anything.	LR
	Unnecessary demand for learning activities.	LR
	A forced one-year plan	LR
	Predict the required learning.	LR
	Simplistic task setting.	LR
	Feedback degrading teams.	LR
Competence reporting not authentic	Relevant education motivates nurses.	LL
	Unrealistic learning requirements are uncompensated.	LL

	Incongruous organizations hinder learning.	LL
	CARNA does not recognize learning that advances competence.	LL
	Competence reporting inaccurate.	LL
	Unstructured learning is entrenched in practice.	UL
	Nursing practice blighted by workload.	UL
	Nursing is culturally hostile.	UL
	CARNA is meaningless and threatening.	UL
	Practice Standards indicators not individually applied to learning.	UR
	Developed learning goals attempt to achieve compliance.	UR
	The indicator does not align with the learning goal.	UR
	Feedback from patients, managers, and colleagues.	UR
	Report fields filled with anything.	UR
	Stated expressions of frustration.	UR
	Reported data are irrelevant to legislation.	UR
	Abandonment	LR
	Report anything.	LR
	Unnecessary demand for learning activities.	LR
	Predict the required learning.	LR
	Undue stress.	LR
	Bait and switch	LR
Practice Standards Indicators not	Nurses are responsible for their practice.	UL
	Quixotic CCP begets inaccurate reporting.	UL

individually applied to learning. The indicator does not align with the learning goal	CARNA is meaningless and threatening.	UL
	Unstructured learning entrenched in nursing practice.	UL
	Relevant education motivates nurses.	LL
	CARNA does not recognize learning that advances competence.	LL
	Competence reporting inaccurate.	LL
	Competence reporting not authentic.	LL
	Developed learning goals attempt to achieve compliance.	UR
	The indicator does not align with the learning goal.	UR
	Non-specific learning.	UR
	Report fields filled with anything.	UR
	Minimal effort and thought to meet minimum requirements.	UR
	Stated expressions of frustration.	UR
	Reported data are irrelevant to legislation.	UR
	Authentic learning underreported.	UR
	Abandonment	LR
	Report anything.	LR
	Predict the required learning.	LR
	Undue stress	LR
	Simplistic task setting	LR
	Choose code of ethics versus getting caught.	LR
	Nurses are responsible for their practice.	UL
	Unstructured learning entrenched in practice.	UL

Developed learning goals to achieve compliance	Nursing practice blighted by workload.	UL
	Constant change diminishes competence.	UL
	Quixotic CCP begets inaccurate reporting.	UL
	CARNA is meaningless and threatening.	UL
	Relevant education motivates nurses.	LL
	Incongruous organizations hinder learning.	LL
	CARNA does not recognize learning that advances competence.	LL
	Competence reporting not authentic.	LL
	Non-specific learning	UR
	Report fields filled with anything.	UR
	Stated expressions of frustration.	UR
	Reported data are irrelevant to legislation.	UR
	Authentic learning underreported.	UR
	Report anything.	LR
	A forced one-year plan.	LR
	Predict the required learning.	LR
	Undue stress.	LR
	Choose code of ethics versus getting caught.	LR
Feedback from patients, managers and colleagues	Nurses are responsible for their practice.	UL
	Nursing is culturally hostile.	UL
	Quixotic CCP begets inaccurate reporting.	UL
	CARNA is meaningless and threatening.	UL
	Nurse managers experience moral distress.	LL
	Incongruous organizations hinder learning.	LL

	CARNA is threatening and irrelevant.	LL
	Competence reporting inaccurate.	LL
	Report fields filled with anything.	UR
	Stated expressions of frustration.	UR
	Abandonment	LR
	Report anything.	LR
	Simplistic task setting.	LR
	Feedback degrading teams.	LR
	Over-reliance on whistle-blowing.	LR
Non-specific learning	Unstructured learning is entrenched in the workplace.	UL
	Nursing practice blighted by workload.	UL
	Constant change diminishes competence.	UL
	Relevant education motivates nurses.	LL
	Nurse managers experience moral distress.	LL
	Competence not addressed.	LL
	Competence reporting not authentic.	LL
	Practice standards indicators not individually applied to learning.	UR
	Developed learning goals attempt to achieve compliance.	UR
	The indicator does not align with the learning goal.	UR
	Non-specific learning.	UR
	Report fields filled with anything.	UR
	Stated expressions of frustration.	UR
	Reported data are irrelevant to legislation.	UR

	Authentic learning underreported.	UR
	Report anything.	LR
	Unnecessary demand for learning activities.	LR
	Time burden.	LR
	Simplistic task-setting	LR
Report fields filled with anything Authentic learning underreported	Quixotic CCP begets inaccurate reporting.	UL
	CARNA is meaningless and threatening.	UL
	Unrealistic learning requirements are uncompensated.	LL
	Incongruous organizations hinder learning.	LL
	CARNA is threatening and irrelevant.	LL
	CARNA does not recognize learning that advances competence.	LL
	Competence reporting not authentic.	LL
	Competence reporting inaccurate.	LL
	Competence not addressed.	LL
	Developed learning goals attempt to achieve compliance.	UR
	The indicator does not align with the learning goal	UR
	Non-specific learning.	UR
	Reported data are irrelevant to legislation.	UR
	Authentic learning underreported.	UR
	Abandonment.	LR
	Report anything.	LR
	Bait and switch	LR
	Choose code of ethics versus getting caught.	LR

Minimal effort and thought to meet minimum requirements	Nursing practice blighted by workload.	UL
	Diversity adds to collective wisdom.	UL
	Quixotic CCP begets inaccurate reporting.	UL
	Incongruous organizations hinder learning.	LL
	CARNA is threatening and irrelevant.	LL
	Competence reporting inaccurate.	LL
	Competence reporting not authentic.	LL
	Practice standards indicators not individually applied to learning.	UR
	Developed learning goals attempt to achieve compliance.	UR
	The indicator does not align with the learning goal.	UR
	Feedback from patients, managers and colleagues.	UR
	Non-specific learning	UR
	Report fields filled with anything.	UR
	Authentic learning underreported	UR
	Abandonment	LR
	Report anything	LR
	Bait and switch	LR
	Simplistic task setting	LR
	Feedback degrading teams.	LR
Stated expressions of frustration	Nurses are responsible for their practice.	UL
	UNA is the only visible advocate.	UL
	Nursing practice blighted by workload.	UL
	Nursing is culturally hostile.	UL

	Quixotic CCP begets inaccurate reporting.	UL
	CARNA is meaningless and threatening.	UL
	Unrealistic learning requirements are uncompensated.	LL
	Incongruous organizations hinder learning.	LL
	CARNA is threatening and irrelevant.	LL
	CARNA does not recognize learning that advances competence.	LL
	UNA an advocate.	LL
	Competence reporting not authentic	LL
	Report fields filled with anything	UR
	Minimal effort and thought to meet minimum requirements.	UR
	Reported data irrelevant to legislation	UR
	Abandonment	LR
	Report anything	LR
	Undue stress	LR
	Time burden	LR
	Bait and switch	LR
	Simplistic task setting	LR
	Feedback degrading teams.	LR
Reported data irrelevant to legislation	UNA is the only visible advocate.	UL
	Quixotic CCP begets inaccurate reporting.	UL
	CARNA is meaningless and threatening.	UL
	Incongruous organizations hinder learning.	LL
	CARNA is threatening and irrelevant.	LL

	CARNA does not recognize learning that advances competence.	LL
	Competence not addressed.	LL
	Competence reporting inaccurate.	LL
	Competence reporting not authentic.	LL
	Practice standards indicators not individually applied to learning.	UR
	The indicator does not align with the learning goal.	UR
	Feedback from patients, managers and colleagues.	UR
	Non-specific learning	UR
	Report fields filled with anything	UR
	Minimal effort and thought to meet minimum requirements	UR
	Stated expressions of frustration	UR
	Authentic learning underreported.	UR
	Abandonment	LR
	Report anything	LR
	Undue stress	LR
	Time burden	LR
	Bait and switch	LR
	Simplistic task setting	LR
	Code of ethics versus getting caught	LR
Abandonment	Nurses are responsible for their practice.	UL
	UNA is the only visible advocate.	UL
	Nursing is culturally hostile.	UL

	Quixotic CCP begets inaccurate reporting.	UL
	CARNA is meaningless and threatening.	UL
	Unrealistic learning requirements are uncompensated.	LL
	Incongruous organizations hinder learning	LL
	CARNA is threatening and irrelevant.	LL
	CARNA does not recognize learning that advances competence.	LL
	Competence reporting inaccurate	LL
	Competence reporting not authentic.	LL
	Developed learning goals attempt to achieve compliance.	UR
	Report fields filled with anything.	UR
	Stated expressions of frustration	UR
	Authentic learning underreported.	UR
	Unnecessary demand for learning activities.	LR
	Forced a one-year plan	LR
	Undue stress	LR
	Bait and switch	LR
	Feedback degrading teams	LR
	Code of ethics versus getting caught	LR
Report anything	Unstructured learning entrenched in practice.	UL
	Nurses are responsible for their practice.	UL
	Quixotic CCP begets inaccurate reporting.	UL
	CARNA is meaningless and threatening.	UL
	Unrealistic learning requirements are uncompensated.	LL

	CARNA does not recognize learning that advances competence.	LL
	Competence not addressed.	LL
	Competence reporting inaccurate	LL
	Competence reporting not authentic.	LL
	Minimal effort and thought to meet minimum requirements.	UR
	Report fields filled with anything.	UR
	Authentic learning underreported.	UR
	Abandonment	LR
	Unnecessary demand for learning activities.	LR
	Bait and switch	LR
	Choose code of ethics versus getting caught.	LR
Unnecessary demand for learning activities Forced a one-year plan	UNA the only visible advocate.	UL
	Unstructured learning is entrenched in practice.	UL
	Quixotic CCP begets inaccurate reporting.	UL
	CARNA is meaningless and threatening.	UL
	Relevant education motivates nurses.	UL
	Nurse managers experience moral distress.	LL
	Unrealistic learning requirements are uncompensated.	LL
	CARNA is threatening and irrelevant	LL
	CARNA does not recognize learning that advances competence.	LL
	Authentic learning underreported	UR
	Non-specific learning	UR

	Abandonment	LR
	Forced a one-year plan	LR
	Predict the required learning	LR
	Undue stress	LR
	Time burden	LR
Predict the required learning	Unstructured learning is entrenched in practice.	UL
	Nursing practice blighted by workload.	UL
	Quixotic CCP begets inaccurate reporting.	UL
	CARNA is meaningless and threatening	UL
	Unrealistic learning requirements are uncompensated	LL
	Incongruous organizations hinder learning	LL
	CARNA is threatening and irrelevant	LL
	CARNA does not recognize learning that advances competence.	LL
	Practice standards indicators not individually applied to learning	UR
	Developed learning goals attempt to achieve compliance.	UR
	The indicator does not align with the learning goal	UR
	Non-specific learning	UR
	Stated expressions of frustration	UR
	Authentic learning underreported	UR
	Forced a one-year plan	LR
	Undue stress	LR
Undue Stress	UNA is the only visible advocate.	UL

Time burden	Nursing practice blighted by workload.	UL
	Nursing is culturally hostile	UL
	CARNA is meaningless and threatening	UL
	Nurse managers experience moral distress	LL
	Incongruous organizations hinder learning.	LL
	CARNA is threatening and irrelevant	LL
	UNA an advocate	LL
	Minimal effort and thought to meet minimum requirements	UR
	Stated expressions of frustration	UR
	Authentic learning underreported	UR
	Abandonment	LR
	Bait and switch	LR
Bait and switch	Quixotic CCP begets inaccurate reporting	UL
	CARNA is meaningless and threatening.	UL
	Unrealistic learning requirements are uncompensated.	LL
	Incongruous organizations hinder learning	LL
	CARNA is threatening and irrelevant.	LL
	Competence is not addressed.	LL
	Practice standards indicators not individually applied to learning	UR
	Developed learning goals attempt to achieve compliance	UR
	Report fields filled with anything	UR
	Minimal effort and thought to meet minimum requirements	UR

	Stated expressions of frustration	UR
	Reported data irrelevant to legislation	UR
	Authentic learning underreported	UR
	Abandonment	LR
	Report anything	LR
	Force one-year plan	LR
	Predict the required learning	LR
	Simplistic task setting	LR
	Over-reliance on whistle-blowing	LR
	Code of ethics versus getting caught	LR
Simplistic task setting	Diversity adds to collective wisdom	UL
	Nurses are responsible for their practice.	UL
	Unstructured learning is entrenched in practice	UL
	Constant change diminishes competence	UL
	CARNA is meaningless and threatening	UL
	Incongruous organizations hinder learning.	LL
	CARNA is threatening and irrelevant	LL
	CARNA does not recognize learning that advances competence	LL
	Competence is not addressed	LL
	Competence reporting not authentic	LL
	Practice standards indicators not individually applied to learning	UR
	The indicator does not align with the learning goal.	UR
	Report fields filled with anything	UR

	Reported data irrelevant to legislation	UR
	Abandonment	LR
	Report anything	LR
	Undue stress	LR
	Predict the required learning	LR
Feedback degrading teams	Diversity adds to collective wisdom	UL
	Nurses responsible in their practice	UL
	Nursing is culturally hostile	UL
	Quixotic CCP begets inaccurate reporting	UL
	CARNA is meaningless and threatening	UL
	Nurse managers experience moral distress	LL
	Incongruous organizations hinder learning	LL
	CARNA is threatening and irrelevant	LL
	Competence is not addressed	LL
	Feedback from patients, managers and colleagues	UR
	Report fields filled with anything	UR
	Reported data irrelevant to legislation	UR
	Abandonment	LR
	Report anything	LR
	Simplistic task setting	LR
	Over-reliance on whistle-blowing	LR
	Code of ethics versus getting caught	LR
Over-reliance on whistle-blowing	Nurses are responsible for their practice	UL
	Nursing practice blighted by workload	UL
	Nursing is culturally hostile	UL

	CARNA is meaningless and threatening	UL
	Incongruous organizations hinder learning	LL
	CARNA is threatening and irrelevant	LL
	UNA an advocate	LL
	Nurse managers experience moral distress	UR
	Feedback from patients, managers and colleagues	UR
	Report fields filled with anything	UR
	Minimal effort and thought to minimum requirements	UR
	Reported data irrelevant to legislation	UR
	Abandonment	LR
	Report anything	LR
	Undue stress	LR
	Bait and switch	LR
	Feedback degrading teams	LR
Choose code of ethics versus getting caught.	Diversity adds to collective wisdom.	UL
	Nurses are responsible for their practice.	UL
	Constant change diminishes competence	UL
	Quixotic CCP begets inaccurate reporting.	UL
	CARNA is meaningless and threatening.	UL
	Nurse managers experience moral distress.	LL
	Unrealistic learning requirements are uncompensated.	LL
	Incongruous organizations hinder learning	LL
	CARNA is threatening and irrelevant.	LL
	Competence is not addressed	LL
	Competence reporting inaccurate	LL

	Competence reporting not authentic	LL
	Developed learning goals attempt to achieve compliance	UR
	Feedback from patients, managers and colleagues	UR
	Non-specific learning	UR
	Report fields filled with anything	UR
	Stated expressions of frustration	UR
	Authentic learning underreported	UR
	Abandonment	LR
	Report anything	LR
	Bait and switch	LR
	Over-reliance on whistle-blowing	LR