Workplace Learning: Exploring the Context and Culture in New Zealand.

Jodi Miller
1450586

Submission for Master of Health Sciences endorsed in Nursing
University of Otago
Christchurch Campus
ABSTRACT

Aim

The aim of this study was to explore the context and culture of workplace based learning. This research utilises the perspective of nurse educators employed in District Health Boards (DHB’s) that are not in tertiary centres throughout New Zealand. These specific DHBs were chosen because of their geographical isolation from Universities who provide alternative choices of ongoing post-registered learning.

The objectives of this research were to explore the rationale underpinning the development of education programmes within urban district hospitals throughout Aotearoa, New Zealand. As well as to discern how these workplaces develop education programmes and to consider how prepared nurse educators were to fulfil their roles as lifelong learning facilitators and mentors.

Background

Nurses struggle with issues surrounding work life balance and have difficulty accessing other forms of professional development (Aoki & Davies, 2002; Bahn, 2007; Brinkman, Wilson-Salt, & Walker, 2008; Dorian, Hall, & Jones, 2008; Gould, Drey, & Berridge, 2007). The current financial and lifestyle circumstances impact upon workplace-based learning and has become more significant than ever before. There is an obvious gap between the learning nurses engage in at the pre-registration level and the formal post graduate level of professional development. There is a clear requirement to foster learning during a nurses development post registration (Brinkman et al., 2008). The majority of nurses in New Zealand have identified that they prefer and choose to participate in workplace based professional development (Brinkman et al., 2008). This research has been undertaken to paint a picture of workplace based learning for nurses practicing in these unique areas throughout New Zealand.
Method

A mixed methods study was undertaken. A questionnaire was developed and was sent to nurse educators employed in urban hospitals throughout New Zealand. This was followed by seven educators participating in telephone interviews, which generated a wealth of qualitative data. The SPSS computer software was utilised to manage and analyse the quantitative data. The semi-structured interviews were transcribed verbatim and thematic analysis was undertaken for this qualitative data.

Findings

The sample surveyed (n=105) nurse educators throughout 13 District Health Boards within New Zealand, Aotearoa. The research found a dichotomy existed between the views of the educators and the practice of workplace based learning within the organisations that they were employed. The educators viewed nurses learning was a priority for both the organisation and the nurses they work alongside. Whereas the findings from this relatively small study suggest that in practice there was little actual support in place to create and promote an environment of perpetual learning. The basics required for optimal learning were not present in all the establishments surveyed. These basics included a number of key requirements for optimal learning to occur, these included; organisations lacked the ability to communicate philosophies of learning clearly to staff, there were barriers associated with the sparseness of available resources and equipment along with limited access to ideal learning environments whereby learning was expected to take place. However despite the restrictions surrounding learning in the workplace, the nurse educators themselves had demonstrated they were well motivated and had clearly prepared themselves commendably in terms of postgraduate learning in order to fulfil their role.

The findings surrounding strategies to encourage and support both Maori and overseas nurses to participate in workplace based learning found little or no insight to provide strategies that support groups that New Zealand struggles to recruit and retain in its workforce.
Conclusion

In order for New Zealand to provide quality care to the public, the utilisation of workplace-based learning is necessary to foster a pioneering nursing workforce. The nursing workforce in New Zealand was made up of 92.5% women and the average age was 45 years (Health Workforce New Zealand, 2012; Nursing Council of New Zealand, 2012a). The profile of the nursing workforce reflects a group of people who juggle unpaid external responsibilities alongside professional demands (Dorian et al., 2008). There is a clear demand for an innovative learning culture to exist that can be utilised and meet both the demands of the nurse and those of the organisation (Garcarz, Chambers, & Ellis, 2003). A number of themes evolved within this study, suggesting a way to develop this important concept within urban district hospitals. One key area was the provision of well-structured and sufficiently resourced learning programmes. The lack of a clear philosophy would appear to fall down in the communication process. Many participants suggested that the leadership within organisations need to establish and communicate clear philosophies of lifelong learning, which emphasise and value all nurses’ unique needs including academic, professional and cultural ongoing professional development. Meeting the needs of the organisation, the individual and the nurse educator’s needs could bring about a revolution of lifelong workplace learning. These needs identified in this study were time, resources, and equipment to empower all stakeholders to fulfil their roles, all of which would have an impact on quality, safe and sustainable health care.

Key words

Adult learning, critical reflection, learning culture, work-based learning, workplace based learning.
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Thank you all for your fabulous support. You all have helped me enormously in a multitude of ways, without you all, this project may never have come to fruition.
"Ka huri taku reo
Kit e hiku o te ika
Ki ti hiku o te rangi
Ki runga rawa e
E hine, te tama
E koro, e kui"

Ka huri mai, whakarongo mai-
My words call out
To the end of the land
And to the sky,
Men, women,
Old and young,
Turn this way
So that we can talk together.

Author unknown
(cited in Greenwood & Brown, 2007, p. 67)
## Abbreviations

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<th>Description</th>
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<tbody>
<tr>
<td>CNM</td>
<td>Clinical Nurse Manager</td>
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<td>CNS</td>
<td>Clinical Nurse Specialist</td>
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<td>CPD</td>
<td>Continued professional development</td>
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<td>DHB</td>
<td>District Health Board</td>
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<td>DON</td>
<td>Director of Nursing</td>
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<td>IT</td>
<td>Information Technology</td>
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<td>MECCA</td>
<td>Multi-employer Collective Contract Agreement</td>
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<tr>
<td>MOODLE</td>
<td>An online learning website which organisations can set up to assist learning.</td>
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<td>NZNC</td>
<td>New Zealand Nurses Council</td>
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<td>NZNO</td>
<td>New Zealand Nursing Organisation</td>
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<tr>
<td>PDRP</td>
<td>Professional development review programme</td>
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<td>SPSS</td>
<td>Statistical Package for the Social Sciences</td>
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<td>WPL</td>
<td>Workplace learning</td>
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Glossary of terms

Context
“Context does not simply imply geographical, spatial or institutional location, but also includes established rules, norms, values and inter-relationships that enhance or inhibit the success of the role” (McCormack et al., 2002, p. 143).

Culture
Culture is formed continually by the way individuals and groups interact and behave, it is within us and around us, it is the ‘here and now’ (Schein, 2010).

Iwi
Tribe, nation, people, extended kinship, group, tribe, nation, people, nationality race – often refers to a large group of people descended from an ancestor they have in common (Moorfield, 2001).

Lifelong learning
The recognition of peoples need to continually learn new skills, take on new knowledge and develop new behaviours and attitudes throughout their life, from the ‘cradle to the grave’ (Garcarz et al., 2003, p. 3).

Magnet hospitals
A hospital where nursing delivers excellent patient outcomes, where nurses have a high level of job satisfaction, and where there is a low staff nurse turnover rate and appropriate grievance resolution. Magnet status is also said to indicate nursing involvement in data collection and decision-making in patient care delivery (Segans, 2012).
Matauranga Māori
Traditional knowledge of Māori (Ryan, 2012).

Tikanga
Is the general behavior in daily life and interaction in Māori culture. It is the experiences and learning that is passed down through generations (Ryan, 2012).

The Treaty of Waitangi
This is considered New Zealand’s founding document signed in 1840 by representatives of the British crown and chiefs from the North Island of New Zealand. It recognized ownership of their lands and other properties, and gave the same rights of British subjects. There were two versions of this document and there has been no agreement, as to what was decided the treaty was agreed upon (King, 2003).

Urban district hospital
For the purposes of this study an ‘urban district hospital’ includes all district hospitals throughout New Zealand with the exception of the five centers Auckland, Waikato, Wellington, Christchurch and Dunedin.

Whānau
Extended family (Moltzen & Mcfarlane, 2006).
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Introduction

All allied health professionals involved in contemporary health care have a requirement to fulfil professional life-long learning. Brinkman et al. (2008) found that almost eighty percent of nurses prefer, and chose to participate in learning that occurred in the workplace. It is highly probable the rationale behind this is related to the hurdles associated with an overwhelmingly female workforce (97.2%) (Nursing Council of New Zealand, 2012a), and the ongoing struggle women experience when trying to manage their work-life balance. The key influences that impact upon work-life balance involve income, time, family and extracurricular demands on the lives of women (Dorian et al., 2008). There is a greater expectation placed upon nurses to prove their competence, hence the introduction of the Health Practitioners Competency Assurance Act (2003). The Act advocates that professionals keep abreast of changes, are critical and innovative thinkers and are competent practitioners in order to keep the public safe, whilst being cared for by health professionals delivering a quality service. However, unless systems are in place to enable good quality lifelong learning to occur within health care organisations, there is potential for an ineffective learning culture to exist. This then defeats the purpose of the legislation. In order for learning outcomes and the practice theory gap to be reduced, nurses need the opportunity to apply theory to the context of their practice (Finn, Fensom, & Chesser-Smyth, 2010b; Price, 2003).

The health care sector has experienced turbulent times over the last couple of decades including the impact of the 1990’s health reforms, the rising aging population and increasing number of patients with long-term conditions; an increasing demand for services and access to improved technologies. There are further demands on the New Zealand service in terms of the dire disparities in health of the Maori population (Ratima et al., 2008; Reid & Robson, 2006). While these factors burden the health sector greatly financially and in terms of creating strategies to improve the service delivered to its people. There is a constant requirement for health care organisations to
maintain and develop the health workforce. This includes recruiting and retaining
health professionals and ensuring that the workforce evolves to support future models of
care and service innovations (Auditor-General, 2012). The demands upon the health
system are both diverse and immense. However, developing environments whereby
nurses learning in the workplace is fostered, encouraged and critiqued is essential for
the provision of safe health care services.

This research intended to explore the secondary health services throughout New
Zealand and paint a picture of the learning environments within the workplace. The
purpose of this research was to gather the knowledge and experiences of nurse
educators practicing in urban district hospitals, to explore the context and culture of
workplace based learning throughout Aotearoa, New Zealand.

The author chose to sample nurse educators working in organisations that were not
situated in the four tertiary centres throughout New Zealand. This decision was based
upon the fact that there is a potential for educators and nurses in urban areas to be
physically isolated from the potential external education opportunities that a major
centre can provide. Therefore the author’s aim was to explore the context and culture of
workplace learning within the workplace of organisations where their choice of
professional development may have been limited due to their geographical
circumstances and experience a potential limit of the choices of education opportunities
available to them. The rational supporting this group of workplaces stemmed from the
theories that nurses are overwhelmingly female (92.7%), they have difficulty
maintaining work life balance because of the external demands placed upon their time
and they tended to choose to participate in workplace based learning in New Zealand
(Brinkman et al., 2008; Dorian et al., 2008; Nursing Council of New Zealand, 2012b).
Therefore the author of this study was curious how these organisations facilitated and
promoted learning within the workplace for this group of nurses.

The key issues surrounding workplace education is an area in which processes are
largely unmeasured, the benefits are unknown, and the context of which may vary in
workplace environments and cultures. Hardcastle (2008) identified gaps in the current
literature surrounding the effectiveness of how nurses used learning to develop their practice. In stepping away from the effectiveness of learning, this research sought to explore, from the perspective of nurse educators, their views of the culture of learning, for purposes of professional development for nurses at the bedside in New Zealand’s urban district hospitals.

In order to gain a greater understanding of the topic at hand, a review of the literature was carried out and is discussed in chapter one. The issues deemed pertinent to this research included a greater understanding of education, adult learning, learning organisations, culture and workplace learning. This knowledge informed and provided a basis for the design of the research and the tools used to collect and interpret the data.

The research is presented in chapters discussing key aspects of the topic. The first chapter discusses the literature that is pertinent to establish the conceptual framework that underpins the context and culture of workplace based learning for nurses in New Zealand. The following chapter outlines the methods considered and the research design used to develop the study and establish tools for data collection and analysis. In chapter three the findings are presented. The discussion chapter explores the findings in relation to the aims of the research undertaken. The final chapter describes the conclusions that the author has drawn from the study and wider literature. An epilogue concludes the thesis, outlining some personal reflections associated with the researcher’s journey with this study.
Chapter One: Literature review

The purpose of a literature review is to put a research problem into context, the process involves reviewing the literature, critiquing and summarising the research (Polit & Beck Tatano, 2004). The literature review process is usually a method utilised to develop a research question through exploring the literature surrounding the primary topic in question (Scheider, Elliot, Lo-Biondo-Wood, & Haber, 2003). Although this is not a hard and fast rule, some qualitative researchers utilising grounded theory will perform a literature review as the final aspect of their research, this is because researchers want to prevent the development of their own ideas being influenced by the ideas of others (Polit & Beck Tatano, 2004). Whereas phenomenologist’s will use the process at the start of the process and use the review method to grasp the topic from a number of viewpoints (Polit & Beck Tatano, 2004). In this research the literature review was undertaken in the beginning of the project, firstly to enable the author to develop a broader knowledge of the subject and what is understood about the problem. Secondly, the review aided the development of the research aims and goals.

The aim of this review is to explore the literature surrounding the culture of learning within the context of health care organisations. The role of culture within an organisation is crucial in terms of maintaining a happy healthy workplace (Kane-Urrabazo, 2006). The culture of workplace learning is essentially the way things are done or are expected to be carried out. The term workplace culture constitutes the shared expectations, attitudes, and values in regard to learning amongst organisations where nurses are employed. These features influence how people communicate and carry out their learning in the workplace.(Anderson, 2006).

Workplace based learning for nurses as a means of ongoing professional development is of interest internationally (McCormack et al., 2009). It is crucial for health care organisations to strive for, and provide quality and safe health care. It is well understood that the provision of quality health care relies upon effective ongoing
professional development. The process of determining how workplace learning was carried out and prioritised within District Health Boards (DHBs) throughout New Zealand, there were a number of factors to consider. This literature review is broken up in sections that the review identified as key aspects of learning within the workplace that when linked together provide a broad picture of what constitutes culture and workplace based learning. The categories consist of gaining knowledge of what learning is, organisations attitudes and philosophies surrounding learning, barriers to learning, clinical governance and its relationship with learning, leadership and its role in the learning process. These issues need to be looked at in context to the research subject to gain an overall perspective of the key issues for the stakeholders. Therefore the review does appear to be somewhat descriptive. However there are key issues that pertain to nurses learning in their workplace in New Zealand.

This literature review intends to explore important aspects of the available information in terms of:

- The key elements of the concept, context and culture of workplace-based learning.
- Defining a culture of learning within health care organisations.
- How workplace based learning occurs best within health care organisations.

The search strategies utilised databases that included CINAHL, EMBASE, ERIC (Educational Resources Information Centre) OVID (Including Medline, EMBASE, Nursing, Psych Info) and Google Scholar. Other strategies included a number of reference books, library services and the media. The search strategies utilised key words to search for material surrounding the subject being explored these were: Adult learning, critical reflection, learning culture, work-based learning, workplace based learning.

Brinkman et al. (2008) carried out an extensive study on behalf of the New Zealand Nurses Organisation. This study explored the implications education has for and on practice. They carried out a survey with a random sample of 1650 of the 33,000 potential participants and received a response rate of 43.5 per cent. A significant
finding from the Brinkman et al. (2008) study, was that over eighty per cent of nurses clearly identified a preference for workplace based learning in terms of ‘in-service learning’ to achieve their ongoing professional development requirements. The study failed to clearly define the term ‘in-service education’. The majority of nurses in New Zealand have identified that they prefer and choose to participate in workplace based professional development (Brinkman, Wilson-Salt, & Walker, 2008). A precursor to this finding is that nurses struggle with issues surrounding work life balance, and have difficulty accessing other forms of professional development in order to achieve and maintain their competency based accreditation. The current financial and lifestyle circumstances impact upon workplace-based learning has become more significant than ever before. This research has been undertaken to paint a picture of workplace based learning for nurses practicing in these unique areas throughout New Zealand.

However, anecdotally within New Zealand health care organisations in-service education is widely understood to be learning which occurs within the workplace. Education sessions for nurses are usually based within the nurses immediate work environment or through organisational study days.

**Understanding learning**

Learning is something individuals do from birth; physiologically human beings are innately predisposed to learning. This is a relationship entwined with both the individual and the environment (Wirth & Perkins, 2008). Although the following definition is simplistic and open to much debate, most people have a general sense of what learning is “knowledge gained by studying” (Crozier, Grandison, McKeown, & Weber, 2006, p. 455).

Learning can occur in a variety ways and environments that are not likened by any means to the process of academic study. Knowledge can be gained through a number of methods such as conversations, shared experiences and observation, to name a few.
Learning can also occur for nurses through a reflective process of considering events and how a nurse can or would approach situation differently in the future (Benner, 1984; Garcarz et al., 2003; Gross, 1977; M Jasper, 2007; Schon, 1983).

The process of gaining the product of knowledge can occur in a number of ways. Experts have theorised for many years about what learning is and how it occurs. There are large quantities of information available, regarding how the human brain physiologically assimilates information and the many processes associated with learning (National Research Council, 2000; Wirth & Perkins, 2008). The theories of learning are extensive. Examples of some theorists to name a few in this area are Blooms Taxonomy, Maslow and Rogers humanist approach, Knowles view on adult learning and Gestalts cognitive approaches or the behaviourist and social/situational orientations (M Jasper, 2007; Senge, 1990). The key to summarising all theories is that people all learn in unique ways and individuals have preferred learning styles. Subsequently when facilitating any learning, it is important to utilise a variety of different styles. It is crucial that pupils realise that learning is a two-way relationship, learning will not occur unless the student has a desire for learning and is actively engaged and participates in the learning (Garcarz et al., 2003; Houle, 1980; Knowles, 1975). This includes partaking in self-directed reading and research around the desired topic to ensure the knowledge gained is embedded (Knowles, 1975). In terms of learning for nurses within the workplace, the clinical environment is constantly changing, yet nurses are required to have skills to adapt learning and later apply it to their evolving environment. These clinical situations often include the need for practitioners to be able to reason in an imaginative way that utilises clinical, critical and scientific reasoning (Benner, Sutphen, Leonard, & Day, 2009). The importance of facilitating these skills to enhance nurses abilities is crucial for the provision of effective health care (McCormack & Slater, 2006).

Adult learning theories tend to have similar ideas in terms of changing behaviour and experience (Merriam, Caffarella, & Baugartner, 2007). There are theorist who presume that adult learners are motivated and bring a reservoir of experience that adds to their ability to consolidate and reflect their learning (Knowles, 1975). Utilizing experience to learn is linking the doing with thinking and visa versa, the learning experiences in turn
guides the choices made in the future (Jarvis, 1983; Kolb, 1981). The key to using experience to learn is that it offers adults a meaningful advantage in the learning process because they bring life experience which in turn can be utilised for critical reasoning to that learning (Jarvis, 1983).

In terms applying adult learning theories to organisational learning requires the workplace to facilitate an environment of acceptance empathy, trust and safety (Mezirow, 1981; Schein, 2010). Schein (2010) emphasises the need to be aware of the anxieties that can come from workers being forced to rethink and unlearn old practices. The time involved to learn and adapt practice cannot be rushed, the environment and timing is crucial to ensure optimal learning (Schein, 2010). These features follow the transformational leadership theory that provides positive opportunities, blame free environments minimising failure to optimise learning within organisational life (Cranton, 1994; Schein, 2010).

**Workplace based learning.**

The nursing literature that discusses workplace based learning for nurses identifies the need for facilitators to be prepared, and that nurses be equipped with skills to take on board previous learning and adapt it to current scenarios (Benner et al., 2009; McCormack & Slater, 2006). The literature surrounding what constitutes workplace learning in general is vast and many have found it difficult to define. Numerous and varied fields have attempted to define ‘workplace based learning’ or ‘work based learning’.

An example of the variety of areas that have made attempts has been eloquently summarised by Candy and Matthews (1998, p. 15)

> ‘Coming from a range of fields of study [in relation to what constitutes workplace based learning] (adult education, higher education, cultural anthropology, organisational theory, innovation studies, industrial economics, management studies, vocational education, etc.), a variety of theoretical perspectives (behaviourism, interpretivism and critical theory), different points
of view (the manager, the learner/worker, the development practitioner), various contexts or environments (manufacturing/production-based industries, knowledge- or service-based organisations, the public sector, universities, professional practice etc.), and using every imaginable methodology (from surveys and interviews, to diaries and participant observation) they have generated a bewildering array of models’.

Searching the literature revealed that the terminology used in the published material was inconsistent. The term ‘workplace learning’ lacked a unified approach to establish a definition to gain a clear view as to what workplace learning should be, or who the anticipated audience would be. Many decided the term, ‘workplace learning’ needed to be used with some flexibility (Candy & Matthews, 1998; Lee et al., 2004; Stern & Sommerlad, 1999). Therefore by exploring the term with flexibility, Stern and Sommerlad (1999) suggests, logically that the workplace was a site for learning, it was a learning environment and that learning and working are inextricably linked.

There appears to be a consensus within the literature that ‘workplace based learning’ refers to ongoing education that takes place at work. It concentrates on how learning takes place within that environment, in terms of during, on hindsight or for the purpose of work (Manley, Titchen, & Hardy, 2009; Seagraves, Osbourne, & Neal, 1996). Barr (2003) added that the aim was to enable the practice of the learner to be improved in the workplace. Barr kept the focus on learning being the process of work, but breaks up learning into two subsections namely learning occurring at work and learning that occurs away from work. The difference in these opinions appears to be semantics and the meanings obvious.

The information technology (IT) sector is well known for its reputation for innovation and creative thinking. This thinking has challenged traditional ways of managing human resources for a number of successful years. Sangster, Maclaren, and Marshall (2000a) looked at workplace based learning from an information technology perspective, as the methods used have clearly moved away from the traditional didactic views of learning. They described individuals who develop from learning, as opposed
to being taught. This particular view described learning as an activity that is collective, shared, and focused upon the needs of the individual. This employee development framework was linked to the aims and objectives of the organisation and were flexibly negotiated within the organisation (Sangster, Maclaren, & Marshall, 2000b). This perspective emphasised productivity and the appreciation of learning was underpinned by market driven philosophies. The benefits of this approach have seen information technology areas soar in terms of growth and ingenuity, which may be embraced by the innovative private sectors. This may not necessarily be said for the economically constrained health sector, which does not generate income as such, or profits. There are some concepts, which do pervade both the private and public sectors. Flexibility is difficult in organisations who struggle with the basic requirements such as adequate resourcing, staffing and rostering (Paterson, Henderson, & Trivella, 2010).

Ongoing professional development is expensive, at face value to support and supply (Garcarz et al., 2003). However, the cost to a community may well be more expensive if the nursing profession fails to maintain safe quality care. A training manager in the Ford motor company stated “if you think training is expensive you should try ignorance” (Jarvis, 1987, p. 54). To which Jarvis (1987) commented later that if this is true for the motor care industry how much more should it be for the caring industry. The implication being that avoiding spending time and resources on learning has the potential to be very costly.

There are differing opinions from those authors who have written about what constitutes work based or workplace learning, there is the opinion that it is a managerial and economic solution to ongoing professional development of large workforces (Burton & Jackson, 2006). However Garcarz et al. (2003) would strongly argue that if done well, workplace based learning is not a cheap option for professional development. Whether this is true or not, for reasons relating to the provision of quality care, the reality is that health care organisations are required to ensure their staff are capable of providing safe care to the public. In order to ensure this occurs, education is required. There is a previously acknowledged demand by nurses for learning to occur within the workplace (Brinkman et al., 2008). If this demand by New Zealand nurses is mainly due to work-life balance, it does not remain the sole contributing force for workplace learning to
occur. The most important reason must be the supply of safe, quality up to date health care to the public.

The learning culture within the workplace.

The process of defining what the culture of learning is in the workplace, is again complex. The term ‘culture’ is multifaceted, although people can usually recognise cultural differences at more obvious levels such as ethnicity and national levels but struggle to comprehend them at a group, organisational or occupational level (Schein, 2010). However we use the term ‘culture’ in everyday language when discussing workplaces and relationships with individuals and groups, and people tend to understand what is meant literally. Yet struggle to define its meaning (Schein, 2010).

There has been an explosion of literature and research within this field (Schein, 2010). Culture can mean many things for many people. Some explanations seem far from and irrelevant to the workplace and appear more relevant to anthropological studies. Culture is formed continually by the way individuals and groups interact and behave; it is within us and around us, it is the ‘here and now’ (Schein, 2010, p. 3). The New Zealand historian (King, 2011, p. 37) referred to culture being ‘the rituals and values through which people receive and feel their identity; and by which society accepts them – culture by nature is both inclusive and exclusive’. When considered these two points of view are alike, King (2011) probably from a historic view of New Zealand society and Schein a reflection on an organisational perspective. Schein (2010) considered specifically the individual and how their actions and ways of being have the potential to cause a domino effect upon a wider culture within the workplace. Culture can be a powerful influence, it can keep a workplace stagnant or it can propel a workplace towards innovative practice (Schein, 2010).

King (2011) was clear to point out he was not merely referring to the arts as is often referred to when ‘culture’ is defined. Instead this definition clearly implied that when looking at workplace culture of learning, King’s definition potentially implicated the
nurses’ perception of themselves, their professional identity, their academic identity and how their organisation valued their academic and professional knowledge. It may well call into question the value both nurses and the various organisations place upon nurses’ ongoing professional development within New Zealand.

The nursing profession has progressed a long way from the subservient profession of the past whereby nurses were expected to be seen and not heard, and their learned opinion may not have been given the respect it deserved (Gordon, 2005). The nursing profession has some distance to travel to gain the autonomy, respect prestige that other professions enjoy (Yam, 2004). The development of nurses’ knowledge and skills over time has been referred to as the ‘art of nursing’. This informal learning has also been described as ‘know-how’ learning, which is knowledge that is transferred through word of mouth, personal experiences or via observation (Carper, 1978; Gunilla, Drew, Dahlberg, & Lutzen, 2002; Royal College of Nursing, 2003). It is not like the scientific knowledge that occurs in formal settings, nor is it a consequence of research and theory often referred to as the science of nursing and referred to as “know-that’ knowledge (Royal College of Nursing, 2003).

In terms of the professional role within the workplace, nurses are required to embrace both types of learning that are significant to a unique profession. In order to get a balance of both the art and the science of nursing, nurses are required to demonstrate self-responsibility in terms of their participation in all phases of workplace learning. To be more specific, learning needs assessments, curriculum planning, implementation of education, and evaluation of learning is required to support and progress the workplace learning within nurses work environments (Knowles, 1975; Yam, 2004).

There are a number of key elements that the literature has clearly highlighted as being crucial within organisations committed to developing an effective culture of learning (McCormack, Wright, Dewar, Harvey, & Ballantine, 2007). These factors include a philosophy that education is prized in itself, leadership that leads by example, structural changes that facilitates learning for all, a clear understanding of the beliefs and values surrounding learning, a shared vision for practice, a high regard for individuals and an
organisation with the skills and processes in place to support the commitment to a progressive culture of learning (Garcarz et al., 2003; McCormack et al., 2007; Spouse, 2001). A commitment to develop and foster a learning culture is more than merely providing training. It is a process that ‘lights a flame’ in learners and fosters the desire to learn in its employees (Garcarz et al., 2003; Kaeufer, Scharmer, & Versteegen, 2003; Williams, 2010). The development of an organisation’s culture of learning is a professional responsibility of both nurses and the organisation.

A positive learning culture is one whereby learning is seen as the role of everyone within the organisation (Garcarz et al., 2003; Garvin, Edmondson, & Gino, 2008; Williams, 2010). Nurses can become change agents when questioning existing practice, assumptions and cultures which are routine and accepted within the organisation (Williams, 2010). Organisations committed to the philosophy of lifelong learning in practice and not merely in principle are those which appreciate learning as an integral key to delivering services that meet the needs of patients, the organisation and future changes within that organisation (Garcarz et al., 2003). Through their work transforming the National Health Service (NHS) organisations in the UK into learning organisations Garcarz et al. (2003) established practical tools to aid the development of a learning culture. This work was rigorously supported by theories of lifelong learning and interwoven with models of learning, emphasising learning as a process of continual improvement and innovation thereby creating a cycle of action and reflection.

There is the need for nurses to feel comfortable in their workplace to share their ideas amongst their colleagues if critical dialogue is to be achieved. Critical dialogue engages nurses in discussion and debate, and can help to shift a workplace towards an active culture of learning. This learning is able to draw from and utilise personal experiences to debate, critically analyse and reflect upon practice to enhance learning as individuals and therefore influence the wider organisation (Cook & Leathard, 2004; Jarvis, 1987; Manley et al., 2009; Williams, 2010). The environments nurse’s practice in requires a non-judgemental setting whereby they feel at ease to debate issues that affect their practice.
In terms of learning theories, the current era of lifelong learning is the guiding principle forming the framework of professional development and legislation within New Zealand. This legislation is to ensure health professionals maintain competency as a means of protecting the public. Prior to the introduction of the Health Practitioners Competency Act (2003), nurses signed a registration declaration every year and paid an annual fee to maintain their registration or enrolment, without any obligation to maintain professional development (Burgess, 1984). Now nurses are expected to maintain an up to date portfolio demonstrating their continuing professional development and may be subject to an audit by the New Zealand Nurses Council (New Zealand Nursing Council, 2010).

**Barriers associated to nurses learning**

**The financial barriers**

Workplace based learning within a health care context has the potential to meet many of the nurse’s professional requirements. A philosophy of learning that promotes a theoretical and reflective framework could meet the needs of a market driven, rapidly changing environment and assist in maintaining competence of employees (Burton, 2005; Hicks & Hennessy, 1997; E. Walker & Dewar, 2000). Offsetting this, the actual cost of education to both the organisation and the nurses themselves is high (Dyson, Hedgecock, Tomkins, & Cooke, 2009). Dyson et al. (2009) succinctly pointed out that as knowledge based profession nurses are required to keep abreast of advances in social, medical and technological changes. Nurses are required to continuously adapt, by demonstrating the application of evidence-based knowledge and reasoning to practice.

The practice of cutting ongoing education initiatives first, when organisations are feeling the burden of financial constraints is not uncommon (Dyson et al., 2009; Levett-Jones, 2005; Lindy & Reiter, 2006). New Zealand’s recent health care history of the 1990’s is a good example of this practice. It has been well documented that the
introduction of the market driven economy had a high impact upon learning for nurses. Resources were cut and ongoing professional development could be described as a ‘victim’ of the market economy within the public health care sector (A. Bamford & Porter-O'Grady, 2000; Easton, 1997; Gage & Hornblow, 2007; McCloskey & Diers, 2005). This caused a professional development freeze for many nurses throughout New Zealand, which, in turn, affected the culture of learning for a significant period of time.

This time span possibly extended until the Health Practitioners Competency Act (HPCA) in 2003 had had time to become embedded and nurses’ requirements were fully understood by all stakeholders. This Act primarily provides a mandate to provide the public of New Zealand with safe, competent health care (Dyson et al., 2009). Despite this, the disparities in funding ongoing education persist today. The evidence is clear. Nursing represents the largest health care workforce (36%) and yet only receives an allocation of 9.86% of the central training agency budget (Brinkman, 2010).

Dyson et al. (2009) undertook a descriptive quantitative study of the learning needs of nurses in an acute care setting. The study sampled two groups of nurses; the first were clinically based registered nurses, the second nurses in senior roles such as managers, educators and specialists. The senior groups response rate was significantly higher (63% n=101) than that of the clinically based nurses (35% n=565). Both perspectives of nurses and senior nurses (which included clinical nurse managers, specialists and educators) were considered and they argued that ongoing learning programmes needed to be cost effective, able to satisfy the nurses and have an impact on practice, in a way that ultimately improved health outcomes for both clients and communities. For this to occur, education needs to move away from the ad hoc traditional practices of the past, which in some instances still exist today. These practices usually plan education on a ‘hunch’, or ‘felt need’ basis, without needs assessment being carried out in consultation with the nurses, for whom the education is planned (Claflin, 2005; Desilets, 2006; Dyson et al., 2009; Grant, 2002). Education that is wanted by the staff, well researched and based upon sound data and information (Pedder, 1998) is more likely to be far more cost effective for the organisation in terms of increased attendance, participation, commitment and the feedback from evaluations following learning (Dyson et al., 2009).
**Work and life balance**

The work life balance is the process of juggling paid employment and activities people are engaged in outside of work (Kalliath, 2008). It is understood that business benefit from a more productive happier, healthier workforce whereby optimal work life balance is fostered (Kalliath, 2008).

As previously mentioned nurses make up the largest division of the health care workforce within New Zealand (Dyson et al., 2009). Whilst women remain the predominant group, men make up 7.4% of the nursing workforce in New Zealand (Nursing Council of New Zealand, 2012a). The nursing workforce is an aging professional group and is faced with the challenge of attracting people to nursing and retaining the nurses it has (Jackson, 2008; McMillan & Conway, 2007; Te Rau Matatini, 2009). It is understood that the reason behind the concept of the aging workforce are complex. This is not just a problem within New Zealand but also a global concern. The average age of New Zealand nurses is 45 years old, with 39 per cent of the workforce being 50 years or older (Nursing Council of New Zealand, 2012b).

Nurses undertake a number of roles and it is commonplace for nurses to juggle many responsibilities outside the work environment. It is essential to take into account that three quarters of unpaid care is carried out by women (Brinkman et al., 2008; Dorian et al., 2008). These facts highlight further demands upon female nurses in our communities. A much higher potential exists for them to be partners, primary caregivers, mothers, daughters and students; their responsibilities may include childcare, household duties, extramural study, care of their elderly parents to name a few of their roles. These additional roles have been identified as having an impact upon both a nurses health and their ability to perform within the workplace (Killien, 2004; Schluter, Turner, Huntington, Bain, & McClure, 2011). The investment of their personal time to ongoing professional development can be challenging and has the
potential to add further pressures to the equilibrium of their work life balance (Aoki & Davies, 2002; Bahn, 2007; Brinkman et al., 2008).

Specifically in relation to Aotearoa New Zealand, Te Rau Matatini (2009) undertook research in 2009 and documented a report on behalf of the Ministry of Health, which explored issues surrounding Māori nurses and midwives. This research gained a greater understanding of issues surrounding attracting Māori to nursing. Key findings involved professional development and leadership challenges associated with Māori in the health service. It utilised a mixed methods approach its n=313, of this total group 160 responded to email survey and 153 participated in one of 10 focus groups. This report highlighted the fact that Māori were 12 per cent of New Zealand’s population and nurses who identify as Māori were 7.1 per cent of the total population of nurses and midwives who at the time held current practicing certificates (Ministry of Health, 2006; Nursing Council of New Zealand, 2012a). The total number of nurses and midwives in New Zealand are 45,000 and 2869 identified their ethnicity as Māori (Broodkoorn, 2010).

This review found that there were almost identical issues experienced by Māori nurses, as experienced by the general population of nurses (Brinkman et al., 2008; Dorian et al., 2008; Te Rau Matatini, 2009). Issues surrounding work life balance and the external pressures associated with nurses responsibilities outside the workplace affected their ability to access and participate in ongoing professional development. These external responsibilities associated with working professionally, limited their availability to access professional development. Therefore as with non-Māori, these factors contributed to the reliance upon the employer, to provide opportunities for ongoing professional development.

An issue specific and unique to Māori nurses was the importance of the organisation and colleagues within the organisation, to respect and appreciate the value the dual roles many Māori nurses provide. They enable specialised and unique care to the Māori patient and their whānau. Te Rau Matatini (2009) found Māori nurses required protected time for facilitated reflection upon their clinical and cultural practice, peer
support along with cultural and clinical supervision for Māori. The need to have knowledgeable people to support the facilitation of ongoing cultural development for nurses by experts in the field is essential (Te Rau Matatini, 2009). These challenges need to be met in addition to usual allocated time for professional development for Māori nurses.

Te Rau Matatini (2009) clearly stated that steps were required to be taken to recruit and retain Māori into the nursing profession. A major step for Māori would be the provision of ongoing professional development throughout the career lifespan of Māori nurses and not just in the new graduate programmes currently facilitated in the workplace. The key clearly being highlighted was the ongoing nature of education required for Māori nurses’ cultural development and for it to be differentiated from other forms of professional development.

In New Zealand real concerns exist specifically in regard to recruiting and retaining Māori to the nursing profession. Māori are underrepresented in the nursing profession and over represented in terms poor socio economic statistics alongside, the poor ability for the health sector to provide quality holistic care for the indigenous people of New Zealand (Broodkoorn, 2010; Ratima et al., 2008; Te Rau Matatini, 2009; D. Wilson & Barton, 2012).

**Clinical governance and workplace learning**

Clinical governance is a system designed for improving the standard of clinical practice (Derry, 1999; Swage, 2000). In terms of workplace based learning, it is no longer acceptable that practitioners can abstain from ongoing professional development following gaining initial qualifications (Swage, 2000). In the United Kingdom the funding of ongoing learning is a joint responsibility of the NHS (National Health
Service) and the clinician. This has been effective, but funding has been described as cumbersome (Starey, 2001).

The transition of health care organisations incorporating clinical governance philosophies into the workplace provides a framework that clearly identifies the significant need for ongoing education and professional development. To maintain a high quality standard of health care, the evidence that nurses have more influence over patient outcomes, standards of safety and the professional work environment is becoming increasingly compelling (Aiken & Patrician, 2000; Brinkman et al., 2008; Garcarz et al., 2003; McCloskey & Diers, 2005; Tourangeau, Doran, & McGillis Hall, 2007). Professional development is an essential building block to providing quality and safe health care (Derry, 1999; Garcarz et al., 2003; Spouse, 2001). For quality and safe care, health care organisations and the public rely upon nurses to be effectively prepared. Nurses require the opportunity to integrate their knowledge within practice and need ongoing assistance and support to keep up to date with current evidence based practice. This is especially crucial in a rapidly changing world, not only is there a wealth of new information confronting the nursing profession, there are fundamental challenges within the profession itself which affect learning and indeed service provision (Crotty, 2010; Henderson, Briggs, Schoonbeek, & Paterson, 2011).

Figure one, on the following page, presents an adapted version from a clinical governance model developed by Swage (2000) for the health service in the United Kingdom (UK). This adaptation of the model outlines the possible model for the New Zealand health system, identifying education at pivotal point of developing practice and delivering good quality of care.
Figure 1: A possible model of clinical governance (adapted from Swage, 2000)
Leadership

Leaders are those individuals who possess the abilities to transpose qualities that can influence, and these unique qualities enable a culture to become embedded (Schein, 2010). According to Schein (2010) both leadership and culture are two sides of the same coin. The clearest connection between leadership and culture is in organisational culture. Successful learning cultures can be created and maintained with the support of innovative leaders (Henderson et al., 2011; Schein, 2010). Effective inspirational leadership can impact upon staff satisfaction and the wellbeing of patients via their influence as role models and advocates of professional nursing behaviours (Paterson et al., 2010). If elements become dysfunctional within the culture of the workplace, leaders need to be able to overcome their own culture and be prepared to apply forced managed culture change programmes to elicit a return to positive behaviour and communication patterns (Schein, 2010).

Workplace based learning has a potential role to meet both organisational needs in regards to the provision of quality up to date health care and the needs of nurses for ongoing professional development. If done well, and not merely paid ‘lip service’ as described by Dyson et al. (2009), stakeholders namely the patient, the organisation and the nurse, could achieve successful outcomes. There are collaborative ventures between staff, the employing organisation and an education facility, which work well. (Dewar, Tocher, & Watson, 2003; Dyson et al., 2009; Gould, Berridge, & Kelly, 2007). Models of work-based learning would be useful to integrate practice environments, to develop and foster a culture of learning within the nursing workforce (McCormack & Slater, 2006). The context of this study focuses purely on the healthcare organisation in isolation from any education facility.

In the past nurses have been expected to intrinsically possess leadership skills, but traditionally they have been poorly prepared to meet expectations to guide or inspire others (Cook & Leathard, 2004; Heller et al., 2004; Paterson et al., 2010). These skills are required to be learnt and facilitated. For example, a programme in an Australian magnet status hospital instigated an emerging leaders programme. This programme...
encompassed all staff including new graduates and all employees within six months of their start date. It anticipated that *those* undertaking the programme would inspire a mirror effect of leadership in those they work alongside within the organisation (Paterson et al., 2010).

The inclusion of new graduates and nurses new to the organisation is an insightful approach. This practice challenges traditional assumptions that only experienced senior nurses are ready for leadership training, whereas it is expected here that all nurses at all levels are able to start learning to demonstrate and facilitate good leadership practices within their workplace. This process helps to spark change in leadership culture, which in turn contributes importantly to the learning culture. The fundamental belief is that leadership within the health care setting includes the ongoing development of others. This is the process of embedding leadership and role modelling into everyday practice (Davidson, Elliot, & Daly, 2006; Paterson et al., 2010).

**Magnet hospital principles as role models**

Magnet hospitals are organisations who have clear commitment to implementing philosophies and strategies to improve their ability to retain and recruit staff and improve quality of care to their patients (Buchan, 1999; Segans, 2012). By prioritising these issues magnet hospitals found that nurses experience significant improvement in job satisfaction and these organisations have reduced staff turnover and grievance resolution (Buchan, 1999; Segans, 2012). Magnet hospitals tend to demonstrate a strong commitment to ongoing professional development. The adoption of these philosophies have demonstrated clear changes in both workplace culture and their ability to recruit, retain and improved staff satisfaction (Dyson et al., 2009; Krammer & Schmalenberg, 2004; Zurn & Dumont, 2008).
Health care organisations that overlook the philosophies that are integral to the magnet organisation are unlikely to successfully instigate and maintain productive workplace learning programmes. That is, without an organisational change of vision into learning practices, the barriers that enable learning will continue to be perpetuated. These barriers include lack of resource allocation, rostering allowing education to occur, and a skills mix that fosters and supports learning (Cook & Leathard, 2004). Cook and Leathard (2004, p. 440) are not unrealistic when they stated ‘without the basics, it is difficult to help staff focus on other priorities’.

Contemporary health care is currently in a phase whereby philosophies encourage interdisciplinary learning (Davidson et al., 2006). The ideal model of health care would be an organisation that demonstrates magnet hospital qualities. Along with these philosophies, there remains the ever-increasing burden of the increasing cost of healthcare. The priorities demonstrated by current models when delivering care in a non-magnet organisation, negate the responsibility of organisations to facilitate the professional development of nurses in terms of ongoing education and provision of quality of care. Effective leadership and the development of a learning organisation must be symbiotic in their relationship (Garcarz et al., 2003; Garvin et al., 2008; Krammer & Schmalenberg, 2004; Senge, 1990).

**Organisational philosophies and responsibilities**

The provision of education and training within an organisation does not imply that a culture of learning exists within that learning organisation (McCormack & Slater, 2006; Williams, 2010). Similarly the provision of education does not automatically correlate with actual learning occurring (Garcarz et al., 2003). Current organisations and those of the past, are under the impression that a learning organisation provides work-based learning by facilitating task focused on-the-job training, articulating expectations and
the provision of training (Garcarz et al., 2003; Garvin et al., 2008; Williams, 2010). However, without an understanding of how adults learn and apply these principles and foster a culture that ‘prizes’ learning, little education is likely to occur (Garcarz et al., 2003; Garvin et al., 2008).

In order to learn, adults require the inherent desire, motivation and the expectation within their environment that believes ongoing learning is essential to maintain quality up to date safe health care (Garcarz et al., 2003; Gould, Drey, et al., 2007; Knowles, 1975; Schoobeck & Henderson, 2011; Williams, 2010). These factors are crucial in the development of an accepted learning culture, without which, little learning will occur. McCormack and Slater (2006) evaluated the role of clinical education facilitators and found, that the role of facilitator providing learning had very little impact upon the actual culture of learning within the organisation. In contemporary nursing, the expectation is clear in terms of the Health Practitioners Competence Assurance Act (2003) (HPCA Act), that nurses are required to demonstrate participation and commitment to ongoing professional development.

The introduction of the HPCA Act (2003) was designed to protect the public and to ensure practitioners were responsible for providing quality health care, and the requirement for health professionals engage in career long learning is explicit (Ministry of Health, 2007; Wright, Malcom, & Barnett, 2001; Zurn & Dumont, 2008). McCormack and Slater (2006) utilised a realistic evaluation methodology which interviewed 105 nurses ‘on the spot’, the findings indicated a clear need for further research into the culture of learning for nurses within healthcare organisations. This research did not evaluate the effectiveness of the nurse educators in facilitating a culture of learning; it merely used professionals as a means to provide education. Nurse educators are a pivotal link between the management of the organisation and the nurses participating in professional development (McCormack & Slater, 2006).
Strategies surrounding the processes of learning

Literature surrounding theories of learning appear to have influenced philosophies of ‘workplace based learning’ or ‘work based learning’. The adult learning paradigm is a multi-dimensional phenomenon, focusing on the process of learning rather than on content alone, and is not merely a didactic process (Knowles, 1975). A systematic review of the literature available between the years 1990 and 2007 was carried out by Gijbels, O'Connell, Dalton-O'Connor, and O'Donovan (2010) and explored the impact of nurse and midwifery education and practice post registration. The review found that learners demonstrated a change in attitude and perception following the acquisition of new skills and knowledge. The findings from those involved in workplace learning related to the personal and professional development of the learners involved, rather than practice development, organizational change or patient outcomes (Gijbels et al., 2010; Williams, 2010). These insights from the study were not new, as it had earlier been recognized that education needed to meet the needs of the nurses, in terms of knowledge and skills required by the workforce (Dearing, 1997; McCormack & Slater, 2006).

It is not enough for a learning organisation to remain static in its approach, education must be joined with learning that enhances the individuals within the capacity to create change and transfer knowledge (Garcarz et al., 2003; Garvin et al., 2008; Senge, 1990; Williams, 2010). Organizations need to facilitate learning using methods that enhance learning for all their staff throughout their career lifespan. There are methods that are better suited to junior staff such as the affirmation model which encourages junior staff to upskill and meet the employers needs for a stable effective workforce (Brown, Harte, & Warnes, 2007; Macleod & Lyon, 2007; Williams, 2010). In contrast, the Transformative Model has the potential to meet the needs of those who are ready to become creative thinkers, leaders and change agents (Brown et al., 2007; Macleod & Lyon, 2007; Williams, 2010). These are more likely to be nurses with more experience, so that when familiar situations arise, these nurses are able to draw from their reservoir.
of experience (Knowles, 1975) and engage meaningfully to apply critical reasoning (Benner, 1984) to a specific situation and thereby harness potential learning opportunities for others.

Some learning requires regular maintenance and updating to keep staff focused and cognisant of maintaining standards of care. Regular maintenance or ‘mandatory learning’ keeps areas of practice fresh in nurses minds for example, cardiopulmonary resuscitation and life support, fire safety, falls prevention, infection control, universal precaution, hazardous waste disposal (Furze & Pearcey, 1999; Gould, Drey, et al., 2007). It is widely understood that learning requires reinforcement or ‘loops of learning’ whereby learning is refreshed in order to aid the embedding of knowledge (Moore, 2007).

The need to provide reoccurring learning is crucial in health care organisations where regular learning is required to be reinforced to maintain standards and patient safety (Guardini, Talami, Fiorillo, Lirutti, & Palese, 2008). Single loop learning predominantly refers to task orientated learning that requires little or no debate and “interpretative-based intervention” (Flood & Romm, 1996). Examples of single loop learning would be the detection and correction of errors associated with tasks. Argyris and Schon (1978) suggested that for learning to be taken away, adapted and added as a tool to the nurse’s resources tool kit there is a process that needs to occur: The information the learner was exposed to, needs to be interpreted. Once this ‘interpretive phase’ has occurred the learner is able to challenge the barriers to change and manage their own anxiety associated with practicing independently. This takes double loop learning skills to reason, debate, critically reflect and have the ability to use knowledge creatively (Moore, 2007). These skills do not come from task orientated single loop learning, where the learner is attempting to get the basics correct but instead, from double loop learning. Whereas triple loop learning occurs when a learner has the skills to gain an overview, make sense of the context and dilemmas within their practice (Argyris & Schon, 1978; Senge, 1990) and is able to adapt knowledge to the ever changing environment (Flood & Romm, 1996; Moore, 2007).
According to Moore (2007) learners tend to swing between first and double loop types of learning, depending on how comfortable they are with the topic in question. If not ready to be critically reflective, a learner may return to old ways of learning and continue to be reliant upon task-orientated learning.

Organisations, leaders and nurses committed to double and triple loop learning demonstrates an understanding and commitment to meaningful learning (Moore, 2007). Commitments from all stakeholders have the potential to enable a cultural shift that can empower nurses who were traditionally, dependent upon a task orientated style of learning towards innovative ways of integrating new ideas into their practice. A transition to this type of education could pose as a struggle due to barriers continuing to exist within the workplace. These barriers are burdens of the clinical load, increased acuity of patients and insufficient staffing levels (Cook & Leathard, 2004; Walbridge, 2012). When nurses are cognitively overloaded they experience consistent barriers and pressures in an environment that does not allow change to occur, resulting in missed care and reduced quality of care for the public (Walbridge, 2012). Some nurses and their organisations may demonstrate a reluctance to move from traditional forms of learning to innovative learning methods. Learning how to learn and the provision of support for nurses to transition towards more effective learning methods is important when facilitating workplace-based learning (Finn, Fensom, & Chesser-Smyth, 2010a).

Both internationally and nationally, health care organizations have been acutely aware of the need to retain and provide ongoing professional development (Zurn & Dumont, 2008). The transition of health care organisations to incorporate clinical governance philosophies into the workplace provides a framework that identifies the need for ongoing education and professional development as an essential building block. This building block underpins the provision of quality and safe delivery of health care (Derry, 1999; Garcarz et al., 2003; Spouse, 2001) As is evident by the new graduate programs occurring within organisations, which encourage the development and growth of newly registered nurses entering their first year of practice. Although these programs are valued and are significant to ongoing learning, it is important to remember that the need to facilitate learning does not stop after the new graduate career phase (Te Rau Matatini, 2009). Learning is significant throughout the career lifespan of nurses.
Rhodes and Shiel (2007) suggested that projects that are negotiated with the individual, with the aim of promoting change within an organisation are beneficial to both parties.

Utilising methods of collaboration provides the opportunity to gauge the opinion and needs of the individual (Dyson et al., 2009). That would result in the setting of learning objectives that suites individuals and the organization alike. As a consequence learning then becomes meaningful and provides the opportunity to enable change, and the potential to benefit all stakeholders.

The health care sector is complex, as it requires staff to have numerous skills and attributes. The expectations of the nursing role over time have changed; there are greater acknowledged technical expectations. Nurses are experiencing increased responsibilities, as well as the more complex higher acuity patients (Walbridge, 2012). It is because of these ongoing challenges that the roles and expectation of nurses to keep abreast of changes and maintain up to date evidence based care, has subsequently placed further pressure upon modern organisations to be flexible to meet the changing needs of both the organisation and their staff (Crotty, 2010).

The expectation that staff continue to learn and adapt throughout their career is not new. Zuboff (1988, p. 3 cited in Silverman 2003) described ‘learning is the new labour’ these are common expectations in today’s world. This theory gives importance to learning; many organisations (not just in health) see learning and the ongoing development of knowledge as a significant asset within their team. Within New Zealand’s health care history of 1991-1993 (Easton, 1997) and, possibly in the current economically constrained era, the facilitation of learning was considered a cost and therefore something that could be rationalized and perceived as too much of an expense (A. Bamford & Porter-O'Grady, 2000; Gage & Hornblow, 2007) and therefore a luxury as opposed to an immediate need.
Identifying learning needs.

The first step in the learning process is assessing what is required to be learnt by the individual (Dyson et al., 2009; Furze & Pearcey, 1999). The reason for this is that people all have different learning requirements, which may be due to the fact they have all very different professional knowledge and experiences. Within the literature surrounding learning organisations, cultures of learning and adult theories of learning, there is discussion surrounding nurses identifying their individual learning needs (Dyson et al., 2009; Furze & Pearcey, 1999; Garcarz et al., 2003; Gould, Drey, et al., 2007; Grant, 2002; Manderson, 2011; Manley et al., 2009). Organisations are required to provide a large amount of mandatory education. The purpose of this learning is to try to ensure staff have met the minimum requirements needed for the organization to demonstrate that it provides a safe quality service (Dyson et al., 2009). This learning is restrictive as it facilitates a narrow spectrum of learning and may fail to meet the needs of nurses given the enormity of roles and challenges faced every day (Cheek & Jones, 2003; Gould, Berridge, et al., 2007). Nurses require an extension of their knowledge to advance their professional practice (Gould, Drey, et al., 2007; Levett-Jones, 2005). Health care organisations tend to favor the mandatory skills training as their number one priority, whereas both areas are of equal importance (Levett-Jones, 2005). The reason for this may be the cost of ongoing learning. Both are necessary, firstly to provide basic safety and secondly to extend nurses practice which is equally effective at improving staff satisfaction and retention (Levett-Jones, 2005). This may be seen as a crucial factor when considering workplace learning in an era whereby retention of skilled staff is a global challenge.

In order to meet the ongoing needs of individual nurses, a needs analysis can be a critical tool (Dyson et al., 2009). A needs analysis identifies the educational needs of an individual or clinical group of nurses (Benner, 1984; Dyson et al., 2009). This is necessary as the learning needs of nurses’ change throughout their career; thereby, improving motivation, participation and an inherent commitment to learning is an
ongoing process for an employer (Bowman, 1987). This process also involves leadership and promotes learning as a priority for the organization. A learning needs assessment provides the organisation with an ideal opportunity to receive feedback from their staff, regarding their individual requirements for ongoing professional development throughout the organization (Bowman, 1987; Dyson et al., 2009).

Learning needs assessments can be enormously beneficial, however the level of self-awareness individual nurses may or may not have, surrounding their own practice, needs to be kept in mind. Concerns were expressed by Grant (2002) that at times learning needs assessment can be taken too literally. Nurses have generally been inclined to cling to the traditional learning frameworks that have tended to haunt the contemporary nursing profession. Nurses predominantly focused upon task orientated learning and areas whereby they have specialty interests. Grant’s view was that nurses needed to step out of their areas of comfort and broaden their learning focus and explore areas that were not so familiar to them.

By making the education journey collaborative and in consultation with the organisation, the learning requirements of both stakeholders could be met a lot more efficiently (Dyson et al., 2009). It is clear that educational opportunities require careful and collaborative planning to enable learning to be well accessed by enthusiastic participants. There is a need for organisations to take these assessments and recognise nurses’ specific learning needs. This aids the facilitation of both effective successful learning outcomes and the organisation achieving greater value in terms of their financial investment.
Implications of lifelong learning

The utilisation of a variety of learning methods, acknowledges that the organization recognises the enormous reservoir of prior experience and knowledge nurses bring to the learning environment. This is reflective of Knowles (1975) theories of andragogy and adult learning which subsequently enhances learning through critical self-reflection, and results in a better understanding of nurse’s own practice and perspective. This process enables a more inclusive understanding of the nurses own experience and, by acting on these insights, may adapt their practice (Mezirow, 1990). Learning organisations are moving away from old styles of ‘command and control’ and taking up innovative, creative, collaborative modern leadership and management models. The intention is to provide an environment for creative and effective learning that meets the learning needs of the individual, the immediate environment and the wider organisation (Crotty, 2010; Garcarz et al., 2003).

Knowles believed an essential element of learning was to value and respect learners. Knowles in particular insisted on speaking to learners respectfully and treating all with a sense of collegiality: this formed the basis for effective learning situations (Cook & Leathard, 2004; Crotty, 2010; Knowles, 1975). Creating an environment that encourages dialogue, supports and encourages mutual respect between staff and those in authority creates an environment ready to nurture learning. Within such organisations critical thinking can be increased, because nurses are able to question and make decisions based on their knowledge and experience (Cook & Leathard, 2004; Crotty, 2010; Knowles, 1975).

Garcarz et al. (2003) used the interpretation of lifelong learning established by Stern and Sommerlad (1999) who stated ‘the recognition’ people need to continually learn new skills, take on new knowledge and develop new behaviours and attitudes throughout their life, from cradle to grave (Garcarz et al., 2003). It is interesting that
when lifelong learning was first debated it was seen as, potentially ‘imprisoning learners in a global classroom’ (Illich & Verne, 1976, p. 50 cited in Jarvis, 1987).

The current understanding of lifelong learning acknowledges that learning is ongoing but can be inconsistent at times (Garcarz et al., 2003). People take breaks from ongoing learning for a variety of reasons such as parental leave, experience demanding work/lifestyle pressures which may impact upon their learning ability. Experiences during these breaks may also be considered valuable learning. This learning which could be considered informal, however has potential to bring rich experiences that are valuable to everyday practice within the workplace. These are distinctive factors that identify nursing as a unique profession, insofar as not all learning that is helpful or valuable is academic, it may be informal as personal life experience may help a nurse to enable care or be a change agent in the clinical area. There are times where learning tapers off and other times where learning is intense at different times in the career lifespan. The phenomenon recognises that current practices change and evolve and that concepts expire and need updating (Williams, 2010).

The era of completing initial training programmes and participating in little or no further professional development has officially ceased since the introduction of the Health Practitioners Competency Act (2003). This piece of legislation meant that governing bodies developed policies to scrutinise nurses lifelong learning to maintain professional practice standards. It has caused the individual nurses to be responsible and accountable for their own competence, but has had an impact upon the employer to aid the process. They may do this by facilitating the competence process for nurses through their workplace learning programmes.

The introduction of legislation and the requirement for professional bodies to examine portfolios of evidence does not necessarily translate to learning taking place and “learning is a process and it is a lifelong discipline” (Senge, 1990, p. 142). Knowles (1975) was a firm believer in adult learners planning the curriculum. This is a means of taking charge and self-directing the learning to meet the needs of the individual. Adults learn best when they feel the need to learn, and in an environment that stimulates and
supports the learning. Adults can set their own goals within a learning experience and participation is active during the learning process. They draw upon, and relate their learning to their reservoirs of life experience, and take responsibility for their learning alongside the educator (Jarvis, 1987). This self-directed approach would have to be in consultation with those who have expertise in areas of learning and practice. This is because within a profession in which quality and public safety is crucial, curriculum planning needs to occur in the workplace in collaboration with staff, and yet keeping in mind the individuals goals.

The nursing profession is unique because nurses can practice within a vast variety of areas, requiring a wide array of skills and knowledge. Nurses can change practice areas throughout their careers, and the knowledge required on any one day in any area may alter considerably. Both Benner (1984) and Flower (1999) describes a ladder of competency in terms of consciousness surrounding nurses abilities to perform, the levels described are unconscious incompetent, conscious incompetent, conscious competent and unconscious competent. Quite similar to the novice to expert theory of Benner (1984), both describe the need to have had previous experience in order to have the benefit of insight and the ability to relate prior knowledge to their practice. To practice in a conscious manner was described by Benner (1984) to be a phase whereby nurses deliberately plan in order to achieve efficient care, and to perform at an expert level. This skill was to have the ability to “visualise what is possible” (Benner, 1984, p. 35).

Both theorists describe the ability to move in and out of the various levels of competency. For example the novice phase of Benner (1984) theory and incompetent phases of Flower (1999) is not limited to students or newly registered nurses. It could, in fact pertain to any nurse (even an expert nurse) who is practicing either outside their familiar workplace setting or in a situation they have not previously experienced. This situation is when the nurse is either aware or unaware of a knowledge deficit or the value of that knowledge. Therefore they may not recognise symptoms of patient deterioration or instead provide care that lacks insight. According to Flower (1999) the strength and stimulus to learn influences how long a learner will remain at these phases of learning. This implies that the culture of learning within the workplace could in fact motivate or impede the movement of nurses through the stages of competence.
Adult learning today is a far cry from the ad hoc didactic workplace education of the past, and relies upon a collaborative partnership between the employer and the employee. It needs to be well planned and responsive to the needs of both the organisation providing and those receiving the education, for both new education and mandatory learning that is required to be regularly updated (Ellis & Nolan, 2005; Furze & Pearcey, 1999; Garcarz et al., 2003; Gould, Drey, et al., 2007; Spouse, 2001; Williams, 2010). Mandatory learning definitely has an important role to play in workplace-based learning. It assists to provide better quality health care by increasing the repertoire of nursing skills required by the workplace. This is especially true within urban district hospitals that tend to have general surgical, medical and paediatric units. Nurses need to have specialist knowledge of multiple areas of care.

Often within tertiary centres, practice areas are specific in terms of conditions cared for such as, surgical areas will be separated into cardiothoracic, urology, gynaecology, vascular, gastrointestinal and orthopaedic units (Dearing, 1997; Williams, 2010). Collaboration with staff when planning education is important because nurses work to meet the individual needs of the immediate practice area, the organisation and the staff. Nurses have often found that their personal needs have been overlooked by the importance of the organisational needs (Furze & Pearcey, 1999; Hicks & Hennessy, 1997)

There are issues in tertiary centres surrounding the issues of ‘bed block’ and overflow of patients into areas that are unfamiliar with the specific needs of patients. Bed block is a situation in hospitals that there is difficulty to access beds on wards for patients who require one, often because beds are already occupied to full capacity; instead patients are cared for in emergency departments. This situation causes problems for emergency departments who are staffed and have the capacity for patients for shorter periods of time than the ward areas. Beds are usually ‘found’, but not necessarily in the specialty area for their condition. Hence, with a variable influx of patients overflowing into ward areas unfamiliar with the patient’s conditions, the experience can be stressful for both the staff and the patient. It is impossible for nurses to be specialists in all areas of the
health service. There is an acute need to continue to maintain generic skills to ensure patient care is safe and up-to-date and to meet the ongoing learning requirements identified by nurses themselves.

**The cost of health care**

The literature surrounding optimal cultures of learning within the workplace tend to have very similar themes and are in consensus regarding a number of key issues. There is the need for a clear organisation wide learning philosophy, and an infrastructure in place to support a culture of workplace learning, the need for learning to be accessed equally by all levels of staff and for there be time allocated to learn (Garcarz et al., 2003; Manley et al., 2009; McLaren, Woods, Boudioni, Lemma, & Tavabie, 2008). As seen previously, the qualities of magnetic organisations suggest they are sought after places to be employed, they experience a stable workforce with reduced turnover and the subsequent cost savings are made by the reduction of staff turnover occurring (Zurn & Dumont, 2008). The turnover of staff impacts upon the time, effort, education and orientation the organisation invests in new staff, plus the ongoing turnover further impacts hospital mortality rates, quality of care and patient satisfaction (Zurn & Dumont, 2008). The estimated cost per nurse leaving an organisation was $19,900, and associated costs of recruitment, hiring and training in 2005 were thought to be between $5,000 and $13,000 (North et al., 2005; Zurn & Dumont, 2008) and more recently North et al. (2012) found the total cost of the turnover of a registered nurse was equivalent to half their salary and was also linked with adverse patient events. This investment is soon lost if that staff member leaves the organisation, but may not be lost forever as they may be of benefit to other organisations nationally or internationally. However, the organisation then has to repeat the process again, costing them time in terms of recruitment and the time, energy and finances it takes to train and orientate new employees.
The publicity surrounding the cost of health care is prevalent. It is widely understood that within most health care organisations budgets are tight and resources slim (A. Bamford & Porter-O'Grady, 2000; Easton, 1997; Gage & Hornblow, 2007) alongside perpetual concerns regarding sufficient staffing numbers and an aging workforce (Zurn & Dumont, 2008). In order for organisations to embrace a culture of learning throughout their organisations, there would undoubtedly be some financial discomfort, and the outcomes for this outlay are difficult to measure.

In principal the introduction of health care organisations becoming learning organisations, seems an obvious choice. However the implementation of a learning culture could be fraught with difficulty in large organisations that already face unforseen demands on their resources. In the past when under pressure the training and education budgets have been cut because in traditional health care organisations education is seen as an expensive perk and not an asset (A. Bamford & Porter-O'Grady, 2000; Garcarz et al., 2003).

The conscious effort to make cuts in education causes problems, as this may cost the organisation more at a later date (Garcarz et al., 2003). A paradigm shift is required in terms of viewing nurses learning as an asset and giving it the value it deserves as opposed to following the historical path whereby nurses education has been seen as a cost and spending reduction or frozen by organisations who are frequently faced with financial pressures and limited funding. Improved practice development leads to better patient care, therefore the benefits that nurses’ learning has on the well being of the public surely outweighs the cost of the provision of education. For organisations to consider reducing or freezing education budgets because of fiscal demands seems short sighted, notwithstanding those organisations who support and encourage nurses to demonstrate improved evidence of practice development, is integral as a means of recruiting and retaining staff (Fulbrook & Cockerell, 2005; Williams, 2010).

The implications of embracing the conceptual shift that views education as an asset is to move to a ‘spending to save’ philosophy (Williams, 2010). A change of culture regarding learning for nurses within the workplace ultimately requires an imaginative
and creative organisation with the drive and enthusiasm to make it work, to ultimately benefit the organisation, nurse and the patient.

Summary

The key elements of the available literature pertaining to the culture of workplace-based learning have been drawn together here. There is an obvious lack of literature nationally that is aimed at exploring the culture of workplace learning within New Zealand’s nursing profession, whereas internationally there is a growing significant body of research.

It has been identified that nurses in New Zealand prefer to partake in ongoing professional development within the workplace. This is the most convenient, practical avenue for nurses with multiple demands outside of the workplace to complete professional development requirements (Brinkman et al., 2008). Didactic learning that does not challenge and encourage participation and collaboration from the participants fails to meet the individual needs and desires for nurses learning (Ellis & Nolan, 2005; Furze & Pearcey, 1999; Garcarz et al., 2003; Gould, Berridge, et al., 2007; Knowles, 1975; Spouse, 2001; Williams, 2010). However, learning in the workplace needs to be a bipartisan relationship that meets both the needs of the organisation and those of the nurses (Dearing, 1997; Gijbels et al., 2010; McCormack & Slater, 2006; Williams, 2010).

The nursing profession is unique, because the experiences and knowledge of each nurse is different. Each nurse comes to any learning experience with an enormous reservoir of knowledge, this knowledge needs to be shared, debated and respected (Royal College of Nursing, 2003; Yam, 2004): The environment needs to foster learning as an asset to be prized (Garcarz et al., 2003; Gould, Drey, et al., 2007; Knowles, 1975; Schoobeck & Henderson, 2011; Williams, 2010). A workplace that is flexible and has leadership that provides inspiring role models who encourage and advocate for magnet organisational
elements will retain staff and nurture a contemporary innovative workforce (Dyson et al., 2009; Henderson et al., 2011).

A contemporary workforce is a nursing workforce who is motivated and committed to current quality care through effective learning within the workplace (Garcarz et al., 2003; Gould, Drey, et al., 2007). Embedding innovation and enthusiasm for learning into the culture of workplaces, would be a break away from the shackles of current education practice, currently such thinking is limited along with the constrained fiscal budgets surrounding cost neutral workplace education.

A definition identified by King and published posthumously in 2011, identified the key elements of culture in any environment is the relationship between the individual and the wider society (King, 2011). Nursing has transitioned over the past 40 years from a vocation to a profession. For this transition to be complete it requires a shift in the overall perception, for both parties, of what being a profession involves and the responsibilities associated with being a professional body. Using King’s key elements in terms of learning within an organisation, the learner is the individual and the society is the organisation. For most relationships to be successful stakeholders need to foster an environment of respect, value and the ability to listen to the needs of each other. Both of these stakeholders need to work together in order to create strategies for learning that develop workplace based learning that meets the needs of all parties.

The transition for nursing to being identified as a profession requires the organisation and society to become a mature innovative network. More specifically this network involves innovative leadership, encouragement of nurses to share ideas and vision, a mutual respect and motivation to learn throughout the career lifespan (Cook & Leathard, 2004; Crotty, 2010; Garcarz et al., 2003; Knowles, 1975).

The inclusion of ongoing professional development as a crucial building block within the clinical governance paradigm is crucial to ensuring that ongoing learning is occurring within the workplace. The reason for this is quality and safety, as the only
way the public will receive such health care from New Zealand nurses is if there is an effective culture of learning within organisations (Aiken & Patrician, 2000; Brinkman et al., 2008; Derry, 1999; Spouse, 2001; Tourangeau et al., 2007).

The most obvious recurring theme is that the provision of education is not enough to ensure learning occurs in any meaningful way (Garcarz et al., 2003; Garvin et al., 2008; Senge, 1990; Webster-Wright, 2009). Meaningful learning is learning that which allows the nurse to take the learning and integrate that knowledge in changing scenarios at a later date (Dyson et al., 2009). This type of learning that encourages multiple types of thinking allows the nurse to utilise clinical, creative and scientific reasoning (Benner et al., 2009).

In critiquing the literature surrounding the culture and context of workplace learning, some of literature demonstrates that there is the potential to aid and facilitate effective health care environments. The key element from the literature identified that explicit communication that outlines the organisations learning philosophy and career-learning plan for nurses is needed. This is the first step for an organisation to communicate to staff the importance the organisation places upon the culture of workplace based learning, and their expectations of nurses to participate in ongoing workplace learning.

The major themes that have emerged from the literature encompassed a variety of concepts. These themes included; educational preparedness to apply strategies of assessing, planning and implementing learning, leadership within organisations who may dictate and encourage a culture that prizes learning and enables nurses learning in the workplace and finally the exploration of the barrier that may exist within the organisation which may inhibit learning. Following the finding of these key themes, that surrounds the context and cultures of workplace learning, the author then sought to explore relevant research methodologies. The aim of which was to find an approach that was suitable to gain a further understanding of New Zealands learning cultures within in its urban district hospitals. Chapter two describes the resulting methodology used in this research.
CHAPTER TWO: METHODOLOGY

Introduction

The methodological approach, design and strategies are discussed within this chapter alongside the cultural and ethical considerations necessary to undertake the research in New Zealand. The aim of this study was quite simply to understand how workplace based learning was addressed and prioritised within the organisations sampled. For this study the researcher had three objectives: these were the exploration of the rationale behind the development of education programmes in the workplace; secondly the discernment of how a workplace cultivates continuing professional development as a culture within the workplace; and the third objective was to consider how prepared nurse educators are to fulfill their roles as life long learning facilitators and mentors.

Aim

The main aim of the study was to explore workplace-based learning within hospitals throughout New Zealand. The goal was to utilise the knowledge of those nurse educators who are key personnel in the provision and facilitation of learning within the workplace.

The objectives sought to:

1. To explore the rationale underpinning the development of education programmes within urban district hospitals throughout Aotearoa, New Zealand.
2. Discern how a workplace advances/cultivates continuing professional development as a culture within the workplace.
3. To consider how prepared nurse educators are to fulfill their roles as lifelong learning facilitators and mentors.
Research Design

The methodology was thought about extensively. It is well understood that surveys tend to achieve poor response rates (Polit & Beck Tatano, 2004) and although a lot of data can be gained via this method (Babbie, 2007) the researcher had concerns about the depth of information that could be achieved. Therefore a mixed method approach was considered in order to achieve a greater richness and depth, which an interview can accomplish (Babbie, 2007; Curry, Nemhard, & Bradley, 2009).

The methodological approach, design and strategies are discussed within this chapter alongside the cultural and ethical considerations necessary to undertake the research. The aim of this study was quite simply to understand how workplace based learning was addressed and prioritised within the organisations sampled. The means used to determine this were based on three objectives: these were the exploration of the rationale behind the development of education programmes in the workplace; secondly the discernment of how a workplace cultivates continuing professional development as a culture within the workplace; and the third objective was to consider how prepared nurse educators are to fulfil their roles as life long learning facilitators and mentors.

The study used a mixed methods approach, meaning both a qualitative and quantitative design. In order to answer the question it involved a descriptive survey and census sampling, methods from both research paradigms. The aim was to use census sampling to recruit the entire population of New Zealand Nurse Educators involved in teaching registered nurses employed in urban district hospitals throughout New Zealand. A mixed methods approach was chosen to gain a holistic view of the context and culture of workplace learning within these secondary service healthcare organisations. A mixed method paradigm has the advantage of allowing this researcher the freedom to create a study design that effectively answered the questions posed. According to Johnson and Onwuegbaru (2004) the protocol for using single method paradigms involves each system having a selection of design menus, whereby the student selects what would be most suitable for their research. When endeavouring to understand a
single concept holistically, it is apparent that at times a single method research does not always build comprehensive and competent research (Morse & Chung, 2003). By involving a second phase to data collection, the author then has the freedom to utilise other data collection tools providing further opportunities to gain additional insights, not available from a single-phase method alone (Morse & Chung, 2003).

This research strategy appealed to the author because it lacked constraints and provided flexibility to gather data relevant to the question. The mixed method approach allowed the author a variety of techniques to collect and analyse information. The flexibility allowed the author the tools to gain a greater understanding and view of the context and culture of workplace learning within healthcare organisations in urban district New Zealand. Urban district hospitals are those organisations who provide secondary health services throughout New Zealand, and who are not considered tertiary centres (English, Lanata, Ngugi, & Smith, 2006). The tools used in the data collection involved two phases. The first phase was the quantitative arm that collected the data via a questionnaire and was followed by an analysis of that data. Whereas the second phase, the qualitative arm of the research was underpinned by the principle of ‘where to look next’ which often depended on what was just uncovered (Ragin, Nagel, & White, 2003). From the authors perspective the qualitative arm provided some security that allowed the researcher the opportunity to revisit important aspects of the research; the telephone interview enabled an accurate gauge of the nurse educator perspective to be gained.

The debate surrounding the approaches used in obtaining, discovering and justifying new knowledge and views of research have continued from the time of Plato who was a quantitative researcher and Socrates a qualitative researcher (Johnson, 2007). Since the turn of the century the mixed methods approach, has gained a lot of interest. According to Cresswell and Plano-Clark (2007, p. 12) the definition of a mixed methods study is “research whereby the investigator collects, analyses, mixes and draws inferences from both quantitative and qualitative data in a single study or a programme of inquiry”. The use of both quantitative and qualitative methods provides a better understanding of the issues at hand in more detail than a single method approach (Devers & Frankel, 2000).
The type of mixed method design used was ‘within-stage’ design defined by the merging of methods across the stages of the research process (Johnson & Onwuegbuzie, 2004). To meet the within-stage mixed model criteria in phase one a questionnaire was used to collect data, utilising summated rating scales (Likert scale). This questionnaire included at least one or more open ended questions fulfilling the quantitative and qualitative aspects of mixed model research (Johnson & Onwuegbuzie, 2004), for example participants were asked to list the positive and negative aspects of workplace based learning in their organisation.

Phase two was included in the design for two reasons, firstly to strengthen the qualitative aspect of the research and enable the researcher to substantiate findings and have greater confidence in the content. The choice of telephone interviews was to ensure the findings were secure and rigorous, by delving directly into the respondent’s perspectives and to expand the researchers understanding (Curry, Nembhard, & Bradley, 2009; Glaser & Strauss, 1967). The use of interviews had acted as a safety net to avoid some potential problems which may occur with experimental methods used (Johnson & Onwuegbuzie, 2004). Examples of potential problems include missing a page of the intended questionnaire, missing a crucial question required for the research and a poor postal response rate. Another positive aspect of the telephone interview was that they were cost effective in terms of time and financial implications.

During the process of reviewing the literature, the author failed to find a tested validated questionnaire that met the criteria for the research. The criteria for this research were specific in terms of the urban district hospital setting and exploring the culture of learning within the workplace. Therefore to meet the needs of the research a specific questionnaire was devised and based on the literature about learning organisations. Both the questionnaire and interview questions were piloted using five Nurse Educators from one of the tertiary District Health Boards who were not in the geographical study area. This was crucial in formulating data collection tools that were understandable, simple, clear and easily answered (Babbie, 2007; Polit & Beck Tatano, 2004). Information learnt from the pilot study included ensuring that the language was clear and the
The questionnaire could be completed within the time specified in the information sheet. The pilot study tested the content of the questions and verified the intent of the language used; this enabled the researcher to determine whether the questions were appropriate to explore the concepts underpinning the research (Hughes, 2005).

According to Sandelowski (2000) descriptive research design had been described as the crudest type of enquiry. However it provides a platform to make available new information surrounding a topic in which there is a paucity of research (Polit & Beck Tatano, 2004). A descriptive design was chosen as the researchers intention was to gain a direct description of workplace based learning from the Nurse Educator perspective (Sandelowski, 2000). It is a design that allows the researcher the flexibility to search for accurate information about the characteristics of the subjects and their organisations in terms of context and culture of workplace based learning (Scheider et al., 2003).

Descriptive survey techniques enable the researcher to collect a lot of demographic data that is useful when describing the population of Nurse Educators facilitating learning in urban district hospitals in New Zealand (Scheider et al., 2003). There are advantages and disadvantages to using descriptive methods of research. The advantages are that a great deal of information can be obtained from a large population, and both postal questionnaire and telephone interviews can be a very economical manner of obtaining information (Babbie, 2007; Curry et al., 2009; Polit & Beck Tatano, 2004). Survey research also has the advantage of being able to gain very accurate information from those sampled, and even if the sample is small it can provide the researcher with an accurate view of their experiences (Scheider et al., 2003).

There are potential pitfalls in performing descriptive research for inexperienced researchers. These include that information obtained can be limiting because it can be brief and superficial. Furthermore, in order to conduct credible research, those designing tools, sample techniques, and analysing the data require the skills, time and expertise to undertake this complex role (Scheider et al., 2003).
The process of sampling used a census paradigm in this study, census sampling surveys entire populations (Polit & Beck Tatano, 2004). The sampling process involved sending questionnaires to the entire population of Nurse educators employed in the thirteen hospitals which were identified as urban district hospitals throughout New Zealand (Bryman, 2008).

**The recruitment plan**

**Establishing the sample**

The sample is the subset of a group of individuals selected to represent the entire population (Polit & Beck Tatano, 2004; Scheider et al., 2003). In terms of this study the sample group represented all nurse educators employed in hospitals throughout New Zealand, omitting those in the four tertiary centres. This is an example of census sampling whereby the entire population identified are given the opportunity to participate (Polit & Beck Tatano, 2004; Scheider et al., 2003).

The process of establishing the inclusion criteria for what defined an urban district hospital initially began with identifying which District Health Boards were geographically isolated from major tertiary centres. The main criteria for what constituted an urban DHB was that the organisation was a secondary service and not a tertiary centre. This established a benchmark for this study as to what constituted geographical isolation. The rationale for the criteria was simply that each major centre throughout New Zealand (Auckland, Waikato, Wellington, Christchurch and Dunedin) had both universities and polytechnics with established post registration programmes providing a choice of postgraduate education for nurses. These choices include graduate and postgraduate certificates and diplomas, masters and other clinical based learning programmes.
The central theme of this research is to explore the context and culture of workplace based learning for nurses within urban district hospitals in New Zealand, as these nurses are potentially more reliant upon workplace based education for their ongoing professional development. Brinkman et al. (2008) highlighted a significant eighty per cent of nurses who chose to participate in and relied upon workplace based learning to fulfil their professional development requirements. One of the challenges of this workforce is the fact that nursing remains a predominantly female profession and many nurses are mothers, wives with the roles that are pivotal to the day-to-day management of homes and families (A. Bamford & Porter-O'Grady, 2000). This study is aimed at those who may experience more difficulty accessing other options because of lifestyle and work balance, including barriers to travel and attend courses outside of work time (A. Bamford & Porter-O'Grady, 2000). This was the rationale for the focus to be specifically urban district hospitals, omitting those who work in major centres or those able to commute to a tertiary centre within approximately 60 minutes.

The hospitals asked to participate were identified from a New Zealand District Health Board Directory and covered the entire country; the researcher omitted those in the five major centres. The number of District Health Boards found to meet the criteria were thirteen (Ministry of Health, 2011). In order to identify how many Nurse Educators were employed in urban district hospitals throughout New Zealand, each Human Resources department or Director of Nursing (DON) was approached to establish the potential sample size. This resulted in a potential population of one hundred and seven nurse educators who were employed in urban district hospitals throughout New Zealand.
**Gaining entry**

For the purposes of this research, it was the DON who acted as each organisation's gatekeeper. Gatekeepers are individuals who have the power to withhold or allow access to the group the researcher intends to sample (Burgess, 1984; Devers & Frankel, 2000). Gaining permission to research these organisations and develop a relationship with the gatekeeper is essential for the research to be possible (Devers & Frankel, 2000). The power a gatekeeper holds is their potential to influence who participates in the study; this can occur by either allowing access to the sought sample group or by their level of encouragement communicated to participate in the research, especially in terms of those in the sample group who possibly may normally not respond. This coercion, whether innocent or intended, may influence the outcome of the research because of the external political influence over the ability to research the organisation. For the purposes of this study all communication with the sampled groups reinforced that participation was voluntary and therefore not affecting their employment.

The decision to use the DON’s as an intermediary was an ethical consideration because it allowed the respondents identity to remain anonymous to the researcher. The participation and enthusiasm of the DON was crucial to the outcome of the research; and their role was an integral link to receiving a successful study response rate. The researcher needed the DON to consent to the administration staff to distribute the questionnaire packages to each Nurse Educator in their hospital. Utilising the DON as intermediary between the researcher and the sample had the advantage of maintaining the anonymity of the respondent/researcher relationship. Concern and ethical considerations were considered regarding the vulnerability of respondents if they thought that the DON was expecting them to participate and the pressure this may be felt by the respondent. However, the DON’s used their administration staff to distribute the questionnaires and were unaware of who had responded. Likewise there was nothing on the recruitment or reminder envelopes for the DON, if they had time to look, to discern whom the envelopes were going to. Therefore ethically this was agreed as an acceptable method of distributing the questionnaire.
The reasons for potential resistance may be a variety of reasons; firstly the gatekeepers may have concerns surrounding the motives of the research (Skalley, 2007): The researcher was transparent regarding the background and the aims of the research, to demonstrate the researchers motives were genuine. It was clear in terms of all communication with both the organisation and the potential participant that all information was to remain confidential. Therefore the protection of the organisation and the participants was crucial (Dever & Frankel, 2004). It is important to gain a high level of trust with a potential organisation and outline clearly the aims and method of the research in order to maintain the integrity of the research (Devers & Frankel, 2000).

On the other hand, gatekeepers may share common interests with the researcher and therefore be keen to participate. This can benefit the research by spreading enthusiasm to potential participants, which could encourage others to contribute. They can be keen to learn how others think and act within their own organisation and other similar organisations (Dever & Frankel, 2004). All of which can encourage gatekeepers to be willing to allow and support access to the organisations to be researched.

Following the establishment of the possible sample size, the process of collecting the data involved sending a letter of approach to each DON at each DHB (Appendix B). This letter outlined the information pertaining to the background of the study and the process surrounding whom this study would involve, how they would be approached and what the study entailed in terms of participation required of their particular organisation. The participation required was for the research packages to be disseminated to the potential participants, a record being kept as to which research package was issued to which Nurse Educator. The delegated administrator kept this.

The questionnaire needed to be completed and was to be returned in a stamped addressed envelope. There was a questionnaire to be filled out and returned in a prepaid stamped addressed envelope. There was also an opportunity for the participants to volunteer their time to participate in a follow up interview in the near future. This enabled the researcher to maintain the anonymity of the participants during the
questionnaire phase of the study. There was an opportunity at the end of the questionnaire for the participant to reveal their identity if they were interested in taking part further in a follow-up interview.

Each DON was sent a letter (Appendix C) and a form with this information pack as required by the New Zealand Multi-Region Ethics committee to be filled in if they choose to participate in the study. This locality assessment by local organisation (NAF-2009-v1) was to be returned to the author, for their records and the original was forwarded to the Multi-Region Ethics Committee to be kept with the records relevant to this study.

Some organisations required further discussion surrounding the integrity of the study in terms Māori consultation and indemnity insurance. The DHB who required further Māori consultation organised a teleconference with the researcher, research supervisor, the Chief medical officer of the DHB and an Māori representative. The details of the research were discussed in terms of background to the study, ethical considerations regarding anonymity of the organisation, why this study was deemed significant to nurses in New Zealand. Consent was given and an acknowledgment from both the representatives that they felt this study was topical and of significant value to their organisation. There were concerns from one organisation about indemnity insurance. Telephone conversations were undertaken with the research supervisor and the DHB legal representative and permission was granted.

Another organisation required an informal verbal conversation giving some background information and clarification on which the participants would be within their DHB in terms of roles of Nurse Educator, and whether midwifery nurse educator would be appropriate. It was decided that if midwives and nurses were practicing alongside each other in the same areas and participating in the same professional development, then it was an appropriate nurse educator to participate. Once all concerns of all the DHBs were clarified and completed locality assessments returned the actual data collection started.
Response rate to Questionnaires

There were a number of factors considered when considering the sample size. It is reported widely that the response rate of self-administered questionnaires could be as little as 20-50% depending on a questionnaire's content and length (Kelly, Clarke, Brown, & Sitzia, 2003; Polit & Beck Tatano, 2004). A response rate of 50% is an acceptable rate for data analysis although researchers often recommend a higher rate if three reminders are used (Babbie, 2007). Therefore three reminders were planned at least 14 day intervals, following the initial request to be involved.

The collaborative process

Directors of Nursing (DON) have a senior and complex role with a number of demands on their time; and this research did require their participation to access the nurses relevant to this study, however did not require their everyday practical assistance. Their contribution was immense in terms of facilitating the dissemination of the questionnaires and reminders. Without their enthusiasm, participation and access as the gatekeeper to the organisation this research process would have been significantly more difficult and complex.

The contact with the DON was generally a simple straightforward process. It was noted those DONs who were enthusiastic and keen tended to agree to participate immediately and returned the locality agreement form promptly. A number of DONs were keen to assist the process and were enthusiastic to do as much as they could to facilitate the participation of the organisations. Once permission was granted to sample the DHBs nurse educators, the DONs delegated the role of sending the reminders and keeping the educators allocated confidential number to their personal assistant, their nurse educator coordinator or an allocated nurse educator. These then passed on the reminders to nurse educators. Whilst one did not keep records of allocated numbers of the questionnaires disseminated, they did however follow up with general email reminders. It was
unknown the rationale behind educators favourable response rate, it could be presumed that it was a subject that they had a vested interest. However, at no time did the DON’s coerce respondents to reply and participation remained the decision of each individual sampled.

However a number of problems arose at this stage. For example, one organisation experienced delays receiving the documents due to research packages being delivered to the wrong person’s office, but the responses were eventually returned within an acceptable time frame. This caused some delay in their data collection compared to the other DHBs. Their reminders were sent every seven days to hasten the data collection time (whereas, the other organisations were sent reminders every ten days). There were two DHBs who needed follow up discussions in order to allow access to their organisation.

Data collection Instruments

There were no validated tools identified during the literature search that met the criteria for this research. The process of researching the context and culture of workplace based learning from a nurse educator perspective required a tool that was able to explore the key elements that were pertinent to learning for nurses. The closest the researcher came to finding a validated tool was the Nursing Work Index (NWI) or the Revised Nursing Work Index (NWI-R), which are tools, devised initially by Kranmer and Hafner (1989) as a tool to measure organisational attributes of a professional practice environment (Joyce & Crookes, 2007). The NWI-R tool was altered to measure the organisational traits that if present, are considered to be indicative of a culture that supports professional practice (Aiken & Patrician, 2000). However, this adapted data collection tool likewise did not meet the aims of current research. These tools involved some focus on patient care an area, which this study does not address. Rather it was specifically asking for information on the context and culture of workplace education from the perspective of the Nurse Educator facilitating that learning.
Following the establishment that both the NWI and NWI-R were not applicable to this research, the author found literature surrounding learning organisations within the UK. The work of Garcarz, Chambers and Ellis (2003) was found to have completed significant work on establishing a culture of workplace learning within healthcare organisations. The changes surrounding the healthcare environments within the UK between 1990 and 2003 have been well documented (Garcarz et al., 2003; Jarvis, 1987; Williams, 2010) identified a number of key issues surrounding the establishment of learning organisations within health care organisations. Their systematic method of understanding how to make changes to an organisation which will foster a learning culture whilst supported by theories of lifelong learning, hierarchy, proficiency and underpinned by a clear understanding of the trappings of large healthcare organisations is insightful. That being said Garcarz et al. (2003) did not have a tool to survey health care professionals. Their review of the literature provided an ordered framework to aid the development of the questionnaire formulated for this study.

In the literature review the key organisational features were identified for example:

- Shared vision
- Leadership
- Empowerment of the workforce,
- A blame free culture,
- Consumer focused,
- Organisations developing a learning strategy,
- Commitment to teamwork,
- Knowledge management systems,
- Analysis of training and development needs,
- Appraisal and development of staff,
- Protected training budgets,
- Application of new skills,
- Time for learning and feedback
- Evaluation of staff
These subtopics are collaborated by other literature (Derry, 1999; Hoff, Pohl, & Bartfield, 2004; Spouse, 2001; Williams, 2010). The use of Garcarz et al. (2003) framework was crucial to the development of the questionnaire by using the systematic categories as the scaffolding to support the questionnaire and the telephone semi-structured interview for the telephone dialogue.

The instruments the author decided to use were considered to be most useful were a postal questionnaire and follow-up semi-structured interviews. The reasons these were chosen were because they tend to be efficient in terms of targeted data collection, time and affordable in terms of expense (Polit & Beck Tatano, 2004).

Questionnaires bring together an enormous amount of information in an efficient manner in many ways these are: time efficient, inexpensive, possibility of complete anonymity and reduced bias which is almost impossible in interviews (Polit & Beck Tatano, 2004; Scheider et al., 2003). However questionnaires are notorious for poor response rates which is not such an issue for the interview technique (Scheider et al., 2003).

A semi-structured interview is a guideline involves a set of questions that are set in advance (Polit & Beck Tatano, 2004). The structure of the interview cannot predict what the responses will be, it merely ensures that the desired topics are answered (Polit & Beck Tatano, 2004; Scheider et al., 2003). The interview technique encourages participants to freely express their ideas surrounding the topics whilst using their own words, providing an opportunity to tell stories, give explanations and to give as much detail as they would like (Scheider et al., 2003). According to Gibson (1998) participants both preferred and structured interviews and data yielded richer and more detailed data than semi-structured interviews. For the research at hand, author decided on semi-structured interviews because of the structure, to maintain the focus of the interview on the prepared focus points, it reduced the risk of divergence and its aim was to develop a greater understanding of the issues that required further investigation following the analysis of the data the questionnaire produced and also time and
resources required to collect and analyse the data was taken into consideration (Polit & Beck Tatano, 2004).

The process of data collection

Phase One: The Questionnaire

Research packages were sent to each DON at each of the thirteen DHB indentified that met the urban district hospital criteria. The research package given to each participant included a letter of approach inviting the Nurse educator to participate in the study outlining information and background surrounding the study (Appendix D), an information sheet (Appendix E) informing the participant about the research process such as phase one (the questionnaire) and phase two (the telephone interview) and self-addressed envelopes to post back the questionnaire to the researcher. The questionnaire (Appendix F) was completed by participants with no guidance from the researcher and was designed following the review of literature surrounding establishment of learning organisations.

Evidence of consent to participate in the study is assumed by the completion and returning of the questionnaire to the researcher. At the end of the questionnaire, the participant was asked if they would be willing to participate in a follow up telephone interview. The individual completing their contact details gave implied consent. This process then identified them as willing participants to the researcher. The individual’s identity and that of their organisation remained confidential in the data collected.

A reminder letter was forwarded to each DON seven to ten days after sending the first wave of questionnaires. The second reminder returned 35 per cent of the questionnaires. The researcher had significant concerns about this response rate and was cognisant that an optimal return rate was at least 50 per cent. Therefore the third reminder consisted of
another complete research package containing a letter to the potential participant, information sheet and number allocated questionnaire to the DON’ office who disseminated them. Along with this package the DON’s staff were asked to dispose of their records that identified the allocation of the questionnaires with the participants. This approach proved to be a success as the response rate increased to 68 per cent.

Each questionnaire was recorded onto an excel spread sheet, comments were recorded and a number given at the bottom on the column as to whether the participant indicated a willingness to participate in a follow up interview. The spreadsheet was later entered into the Statistics Software Package for the Social Sciences (SPSS) to collate the data.

**Phase Two: The follow up telephone interview**

The selected number of telephone interviews was eight self-selecting respondents to explore certain issues further. Eight were selected given the time frame and resources available for research, with the aim to collect sufficient data. The Permission to tape the interview was sought from each individual prior to the interview commencing. Eight interviews would be an opportune number for thematic analysis of the data collected. Thematic analysis is time consuming and any more than eight could become problematic due to time constraints (E. Hughes, 2005). The method involves identifying, analysing and reporting patterns in the interview data (Braun & Clarke, 2006). Capturing important aspects which are related to the research has been described by Braun and Clarke (2006) as the key to identifying a theme. However the pitfalls of good thematic analysis especially when semi-structured interviews are used, is to ensure the themes do not merely follow the structure of the interview. The interviews were analysed using thematic analysis and findings fed back to the participants to ensure rigour surrounding their reflected experience (Polit & Beck 2004).

The analysis process involved a six stage process, the actual interview, transcribing the data familiarised the author with the data (Polit & Beck Tatano, 2004). Followed by the
coding phase which organises the data in a systemic way and gathering meaningful data that relates to the research question (Braun & Clarke, 2006; Polit & Beck Tatano, 2004). The coding phase is crucial because not the weight of issues is not necessarily given to those factors that are most commonly expressed, the researchers judgement is an important tool in this phase (Braun & Clarke, 2006). Following the coding and recoding the themes are found as key aspects within the codes that reoccur or stand out that provide an accurate understanding of the question at hand (Braun & Clarke, 2006).

There are clear advantages and disadvantages of thematic analysis; the disadvantages of the method of thematic analysis is it may miss the subtleties in the data (Guest, 2012), there are wide varieties of interpretations from the themes (Braun & Clarke, 2006), the process of data reduction through coding and applying themes is difficult when managing a large amount of data (Guest, 2012) and data analysis that is carried out by more that one researcher at the same time is more reliable (Guest, 2012). Unfortunately the availability of another person to analyse and code the data was not possible. Whereas on the positive side of the process thematic analysis methodology is suited to large amounts of data (Guest, 2012), the flexibility it has and was not restricted by singular analysis theories (Guest, 2012) and finally the interpretation of the themes were supported by the data and allows for categories to emerge from the data (Saldana, 2009). The data was reworked at least four times and themes were established by reflecting constantly back to the question at hand.
Interview criteria.

The author met with the two supervisors of the study to explore the questionnaires and decided on the criteria for phase two participants. The interview schedule was based on areas of the research the questionnaire did not cover and needed further exploration. In order to establish an accurate picture of the culture of learning in the workplace, there were areas that required further exploration.

The key elements of the qualitative interview involved exploring areas that involved the organisations support and commitment to the nurse educator role in terms of administration and leadership. In addition, to gather a picture of the strategies the nurse educators utilised to plan, facilitate and evaluate learning, alongside the barriers they experience to facilitate learning and the aspects of their role that work easily. It was thought that exploring how the organisations communicate their expectations of the ongoing learning for nurses, and finding out how each organisation conveys their lifelong learning plan would clarify qualitative areas that the questionnaire was unable to do.

New Zealand is specifically a bi-cultural nation however it is a multi-ethnic community, with specific commitments and obligations to the tangata whenua (indigenous people of the land) under the Treaty of Waitangi. The author thought it significant to find out whether organisations provide specific support and encouragement for Māori nurses to participate in workplace-based learning. The rationale for this was to establish an insight to the organisation in terms of support and encouragement for workplace based learning for nurses who identify as Māori.

There were certain elements of the criteria that naturally emerged from the population itself and the responses to the questions. Māori respondents were interviewed because there is a responsibility in terms of the Treaty of Waitangi to consider Māori
specifically when researching the general population within New Zealand research (Tolich, 2002). There was only one respondent that identified as Māori. However it would be of interest to Māori to explore what strategies organisations have in place (if any) to support and encouragement ongoing learning within the workplace for Māori nurses.

In terms of the qualitative aspect of the research some researchers would wait until they had analysed all the quantitative data before preparing the qualitative questions (Braun & Clarke, 2006; Cresswell & Plano-Clark, 2007). The advantage of analysing the quantitative first would be to establish a clear picture of the data collected and to discover any areas that may have emerged that require further clarification (Cresswell & Plano-Clark, 2007; Devers & Frankel, 2000). If areas were found that needed further investigation, phase two would be an opportunity to gain a greater depth of understanding surrounding specific areas and to utilise the qualitative interview to explore further (Cresswell & Plano-Clark, 2007; Devers & Frankel, 2000; Polit & Beck Tatano, 2004). For this study due to time constraints and the need to move forward with the data collection process all the data was analysed following the collection of both the quantitative and the qualitative components. The time constraints was a definite weakness in this study and possible when considering the interview schedule, the researcher should have considered when formulating the interview schedule that five minutes of dialogue would take fifteen minutes to transcribe (Braun & Clarke, 2006). The selection criteria were established with some consultation with the studies supervisors and researcher.

There were potential disadvantages to moving forward and collecting the qualitative data prior to analysing the questionnaire information. These would more than likely be discovered when analysing the data and establishing the findings. However these pitfalls could lead the researcher to find areas that require investigation in subsequent research in the future.

There was a potential to explore in more depth, how valued nurse educators viewed learning for nurses was within their organisation. The author anticipated that by
interviewing at least three nurse educators from three separate organisations with three varying subjective views, the researcher could gain a broader perspective. Question number 23 (Appendix F) was designed as a tool to assess participants opinion in regard to, their view of the priority placed upon nurses learning by their organisations. The polarising opinion from the responses to this question, were later used as a key selection criteria for the telephone interviews. The response indicated the educators perspective how nurses education was valued within their organisation.

Question 34 read as;

“How satisfied are you, that nurses learning is a priority within the organisation?”

The third criterion was to gain further detail from nurse educator who had been in their role for different lengths of time. The criteria was broken into three sections a NE would be interviewed who had been a NE for less than one year, the second for one to five years and the third for greater that ten years.

Lastly, there was a requirement that all those interviewed were from a variety of DHBs throughout New Zealand. The purpose for this was to ensure a variety of information was gained and to ensure that experiences were gathered from at least 50 per cent of organisations sampled as opposed to interviewing a number from the same area. By gaining views from a number of NE who all work in different DHBs the research hopes to gain a true picture of the context and culture of workplace learning within UDH throughout New Zealand.

The total of nurse educators to be interviewed was eight, all of which represented different DHBs. The qualitative perspective equated to 61.5 per cent of the DHBs sampled. The resource constraints and time it took to transcribe and analyse qualitative data inhibited interviewing all those potential participants and it was pertinent to look at a representative subset. The ethical considerations to bear in mind when collecting data were to be determined by informational needs. This study utilised the principle of data saturation as a guide (Morse, 2003; Polit & Beck Tatano, 2004). This refers to the
concept that collection continues until no new findings are revealed with additional interviews (Morse, 2003; Polit & Beck Tatano, 2004). It is not advised to continue to collect data and expose people to unnecessary research if it poses no advantage to the research (Morse, 2000). If the researcher finds the data collected has been inadequate to understand the phenomenon, they can return to the interview process and gather more data (Patton, 2002).

The system to identify the possible phase two participants, involved reviewing all the returned questionnaires and separating all those who had indicated a willingness to participate in a follow up interview. These were then divided into the thirteen separate DHB categories. The comments were then recorded in a micro soft word document, there length of time they had practiced as a nurse was recorded, their questionnaire was reviewed in terms of whether it answered question 23 in a positive, neutral or negative manner and their ethnicity was recorded.

This process highlighted a possible fault with the questionnaire, as only one respondent identified as Māori. The author queried wether the way the ethnicity box was configured on the page may have caused some confusion. The European New Zealander box was alongside the Māori box. It could have been very easy for a Māori participant to tick the European New Zealand box by mistake. This would cause the findings to be unreliable, or this may be a short fall in the questionnaire design. Alternatively the number responding in the sample group as Māori reflects the number of Māori nurses and those in higher positions. The three key considerations to take into account when discussing the low response rate from Māori: The first, Māori make up only 7 per cent of the general nursing population in New Zealand (Nursing Council of New Zealand, 2012a), secondly considering this small representation of Māori in the nursing profession and the high rates of poor health Māori experience, there has been a reported need to foster and encourage greater number Māori into the health professions (Ratima et al., 2008; Te Rau Matatini, 2009), and finally census figures have previously indicated Māori demonstrate low achievement rates with tertiary and postgraduate qualifications (Statistics New Zealand, 2006), of which a tertiary qualification is necessary to practice and both a nurse and a nurse educator.
Once the eight potential participants were contacted, initially five were contacted to organise a time and date for interviews. A good response from them all was reassuring and the equipment and room was booked and the interviews times were confirmed. These first five were interviewed, and the following three were interviewed four weeks later. The interview schedule remained the same in both sets of interviews.

**Interview Questions**

During the tool development phase of the research some interview questions were drafted and piloted on three nurse educators in a tertiary centre. However once the questionnaire had been returned and information looked at, the author reviewed the aims of the study and found the first draft was broad and detouring from the initial aims of the project. The collection tool required narrowing to keep within a concise framework, without gathering information that was not specific to the research. The purpose of this was to control the quantity of data being collected, and to keep the information collected focused upon the aims and too be as concise as possible. See Appendix (H) for Interview Schedule.

The qualitative data collected from key informants used semi-structured interview questions. The interview questions were developed from the nursing literature and literature surrounding learning organisations. The telephone interviews were open ended to allow for the informant to provide descriptions about their role in terms of the culture of learning within their workplace. The interviews were conducted by the author and took place in a private conference room within the university premises. Each interview was pre-scheduled and set for a time that was convenient to the informant. All participants were asked the same questions; although the order and prompts varied depending on the flow of the responses. There were areas and episodes whereby the question needed further clarification and additional (pre-prepared) prompts were used to tease out information related to specific lines of inquiry. This occurred
when the informant may not have understood the question or the initial response had been focused on another form of nursing education such as post graduate study as opposed to workplace based learning. This technique was helpful.

The first set of interviews completed in one morning were five in total. With the benefit of hindsight five interviews at one time, were too many. The process was reasonably tiring and difficult to keep on track for the final interview. A problem occurred with interview number five as, due to unforeseen earthquake repairs to the building at the time of the fifth interview, it was very difficult to hear the interviewee when the researcher came to transcribe the interview. On hindsight the interviewer should have stopped the interview and rescheduled so as not to waste the interviewees time and optimise content.

The interviews did end up being longer than expected due to the amount of material the interviewees were sharing. The interviewer did not like to interrupt during the dialogue, because it disrupted the informant’s flow and thought processes. This technique was of benefit to the study because by letting the interviewees talk freely the researcher was able to elicit information regarding the organisational support and facilitation of workplace based learning and the culture of learning from the participant that would not have been obtained from the questionnaire schedule (Braun & Clarke, 2006). The second interview session involved two interviews, which went very well and much easier for the interviewer to keep on track. The third interviewee was unable to be contacted on the pre-arranged interview time and at a later date. The data was therefore transcribed and analysed. It was then decided that data saturation had occurred by seventh interview and no new themes were discovered (Polit & Beck Tatano, 2004). Therefore the number interviewed was seven.
Interview transcription

It was necessary to transform the auditory recording to a written document so that the process of thematic analysis could occur. There were two options when faced with the task of transcribing the data. The first the researcher would personally transcribe the data. The second was to employ an experienced transcriber to complete the transcriptions. There is an argument to support the researcher performing the task. The actual process of listening, re-listening over and over again immerses the researcher in their data and helps the researcher develop a better understanding of the results (Bird, 2005; Braun & Clarke, 2006) similarly clarification of meanings are found as transcription is more than merely putting the words that are heard onto paper. Transcribing smooths the way to interpreting and analysing the data because the researcher has closely read and listened to the data so intensely (Braun & Clarke, 2006). The transcription was a time consuming, labour intensive process. At times it was frustrating and there were environmental factors that caused data to be unable to be interpreted. Yet at other times the researcher became immersed in the data and was able to get an idea of the common threads linking each interview. Reportable, these are all common experiences of those who have transcribed interviews therefore it was not totally due to inexperienced researcher (Braun & Clarke, 2006; Lapadat & Lindsay, 1999; Reissman, 1993).

As an emerging researcher and new to qualitative research processes, the goals of the transcription process were to understand what transcription involved and how to achieve the best results. A literature search of qualitative research analysis was undertaken, articles and book sections were read to gain an understanding of what thematic analysis involved and the most appropriate method of breaking down the data collected in a concise accurate way.

There is a definite requirement that thematic analysis it is thorough, in terms of the data used is accurate verbatim transcription, and can include non-verbal expressions. This
may have to be checked and rechecked to ensure that the data is accurate (Braun & Clarke, 2006; Edwards, 1993).

The researchers goals were to:

- Transcribe the information as accurately as possible.
- Give the interviewee an opportunity to review their transcripts and fill in any areas whereby the words were missed or could be misinterpreted by the transcriber.
- Gain insight into potential emerging themes.

The researcher downloaded software so that the interviews could be transcribed from the digital computer recording rather than the tape recorder. Each interview took two and a half hours to transcribe verbatim. Any words or parts of sentences that were unable to be accurately transcribed or understood were left with a (? missed words). When the transcripts were to the interviewee, to check the content for the purpose of achieving accurate rigor, the interviewee was also asked to clarify any parts where there was missing data.

### Data Analysis

It is important that the theoretical framework and methods the researcher used matched what the researcher wants to know (Braun & Clarke, 2006). Braun and Clarke (2006) believed that thematic analysis is a more easily understood form of analysis for those new to research. The reason to choose thematic analysis was that it does not have to conform to rigid framework or require detailed theoretical or technological knowledge of the chosen approach.

The initial decisions required are what constitute the research data set to be used for the thematic analysis. Since the research is a mixed methods study there was qualitative material collected in two ways the questionnaire and telephone interviews. These
represent the data corpus, according to Braun and Clarke (2006) refers to all data collected for a particular research paper. The data set refers to the qualitative aspect of the postal survey and the interviews.

**Testing the transcripts**

Once the transcripts were transcribed they were checked for errors and then emailed to each participant for comment and correction. The purpose of this process was to verify the information collected is accurate and as the participant had intended (Polit & Beck Tatano, 2004). The participants were invited to review their interviews and encouraged to make comments or corrections. The process was to verify the accuracy of the transcript and to ensure the interviewee an opportunity to make sure they had stated what they had intended. This process validated the transcripts as being accurate. Qualitative research in the past has struggled with verification and validity because it has been argued that the analysis of data can be subjective as opposed to objective (Babbie, 2007; Polit & Beck Tatano, 2004). However by ensuring the transcripts were checked by the interviewee, it confirmed the integrity, quality and truthfulness of the data.

**Response from the participants**

The transcripts were emailed to individuals who participated in the interview process and they were promptly returned. Changes were then noted and the odd correction made. There were three changes to transcribed responses. In each case it was to make clear areas whereby there were words missing due to difficulty for the transcriber hearing the recording during transcription.
Data Analysis

Generating Themes

The author utilised an inductive method of analysis to analyse the data, the data collected via the interview process and the responses were analysed by identifying the themes that were strongly linked to the data itself (Attride-Stirling, 2001; Braun & Clarke, 2006). To analyse this qualitative data thematic analysis was the method used to collate, report and interpret patterns (themes) from the data collected (Braun & Clarke, 2006; Polit & Beck Tatano, 2004; Scheider et al., 2003). The literature indicates there is no clear consensus of opinion as to what thematic analysis is or how to go about doing it (Attride-Stirling, 2001; Boyatzis, 1998; Braun & Clarke, 2006).

The level at which the themes were identified used a semantic approach. A semantic approach generates explicit interpretations of the data (Braun & Clarke, 2006), this is where the themes were generated using the verbatim transcription. The information was not theorised it was interpreted, by looking for trends in the verbal responses. The approach has both advantages and disadvantages it can tend to lack depth however, has the potential to be rich in the description of the data set (Boyatzis, 1998). The author’s rationale for the semantic approach was to gain an accurate baseline view of workplace based learning, without distorting it with extraneous theories or ideas.

The process of generating initial themes involves reading and becoming familiar with the gathered material. This includes working through the data and establishing initial ideas, potential themes and making notes about what is pertinent regarding these ideas and making note of interesting words or phrases to make it easier to find them later during analysis (Braun & Clarke, 2006). The researcher added line numbers to the transcription and included double line spacing printed out the transcripts, and collated them into the individual interviews. The initial coding aim was to go through each question one at a time and look at each response to the question. This process was
aimed at gathering initial themes. When these themes were identified references put next to the theme. This reference allowed the researcher to refer to the interviews to find background to the theme e.g.

**Theme: Education as a reaction to events**

Reference: A2: 59-60

Quote found: “Often as a nurse educator it’s a case of putting out fires”

References that appeared crucial to the understanding of the theme were collected and put into relevant themes and sub-themes to be utilised later. References were used for the purpose of enabling the reader to see the theme clearly in context.

Each transcript was transcribed verbatim as mentioned earlier, with each answer to each question recorded on a master document. Following this process, the document was screened for recurrent themes. These were listed and noted the quantity of respondents who answered similarly and conversely the answers that were different or stood out from the common thread.

There were seven major themes initially identified which were financial issues, philosophy of learning, access to learning, service delivery, leadership, support for Māori nurses learning and support for overseas trained nurses learning. These themes did emerge with the help of the questions asked in the semi-structured interview plan, which was structured in response to the literature review and the responses gained from the questionnaire survey. The questions asked as mentioned earlier were intended to elicit an intentional response without leading the respondent in their answers.

Whilst reviewing the seven major themes from the data, sub-themes were identified. These were realised from common pieces of information that were revealed by the interviewee throughout the interview process. Statements were logged and coded and placed in context within each relevant sub-theme. All data used within each sub-theme
was totalled giving each theme a percentage response and a sample number, for example \( n=x \).

The themes, sub-themes and summary points were tabled and put at the start of the findings table to enable both the author and the reader to easily follow the flow as the findings were outlined. The findings of the qualitative aspect of the research were then compiled and written up moving progressively from theme to sub-theme. The author returned to the interviews many times to recheck aspects of the sub-themes because of areas merging between the themes. This process was to check for accuracy and context.

**Ethical Considerations**

The author and thesis supervisor participated in a telephone interview with the Multi-regional ethics committee. Where the research proposal was discussed items which were highlighted, were the need for Māori consultation and to ensure time was allowed for participants to consider their decision, in order to give informed consent. Consent was given by the Multi-regional ethics committee on January 31st 2012 (see Appendix A).

The key ethical issues that were considered when developing the methodology related to the privacy and protection of the individuals. The multi-region ethics committee was approached once the research proposal had reached the stage whereby participation from members of the nurse educator community was required. This was a stage when the background to the study had been established; the participants and organisations identified and the questionnaire and potential semi-structured interview questions were established.

A telephone interview was carried out with the multi-region ethics Committee the researcher and research supervisor being present. The committee gave positive
feedback in terms of the need for research exploring the context and culture of workplace based learning. Their recommendations were to ensure Māori consultation with Māori was demonstrated when discussing the findings in terms of the impact upon Māori. To this end, the author has therefore collaborated and gained advice from Māori during the analysis of the data and in reporting the findings.

The ethics committee also recommended the researcher ensure the respondents have enough time to consider participation in the research. The literature indicated a number of recommended time frames Meho (2006) recommended reminding participants seven days prior to the deadline. However in a systemic review of postal questionnaire surveys found that reminders did in fact increase response rate and their was no recommended timing between follow-up reminders (Nakash, Hutton, Jorstad-Stein, Simon, & Lamb, 2006). Therefore the researcher allowed seven to ten days prior to sending out reminders to consider participating in the research. The timing allowed for delays in the postal services and gave time to ensure delivery within the hospital system. The information gathered from the research has remained confidential and every effort, when reporting the research, was taken to ensure the anonymity of both the participant and the organisation of which they were employed.

There were two District Health Boards that required additional consultation; One DHB required a telephone interview with the chief medical officer and the local Māori representative to ensure the research was both relevant to Māori nurses and was carried out in a culturally sensitive manner. At the interview enthusiasm for the project was expressed and consent was given over the phone and the locality assessment was returned that day. The other DHB had concerns in terms of indemnity insurance and the protection of their participants and the organisation. The supervisor of the research made attempts to clarify concerns with this DON and was referred to consult further with the DHBs lawyer. This discussion outlined the aims and objectives of the research, participation was voluntary, the study involved a questionnaire and a voluntary follow-up interview, and identity of both the organisation and the participant was to remain anonymous. Also there concerns regarding indemnity insurance were allayed following this discussion consent was given and the locality assessment returned.
In recruiting participants for the follow up interview consent was sought in both verbal and in written form. Initial consent was indicated when the respondent gave their contact details when returning their questionnaire in express their interest in participating in a follow up interview. The research package disseminated to the potential participant included a detailed information sheet (Appendix E) outlining the background, aims and processes involved in the study, plus the contact details of the author. The sample group were encouraged to contact the author to answer for any clarification surrounding additional queries that may have arisen in terms of the study. This step was taken to enable consent to be fully informed. The second point of consent was when they were contacted via email or telephone to participate in the interview. There was a third opportunity for the interviewee to withdraw their consent, which was made clear at the beginning of the interview. The researcher asked the participant for their consent to the interview, and to being recorded. It was crucial that they were reminded the interview was voluntary and they could withdraw at anytime throughout the process.

The participant was informed of the aim of the interview, namely that it was to explore the context and culture of workplace base learning from the perspective of the nurse educators being interviewed. It was a priority for the researcher that any information collected was relevant to the aims and objectives of the study so as not to unduly delay the participant from their workplace or glean unnecessary information that was not associated with the study.

To facilitate the comfort of each participant the interviews were carried out in a supportive non-threatening manner by allowing the participants to express themselves freely and to expand as much as they were comfortable to do so.
Māori Consultation

The research was discussed in collaboration with Elizabeth Cunningham, the Māori Research Manager for Māori at Otago University Christchurch. This consultation process occurred very early in the planning process. A copy of the findings will be forwarded to Ms Cunningham as requested as the study may contribute to the development of future research hypotheses or projects pertaining to Māori (see Appendix I). When discussing the findings surrounding implications of this study to Māori, this was completed in collaboration with a Māori representative with specific skills in interpreting this data and its implications to the wider population of Māori. Therefore when researching and writing this aspect of the study the author considered reasonable discussion was required in order to fully encapsulate what is required when researching Māori, the indigenous people within New Zealand as is required in terms of the Treaty of Waitangi.

When gaining consent from individual organisations to sample their nurse educator population, one DHB requested a telephone conference with their organisations Kaunihera Kaumātua. This meeting was undertaken with the researcher and supervisor present. The discussion surrounded the relevance to Māori nurses and to involve iwi (refers to extended family) in the consent process to participate in research.

In the past there was a paucity of research that involved or implicated Māori, and therefore did not have the benefit of the findings, methodology and the research process being critiqued by Māori. The implications for Māori are limited in regards to the impact and accessibility previous research has had on the discussion and findings, and how they impact on Māori is limited. The accuracy of the research is limited because those interpreting the data potentially lack the understanding required to interpret the data collected, also it was common for this data to be interpreted in a manner that reflected non-Māori priorities (M. Durie, 1996; Kingi, 2005). This lack of consideration indicates the potential neglect of the needs of Māori.
Tolich (2002) discussed implications of pakeha postgraduate students deliberately excluding Māori from their general population studies as a ‘paralysis, whereby researchers are unwilling or unable to think through this political minefield’ (Tolich, 2002, p. 168). There was a stage reached whereby researchers fail to fulfil their responsibilities under the Treaty of Waitangi.

The Health Research Council guidelines stated the involvement of tangata te whenua in the research process is crucial, in order to assist in reducing the significant disparities that are currently present (Health Research Council, 2010). Examples of this consultation may have been due to a lack of Māori researchers in New Zealand with the skills to research Māori in the past. This was a time whereby the New Zealand culture lacked the insight of the need for Māori to participate or to feedback findings to Māori. Results from research was largely interpreted from a non-Māori perspective (M. Durie, 1996; Kingi, 2005). The involvement of Māori in this discussion and decision making process demonstrates a collaborative bipartisan model.

In terms of further consultation a copy of the questionnaire and a letter containing information regarding the context of the study and background information supporting the study was sent to Tekaunihera O Nga Nehei Māori O Aotearoa (National Council of Māori Nurses). New Zealand researchers have an obligation to Māori when conducting research to inform and feedback any information pertaining to the possible impact and relevance for Māori (Health Research Council, 2010). When sampling the general population there is a likelihood that up to thirteen per cent of those sampled will be Māori (Tolich, 2002). Therefore having the opportunity to consult with Māori throughout the research process is both collaborative and respectful of the principles of the Treaty of Waitangi. These principles include taking into account partnership, protection and participation to ensure the researcher was at all times working in a culturally safe manner and respecting the needs of the indigenous people of New Zealand (Health Research Council, 2010).
New Zealand is a bi-cultural society, however there are other ethnic groups who participate and have their own individual cultural needs. As nurses working alongside people with various needs and expectations, this research has had to consider the wider cultural impacts on the general population.

Whānau (family) consultation was carried out after collecting the findings and the discussion was complete. The researcher met with Matua Hector Matthews, who is Executive Director of Māori and Pacific Health at a District Health Board. Matua Matthews highlighted areas whereby the recruitment of people to participate in the discipline of nursing could be improved. The issues that were discussed were the need to guide and encourage Māori students during their high school years and promote sciences and subjects that can enhance their potential to enter and succeed within the health professions. Organisations must not presume all Māori are knowledgeable in terms of Tikanga Māori. Māori nurses require the own cultural development to be supported within the organisation and in addition to their other professional development. The findings and discussion within the project, were discussed with and were supported by Matua Matthews.

**Summary**

This chapter has outlined the approach and methods the researcher took designing and undertaking the research. A description of the selecting and recruiting the sample has been reported, including how access was obtained in order to research the required samples. Key issues were the design of the research, ethical and cultural considerations, the creation of a previously untested questionnaire and the reasons for choosing a mixed method approach as the framework behind the research.
The chapter included the design, the process of data collection, how that data was analysed and an overview of how the data analysis tool was tested prior to use. The exploration of the results relating to the context and culture of workplace based learning from the nurse educator perspective in urban district hospitals will be presented in the following chapter.
CHAPTER THREE: FINDINGS

Introduction

The purpose of this chapter is to present the results of the research undertaken. Within the methods chapter there was a description of the two phases of the study, namely the survey and a series of seven semi-structured interviews. The results are described in terms of the background and descriptive data from the respondents, including items such as response rate, demographics, academic qualifications, and experience as a registered nurse. This is followed by specific strategies utilised from the perspective of the individual nurse educators sampled, to assess, plan, implement and evaluate workplace-based learning from the thirteen participating District Health Boards involved in the research.

The key themes within the literature guided the creation of the questionnaire and the semi-structured interview questions. These questions were deliberately grouped into categories relevant to that of a shared vision, the training and development, opportunities for learning, the implications of learning and aspects of job satisfaction (Garcarz et al., 2003). Themes identified by experts in the field of learning cultures and organisations were used as a guide to frame the data collection tool. This method intended to achieve the clearest picture possible of what constitutes the culture of workplace learning within urban district hospitals throughout New Zealand. Using this framework helped the researcher collect data in a co-ordinated manner, which later proved to be helpful in terms of managing, interpreting and analysing that data. Frequencies and descriptive statistics were used to explore the quantitative phase of the research involving the likert scale questions.

The data collected and analysed for the purposes of this research involved two phases. This first phase was a questionnaire completed and returned by post, this involved quantitative and qualitative data. The participants, who took part in the survey were
invited to comment upon aspects of workplace based learning in their organisation and later to add any further remarks they would like to offer. They were asked to expand on a separate piece of paper if necessary. The second phase involved a follow-up interview of seven willing volunteers who had taken part in the previous phase of the data collection.

The data from the questionnaire was analysed using Statistical Package for the Social Sciences (SPSS) software. This was then reviewed by the author, the results of which are described in the following chapter. The interviews with consent from the participants were transcribed verbatim and coded into themes. Themes were found by locating similarities and reoccurring ideas, concepts and beliefs amongst the responses given by the nurse educators interviewed. In addition to the interviews, further qualitative data was available for analysis from the remarks made by participants on the questionnaire comments section of the tool. These were transcribed and became part of the qualitative data and were thematically analysed. Major themes developed with a number of sub themes within the categories. The open ended responses in the questionnaire did not produce the richness of data compared to that gathered from the interviews but comments touched upon similar ideas and feelings surrounding workplace-based learning within urban district hospitals throughout New Zealand. The themes that emerged were the philosophy of learning, access to learning, service delivery and leadership along with issues that pertained specifically to Māori and overseas trained nurses.

**Statistical results from the survey**

The first phase of the research achieved a return rate of 70 questionnaires from a possible 105. Hence this resulted in a 67% response rate. The software program SPSS was used to manage the data and undertake statistical analysis from the questionnaire. The analysis completed the frequencies of the data collected from the questionnaire. The dispersion or variation from the mean value of the results ranged between the smallest standard deviation of the promotion of new skills, which was 0.720, and the
highest standard deviation was 1.101 that occurred for the question on the access to electronic learning. This demonstrates that a low standard deviation was consistent throughout the data analysis, which implies the range of information collected was comparable to the mean (Polit & Beck Tatano, 2004). The range of how the data is dispersed in this research indicates that opinions were similar and there was a small variation of opinion throughout the collected data (Polit & Beck Tatano, 2004). The size of the study sample was not large enough to be statistically significant.

Cronbach’s Alpha is a test that is frequently used to test the accuracy of data collection tools like the questionnaire used in this research (Polit & Beck Tatano, 2004). These tests are required in order to evaluate and critique the reliability and validity of the tools researchers use to collect data (Tavokol & Dennick, 2011). The scale is described as a number between 0 and 1, with the maximum alpha value of 0.90 is recommended (Streiner, 2003; Tavokol & Dennick, 2011). However, values higher than 0.90 may imply that the test may be too lengthy and some items in the questionnaire unnecessary (Tavokol & Dennick, 2011).

The aim of the Cronbach’s alpha is to assess whether items in the questionnaire both measure the same concept and if they interrelate with other information sought from questionnaire (Tavokol & Dennick, 2011). The Cronbach’s alpha reliability score of this research was 0.934; it is possible the outcome was higher because the tool was potentially lengthy (consisting of twenty-four questions). Nevertheless, this result lies in the most favourable measurement for internal consistency. It is likely that if this data collection tool was to be used in future research it could be revised to reduce the number of questions. Which is suggested by the higher Cronbach alpha score, but also from the data gathered as one can identify obvious repetition having used the tool. The pilot data was not tested with the SPSS software, as it was too small a sample group to be able to calculate the Cronbach alpha. If the pilot had been bigger and was tested it may have identified whether any of the questions were redundant. However the pilot was used with an intention to explore whether the questions tended to achieve the mode of enquiry required to meet the aims of the research.
Context and setting of the study

The organisations that have been identified for the purposes of this study, as urban district hospitals, are hospitals providing secondary services in areas that are not identified as tertiary centres. Figure 2 below indicates hospitals with 100-300 beds were considered to be the urban district hospitals. This graph also highlights that a large percentage of respondents (22%) were either unaware of the number of beds in their organisation or missed answering the question.

Figure 2: Reported number of beds in UDH
Demographic characteristics of nurse educators employed in urban district hospitals

Nearly all of the nurse educators who returned questionnaires were female (93%, n=65), leaving seven per cent (n=5) being male. Almost three quarters of nurse educators identified themselves being between 41 and 60 years of age (69%, n=47) as highlighted in figure 3 (below). Followed by 19% (n=13) being between the ages of 31-40 and almost 3% (n=2) under 30 years of age. Figure 4 (pg 80) clearly depicts the majority of nurse educators identified themselves as New Zealand European (72%, n=50) and 4% (n=3) as of Māori ethnicity.
Time, experience, education and where nurse educators are employed.

Figure 5 outlines the careers of the nurse educators who participated in the survey phase of the research. The graph indicates the time in years that those nurse educators have spent in their educator roles, followed by the time they been qualified registered nurses and lastly, the time they have spent in the clinical area in which they teach.

Figure 4: Reported ethnicity of nurse educators employed in UDH

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 NZ Maori 4%
 Samoan 1%
 NZ European 72%
 Other Euro 17%
 Other 3%
 Missing data 3%

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Figure 5 (pg 81) outlines the careers of the nurse educators who participated in the survey phase of the research. The graph indicates the time in years that those nurse educators have spent in their educator roles, followed by the time they been qualified registered nurses and lastly, the time they have spent in the clinical area in which they teach.
The highest duration of time nurse educators had been in their role had been equal in two categories one to five years and six to ten years (38.6%). Whereas, the majority of nurse educators had been nurses for twenty to thirty years (42.9%), thirty per cent who had been nurses for more than thirty years. A quarter of respondents had been teaching and practicing in the same clinical area for six to ten years (25.8%). With another 19% more having taught and practiced for 11-15 years.

Whilst exploring the respondent’s further educational qualifications it transpired, almost sixty per cent had participated in personal and professional development (figure 6, pg 82). The most common form of further educational qualifications was the certificate of adult teaching (CAT) of which 46% of those with educational qualifications had achieved. A further 15% had participated in post-graduate papers that had an education focus and 22% had taken part in certificates that concentrated upon clinical teaching either through tertiary environments involving Polytechnics or College of Education facilitated courses. Another 15% had completed learning opportunities that involved workplace assessor or New Zealand Qualifications Authority courses that focused on education. Seven per cent had either a Bachelors degree in Education or a Bachelors of Nursing with a major in education.

Figure 5: Reported career outline of nurse educators employed in UDH
The qualifications nurse educators had, that related specifically to the realm of nurse were varied (figure 7, pg 83). There was a substantial quantity (88.4%, n=61) of educators who held post-graduate qualifications. A very small per cent of respondents solely held their initial diploma and/or bachelor degree (7.2, n=5) and 4.3 % (n=2) had a graduate diploma. The results were overwhelming in terms of nurse educators preparing well for their roles as educators by participating in post-graduate education.
Those participants in figure 8 (pg 84), (51.4%, n=36) pointed out they were involved in a combination of practice areas fourteen (20%) taught in two areas, fourteen (20%) were involved in three to five areas, and eight (11.4%) were involved in between seven and eight practice areas in their role as nurse educator. This could be considered to link with theme 2.2 unique aspects associated with UDH, in regard to the uniqueness of these regional hospitals and their need to utilise resources over a broad variety of areas.

The demographic data also highlighted the areas where nurse educators were practicing. The significant factors that are notable in figure 8 are that half of the nurse educators employed in urban district hospitals have roles in more than one area. Thirty-six respondents (57%) indicated their role incorporated a combination of areas throughout their organisation and another 17.1% indicated their role was in areas designated as ‘other’ in the questionnaire that the options specified.
Twelve participants (17.1%) identified their role was ‘other’ than those indicated above. Their roles consisted of generic teaching throughout the hospital (n=6, 8.6%). Two were involved in the Professional Development Review Process (PDRP) (n=2, 8.6%), others in education specifically pertaining to intravenous therapy hospital wide (n=2, 8.6%), or practice development (n=1, 4.3%) and finally new graduate programmes such as, NETP (n=1, 4.3%).

The questionnaire collected a variety of data that identified the demographic information surrounding the nurse educator group sampled. The questionnaire identified data that required further exploration to achieve a well-rounded picture of workplace-based learning. The process of analysing the questionnaire data informed the direction the interviews took; in terms of formulating questions that were aimed to seek clarification and enrich the themes already emerging from the questionnaire data. The interview process both added to the existing data and found further themes become apparent.
Thematic findings from data

The interviews were transcribed verbatim, presenting a wealth of qualitative data. A thematic analysis approach was used to discern categories that emerged from the data. A reference table summarising the themes can be found on pages 86-87 (Table 1). The seven key themes that emerged from this data were financial issues, philosophy of learning, access to learning, service delivery, leadership, support for Māori nurses and overseas nurses workplace learning.

Themes

To aid the description of the thematic findings, quotations from the interviews have been dispersed throughout the outcomes. The purpose of using statements from the interviewees was intended for the reader to hear the voice of the participating nurse educators and provide a richer understanding of the nurse educator perspective. The comments are coded by a letter, following a transcript number and text line number. These codes are confidential and only the researcher can identify the source. Due to the nature of mixed methods research there is two sources of data collected. Therefore in order to clarify the origin of the findings in terms of qualitative or quantitative, sub headings are used either outlining the data as findings from the interview or findings from the questionnaire. All themes are reported in more detail in the table and described below.
<table>
<thead>
<tr>
<th>THEME</th>
<th>SUB THEME</th>
<th>SUMMARY POINTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0 Financial Issues</td>
<td>1.1 Financial resources available.</td>
<td>100% (N=7) stated their role inhibited by financial constraints.</td>
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<tr>
<td></td>
<td>1.2 Availability of equipment.</td>
<td>71% (n=5) stated a lack of equipment available.</td>
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<td></td>
<td>1.3 Administration support</td>
<td>57% (n=4) had no admin support.</td>
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<td></td>
<td></td>
<td>29% had admin support but would like more.</td>
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<td></td>
<td>1.4 Time to fulfill responsibilities.</td>
<td>86% (n=6) would like more time to fulfill their role.</td>
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<tr>
<td>2.0 Philosophy of learning.</td>
<td>2.1 Awareness of an organisational learning philosophy.</td>
<td>57% (n=4) unaware of a philosophy of learning within their organisation.</td>
</tr>
<tr>
<td></td>
<td>2.2 Identifying educational needs.</td>
<td>Mixture of means of assessing educational needs of both the nurse and the organisation.</td>
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<td></td>
<td>2.3 Unique aspects associated with urban district hospitals.</td>
<td>29% (n=2) identified areas within organisations generally provide multi-skilled areas of practice.</td>
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<td></td>
<td>2.4 Motivation to learn.</td>
<td>Mixture of levels of motivation identified. n=7 stated nurses enjoyed study days, n=4 lacked enthusiasm, n=3 relied on didactic style of learning, n=2 motivation influenced by life work balance.</td>
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<td></td>
<td>2.5 Participation to learn.</td>
<td>Mixed responses to level of participation. N=7 identified timing linked to participation. n=2 found hurdles to participation in learning.</td>
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<td></td>
<td>2.6 Change Agents</td>
<td>100% linked nurses and the organisations ability to change with education (N=7).</td>
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<tr>
<td>THEME</td>
<td>SUB THEME</td>
<td>SUMMARY POINTS</td>
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<tr>
<td>3.0 Access</td>
<td>3.1 Enabling access to learning.</td>
<td>(n=1) organisation provided regularly education outside the usual practice of in-service education for all staff including night staff.</td>
</tr>
<tr>
<td>to Learning</td>
<td>3.2 Barriers to accessing workplace learning.</td>
<td>100% (N=7) recognised acuity and busyness in the workplace that inhibits access o wall.</td>
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<tr>
<td></td>
<td>3.3 Access to speakers.</td>
<td>43% (n=3) identified a difficulty to get nurses or other health professionals to present.</td>
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<tr>
<td>4.0 Service</td>
<td>4.1 Risk management.</td>
<td>29% (n=2) found their main focus was ‘putting out fires’.</td>
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<tr>
<td>Delivery</td>
<td></td>
<td>14.2% (n=1) use a needs analysis, 29% (n=2) have tried it in the past with a poor response.</td>
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<td></td>
<td>4.2 Planning strategies</td>
<td>85% (n=6) have a plan for the year.</td>
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<td></td>
<td>4.3 E-learning</td>
<td>A dichotomy exists the questionnaire found 71%, n=49 had IT access, yet all seven interviewed (100%) there were barriers to accessing online learning in the workplace.</td>
</tr>
<tr>
<td>5.0 Leadership</td>
<td>5.1 Support for nurses workplace learning.</td>
<td>57% (n=4) of those interviewed found when they had strong leadership support their role was easier.</td>
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<td></td>
<td>5.2 Empowering nurses to share ideas.</td>
<td>43% (n=3) either invited nurses to participate in decision-making surveyed or sought nurse’s opinion.</td>
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<tr>
<td>6.0 Māori support</td>
<td>6.1 Support and encouragement for Māori nurses to learn in the workplace.</td>
<td>71% (n=5) were unaware of any strategy to facilitate and encourage workplace learning for Māori nurses. Two (n=2) DHB were either in the beginnings of facilitating mentorship for Māori nurses, or had a PDRP programme Māori nurses could choose to participate in.</td>
</tr>
<tr>
<td>7.0 Overseas trained nurses</td>
<td>7.1 Support and encouragement for overseas nurses to learn in the workplace.</td>
<td>14.2% (n=1) of organisations recognise the need to work alongside and provide ongoing support for overseas trained nurses. 57% (n=4) rely upon the tertiary institute to ensure readiness to practice. 14.2% (n=1) provide their own in house competency return to work programme. 14.2%(n=1) have not overseas trained nurses so do not see it as an issue.</td>
</tr>
</tbody>
</table>
1.0 Financial Issues

The first of these themes identified was that of financial issues; under the broad financial umbrella there were four sub-themes that were revealed. These were the availability of financial resources, the availability of equipment to aid and provide learning, the level of administration support available to the nurse educator and the time available for the nurse educator to fulfil their role.

1.1 Availability of financial resources.

• Findings from the interview
All (n=7) participants stated their role was inhibited by a lack of financial resources. An example of this was that the education of nurses within the workplace is intended to be cost neutral, therefore nurse educators lack funding to support their learning programmes. One (14.2%) District Health Board had frozen further spending that involved inviting speakers into the organisation who required payment for their services. There was an inability in some areas to roster nurses off to attend education or to provide extra staff to enable nurses to attend the education sessions.

“There is never enough money, you can imagine that the resources to actually deliver education are absolutely deplorable (C33: 20-21)”.

• Findings from the questionnaire
Likewise, participants who had made remarks on the questionnaires (9.5%, n=10) identified that financial issues within their workplace impacted upon their ability to facilitate learning.
Three respondents within this group (2.8%) found workplace based learning to be cost effective and offered value for money. The remaining 6.7% (n=7) indicated that there was a lack of financial support for workplace learning for nurses within their organisation.

1.2 Availability of equipment

• Findings from the interviews

The majority of those interviewed (71%; n=5) recognised a shortage or lack of equipment available to facilitate learning. For some areas this meant there was a dearth of space or a designated area within the workplace to facilitate learning. It is commonplace for nurses learning to occur in a patient lounge:

“We have to use power point on the wall, lucky someone hung a picture just to the left so it does get on the wall…. lack of facilities the patient lounge, waiting room doubles as the education room, at times it’s crowded with patients waiting to go home, patients waiting for a bed and nurses trying to have an education session (D61: 208)”

For another two (29%) areas there were barriers accessing the education and development suites provided for the areas because they were being hired out to private establishments or for other meetings. Hence the educators, experienced difficulties booking a room to hold education sessions for the nurses. Another nurse educator found it difficult to access equipment such as computer equipment, manikins and teaching aids to assist their teaching sessions.

“Very real barriers around accessing resources, can I have a room? Can I have a laser pointer? Can I access a laptop? (C38: 164-166)”
Yet one (14.2%) had a positive experience of good resources, access to equipment and space to fulfil the educational requirements. Likewise in the responses made on the questionnaire, it was the minority (1.4%) who had the benefit of resources. The remaining 6.6% (n=7) from the questionnaire, pointed out that they often lacked one of three key tools to enable or facilitate learning; an available area to hold sessions, IT equipment for learning either by educators or computers available for nurses to access e-learning when they have the time in the practice area.

1.3 Administration support

• Findings from the interviews
Fifty-seven per cent (n=4) of nurse educators had no administration support at all; a further 29% (n=2) who had some administration support indicated that they would like more clerical support. There was a general consensus that administration tasks took them away from the work of actually facilitating learning for nurses.

“Drives me up the wall because it keeps me from doing important strategic stuff, while I am busy printing and binding and creating flyers (C40: 212-214)”

• Findings from the questionnaires
Likewise, a small group of the respondents stated on the comments section of the questionnaires that they were devoid of administration support (1.9%, n=2).
1.4 Time to fulfil responsibilities.

• **Findings from the interview**
The majority of those interviewed 86% (n=6) clearly stated they would like more time to fulfil their role. For nearly half of those interviewed 43% (n=3) the nurse educator role was part-time which they found challenging because there were additional duties that drew them away from their dedicated time to facilitating learning for nurses (14.2%).

The issues that took educators away from their role included:

• Business of the area.
• Lack of staff to care for patients, therefore educators take a patient load.
• Additional tasks or meetings.

“A nurse educator role is one of those that if it doesn’t sit anywhere it will sit at your door (D72: 538-539)”.

2.0 A philosophy of learning

The concept of a philosophy of learning is the values and expectations the organisation hold surrounding ongoing professional development. A philosophy of learning theme has been broken down into five sub-themes the first an awareness of a philosophy of learning and subsequently, identifying educational needs, the motivation to learn, participation to learn and change agents.
2.1 An Awareness of an organisational learning philosophy

• Findings from the interviews
The data retrieved from the interview phase of the research found over half of the nurse educators interviewed, 57% (n=4) were unaware of the existence of a learning philosophy within their organisation (figure 9, pg 93). Almost one third of the respondents (29%, n=2) failed to answer the interview in terms of their organisations philosophy of workplace based learning. Instead, these two participants focused their remarks on numbers of available study days and their organisations emphasis upon postgraduate education for nurses. However, postgraduate learning was not the focus of the study. One educator 14.2% acknowledged it was their role to be developing a philosophy of learning for their organisation; subsequently this acknowledges that the DHB recognises a need for a philosophy to exist.

The second question of phase two of the telephone interview was used to establish an initial picture of the educator’s impression of their organisations culture of learning. The aim of the enquiry was to highlight themes identified in this study that would emerge as both major themes and sub-themes. The responses varied from describing learning as valued, followed by the barriers that prevented learning from occurring. These included, leadership support, mandatory learning requirements, the ability to identify learning needs, barriers to accessing learning such as busyness, rostering, financial issues affecting learning and the changing culture of learning alongside the impact technology has had on learning for example e-learning developments.
• Findings from the questionnaire

The data collected from the postal survey found that quite a different response to the existence of a philosophy of learning within the organisations (figure 10, pg 94). Over half (58.6%, n=41) agreed that their organisation had a clear philosophy of lifelong learning present. A notable 32 per cent (n=22) remained neutral, with neutral indicating that the participant neither agreed nor disagreed that their organisation had a clear philosophy of lifelong learning. The remaining ten per cent of respondents (n=7) identified there was no clear philosophy of learning within their organisation.
Another outcome of the data collected is highlighted in the quantitative results in the above figure 10. The information presented, coincides with the existence of an organisations learning philosophy and an organisations ability to communicate its philosophy or vision to their nursing staff. These findings draws one to the fact that over half of the participants (35.7%, n=25) responded remained neutral and 20% (n=14) disagreed that communication was clear surrounding the organisations philosophy of learning. Whereas, on a more positive outcome 41.4% (n=29) agreed and 2.9% (n=2) strongly agreed that their organisation clearly communicated its learning philosophy to nursing staff (figure 11, pg 95).
Sixty per cent (n=42) of participants agreed that nurses’ learning was a priority for their employer. Those who did not agree constituted 11.4% (n=8) of the sample and a further 28.6% (n=20) remained neutral.

In phase one of the research, the questionnaire invited a response from nurse educators as to their impression of the learning culture within the organisation in which they were employed. The first question enquired about whether the organisation fostered a learning culture. Fifty-eight per cent (n=51) of respondents who agreed, 14.3% (n=10) strongly agreed. Whereas, 11.4% (n=8) of participants disagreed that their organisation fostered a learning culture amongst nurses and 15.7% (n=11) remained uncommitted and responded with a neutral reply.

The following question asked if learning in the workplace for nurses was a priority for their employer (figure 12, pg 96). Again, there was a positive response generally with 47.1% (n=33) agreed that learning was a priority for organisations and 12.9% (n=9) strongly agreed totalling sixty per cent (n=42) who stated nurses learning was a priority for their organisation. A much smaller number of participants disagreed (10%, n=7)
and a mere one educator (1.4%) strongly disagreed. Once more a significant amount of respondents, over a quarter (28.6%, n=20) remained neutral in their views.

Figure: 12: Nurse educators view on whether nurses learning is a priority for their employer

![Learning is a priority for my employer](image)

Nurse educators were later asked within the questionnaire how satisfied they were that nurses’ learning was a priority within the organisation they work. These results indicated quite a different outcome, 32.9% (n=23) were satisfied, 25.7% (n=18) found they were not satisfied that learning was a priority and half of educators (n=29, 41.4%) failed to identify a preference by indicating a neutral response (figure 13, pg 97).
2.2 Identifying educational needs.

There were a variety of methods used by organisations to identify what the actual educational needs were for the nursing workforce. These include the use of needs analysis system, audits, workforce New Zealand requirements, sentinel events, collaboration with staff in terms of PDRP, nurse educator discussions with staff, senior nurse advisement, the nurse educator deciding upon the curriculum or whether the emphasis was placed upon mandatory study days.
• Findings from the interviews

All seven educators interviewed, utilised a combination of ways to assess what learning was required for the nurses. Forty-three per cent (n=3) have engaged in a needs analysis process, endeavouring to discern what the learning priorities were from a nurse’s perspective. However, 29% (n=2) found the response rate was poor and have not pursued this method of enquiry again.

Nurse educators found gaining feedback from nurses indirectly was another means of assessing the learning needs of staff. Almost half of the nurse educators interviewed 43% (n=3) stated that the PDRP process often informed the nurse educators of educational requirements or needs in terms of nurses’ educational goals. A further 43% (n=3) stated they utilise discussions with senior nursing staff, clinical nurse specialists, and medical staff to help plan the curriculum for workplace education.

Each respondent who had identified direct discussions with nurses to identify learning needs had their own unique means of keeping in touch with the needs of nurses in their department. One educator stated, that a new years resolution approach was used whereby they had a discussion with each staff member at the start of every year. This discussion set personal goals and started nurses thinking about the educational needs for the year. A similar approach by another organisation the nurse educator had on file, a career plan for the nurses to fill in on-line and all their education was linked back to this career plan. Another educator promoted an open door policy, as their office was on the ward and the door was consistently open to reduce a physical barrier and enable nurses to access them at any time. This also meant they too could easily access the nurses, and they did so regularly.

Organising the education was on a twelve-month or three year plan for 86% (n=6) for the organisations interviewed. In terms of content nurse educators provided times such as standard modules that exist within the hospital, organisational policies and other mandatory learning, which the hospital is duty bound to provide to comply with
national standards. Almost one third of educators (29%, n=2) found they tended to respond to the immediate need, following sentinel events or findings from audits, which is mentioned in the risk management sub-theme 4.2.

- **Findings from the questionnaire**

The questionnaires (n=7, 10%) identified a small variety of methods by which some organisations identify the learning needs of nurses within their organisations. Those highlighted were as a response to an event, linked to needs analysis undertaken, through collaboration with a tertiary institution. In terms of the deciding upon a curriculum, a nurse educator stated.

“*Staff trust my judgement that training I organise is necessary for them to carry out their work*(Q:69).

![Figure 14: The reported elements of organisations identifying learning needs and planning work based learning](image-url)
The graph on the previous page (figure 14, pg 99) depicts a number of questions from the questionnaire that relate specifically to identifying learning needs, collaboration in identifying the needs of nurses and the level of cooperation between the organisation and the nursing staff when planning nursing focused workplace learning. The first item found that nurse educators could not positively confirm that nurses’ confidently identified their own personal learning goals, almost half the nurse educators surveyed 43.5% (n=30) responded with a neutral response. Almost a third of nurse educators viewed that nurses failed to identify their educational needs (31.9%, n=22). On a positive note, 24.6% (n=17) of those who responded found nurses were able to identify their learning requirements.

An enquiry regarding whether the organisation facilitated and collaborated with nurses to develop learning goals was asked. The responses were positive in regard to collaboration with almost half of respondents (45.8%, n=32), suggesting that nurses themselves were included. A large cohort of participants opinions were neutral (35.7%, n=25), which indicated they were either undecided that their organisation collaborated with nurses to foster learning goals, are not consistently involving individuals in planning learning or are less inclined to give an opinion. A further, 18.5% (n=13) claimed that the organisation failed to collaborate with nurses to establish learning goals to be achieved.

In terms of the responses as to whether organisations were able to facilitate nurses individual learning goals 47.1% (n=33) found their organisation enabled their nurses learning goals. Again, 18.5% (n=13) were of the opinion that their workplaces failed to facilitate individual learning goals. A large quantity (34.3%, n=24)) remained neutral with their response.

The involvement of nurses in the planning of workplace learning was positive. A clear majority of 69% (n=48) involved nurses in the process of planning of workplace learning, and a small 8.6% (n=6) did not involve nurses in the planning of the learning
in their workplace. The neutral opinion drew a quarter of the respondents (22.9%, n=16) to this question.

2.3 Unique aspects of urban district hospitals in New Zealand

• Findings from the interviews
Two participants (29%) identified that urban district hospitals are unique and function differently from tertiary centres throughout New Zealand. How these organisations are distinctive from tertiary centres are that they usually have generic areas of practice that encompass more than one or even two specialties. An example of this type of establishment are that surgical wards may include general surgery and urology also provides care for orthopaedic, otolaryngology, dental, gynaecology and medical services (Taranaki Base Hospital New Zealand, 2012). The broad variety of patients that nurses are exposed to highlights the wide range of learning that needs to occur to maintain provision of up-to-date, safe care of the public. These broad learning requirements place extraneous demands upon both practice areas and educators to meet the educational demands or requirements.

2.3 Motivation to learn

• Findings from the interviews
All participants offered a number of suggestions about the motivation of nurses to learn. Amongst those interviewed 57% (n=4) had the view that some nurses were keen and motivated to learn. However there were those who in the opinion of the nurse educator, consistently lacked enthusiasm for educational opportunities in the workplace. The factors identified by a third (n=3, 29%) nurse educators underlying the reluctance for nurses to be motivated to learn included, that nurses were reliant upon educators and employers to provide them with task orientated learning opportunities. Educators described this as “spoon-fed” learning which is a colloquialism, which translates to didactic, task focused styles of learning.
“We need to change the mindset of nurses to think about what we are doing rather than just going from task to task. I know I used to be like that, I was straight out busy and rather than analysing what I was doing I was getting onto the next task (A11: 348-351)”.

One educator (14.2%) felt that nurses could use self-motivated initiatives and meet some of their own learning needs instead of relying on others to spoon-feed them. Whereas two (n=2, 29%) stated the same nurses tended to consistently lack enthusiasm for education. The impression educators had were that these nurses felt the need or pressure to get home during sessions occurring at the change of shift. They preferred education not to interfere with their work life balance.

Nevertheless the positive finding was, overall 86% (n=7) found most nurses enjoyed and were motivated when attending designated study days. One nurse educator (14.2%) felt that strong nurse educator leadership influenced motivation by the educator merely not accepting anything else. This educator insisted on all nurses presenting learning opportunities in the workplace to colleagues and nonparticipation was not accepted. This respondent had the belief that if a lack of motivation and enthusiasm for learning was accepted then change would never occur.

- **Findings from the questionnaire**

The questionnaire explored nurses’ motivation and enthusiasm for learning by using a three-question approach of enquiry (figure 12, pg 96). The first question sought the educators’ opinion on whether professional development was a priority for the nurses they worked with. The outcome of these findings were that almost half (48.5%, n=34) believed ongoing learning was a priority, whereas 20% (n=14) of these thought it was not a
priority with only one respondent (1.4%) felt strongly that learning was not a priority for nurses. A significant thirty-four per cent (n=24) returned a neutral response, this could indicate one third of participants were either undecided, were unaware, or were unwilling to give an opinion regarding the motivation of the nurses they work alongside.

The next question reflected the subjective view of the educator’s opinion upon nurses’ enthusiasm for workplace learning. Sixty per cent (n=42) believed nurses were enthusiastic about workplace learning. A significantly smaller 12.4% (n=9) disagreed that nurses were enthusiastic about workplace learning, but a larger 27.1% (n=19) neither agreed nor disagreed and caste a neutral response.

The last enquiry as shown in (figure 15, pg 104) into this area related to the level of motivation and enthusiasm nurses had for learning by exploring the level of active participation nurses demonstrated during workplace learning sessions. The results were similar to those responses above. Sixty-two per cent (n=43) stated nurses actively participated in workplace learning sessions, 14.3% (n=10) disagreed and 24.3% (n=17) were neutral.
Motivation and enthusiasm for learning was identified from the questionnaire as either a barrier to learning or a vehicle for change. From the comments section of the questionnaire, eighteen participants (26%) identified motivation in their comments. Thirteen (18.6%) remarked upon the lack of desire or enthusiasm for learning in some nurses’. Whereas a further five (7%) stated nurses were generally enthusiastic for learning and this enthusiasm was central to enable change within organisations. One respondent (1.4%) expressed a concern that attendance at times is linked with nurses’ desire to meet nursing council requirements instead of engaging in learning itself.

The nurse educators were asked how motivated and enthusiastic they personally felt in their role as nurse educators, the results were seventy per cent felt motivated with 32.9% (n=23) of this group feeling highly motivated. The lowest result was 12.9% (n=9) who felt unmotivated and 17.1% (n=12) who responded with a neutral result.

Using the SPSS system the researcher explored how the educators who viewed their level of satisfaction in their role as neutral or unsatisfied, answered the questionnaire on the whole. This was an exercise to investigate whether their satisfaction for their role influenced their answers throughout the survey.
The results found almost one third (n=21, 30%) of nurse educators responded negatively or had not indicated an opinion whether they felt enthusiastic about their role. There were 28 attitudinal questions surrounding workplace learning, that were answered using likert scales. In total there were 567 possible responses, 14 of these individual items were answered in a positive manner leaving a total of 553 answers surrounding workplace learning being neutral or negative. Half of the positive answers were held by one third of this sub group (n=7), who had the view that they were satisfied nurses learning was a priority for their organisation. Those nurse educators, who felt neutral in terms of their enthusiasm for their role, consistently answered either neutrally or answered the entire questionnaire in a similar or negative manner.

2.4 Participation to learn

The timing of the workplace education sessions was identified as a key element to whether nurses participated in learning or not. The interviews found 86% (n=6) of learning occurred during the change of morning to afternoon shifts. This finding coincides with key elements associated with sub theme 3.0 Enabling access to learning.

• Findings from the interview
One participant (14.2%) whose workplace setting was an intensive care unit (ICU) found their needs were specific and often the needs of ICU nurses were not met at the generic teaching sessions provided for the organisation. At times this group felt isolated from accessing education provided by the organisation.

Interdisciplinary learning had been attempted one respondent reported (n=1, 14.2%) and was well attended by nurses, but little participation or enthusiasm was demonstrated by the doctors involved. It had not been attempted again.
Five nurse educators made further comments regarding participation in learning on the remarks section of the survey. Two (2.8%) of these stated nurses would not attend teaching on their days off, whereas one (1.4%) stated teaching sessions were well attended and nurses were paid to come in when not rostered to work. One respondent stated their return to work and new graduate training programmes were a highlight within their organisation. One documented the comment ‘participation in learning’ without indicating what was meant by the comment.

2.5 Change agents

- **Findings from the interview**
All participants (n=7) interviewed linked education of employees to making change happen within health care organisations.

“There is a definite correlation between nurses who engage in education and their ability to effect change” (E:52)

- **Findings from the questionnaire**
In order to explore the implications of learning two questions were used. These were questions 30 and 31 on the nurse educator survey, initially explored whether organisations promote the introduction of newly acquired skills and knowledge. Secondly, the question focused on whether the organisations welcome and support change in practice subsequent to evidence based learning.

The outcomes as to whether organisations promotes the introduction of new skills and knowledge found 71.4% (n=50) agreed that their organisation did promote new skills and knowledge whereas a mere 10% (n=7) disagreed and 18.6% (n=13) indicated a neutral response.
In terms of whether the organisation welcomes and supports change to practice following learning 69.6% (n=48) agreed, a small 5.8% (n=4) disagreed and almost a quarter (24.6%, n=17) were neutral in their response.

Question 17 of phase one of the research explored the organisations framework in terms of whether it encouraged and supported team learning. The outcomes of this question found 22.8% (n=16) disagreed that team learning was supported, whereas 42.9% (n=30) of organisations encouraged and supported team learning, with 34.3% (n=24) of respondents remaining neutral.

3.0 Access to learning

The theme Access to learning was found to identify three sub-themes Enabling access to learning, barriers to accessing workplace learning and the access to speakers.

3.1 Enabling access to learning.

- **Findings from the questionnaire**
  
  To explore access to workplace learning, phase one question 12 asked whether time for workplace learning was actively protected within the workplace followed by question 13 which enquired whether staff were rostered to allow regular workplace learning to occur. Consequently the findings were 35.8% (n=25) who identified workplace-learning time was actively protected, whereas on the other hand 42.9% (n=30) disagreed that time for workplace learning was actively protected and 21.4% (n=15) remained neutral.

In terms of whether rosters allowed regular workplace learning to occur the outcomes found nearly half of nurse educators agreed/ strongly agreed that rosters allowed
workplace learning to happen, with the remaining split between disagreement or had a neutral view on the subject (table 2).

Table 2: Reported rostering to allow learning

<table>
<thead>
<tr>
<th>Rosters allowing learning (SPSS output report)</th>
<th>Frequency</th>
<th>Per cent</th>
<th>Valid Per cent</th>
<th>Cumulative Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid strongly disagree</td>
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<td>16</td>
<td>22.9</td>
<td>22.9</td>
<td>25.7</td>
</tr>
<tr>
<td>neutral</td>
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<td>27.1</td>
<td>27.1</td>
<td>52.9</td>
</tr>
<tr>
<td>agree</td>
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<tr>
<td>strongly agree</td>
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<tr>
<td>Total</td>
<td>70</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

- **Findings from the interview**

However, a contradictory result was found when nurse educators were interviewed, with 100% (n=7) of respondents who identified that the high acuity in the clinical areas was the main barrier to nurses attending workplace-based learning. The interview process found only one organisation provided regular education outside of the morning/afternoon handover time. This particular organisation provided a reliable weekly education session for all nursing staff. Repetitive sessions were held over nurses’ usual lunch breaks such as 11-11.30, 11.30-12.00, and 12.30-1300 and included the provision of a lunch. This session provided nurses with regular reliable ongoing learning at a convenient time to enable nurses to attend, or to attend on rostered days off and was removed from their immediate work environment or the problems associated with sessions held at shift handover. This same organisation provided monthly education for night staff to attend in the evenings and nurses were paid to attend prior to their shift commencing.

The reflections within the questionnaire revealed the belief that amongst nurse educators, workplace learning was a type of learning that facilitated learning for all. The rationale supporting this belief was that learning was based within the practice area. Therefore, ideally there was opportunity for all to attend. Eleven nurse educators (15.8%) believed workplace-based learning was spontaneous, flexible and could be
accessed easily. Another two respondents (2.8%) indicated they worked alongside nurses on the floor as well as their traditional nurse educator role. They found this beneficial because it provided additional, impromptu and enabled an opportunity for needs based learning for the nurse, the patient and the family.

3.2 Barriers to accessing workplace learning

- Findings from the interviews

For the nurse educators interviewed, the issues of rostering and high workload requirements were highlighted as a problem for their organisations. The busyness of the ward and having staff to meet those demands can disrupt learning opportunities for nurses. Two (29%) organisations stated there was an increasing expectation that nurses attend education on their days off. Having a long-term plan individually and organisationally enabled rostering to facilitate greater nurse access to workplace learning. In addition, according to these nurses, long-term planning allowed future planning for learning to occur whilst maintaining safe staffing levels within the practice areas.

“Long term planning does not come without its problems one educator stated, We book people in and keep our fingers crossed and hope it will eventuate and staff do not get pulled of the education (A3: 72)”.

“Rostering is done six weeks in advance. If we have study days in time for the roster it is fantastic, but if not its difficult to get people off (E84: 282-285)”.
• **Findings from the questionnaire**

Half of the nurse educators who returned the questionnaire (51%, n=54) indicated that difficulties existed for nurses to access education sessions during shift handover. This was due to a combination of factors. The reasons identified by the educators were the busyness of the workplace, being short staffed or interruptions whilst attending learning sessions by the need for nurses to care for their patients. The other factors mentioned were associated with nurses difficulty to maintain focus for the duration of learning sessions due to extraneous distractions caused by nurses being preoccupied whilst attending learning sessions in work time, resulting in an inability to concentrate on the learning at hand. The diminished attention to learning in the workplace session tended to be thought to be associated with nurses becoming preoccupied with the needs of their patients and their duty of care. This was evident according to educators who found nurses being interrupted from a learning session to respond to the need of the area. There were additional concerns expressed by 7.6% (n=8) of participants that education sessions were cancelled due to not enough staff available to attend due to the demands of the practice area with one participant indicating non-attendance due to a lack of interest.

3.3 Access to speakers

• **Findings from the interviews**

Getting nurses with particular skills and knowledge or nurses in general to present to their colleagues is a challenge for 43% (n=3) of the nurse educators interviewed. One organisation, (14.2%) overcame this by insisting nurses present to their colleagues within their work area.

“Its really difficult to get nurses to lead education sessions, maybe its because they aren’t immersed in the process enough, its still so foreign to them” (F:102)
• **Findings from the questionnaire**

The questionnaire had responses from seven educators (10%) who commented upon their ability to obtain or coerce nurses or allied health professionals to share their expertise. Three (4.3%) found it was very difficult to get nurses in particular to share their knowledge with their colleagues, whereas the other four (5.7%) stated finding nurses to be speakers in education sessions was not a problem, as nurses were keen to teach and support each other and utilise the wealth of knowledge within their organisation.

4.0 **Service Delivery**

In exploring the process of how learning was approached in the workplace three sub-themes were identified namely; the facilitation of critical thinking and reasoning, mandatory learning and risk management.

4.1 **The facilitation of critical thinking and reasoning**

• **Findings from the interviews**

Nurse educators interviewed identified that those most likely to utilise critical thinking and reasoning were graduate nurses or nurses who have been engaged in postgraduate study (43%, n=3). The three respondents (43%) who made comment on the facilitation of critical thinking and reasoning discussed it in terms of reflective practice, PDRP process and the use of focus charting. Focus charting is a method of nursing documentation that describes actions and responses to the data collected. This documentation style focuses upon the actions, its framework utilises skills in assessment, care and interventions, followed by the response to the care taken (White, 2001).
One participant (14.2%) believed within their organisation, that the majority of nurse’s utilised reflective practice. Unfortunately, they did not discuss how they facilitated or promoted reflective practice in the workplace.

“We need to change the mindset of nurses to think about what we are doing rather than just going from task to task...I know I was like that. I was straight out and busy rather than analyse what I was doing, I was getting on to the next task” (B:11)

There was reliance upon the PDRP process to as the sole means of facilitating critical thinking and reasoning by 43% (n=3) of those interviewed, whereas the earlier findings discovered regular annual performance reviews were not always carried out.

“I think they make a priority when staff are going through the PDRP process, it’s a good motivator for them to do a PDRP and a reflection on their practice then hopefully the manager would do a reflection with them about their education and learning goals and where they see themselves in five years time” (D:68)

• **Findings from the questionnaire**

The survey outcomes found almost a quarter of respondents (24%, n=17) stated that the annual review did not occur on a regular basis, and a further 27% (n=19) provided a neutral response. One nurse educator stated that the use of focus charting in their area was a means of demonstrating critical thinking and reasoning.

There was an emerging sub-theme within the responses on the questionnaire, whereby comments indicated a reliance of nurses wanting workplace based learning to focus upon a task orientated, and “spoon-fed” manner. This became apparent in ten comments (9.5%) from the questionnaires.
4.2 Mandatory learning

- **Findings from the interviews**

Mandatory study days were referred to as clinical refreshers or professional seminars. It was found almost half of organisations (43%, n=3) pool all the necessary mandatory learning into full study days. In terms of being able to ascertain the actual differentiation between what learning was mandatory and what education constituted needs based development was difficult. Although 57% (n=4) of those interviewed stated mandatory learning was the main educational focus in the workplace, one (14.2%) organisation clearly articulated the split between mandatory study days and other study days. This organisation allowed the nurses to pick three days a year and one was required to be a day that constituted a mandatory learning focus.

![Figure 16: Mandatory service provision](image)
• **Findings from the questionnaire**

Phase one of the research found that sixty per cent of respondents who returned the questionnaire were confident that their organisation provided over and above the educational requirements for mandatory service provision (figure 16, 113). One quarter of participants (26%, n=18) remained neutral when they responded and 14.3% (n=10) disagreed with the concept.

### 4.3 Risk Management

• **Findings from the questionnaire**

Phase one of the research explored the nurse educator’s view of their organisation in terms of a blame free culture and whether nurses learnt from their mistakes. The findings highlighted that the majority of nurse educators felt their organisation demonstrated a blame free culture of incident reporting. The remaining responses were split between disagreement or a neutral response, with one non-respondent not returning a response to the question (table 3, pg 115).
Table 3: Reported perceptions of the organisations blame free status

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Per cent</th>
<th>Valid Per cent</th>
<th>Cumulative Per cent</th>
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<tr>
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<td>1</td>
<td>1.4</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>70</td>
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</tr>
</tbody>
</table>

In terms of whether incident reporting informed workplace learning objectives 57.9% (n=40) agreed, 14.55 (n=10) disagreed and 27.5% (n=19) were neutral in their opinion.

- **Findings from the interview**

Discussion arose during the interview regarding a concept identified by an interviewee as ‘putting out fires’ (A2: 59). Two participants interviewed referred to their main educational focus as responding to the immediate needs of the organisation following incidents or audits 29% (n=2).

“Often as a nurse educator it’s a case of putting out fires, education as it pops up i.e. knowledge deficits as it occurs, errors, incidents (A2: 59)”. 
4.4 Planning strategies

• *Findings from the interview*
A significant 86% (n=6) identified that they have a clear education plan for the year or longer. The remaining educators who took part in the interviews failed to answer the question in terms of how they planned their education programme.

• *Findings from the questionnaire*
There were a total of twelve comments (17%) from the returned questionnaires that related to planning strategies surrounding workplace-based learning. Three of these specifically reflected the spontaneity aspect of workplace learning as the ability for learning to be impromptu or flexible. One responder commented that workplace learning was still developing and evolving within their organisation. The last eight enquiries on the questionnaire where concerned with how nurse educators went about planning education and these comments linked strongly to individual learning goals, mandatory learning, risk management and specific information regarding how learning is timetabled throughout the year.

4.5 Electronic based-learning

• *Findings from the interviews*
All seven (100%) participants who were interviewed identified barriers to either accessing online learning in terms of the limited time available within the workplace or the availability of equipment for nurses to access consoles. Another reservation noted was the fear that some nurses were not able to assess and critique the quality of online learning sites.
Three educators interviewed (43%) commented on the introduction of Modular Object-Oriented Dynamic Learning Environment (MOODLE) sites. These are online learning sites whereby organizations can instigate and disseminate their own learning packages or online learning to support nurse’s educational requirements occurring in the organisation.

- **Findings from the questionnaire**

When comparing phase one of the research (the survey) and what was found in phase two, a disparity in the findings was exposed. Phase one of the study, enquired about whether there was access to electronic information systems available for all nursing staff. Seventy-one per cent (n=49) confirmed that electronic systems were available to all staff, 20.3% (n=14) disagreed that there was availability to all nursing staff within their organisation and 8.7% (n=6) were neutral. However, as reported above all (100%) of the nurse educators surveyed identified that barriers existed for nurses to access online learning resources.

A small sample of five (7.2%) who returned the questionnaire made comments highlighting their desire to set up or expand the e-learning opportunities for nurses. In one organisation Moodle was available for nurse educators but not for the general nursing population. Another organisation had national on-line learning systems set up for mandatory learning. The desire for further online education was apparent with each response that mentioned e-learning. The most significant hurdle that four of these educators found were the inability for nurses to access online opportunities. This was due to a lack of equipment available for nurses to utilise online resources.
5.0 Leadership

The term ‘leadership’ as a main theme led on to three sub-themes, which explored how leadership impacts upon workplace based learning further. The themes identified by the respondents were support for nurse’s workplace learning, nurse leaders’ as change agents and empowering nurses to share ideas.

5.1 Support for nurses workplace learning

- Findings from the interview
Over half of the nurse educators interviewed (57% n=4) found that when they received strong support from the organisations nurse leaders; their role as educators was easier.

- Findings from the questionnaire
A smaller quantity of questionnaires returned (10.4%, n=11) remarked that leadership within their organisation lacked support for nurses learning. On the other hand, a similar quantity (n=10, 9.52%) stated they benefited from positive support from the leadership, within their organisation, in terms of the development and promotion of workplace learning.
5.2 Nurse leaders as change agents

• **Findings from the interview**
A resounding 100% (n=7) of those interviewed clearly indicated that change did occur when there were supportive nursing leaders. Two respondents (29%) recognised that the current financial barriers inhibited the resources nurse leaders had access too, in order to facilitate and promote learning.

“I tried to use outside resources as much as possible but that’s been stopped because there is just no budget for it...the clinical nurse manager did those things for me, but there is just no budget. I can’t ask her to do that anymore (E87: 371-374)”.

• **Findings from the questionnaire**
The nurse educators who returned the survey were asked to quantify the level of support they had in their workplace from those they work alongside, with and for. The outcomes found 65.7% (n=46) found they received motivated support, with 28.6% (n=20) of this group receiving strong support, whereas 22.9% (n=16) failed to identify their level of support for their role and 11.4 (n=8) felt their role was not well supported with only one respondent (1.4%) who felt strongly that they received no support.

5.3 Empowering nurses to share ideas

• **Findings from the interviews**
The interview process as previously mentioned in sub-theme 2.1 Identified educational needs were indicated in the PDRP process, as a means of identifying learning needs of nurses.
• Findings from the questionnaire

The questionnaire enquired whether organisations were demonstrating a commitment to learning by performing annual personal development plans. The findings can be seen on figure 17 (below), where 48.6% (n=34) found their organisation carried out annual performance reviews, while 24.3% (n=17) of organisations failed to perform annual reviews and 27.1% (n=19) remained undecided.

Figure 17: Reported outcomes of whether annual reviews occur in UDH

Nurse educators were asked to indicate how satisfied they were in their role. A majority of nurse educators identified they were satisfied in their role (62.3%, n=43). Yet again approximately a quarter of respondents (27.5%, n=19) gave a neutral response and 10.1% (n=7) were not satisfied in their role.
6.0 Support for Māori nurses

The process of exploring the strategies that existed to support and encourage Māori nurse’s workplace learning within the organisations sampled, reported a consensus that no organisations utilised specific strategies to support and encourage Māori nurses workplace learning.

6.1 Support and encouragement for Māori nurses to learn in the workplace

- **Findings from the interview**

Four nurse educators (54%) nurse educators interviewed were unaware of any strategies within their organisation to facilitate and encourage workplace learning for Māori nurses. Two organisations (29%) were either in the beginnings of facilitating mentorship programmes for Māori nurses, and one organisation (14.2%) indicated their organisation offered a PDRP process specifically for Māori nurses as an option (figure 18, overpage).
7. Support for overseas trained nurses

Following the exploration of the support in workplace learning for indigenous Māori nurses, the research discussed what strategies the organisations may have to support learning for nurses who have trained overseas.
7.1 Support and encouragement for overseas nurses to learn in the workplace

- **Findings from the interviews**

One participant interviewed (14.2%) recognised the need to work alongside and provide ongoing support for nurses who trained overseas. Over half of organisations (57%, n=4) provided no specific workplace learning for such nurses. These organisations recognised this as a responsibility for the tertiary education providers who facilitate the return to practice education, to fulfil any learning needs to ensure nurses are ready for the workplace in which they will be employed. This group identified that compliance with the New Zealand Nursing Council requirements, indicated that overseas trained nurses once employed would have the same educational requirements as New Zealand trained nurses. Interestingly, 14.2% (n=1) participants stated they had no overseas trained nurses employed within their organisation.

**Summary**

This research identified a number of issues pertaining to the context and culture of workplace learning from the nurse educator perspectives in urban district hospitals throughout New Zealand. The demographics of the nurse educator cohort were almost identical to that of the nationwide nurse cohort with the exception the Māori representation that were under represented by 2.6% of their professional nursing population nationally. Based on the findings reported this could be attributed to the organisations failing to utilise strategies to support and encourage workplace learning for Māori nurses.

There were seven themes that were highlighted in the findings namely financial resources, the existence of a learning philosophy, access to learning, the delivery of service in terms of workplace learning and how leadership effects workplace learning,
including strategies in place to support workplace learning for two specific groups these are and overseas trained nurses. There were positive and negative aspects of all the themes listed. This research found workplace learning for nurses was in the early stages of development in most of the organisations sampled. There are certainly key areas that this research may be useful for applicable to in order to enlighten change within workplace-based learning settings.

The key issues were:

- A lack of financial resources to supply nurses and nurse educators with ideal workplace learning opportunities.
- Whilst the early stages of introducing philosophies of learning within the workplace were evident, some organisations were more proactive than others. However, communication and the relevant policies could be improved.
- Prioritising nurses learning; requires consideration due to the significant neutral responses surrounding learning priorities on behalf of the organisation and the professional nurse.
- The processes of identifying the learning needs of nurses were lack lustre.
- Incident reports were used widely to inform and direct teaching plans.
- Nurses on whole were well motivated to learn when the timing was right.
- Education was highlighted as the key to facilitate change.
- Access to learning was a barrier to workplace learning: The timing of education sessions meant it was difficult for nurses to attend and work life balance remains an issue for nurses accessing workplace learning.
- The facilitation of critical thinking and reasoning appeared limited from the reported findings.
- Although mandatory learning was the main focus of most organisations the majority believed they provided over and above mandatory requirements.
- No longer can workplace learning be described as ad hoc when more than three quarters of workplace learning is planned between 12months to three years ahead of time.
- Leadership is crucial to the success of workplace learning and change.
- There was clear evidence that workplace learning for both nurses and those nurses working in New Zealand who were originally trained overseas, requires
attention. This attention is required for two reasons, to retain and recruit nurses who are both from and overseas decent and to provide a workforce who is enabled to provide culturally sensitive care to the New Zealand public.

The responses to both phases of the research process found that there were some interesting and pivotal points raised by the nurse educators. These results will be discussed in the following chapter within the context of the research aims and the literature.
CHAPTER FOUR: DISCUSSION

Introduction

The purpose of this research was to explore workplace-based learning in terms of the culture and context within urban district hospitals throughout New Zealand. There were three main aims identified by the researcher to begin to understand the culture of workplace learning throughout these unique organisations in Aotearoa. Firstly, there was a need to explore the rationale underpinning the development of education programmes within the organisations. This was followed by an attempt to discern how these workplaces develop continuing professional development, as a culture within the workplace. Finally there was consideration of how prepared nurse educators are to fulfil their roles as lifelong learning facilitators and mentors. Through the literature review process, a conceptual framework (figure 19) was developed to enable the researcher to manage the literature and assisted the researcher to paint a picture as to what the culture of workplace learning was like within this particular aspect of health care in New Zealand today.
The methodology was discussed extensively in an earlier chapter (see chapter 2); The interpretation of the research has the power to do one of two things: It is the intention of the author to use the information and the relationships formed whilst collecting the data to empower and inform nurses, nurse educators and the leadership within the New Zealand health sector with a greater understanding of the culture of workplace learning for nurses. There are some areas whereby subjective data is interpreted and discussed; methodological triangulation is used to combine methods to enhance the validity of the findings (Berman, Ford-Gilboe, & Campbell, 1998; Polit & Beck Tatano, 2004; Scheider et al., 2003). The triangulation method used the data from the interviews, the questionnaire and the additional comments that were reflected upon in the returned survey.

Figure 19: Workplace based learning conceptual framework
Interpreting neutral outcomes

The middle response, neutral when using likert scales is an option where respondents either imply they have an opinion or that they do not have a strong view either way about the topic (Polit & Beck Tatano, 2004). The general consensus is undecided whether to include or exclude the undecided middle option when collecting data (Scheider et al., 2003). Some research experts have suggested that it is pertinent to include the middle (neutral) option for factual questions and omit it for attitudinal enquiries (Polit & Beck Tatano, 2004). The authors conclusion here in was to include the neutral option because some experts have been inclined to consider that omitting this option may not change the outcomes; respondents may decline to respond to questions, where there was no available answer to a question that best suited their knowledge or opinion (Polit & Beck Tatano, 2004).

The questionnaire was broken down into sections; the initial demographic data, a shared vision, a training and development needs analysis, a focus on learning from mistakes, the implications of learning, an indication of motivation and job satisfaction of the nurse educator, followed by an opportunity for the participant to list positive and negative aspects of workplace based learning within their organisation along with an opportunity to add further comments.

The participants were a sample of New Zealand nurses employed as nurse educators in thirteen urban district hospitals throughout New Zealand. A questionnaire was sent to each director of nursing who then passed on the questionnaire and information pack to all nurse educators employed. This research involved two phases; phase one was a questionnaire and phase two a voluntary telephone interview. The quantitative data from the questionnaire was analysed utilising SPSS software in a descriptive manner. The seven key themes that emerged were financial issues, philosophy of learning, access to learning, service delivery, leadership, support for Māori nurses and finally support for nurses trained overseas. These themes and summaries of points can be seen.
on table 1, at the beginning of the findings chapter. Throughout the discussion, the qualitative data is discussed alongside the quantitative data.

The demographic data

It was clear that the analysis of the gender data was consistent with the demographics identified by the New Zealand Nursing Council data: Women make up a significantly higher number of the workforce 92.8% (Health Workforce New Zealand, 2012) than the male cohort of nurse educators (7.2%), this was consistent with that of the general population of male nurses registered to practice in New Zealand (Nursing Council of New Zealand, 2012a). The largest group of nurses employed as educators were between the ages of 41-60 years. This was consistent with Health Workforce New Zealand’s (2012) report which found that New Zealand nurses practicing are older now than they were in 1998. Since 1998 the average age of nurses has increased from 42.6 years to 46.7 years in 2010.

The majority of nurse educators are employed to practice in a combination of areas, the most common being three to five. This may be due to urban district hospitals requiring practice areas to be more multi-faceted in their nature. An example of this is a general surgical ward, which may include colorectal surgery, urology and ophthalmology or a orthopaedic area including gynaecological surgical patients and ear nose and throat specialties (Taranaki Base Hospital New Zealand, 2012). This indicated that nurse educators are working within a number and variety of practice areas as are the nurses they facilitate education for.

Māori are under-represented in the overall nursing profession (Broodkoorn, 2010; Maxwell-Crawford & Moeke-Maxwell, 2012; Ministry of Health, 2007a; Ratima et al., 2008; Te Rau Matatini, 2009); this study demonstrated that they remain under represented in the nurse educator group as well. Māori make up 12% of New Zealand’s total population and this figure is expected to rise to 17% by 2021 (Te Puni Kokori,
Although nurses make up the largest cohort of Māori health professionals in New Zealand (Maxwell-Crawford & Moeke-Maxwell, 2012; Ministry of Health, 2007a), they remain only 7.1% of the total population of nurses’ practicing in Aotearoa New Zealand (Nursing Council of New Zealand, 2012b) this study found that 4.4% (n=3) of nurse educators identified as Māori. The key rationale underpinning why Māori nurses represent a smaller cohort in the nurse educator group could lie in the fact that only 0.7% of the total 27.9% of Māori who leave school after the age of fifteen go on to complete further qualifications, gain postgraduate qualifications (Statistics New Zealand, 2006). Their lowered participation in postgraduate learning may be a barrier to Māori gaining nurse educator roles.

The need to retain and recruit Māori to the profession has been well highlighted (H. Hughes, 2009; Maxwell-Crawford & Moeke-Maxwell, 2012; Rameka & Law, 1998; Ratima et al., 2008; Te Rau Matatini, 2009; D. Wilson & Barton, 2012). Ratima et al. (2008) identified that widespread barriers existed which affect recruitment and retention of Māori to the health workforce: These barriers include structural, systemic, organisational and individual factors. The Māori health workforce were clustered in the lower level qualifications as opposed to nursing (Maxwell-Crawford & Moeke-Maxwell, 2012). Changes need to occur to support, encourage and facilitate Māori to ensure their success and longevity within the nursing profession. This is important in regard to the Treaty of Waitangi, the terms of the document did claim to protect the rights of Māori and control over their ‘tino rangtiratanga’, which is accepting the rights of Māori to control what is significant in terms of decision making and control in order to achieve self-determination, which is critical in terms of health for indigenous people of New Zealand (Nursing Council of New Zealand, 2005).

The demographic data gathered as part of the interview process found that the journey from nurse to nurse educator was varied. For some it was a goal of nurses, for others it occurred accidentally or through coincidence because it suited their work life balance at the time. The majority of educators had been in their role for between one and ten years. Over half of the participants reported they had achieved further qualifications in education to assist them in their roles as educators. Nurses have traditionally been contractually obligated to teach and this has been documented in their job descriptions.
(Omansky, 2010). Nurses and in particular nurse educators need to be equipped with the skills to meet both the learning needs of the nurse and the employer in addition to facilitating the transfer and utilisation of knowledge (Clarke & Copeland, 2003; Sobiechowska & Maisch, 2006; Swollow, Chalmers, Miller, Piercy, & Sen, 2001; Williams, 2010).

Overall the nurse educators in this study were well qualified in terms of post-graduate learning as approximately 70% held a postgraduate diploma or Masters degree. This demonstrates the commitment of this particular group to participating in ongoing professional development to improve their potential ability to perform their role. These attributes are integral in order to bridge the divide between practice and theory with application of critical analysis and reasoning to professional practice. Gijbels et al. (2010) would argue that the impact of post registration learning on practice is yet to be fully explored.

The theories of adult learning view adult learners as self-directed, motivated and autonomous (Knowles, 1975; Sobiechowska & Maisch, 2007). This may be true for motivated adult learners, however may not be the case for all the demographic. This study found that participants reported that many nurses did not confidently identify their own learning needs, and nurses who graduated with degrees or postgraduate qualifications were identified as those who were more able to identify their learning needs and to critically reason and analyse. In addition to engaging in processes to aid goal setting, learning needs and the facilitation of critical reasoning, the role of a skilled educator is to support and guide nurses to question practice and learn from their experiences as well as to guide the introduction of evidence into practice (Harvey, Loftus-Hills, & Rycroft-Malone, 2002; McCormack & Slater, 2006; Rycroft-Malone et al., 2004; Williams, 2010). The expertise required by nurse educators calls for them to have specific skills and understanding of adult learning theories and how to apply this knowledge in their roles as educators.

Although the role of nurse educators have not been shown to change the learning culture (McCormack & Slater, 2006). The fact remains without skilled facilitation
learning will remain dependant upon didactic methods which has limited effect on learning (O’Brien, Freemantle, Oxman, Davis, & Herrin, 2007). When skilled facilitation is used in isolation of other methods, there is a likelihood that fostering learners who are inquisitive problem solvers will fail (Senge, Scharmer, Jaworski, & Flowers, 2005). Therefore, the need to value, encourage and facilitate nurse educators to pursue further participation in programmes that specialise in adult learning would help to improve workplace-learning programmes in the future.

Financial issues pertaining to the facilitation of learning

The lack of financial resources remained a consistent theme overall, as this resulted in a paucity of resources available to facilitate learning programmes. Overall respondents cited the shortage of financial resources to support and facilitate learning. Examples of how financial constraints have affected aspects of their education programmes included an overall naivety to access budgets for nurse educators, one organisation recently stopped nurse educators utilising resources from outside their DHB, a respondent described their “resources to deliver education as deplorable” (C2: 20) and another stated that their DHB had put a freeze on nursing funds and nurses were now expected to pay half of any course of education they attended outside of the workplace. This respondent revealed how they had enjoyed bringing in outside speakers from other hospitals, to aide and inform their staff learning. This practice has been found to have an enormous positive contribute to their programmes. Throughout all the interviews there was a general consensus that financial resources were slim and the theme emerged that nurse leaders appeared powerless to change this factor within their areas.

The health dollar is well known to be in short supply and the demand for each portion of resources was high. Education that was well researched and based upon sound information was more likely to be cost effective. The expectation that workplace based learning comes cheaply or without a cost is unrealistic (A. Bamford & Porter-O’Grady, 2000; Dyson et al., 2009; Garcarz et al., 2003; Pedder, 1998). Nurses remain at the
front line of patient care, and are crucial and highly influential in each patient’s journey throughout their hospitalisation and recovery. Quality, safe health care remains the goal of all organisations and nurses have been intrinsically linked to better outcomes for patients (McCloskey & Diers, 2005). The key to quality safe health care is a thinking workforce who is committed to lifelong learning to improve and develop great health care.

In the past alongside other countries, New Zealand has struggled under the ever-increasing cost of health care. The introduction of the health reforms in the nineties was an attempt to control spending (Easton, 1997; Gage & Hornblow, 2007; McCloskey & Diers, 2005). As mentioned earlier these reforms had enormous impacts upon nurses as the largest cohort of the health workforce. The budgets surrounding nursing are often targeted because of enormity of the workforce (McCloskey & Diers, 2005), reducing the operating costs of this group created significant short term financial relief, although the relief was short lived. The effect of organisational changes upon nursing had a snow-ball effect in terms of the increase in adverse clinical outcomes (Garcarz et al., 2003; McCloskey & Diers, 2005). Even though the reforms of 1993-1996 were dismantled and New Zealand was considered too small for a market driven health care system, nurses have failed to regained the leadership positions and budget control they previously had enjoyed (McCloskey & Diers, 2005).

To improve the culture of professional practice and sustain learning in practice there is a real need to prioritise and support educated nurses in the workplace (McCormack & Slater, 2006). For meaningful learning cultures to exist and flourish within urban district hospitals, active advocacy and adequate resourcing from the organisations leadership is required. It has been suggested from these findings that flaws exist within the organisations sampled. Financial barriers clearly exist preventing nurse educators to be well prepared to facilitate learning. Nurse educators reported in this study a lack of available equipment, dedicated learning areas, protected learning time, computer equipment, financial resources to source outside speakers and an overall lack of time and administrative support to aid nurse educators to fulfil their role.
The inability and frustration experienced by educators to access basic resources was found to be unacceptable. Nurses are a recognised and trusted professional group and the fact is, that many attend education sessions in areas that are not equipped adequately for the basic requirements needed for professional learning such as absence of screens for power point presentations, lack of designated areas for professional development and education is performed in waiting areas or patient lounges, unavailable computer equipment or electronic teaching aids. Failing to provide the basic resources to facilitate learning in the work setting puts an onerous task on educators to foster a positive learning culture. Nurses need to feel valued and respected in order to foster a sense of worthiness that nurtures a commitment to the culture of learning.

Workplace learning is a medium by which employers can utilise their resources within their broad service areas to maintain the competence of the staff they employ (Burton, 2005; Dewar et al., 2003; Williams, 2010). There appears a premise from this sample group, that aside from the nurse educator’s salary, workplace education is expected to be cost neutral for the organisation. From this research organisations in New Zealand’s urban district hospitals appear to consider workplace learning as a low budget option for nurses’ ongoing professional development. Ongoing professional development for nurses needs to be valued as an asset and not merely an added perk by the leadership. If done well workplace learning is a costly exercise for both the employer and employees in their time, energy, and money, and not an inexpensive option (Dyson et al., 2009).

**Awareness of an organisational learning philosophy by nurse educators**

The existence of a learning philosophy is crucial, in that it makes clear the expectations of both the organisation and the employee’s commitment to ongoing learning (Garcarz et al., 2003). There was a disparity of results in terms of the existence of a learning philosophy between the two phases of data. The interviews found over half were unaware of an organisational philosophy of learning, and a comparable percentage from the survey were aware of the existence of a philosophy. Even so, this leaves almost half of nurse educators surveyed unaware that a learning philosophy existed.
within their organisation. These very same people have a role that is immersed in professional development. Whichever way the data is interpreted, urban district hospitals tend to communicate their learning philosophy poorly.

Lifelong learning is one of the five essential building blocks fundamental to the provision of a safe quality health care service underpinning clinical governance (Derry, 1999; Spouse, 2001). For an organisation to provide safe health care to the public, the need to maintain up-to-date professional development is essential. Evidence based health care is constantly changing, and the expectation to keep up to date is high. Even in a self-regulated profession such as nursing the need for assistance, support, resources and facilitation to maintain training needs, require significant support (Garcarz et al., 2003). The need for a philosophy that enables nurses learning is essential, as nurses struggle to maintain professional development requirements outside the workplace. This was evident in Brinkman et al. (2008) research, where 80 per cent of New Zealand nurses chose and preferred workplace based learning to maintain their competence. The key reason found was the pressure upon their work-life balance.

Work-life balance

The need for nurses work-life balance has been clearly documented throughout nursing literature (Aoki & Davies, 2002; Bahn, 2007; Brinkman et al., 2008; Dorian et al., 2008; Killien, 2004; McCloskey & Diers, 2005; Schluter et al., 2011). As mentioned previously, the nursing profession is predominately female. Nurses tend to have a number of external responsibilities, which limit their ability to access learning outside the workplace. This is due to additional responsibilities than purely their role as nurses. Women are more often engaged in a range of unpaid activities (Dorian et al., 2008), this limits nurses abilities to engage many in further education opportunities (Aoki & Davies, 2002; Bahn, 2007).
Workplace based learning meets the needs of nurses for multiple reasons; as it is relatively more easily accessible, flexible, economically viable, relevant to practice and workplace learning, and meets most of the requirements to procure their annual practicing certificate. Whether it meets their individual learning needs, facilitates critical reasoning and thinking, or engages them actively in learning needs further exploration. The provision of education does not mean learning takes place (Garcarz et al., 2003; McCormack & Slater, 2006; Williams, 2010). Being present at an education session does not imply the transfer or knowledge has occurred. For learning to occur, it is required to be flexible, accessible, in an environment with ideal conditions for learning (Chalmers, Swollow, & Miller, 2001). The learning process needs to be engaging and challenging the participant in order to encourage nurses to think actively reflect and critique their practice.

Access and participation in learning

Access to learning has been found to be problematic within the busy hospital setting. This research found that there were difficulties for organisations to be able to release staff to attend learning opportunities. The high acuity of the setting was thought by all those interviewed to be the main barrier to nurses attending and participating in workplace-based learning. Almost 90% of workplace learning from this research was found to occur at handover between morning and afternoon shifts. Whilst over 60 per cent stated learning time was not protected and rostering allowed for learning only if it was a planned well in advance. This rostered learning however, routinely occurred for organisational study days such as advanced life support, clinical refreshers, professional seminars of which the curriculum was to meet mandatory learning requirements.

Flexibility is challenging when the basic requirements such as adequate resourcing, staffing and rostering are unavailable (Paterson et al., 2010). When the timing of learning is during shift handover and carried out in the practice area or environments where distractions are common, often limits the number of nurses who are able to attend and the potential to learn. Furthermore there are additional problems as nurses
attending the sessions are often distracted to care for patients. A number of the nurses would be nearing the end of the shift and felt pressured to get home to meet their external responsibilities. Other factors reported included nurses being fatigued during the last part of their days work and nurses were frequently called away from the sessions, to meet patient needs or due to the lack of adequate staffing. These poor learning conditions are far from ideal and have consequences on the quality and transfer of knowledge for nurses.

However, alternatives to traditional workplace learning were found to occur in one organisation in particular. The organisation realised the limitations of ward-based model being the primary focus for workplace learning and therefore in addition to their usual ward-based learning they provided weekly education sessions that in a dedicated area separate from the ward setting. The sessions would run repeatedly throughout the lunchtime period enabling the nurses to access them. Food and refreshments were provided to encourage nurse attendance during their meal break time. These sessions were removed from the busyness of the work environment. As a result there were improved conditions for learning because the distractions were lessened. This example would appear to be a good model for other organisations to adopt to improve education on site.

The same organisation as above encouraged and facilitated their educators to be accessible to nurses working in the clinical environment. Educators could be paged for assistance when nurses required additional support and guidance during a scenario in the workplace. These educators also dedicated time to work alongside nurses in their practice; they found this provided opportunity for on the spot learning sessions and also helped educators to establish practice issues that may be helpful for future planning of education. In addition this innovative DHB provided payment to attend on their rostered time off. Education sessions were also rostered prior to the commencement of the night shift once a month.

According to the nurse educators sampled there is an increasing expectation that nurses will attend education sessions in their time off. Whilst the rotating lunchtime example
mentioned above provides the option for nurses to come in on their rostered days off, which has the potential to suit nurses with school age children. The advantages of a lunch time session include the fact that it is at a time whereby the pressures to be home for children after school are less prominent and it is a reliable and regular learning opportunity, attendance can be planned ahead of time, plus they have control over when they attend. This flexibility in thinking through these issues is encouraging for future workplace learning for nurses.

The strategies used to provide education to nurses are crucial for the effectiveness of their ongoing professional development in the workplace. Organisations need to be innovative and ‘think outside the square’ to ensure barriers to learning and distractions are reduced or removed to make sure learning opportunities are optimised. The consequences of well-planned learning are that organisations will receive better outcomes for the resources invested into the professional development of nurses. This will result in improved quality of workplace learning which is mutually beneficial to both the organisation and the nurse, the organisation and ultimately the health consumer (Jasper, 2010).

Identification of learning needs

Workplace based learning has been a traditional source of learning for nurses, however since the introduction of competency based frameworks to assess fitness to practice such as the Health Practitioners Competency Act in 2003, the effectiveness of workplace based learning systems have required further exploration. There has been a significant shift away from the ‘one size fits all’ approach to nurses’ workplace learning. It has been recognised that individual nurses have different learning requirements. Professional development has to be tailored to meet the needs of the individual as well as the organisation (Jasper, 2010). For these reasons the learning needs of individuals are required to be established and the learning goals outlined for both the organisation and the nurse to ensure adequate planning, preparation and provision of appropriate education occurs (Jasper, 2010).
There was no one unifying consensus of how educators identified the learning needs of nurses. A number of methods were utilised and these included, needs analysis tools, discussions with senior staff, collaborations with individual nurses to set learning goals, career planning and incident reports were utilised to inform plans. Two-thirds of those who engaged in a needs analysis tool were confounded by a lack of participation from nurses and therefore have not repeated the process. This was unfortunate because a needs analysis is a collaborative tool, which engages the views directly from staff (Dyson et al., 2009). The results of a needs analysis enable appropriate curriculum planning and development strategies.

Adult learning theories advocate for learners to identify their own learning requirements (Knowles, 1975; Senge, 1990). Understanding the learning needs of nurses is important for the success of vocational education, and it underpins the curriculum content of the learning required by nurses is thought to be crucial (Grant, 2002; Ramsden, 1992; Seaton et al., 2010). In order to promote nurses ability to identify their learning needs, their needs to be a strong element of ownership of individual professional development; according to (Garcarz et al., 2003) establishing methods to optimise meaningful personal development can be achieved by, the provision of resources to enable nurses to find their learning needs and preferred learning style. Contrary to the principles of adult learning theory this research found the opinion of three quarters of nurse educators reported that, nurses failed to confidently identify their individual learning needs. Subsequently, this outcome, the support nurses received from the organisation to establish and facilitate their learning goals was found to be inconsistent. More than 40 per cent of organisations failed to reliably facilitate nurse’s individual learning goals and another 40 per cent did not seek the learning goals of their nurses in a collaborative manner. The need to collaborate, encourage and empower nurses to gain the skills to identify their learning needs may contribute nurses improving their motivation, enthusiasm and confidence to identify their individual learning requirements.

The process of constantly ‘putting out fires’ was highlighted by one nurse educator who felt their role was constantly dealing with issues that have emerged as a result of
incident reporting. There are two possible problems isolated in this scenario; the first is more likely to be in regard to the lack of time and resources available to the educator to fulfil their role and to carry out planned education, and the second is that the professional development surrounding incidents utilises an interpretative style. This is a method whereby learners can debate and critically reason during learning opportunities aimed at managing the development of knowledge surrounding incidents (Argyris & Schon, 1978; Flood & Romm, 1996; Moore, 2007). Reactive teaching that does not promote debate, problem solving and is solely task focused is unlikely to promote double or triple loop learning that is essential to enable critical reasoning in similar situations in the future (Flood & Romm, 1996; Moore, 2007).

A blame free culture within an organisation requires its members to feel responsible and encourage the maintenance of continuing high standards (Garcarz et al., 2003). The fact that almost two thirds of educators reported their organisations demonstrated a blame-free culture was encouraging. Open disclosure is the key to blame free culture is one that encourages the reporting of near misses and incidents so that the focus can be placed on the systemic factors that lead to the errors as opposed to the individuals (Garcarz et al., 2003; Walton, 2004).

The opinion of this research is the need to prioritize the establishment of learning goals for individual nurses. The creation of a framework and process that underpins reflective practice and critical reasoning will endeavour to equip nurses with the skills required to confidently identify their own learning needs. The process of guiding and empowering nurses to establish their learning needs and set goals, to describe the relevance of the learning to their practice, balancing their learning alongside the nurses’ level of skill and knowledge, will ideally foster enthusiasm and their interest in further learning. It is important for educators to keep the issues of “putting out fires” and include these in the collaboration process with individual and area specific assessment and planning of learning strategies and frameworks.

These processes explored, have the potential to identify needs in others and improve the overall knowledge and practice within the workforce. Taking measures which enable
nurses to take control over their learning and practice, involve them in decision making and recognise their existing skills, is a key feature of sustaining and creating a learning culture within the workplace (Buchan, 1999; McCormack & Slater, 2006).

**Motivation**

Motivation and enthusiasm to learn is integral for the success of an effective culture of workplace learning (Garcarz et al., 2003; Gould, Drey, et al., 2007; Knowles, 1975; Schoobbeck & Henderson, 2011; Williams, 2010). The challenge for educators is to engage nurses, to validate the value of their contribution is valuable and that they have an overall impact on the health experiences of the public (McCloskey & Diers, 2005).

Educators in this study found that motivation was mixed amongst nurses they worked alongside. Over half of participants surveyed found nurses to be enthusiastic about learning; they actively participated in learning and just below 40% found continuing professional development was a priority for nurses. The concerning area surrounding nurses motivation for learning sits in the middle responses and below as these represent almost half of the negative responses. This indicates that potentially almost half of nurse educators find nurses are reluctant learners who fall short at prioritising continuing professional development. However, the educator themselves would appear to have prepared themselves well for their roles and prioritise learning, as almost three quarters of educators had postgraduate qualifications.

Nurse educators are role models and advocates for nurses ongoing professional development; their own motivation has the potential to affect performance in their role. This study found almost seventy-five per cent were motivated in their role and thirty per cent were either unmotivated or had no opinion on their own level of motivation.

Even though the majority of nurse educators felt motivated, this tended to have little effect upon the motivation of nurses around them, a similar finding to McCormack and
Slater (2006). It could be argued that the lack of motivation for learning of almost half of this cohort of New Zealand nurses could be influenced by factors other than leadership in the field of education.

Learning is known to be a two-way relationship, in order for organisations to deliver quality safe care, nurses need to maintain and continue to develop their skills and knowledge (Garcarz et al., 2003; Schoobeck & Henderson, 2011; Williams, 2010). Their needs to be responsibility taken by both the organisation employing nurses and nurses to engage in learning. The major step toward achieving this has to include organisations raising the profile of workplace learning for the nurses and prioritise and prize ongoing learning in the workplace. The opinion of almost two thirds of nurse educators was that the organisations whereby they work prioritised nurses learning. However, almost half felt it was a priority for nurses and thirty per cent remained undecided on whether professional development was as priority for the nurses they work with.

Organisations who profess to identify nurses learning as a priority has to be questioned, when the facts from this study found a number of issues that find fault in this belief. There are some essential issues that fail to support nurses’ workplace learning. These are; the lack of financial resourcing to support an optimal learning environment within the workplace; lack of administration support to facilitate their role; paucity of equipment; nurse educator time; protected time for learning to occur; and finally the lack of communicated philosophy of lifelong learning. If all or most of these features existed then the evidence would be present to support the claim that organisations value and prioritise nurses learning in the workplace. These barriers can be overcome by the leadership within the organisation that controls the fiscal responsibilities associated with workplace learning; to provide adequate resourcing, protected learning time, involving nurses in curriculum development and planning, engagement in analysis of nurses individual needs, and incorporate learning that involves targeting and challenging nurses skills in critical reasoning and thinking in a positive safe manner.
Change agents and leadership within workplace learning

This study found unanimous support from nurse educators that education is the key to facilitating change within healthcare organisations. Similar findings suggest that nurse educators felt that their organisation encouraged the introduction of new skills and knowledge following learning. For workplace based learning to facilitate change it requires specific skills, enabling practitioners to actively learn and facilitate change. Skilled facilitation is required so, that nurses can be guided on a learning journey, explore and challenge practice using critical reflection and reasoning to enable change and practice in an up-to-date manner within a perpetually challenging and evolving environment (Williams, 2010).

There is some literature, which clearly links leadership and the development of learning environments as integral factors that enable change (Garcarz et al., 2003; Krammer & Schmalenberg, 2004; Senge, 1990). McCormack et al. (2009) described the need to be deliberate and systematic when empowering staff to encourage the delivery of quality care which is the ultimate responsibility of all stakeholders. Over half of nurse educators who responded in this study had undertaken additional learning that pertained specifically to education and 70 per cent held postgraduate diplomas and higher qualifications. This demonstrates their own commitment to lifelong learning and certainly interests in extending their capabilities as educators of nurses. Their ongoing participation in external learning has the potential for these educators to be role models and mentors for nurses they work alongside.

Leadership is not a characteristic that is limited to those whose role is solely within the management structure of an organisation (Moss, 2003; Parry, 1998). Instead leaders could be described as individuals who possess qualities that can influence change (Schein, 2010). Nurses in the past have been expected to naturally have skills to lead without preparation (Cook & Leathard, 2004; Paterson et al., 2010). The facilitation of leadership skills in New Zealand and Australia in the past has been poor. Leaders, instead require guidance, as these are not necessarily innate skills (L. Wilson, 2000). These skills need to be fostered early in nurses careers as opposed to leadership training.
being an ‘add on’ later in the career trajectory (Paterson, et al 2010). It is through utilising leaders as role models, who are able to ‘walk to talk’ that enable a culture of learning to be fostered and thrive through demonstrating critical reasoning, reflection through lifelong learning (Garcarz et al., 2003, p. 31). Leadership development is essential to guide and nurture leadership in all nurses to be adaptable pro-active problem solvers based on perpetual learning throughout the career lifespan (Schein, 2010).

Service delivery

Theories of adult learning focus on the process as opposed to solely centred on the content of learning (Knowles, 1975). As mentioned previously workplace based learning needs to benefit all parties; the nurse, the organisation and ultimately the consumer of healthcare (McCormack et al., 2009). The traditional didactic methods of the past still play a role in the learning process today, although when it’s the only method used, it tends not to meet the needs of all learners. Didactic teaching methods can fail to activate and engage the reluctant learner in critical reasoning (Simpson & Courtney, 2002). Critical reasoning skills have been identified earlier as a skill nurses are lacking. Contemporary learning methods are multifaceted to suit the learning styles of many (Argyris & Schon, 1978). Taking into account these theories how workplace based learning is facilitated is crucial to whether nurses are challenged to take their problems, experiences and learning needs and explore them. The combination of critical dialogue, reasoning and encouraging others to question practice when linked with reflection, aides the integration of knowledge and learning into the forever changing practice environment (Benner et al., 2009; Cook & Leathard, 2004; Crotty, 2010).

This study found that approaches to assessing and measuring the use of critical thinking and reasoning from the participating organisations required further exploration. Almost half of those interviewed held the view, that nurses who were based on graduates or had participated in post-graduate education, as these individuals were nurses who tended to
demonstrate critical thinking and reasoning. The survey found that almost half of the organisations utilised the professional development review process and a small quantity used focus charting to demonstrate nurses’ ability to critically reason and reflect. Focus charting is a patient centred documentation style that concentrates on a problem, identifies actions taken and documents the response to that action (Allan & Englebright, 2000).

However, almost a quarter of organisations failed to carry out regular annual reviews and none of the respondents described a system that outlined any mechanisms in place to review the process of how reviewing how critical reasoning is measured. Utilising a PDRP process only demonstrates critical thinking and analysis in a place in time, and does not demonstrate ongoing ability and adaptability in the workplace. Unfortunately, this research failed to explore more fully how reflective practice or critical reasoning was encouraged or measured within the urban district hospitals. This is an aspect of workplace learning that would benefit from future research. This finding highlights the need to explore the rationale for this view and what frameworks and strategies both organisations and nurses have in place to establish a workforce who enabled to utilises these essential skills.

Nurses have traditionally experienced task focused learning; the interviews and almost a tenth of comments made on the survey indicated that nurses continue to rely on the provision of task focused didactic learning, described as ‘spoon fed’ learning by participants. Although Seaton et al. (2010) found that how nurses learn is the key to successful learning, it is important that the learning process is meaningful and nurses are engaged and challenged in order to apply learning to their practice.

If old myths are to be extinguished and new learning is to be achieved nurses require a safe supportive environment that respects them as individuals and professionals to challenge themselves and move out of their comfort zones (M. Jasper, 2010; Seaton et al., 2010). The responsibility of providing this nurturing environment falls to the organisation, the educators and the professional accountability of the individual nurse. The need to invest in nurses and value their contribution to the patient outcomes is the
beginning of establishing a framework of collective responsibility for perpetual lifelong learning (McCormack et al., 2009). Once an environment is safe to share ideas, nurses feel empowered with raised self-esteem and the barriers that have been identified within this research may reduce. Establishing a safe environment for nurses to share their knowledge and aid the development of reciprocal learning relationships as suggested by Seaton et al. (2010) is vital.

The provision of learning was reported by 60% of educators to be over and above the mandatory required learning and over half stated their main focus was indeed mandatory learning. Gaining a clear differentiation between mandatory and specific learning that focuses on the requirements of individuals, or requests by areas of practice would be helpful in the future. This knowledge would be useful to ascertain the quantity of learning, and meets the learning needs nurses have highlighted.

Mandatory learning is necessary to enable organisations to maintain basic standards of care (Furze & Pearcey, 1999). The consequence of organisations centring their goals primarily on providing mandatory learning restricts the development and progression of an innovative nursing workforce. The fact that 80 per cent of the New Zealand nursing workforce have reported a preference for their ongoing professional development to occur within the workplace cannot be ignored (Brinkman et al., 2008). Organisations need to look at the learning services they provide and ensure their education strategies support, facilitate and meet the requirements of the organisation, the patients and the needs of nurses.

An organisation that is explicit and raises the profile of learning by clearly outlining its expectations and provides the resources, guidance and support for nurses to engage in lifelong learning within their workplace potentially will produce a nursing workforce who will provide quality care to the public. An organisation which has no clear philosophy or culture of learning and who fails to communicate their philosophy to their employees is both failing their staff and the public. The public have an expectation and a right to receive quality up to date health care.
E-learning in urban district hospitals

A dichotomy existed between the two phases of data collected that relates to the access to electronic information systems. Almost three quarters of those surveyed confirmed electronic resources were available to nursing staff. Yet, phase two (interviews) stated that barriers existed when nurses wanted to access information systems. These barriers included the lack of available time to access online learning opportunities at work, and the need of equipment for all nurses to utilise in the practice setting and not all DHBs had online learning available to all nurses. Furthermore the educators reported that there were organisations that had not or were yet to implement on-line learning for nurses. This is certainly an area that has enormous potential to contribute to nurses learning whilst in the workplace.

Due to the fact that a significant proportion of nurses’ in urban district hospitals work rotating shifts, not all shifts or days are as busy as others therefore, time may be available to access journals, research sites, MOODLE sites, or DHB learning sites to name a few. Nurses require the right to access and have available consoles in their practice environment to use for ongoing professional development when time is available in practice.

Information and technology exists in everyday life. The need for access to this technology has moved from being thought of as a luxury to what could now be described as a basic necessity. It is therefore expected that the availability of technology at home would transpire to the workplace.
The culture of learning within urban district hospitals

The discussion of the context and culture of workplace learning within this group of urban district hospitals is more than merely what is provided in terms of visually tangible strategies and resources. As McCormack et al. (2002) suggests above and is clearly outlined by Schein (2010) that to attempt to understand the context and culture of an organisation, consideration of artefacts, espoused beliefs, values and lastly the basic underlying assumptions people take for granted within and organisation, requires exploring.

“Context does not simply imply geographical, spatial or institutional location, but also includes established rules, norms, values and inter-relationships that enhance or inhibit the success of the role” (McCormack et al., 2002, p. 143)

The findings demonstrate there is a clear intention of urban district hospitals to develop productive cultures of workplace learning. Nurse educators reported the belief that nurses’ learning was a priority for both the nurses and the employer, both of these responses ranged between 47% on behalf of nurses and 60% in terms of the employer. Unfortunately, overshadowing both these findings were the 29% to 42% of educators who reported neutral responses to all three enquiries. The significant neutral cohort indicates that further development of positive learning cultures within the workplace is required.

When exploring the responses from the interview there are multiple factors to consider which may have influenced the way the nurse educators responded. The items reported were associated with the educators’ impressions of the culture of learning within the DHB where they were employed. These were disseminated amongst the relative themes. There are three main factors that influence the strength of a culture, namely the length of time, stability of the membership and the emotional intensity of the actual historical experiences they have shared (Schein, 2010). It was not possible with the
data collected to address all these elements. A study that involved an observational component would have provided a more holistic insight, however, the scope of this project did not allow for this opportunity. Yet, it is important to keep these factors in mind when considering the participants view of their learning culture.

There have been significant influences upon the nurses in New Zealand over the past thirty years, in particular the health reforms and the disintegration of the multi-employment contracts during the Crown Health Enterprises era, the loss of nurses in key management roles and the budgets nursing previously had prior to the re-engineering of the health system (McCloskey & Diers, 2005). It is impossible to view the culture of today without considering the political past and how these events have influenced the nursing profession that exists today. Thirty years following the health reforms in New Zealand, nursing has never fully regained their positions within management or budget control within the health care sector (A Bamford, 2004; McCloskey & Diers, 2005). This also demonstrates nursing has never regained the leadership required to steer and develop their profession in the workplace setting.

The importance of the existence of an embedded culture of learning within the workplace is evident from the research carried out by (Brinkman et al., 2008). As mentioned earlier, New Zealand nurses have clearly indicated their preference for their ongoing professional development to occur within the workplace. This reliance places significant responsibility upon the employer to provide the necessary learning to maintain and improve nurses’ practice. Consequently, workplace learning for nurses can no longer be ad-hoc. This research found some educators planned their education 12-36 months in advance. This study has failed to demonstrate a well supported and resourced workplace based learning structure within urban district hospitals in New Zealand.

Placing the responsibility of maintaining competence back to the employee in the era of self-regulation by professional bodies, may relinquish some responsibility from employers. However, employers cannot continue to ignore that nursing is predominantly female and makes up the largest health workforce in New Zealand, many
of whom experience enormous external pressures on their work-life balance. Organisations who are committed to providing the public with a reliable quality health service employ quality frameworks and strategies to implement quality workplace learning systems (Cook & Leathard, 2004). These failings are not unique to urban district hospitals in New Zealand. They have been previously documented in literature researching the introduction of workplace learning globally (Garcarz et al., 2003; Silverman, 2003).

By far the biggest issues pertaining to the development of a culture of workplace learning found in this study, has to lie in placing greater value in nurses learning in the workplace. This needs to be demonstrated by equipping the service with resources to support and facilitate the concept of perpetual lifelong learning. The key issue identified in this research is the immediate need to provide and communicate the organisations expectations that nurses are required to engage and participate effectively in lifelong learning. The need for organisations to instigate and disseminate their philosophy of learning is crucial to changing the patterns of the past, whereby both the nurses and organisations practice as fragmented forms of learning such as ‘reactive survival’ learning as opposed to ‘creation learning’ which develops new innovative ways of practicing and problem solving (Garcarz et al., 2003; Senge, 1990).

Workplace based learning as a method of education requires financial resources to enable effective learning to occur, establish environments that are conducive to learning, implementing an essential framework that support nurses to develop their skills in terms of identifying their own learning requirements, facilitating critical reasoning and analysis for all nurses, and prioritising learning which installs an infra-structure that facilitates and supports critical reasoning and analysis in the workplace. Lastly, prizing and valuing learning that set goals for individuals and helps those goals be achieved. This involves undertaking strategies that collaborate with and alongside nurses in order to achieve a successful culture of learning. Workplace learning can no longer be seen as a cheap form of provision of learning and ticking the box so to speak.
Barriers to introducing or achieving an environment of learning identified in the literature clearly correlate to the findings within this research. These included the freedom for employees to share their ideas, an environment that supports and encourages inquiry and for an environment to exist whereby learning opportunities are recognised and taken advantage of. Nevertheless, these characteristics are only able to exist in workplaces whereby employees feel their requests or inquiries are met positively (Schruck, 1996; Silverman, 2003).

One respondent identified that within their organisation there was the perception that the organisation had a strong learning culture, which was not actually the case.

When discussing these particular findings, it is important to keep in mind that these impressions are from one person from within each organisation. Although these have value, this type of research has the potential to conjure artefact rich data from within organisations. These artefacts are a variety of aspects from within an organisation, and can be visible, but also underlying examples are the assumptions, myths and beliefs about a workplace (Schein, 2010). Schein (2010) warned that interpreting people’s assumptions is a very unreliable means of researching the climate because this information is a subjective outcome of the participant’s own feelings and reactions to that workplace. These have been events that have impacted on the nursing professions history of disempowerment within the healthcare industry, in terms of being viewed as hand maidens or more recently the health reforms of the nineties and the introduction of the HPCA Act (2003) these have had an impact upon the progression of the profession. These findings are in fact important to reflect upon as an initial snapshot or first impression of the culture of learning within the organisations explored. However, remembering to bear in mind the impartiality of the opinion within the findings can be influenced by numerous factors whether subjective or objective.
Strategies to support and encourage Māori nurses in workplace based learning.

The population of nurses and midwives who identify as Māori and hold a current practicing certificate in Aotearoa New Zealand is 7.1% or 2869 (Broodkoorn, 2010). This study found 4.4% of nurse educators who responded identified as Māori. The Māori nursing workforce is predominantly female with figures standing at 92.8% and the average age is 45 years, which is consistent with that of the non-Māori workforce (Ministry of Health, 2006; Nursing Council of New Zealand, 2012a). Yet, in the general population of New Zealand the Māori cohort is 12% and are over represented in the countries poorest health statistics (Broodkoorn, 2010). Therefore given that Māori suffer significant health problems, they require care that is enabled to prioritise the maintenance of Māori identity, values and culture (R. J. Walker, 1990) through actively facilitating nurses knowledge of Māori traditions (Matauranga Māori) and essential issues surrounding providing optimal care for Māori patient and thier families (whanau).

In order to improve the care Māori receive in the health system there is a compelling need to increase the population of Māori nurses who are skilled in providing culturally appropriate care to Māori (Health Workforce New Zealand, 2012). Following the ground breaking work by I. Ramsden (1992), New Zealand nurses have been in the forefront of acknowledging the need for a culturally sensitive workforce (Jungersen, 2002; Tolich, 2002). Despite the attempts by the nursing profession, Māori remain marginalised within the health care environment and continue to suffer disparities in their care which result in early discharges (D. Wilson & Barton, 2012). The fact that nursing care is linked with the quality of care patients receive in hospitals (McCloskey & Diers, 2005). The nursing profession has the ability to change this; recommendations suggested by D. Wilson and Barton (2012, p. 2324) identified the need to “provide quality nursing care that establish relationships with patients and families and incorporate cultural beliefs and practices into care plans”. Finally, increasing the number of Māori in the nursing workforce there is the potential to impact on the care and health outcomes of Māori. The presence of more Māori nurses can help to improve
the health service to Māori by taking steps to providing more holistic care and creating an environment whereby the tangata whenua (people of the land) are more at ease.

Māori represent 12 per cent of New Zealand’s total population; historically public policies that failed to protect and give social equity to the tangata whenua (people of the land). Historical political strategies have resulted in the Māori population having poor health outcomes and have struggled to succeed in education, to name two critical issues for Māori (Rameka & Law, 1998; Walker, 1990). Less than a generation ago those in power intentionally assimilated Māori figures into the majority dominant group. Therefore little statistical data was available for analysis and little understanding of the disparities were apparent (Rameka & Law, 1998; Statistics New Zealand, 1994). In response to this subjugation there has been a cultural renaissance that has challenged and striven to improve the future for Māori (Walker, 1990). To recover the disparities and lessen the gap between and non-Māori health outcomes, there needs to be innovative methods of attracting and retaining Māori to the nursing profession.

There have been long standing issues surrounding the support and encouragement of Māori within the education system from early childhood through to tertiary levels. The fact that the education system of the past has failed Māori has been attributed to embedded economic, social barriers and ideological biases (E. T. Durie, Latimer, & Temm, 1996; Greenwood & Brown, 2007). Examples of where the gaps remain are; that there are fewer Māori enrolled in preschools, Māori students leaving school without school qualifications in the year 2006 was 39.9%, those with a school qualification 32.2% and those with a post qualification 27.9% of this group 5.5% held bachelors degrees, 0.7 had post-graduate and honours degrees, 0.8% held Masters degrees and 0.1% had doctorate degrees as their highest qualification (Statistics New Zealand, 2006). These figures only included the resident population aged 15 years and over. These statistics demonstrate that a large proportion of Māori leave school without a formal compulsory school qualification and few Māori hold tertiary qualifications. The department of Statistics New Zealand (2006) highlighted that from the 2006 census it was more likely for Māori women to have a formal qualification that Māori men. Therefore the reasons behind these biases are complex and stem from disparities within the education system since colonisation of Aotearoa New Zealand (Durie et al., 1996).
The Ministry of Health and the Māori Innovation Sector Capability and Innovation Directorate, supported Te Rau Matatini to research and produce the 2009 report on Māori nurses and midwives. Two key elements were identified that would help retain Māori nurses in the profession. The first was ongoing professional development and secondly the need for organisations and staff to appreciate and recognise the value of Māori nurses cultural and clinical knowledge and the impact that they could potentially have on patient care.

As with non-Māori nurses, Māori nurses have a reliance on the organisation for the facilitation of ongoing professional development. For nurses following the customary orientation period that is designed to assist in the transition of nurses into their employment, it has been identified by Te Rau Matatini (2009) that it is vital that ongoing professional development continues throughout the nurses career.

For Māori nurses the issues are similar to that of non-Māori, with the exception that Māori nurses have a dual role in terms of their specialised cultural responsibilities’ (Ratima et al., 2008; Te Rau Matatini, 2009). As females are more commonly involved in non-paid care-giving roles, the demands upon their lives are significant and find it more difficult to juggle issues surrounding work life balance. This is highlighted by nurses who experience difficulty accessing learning outside the workplace due to demands on their work life balance. The most extensive role for many women and Māori is the responsibility of whānau. Whānau is an essential element of Māori society it includes the hapu (sub tribe), iwi (tribe) and waka which is the extended family group that travelled to Aotearoa upon each ancestral canoe in the fourteenth century (Rameka & Law, 1998; Walker, 1990). For many fulfilling these responsibilities are in addition to other external demands in their day-to-day lives.

The key finding within this research was there was a paucity of insight into the specific needs Māori nurses may have, in terms of strategies to support and facilitate their workplace learning by the organisation. Of those interviewed 57% (n=4) were unaware of any strategies within their organisation to support and encourage Māori nurses with
workplace learning, whereas 29% (n=2) were in the beginnings of the process to establishing mentorship programmes for Māori nurses and one DHB offered Māori nurses a separate PDRP programme. It was clear in this research that there was a lack of awareness of any specific learning strategies in UDH that were used to support and encourage Māori nurses’ professional development within the workplace. There was interest expressed to explore possible opportunities in the future. Māori nurses’ workplace needs were clearly facilitated as the same as non-Māori.

Although tertiary education is not an aspect of this study, one nurse educator interviewed recognised the need to mentor and support Māori nurses engaged in postgraduate education. This was due to observed increased attrition rates outlined previously. This particular educator was taking steps to facilitate a mentoring programme for Māori nurses undertaking postgraduate education. This has definite potential for further investigation due to the 2006 Census highlighting the paucity of Māori with post graduate qualifications (Statistics New Zealand, 2006). This may well be a contributing factor for the reason why Māori are underrepresented in the nurse educator role.

The report carried out by Te Rau Matatini (2009) found responses from Māori nurses and midwives nationally had similar themes that to which had emerged from the data within this research. These themes included a need for access to learning to be more flexible, and for ease of access to becomes embedded into the culture of the work environment. Nurses require a period of protected learning time, effective financial resources to aid the facilitation of learning, effective management and leadership to support nurses learning and incentives for learning. There were other issues identified that were associated with further postgraduate study, which was not an aspect of this research.

A significant finding from Te Rau Matatini (2009) report was the need for Māori nurses to be valued and recognised for Matauranga Māori (traditional knowledge). Their colleagues and employers to demonstrate insight, appreciation and respect for the dual roles Māori nurses have within the workplace, without the presumption that this
knowledge exists merely because they are Māori (Rameka & Law, 1998; Ratima et al., 2008). In order for Māori nurses to maintain and improve their cultural liaison within the workplace, they require skilled facilitation and ease of access to workplace based cultural support, supervision and cultural development. Time and resources are required to perpetuate the improvement of their roles in terms of specific cultural learning for Māori nurses, in addition to their continuing competence education. This time is needed to be protected learning time and be facilitated by leaders who hold the appropriate skills to support and nurture this crucial aspect to New Zealand’s healthcare environment.

In addition to these findings, it cannot be taken for granted that because nurses are Māori that they are automatically proficient and are in touch with all things Māori. Therefore, these nurses need specific support to nurture their cultural learning. This learning needs to be sensitive to the wishes of individual nurses (Matthews, 2012).

The findings and discussion that specifically pertain to Māori were discussed with Matua Hector Matthews whose role is executive director of Māori and Pacific health for a District Health Board, who concurred with the findings and discussion. Matthews (2012) also contributed to the discussion by arguing that in order to recruit Māori to nursing, further support is required at secondary schooling level. Support in secondary schooling is essential in order to encourage and enable Māori to gain secondary school qualifications so they then may access tertiary study. Matthews (2012) pointed out that Māori tend not to choose science based subjects and success in these subjects may lead to more Māori entering health professional fields.
Overseas trained nurses

The demographics of the New Zealand nursing workforce are rapidly changing, along with the increased global demand for nursing skills (Head, 2010; L. Walker, 2008). Twenty-five per cent of registered nurses practicing in New Zealand gained their initial qualification overseas and 40 per cent of these were from the UK (Nursing Council of New Zealand, 2012b). The following two largest cohorts of overseas trained nurses in New Zealand were, Indian 11.2 per cent, and South East Asian 16.7 per cent. New Zealand’s neighbours represent much smaller figures, Australia is 6.7 per cent, and similarly South African nurses make up 6.4 per cent.

The overall view regarding the role organisations have to facilitate and encourage workplace learning for overseas trained nurses was passive. The educator’s perspective was that they either gained registration in New Zealand therefore specialised support was not necessary, or the process of gaining registration through the return to work process was expected to bring the nurse who was ready to practice with the educational responsibilities fulfilled.

The fulfilment of the requisite to be a registered nurse is merely the tip of the iceberg in terms of the requirements for the progression from novice to expert nurse. Even taking into account an overseas trained nurse’s previous experience, the effect needs to be acknowledged of changing countries, language, values, ethical considerations, demographic change and a radical transformation in professional expectations and training competencies of the nursing roles between countries must have an impact on practice and competency. The process of gaining registration to practice as a registered nurse is merely the first hurdle for many to overcome.

Approximately 50 per cent of skilled migrants on average return to their home country within five years (Lowell & Findlay, 2002). L. Walker (2012) questioned the adequacy of the succession planning for nurses’ leadership and education and whether the same
quantities of nurses trained in the UK return home at the same rates as other overseas trained nurses.

From a survey of NZNO members Walker (2012) found from a survey of NZNO members, that many overseas trained nurses from India and South East Asia had not decided whether they intended to remain in New Zealand long term. The survey also identified that these nurses had experienced discrimination from colleagues and management. NZNO made a number of recommendations, however those that pertain to the culture of workplace learning involve education sessions for both New Zealand trained nurses and overseas trained nurses to facilitate an understanding of the rapidly changing workforce, and how to help support and transition the workforce, to encourage a more welcoming environment and opportunities for overseas nurses to enable them to understand the workforce more and work within the health service more effectively.

The same issues that are essential to build an optimal culture of workplace learning which is pertinent for New Zealand nurses are also essential for overseas trained nurses. These are:

- Respect for their skills, experience and role.
- Respect the cultural differences and embrace the changing workforce dynamic.
- Valued as essential to the provision of health care.
- Involved in the assessment of learning needs and planning of workplace-based learning.
- Being encouraged and supported to share their ideas.
- Being given the guidance and support to encourage and instigate critical reasoning and analysis.

Nurses work closely together sharing experiences and ideas, often learning from each other. The need to foster the same supportive, valued and respected values apply to overseas trained nurses that apply to New Zealand’s own. In order for workplace learning to be effective and critical dialogue and reasoning to be embedded into the
culture, nurses need to feel free to share their experiences in a supported environment free from discrimination and fear.

Walker (2012) believed New Zealand trained nurses have been unprepared for the rapid change and strains the reliance upon overseas trained nurses has had on the workforce dynamic. In order to foster the ongoing development of New Zealand changing workforce both parties require support and education to support and assist overseas trained nurses to feel accepted and valued.

Organisations can no longer rely on tertiary education programmes to fulfil all overseas trained nurses needs, just as they do not fulfil all the needs of any nurse entering practice in a new environment. New Zealand’s reliance on overseas trained nurses is not going to diminish and workplace education planning needs formulate strategies to support the 25% of nurses who are overseas trained.
Limitations of this study

The interview phase of the research involved seven interviews; the initial intention was to interview eight. One interviewee was not able to be located for an interview, resulting in the seven interviews undertaken. Whilst Patton (2002) supports the use of smaller numbers in qualitative studies, it was questionable whether seven interviews were sufficient. The data produced from these seven interviews were thought to be sufficiently in-depth and had yielded rich data. Together with the demographic data alongside the qualitative data from the questionnaire it was felt that sufficient data had been collected to fulfil the research criteria. The researcher was of the opinion any more information sought would not add anything new to the outcome; also the researcher was limited by the time frame for this study.

Future research exploring further how the workplace facilitates the use of critical analysis and reasoning in the workplace would be insightful. This information would be helpful to understand the impact workplace learning has on these essential skills, and how they can be developed further. These areas need to be measured in some way in order to understand how efficient nurses are at these skills and how organisations and educators can assist the development of these skills.

An observational phase would be useful in further research to witness and analyse the climate and culture of an environment more holistically. Interviews and questionnaires are useful and data rich tools, but they can be subject to misinterpretation. The ability undertake an observational study and triangulate results from questions, interviews and observations in future research with an observation method would be enormously useful and has been found as a more effective means of exploring cultures (Schein, 2010).

The implications for organisations committed to providing environments that fosters and prioritises learning cultures and nurses learning, demonstrates a commitment to quality workplace based learning programmes. This does one of two things; firstly it acknowledges that it prizes nurses learning and acknowledges nurses struggle to
achieve work-life balance. The second issue is putting into place the resources to
enhance ongoing professional development in the workplace, by making access to
learning easier for nurses, ensuring optimal environments, and timing that enables
quality learning. This fosters the sharing of ideas and provides nurses with the
professional respect they require in order to become innovative thinkers. The provision
of resources, tools and the skills to enhance learning for the largest group of health care
professionals in New Zealand can only enhance the quality of care provided to the
public.

A comparative study of the context and culture of workplace learning in both tertiary
and secondary health sectors would be of use, in order to gain a view of the learning
environments for nurses across the health care spectrum in New Zealand. It would be
enormously helpful to include an observational aspect to this research and use focus
groups as opposed to telephone interviews. This then has the potential to paint a more
accurate picture of the learning environments being explored.

The implications for future research involve exploring further the promotion, the use,
and evaluation of critical reasoning and analysis in the workplace. This was not
explored in any depth in this study and has been identified as an issue. Critical analysis
and reasoning is widely documented throughout the nursing literature as an essential
tool for nurses to utilise in order to make the most of their own experiences and
knowledge gained to evaluate and extend their skills and improve their practice. Yet,
this study identified that this is poorly promoted, assessed and evaluated in an ongoing
fusion.
Conclusion

This study, looked at a small group of organisations in New Zealand’s secondary health services; and provides information about this group of organisations and their approaches to nurses’ workplace learning. This study explored the context and culture of workplace based learning from the perspective of nurse educators in urban district hospitals in New Zealand. It is clear that the context and culture of workplace learning has many elements. The success of embedding a culture that prizes workplace learning in the secondary service relies heavily on the commitment of all stakeholders.

These findings are the perceptions of 70 nurse educators from thirteen urban district hospitals. Seven participated further in the interview process. Because of the willingness of these nurses to participate in the research, there is now a number of key ideas known about the context and culture of workplace based learning in urban district hospitals throughout New Zealand.

The research is not without its limitations, but there is now helpful information known about this method of learning for nurses in New Zealand. This research found an overwhelming majority of nurse educators had prepared themselves well for their role. Seventy per cent of these nurses have extended their professional development formally and held postgraduate diplomas and master’s qualifications, and over half had engaged in learning specific to education to assist them in their roles as educators. Where theses educators were not supported to fulfil their role was within the infrastructure of the organisation. They were found to have minimal financial resources to adequately fulfil the requirements demanded by the nursing workforce. This was evident in regard to the lack of time to do their job, the lack of sufficient administration support, basic equipment, protected learning time and dedicated areas to teach or available budgets to manage a learning programme.

There were a number issues that were the primary outcomes of this research in terms of the context and culture of workplace learning these were, the need to value nurses
learning and its impact on quality care, the need to have and disseminate a clear philosophy of learning, the need to prioritise funding to service a lifelong learning framework within the workplace, to foster an environment that nurtures leadership and the sharing of ideas and experiences, the need to develop structures that facilitate the skills and protect time for all nurses to critique their practice, to apply critical reasoning to practice and the time to reflect on their practice. Finally, it is crucial for workplaces to consider and collaborate with all nurses to encourage, counsel in terms of identifying and plan to fulfil those learning needs and goals.

In the health care workforce there is an acute need to recruit and retain both Māori and nurse from overseas. Māori Nurses, are essential because the growing Māori population, do poorly in regard to a number of socioeconomic issues and in particularly health. Māori need more Māori nurses to assist in preventing Māori discharging early and provide the indigenous people of New Zealand with carers that patients can identify with, relate to and improve Māori health and well being. To retain and recruit Māori nurses in our workforce, strategies need to be in place to enable and encourage their workplace learning both in regard to cultural considerations and ongoing professional learning.

It is clear that New Zealand will experience an ongoing reliance on overseas trained nurses to enable our health care services are well staffed. This group of nurses need ongoing support and education within the workplace to enable them to feel welcomed, supported and comfortable to share their ideas and develop a greater understanding of the culture of learning within the workplace.

These findings reflect workplace learning for nurses is not given adequate priority or value within many of the organisations surveyed. The lack of financial resources suggests nurses may not have a voice when planning where and how these resources are distributed amongst the health workforce in these organisations. Further exploration into the distribution of nursing funds for educational purposes would enlighten this research further.
The basics that underpin workplace learning and learning organisations are organisations having and making clear to staff their philosophy of lifelong learning along with their expectations of their staff. The fact that availability of this knowledge was sparse at best indicates the low priority that the provision of nurses’ learning and professional development is given within these organisations.

The processes within the organisation that either assists nurses in developing their critical analysis and reasoning skills, or measures their ability to do so were limited and appeared to be lacking frameworks to support and perpetuate this crucial skill; a skill that facilitates nurses transition from novice to expert. This is more than likely due to the timing of education and the availability of resources.

Workplace learning is necessary to develop an innovative nursing workforce (Garcarz et al., 2003). Nurses are a unique profession in which they place reliance on and preference for their professional development to occur within the workplace. This fact is unlikely to change in the future, because women make up 92 per cent of the cohort. Organisations cannot ignore this fact, and they cannot continue to treat workplace learning as a ‘cheap option’. Time, resources and leadership skills for all, need to be integrated into the workplace learning structure. Learning in the workplace has the ability to be a powerful and innovative resource that may have a real benefit to patient outcomes. For these organisations to truly become learning organisation, changes need to occur to support nurse educators and nurses to engage actively in workplace learning.

There is significant work to be done to develop better cultures of learning in the workplace for New Zealand nurses. Small steps have been taken since the introduction of the HPCA Act (2003). However, purely meeting the needs of mandatory requirements is not enough. Nurses require their individual needs to be met in order to provide an improved service. Hopefully, this research is a start to realising the journey that organisations need to take to improve their service by taking responsibility as leaders, to begin the process of enabling well-developed cultures of learning in New Zealand’s health care services.
Epilogue: a personal reflection

I began this research in order to see how learning in the workplace had progressed since I graduated as a registered nurse in 1992. My experience of being a nurse, who became registered during the health reforms, was that of little expectation of what constituted workplace learning. After seven years I had the impression that I was competent and maintained competency. I then changed practice settings and moved to an area, which had an innovative and challenging practice. This new area had a culture that expected nurses to critically analyse their practice. This was new and I found it confronting, yet on reflection it was in this situation that I took my largest learning strides in the clinical arena. In hindsight, because of the learning culture, I learnt more in those two years than I had in the previous seven. This triggered my interest in the culture of workplace learning for nurses in New Zealand, and because I worked in an urban district hospital I wanted to explore nurse education in these hospitals.

When I commenced this research I felt strongly that workplace-based learning needed exploring, that the profession and those who employ nurses needed to acknowledge the importance of workplace learning and there was a need for it to be strategically approached. I felt there was a gap in the New Zealand research pertaining to how organisations value and invest resources, to enable nurses to learn at work. Having sparse knowledge of learning processes, organisational theory and learning organisations, this journey has been enormously challenging. The attitudes and responses to both the questionnaires and the interviews have resonated with me.

It is my impression that this research has a somewhat negative sense. However, workplace learning and understanding learning cultures in health workforces in New Zealand is in its infancy. It is only in recent times these learning opportunities are being explored. In the past the nursing profession has made enormous leaps; it is a highly adaptable workforce, which has the potential to thrive within environments where innovation and enquiry is fostered. This research is my first attempt at exploring this territory; my hope is that the culture of workplace learning for nurses is valued,
challenging, fosters enquiry and is integrated into ideal learning conditions and everyday practice.
References


doi:0.1108/00400910710749332


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doi:10.1016/0260-6917(87)90061-x


doi:10.1002/pdh.284


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APPENDIX A
31 January 2012

Gillian Halksworth-Smith
Centre for Postgraduate School of Nursing
Otago University
72 Oxford Street
Christchurch 8014

Dear Ms Halksworth-Smith

Re: Ethics ref: CEN/11/12/067 (please quote in all correspondence)
Study title: A Study Exploring the Context and Culture of Workplace Based Education from the Perspective of Nurse Educators in Urban District Hospitals in New Zealand.
Investigators: Gillian Halksworth-Smith, Jodi Miller

This study was given ethical approval by the Central Regional Ethics Committee on 31 January 2012. A list of members of the Committee is attached.

Approved Documents

- National Application Form with requested amendments made
- Part 4 Declaration for Gill Halksworth-Smith
- Evidence of Maori Consultation – letter from the University of Otago
- Participant Information Sheet (no date or version number)
- Telephone Interview Questions (no date or version number)
- Letter to Nurse Educators (no date or version number)
- Letter for Consent to Participate (no date or version number)
- Questionnaire - A study exploring the context and culture of workplace learning from the perspective of Nurse Educators in urban district hospitals in NZ

This approval is valid until 31 January 2017 provided that Annual Progress Reports are submitted (see below).

Amendments and Protocol Deviations

All significant amendments to this proposal must receive prior approval from the Committee. Significant amendments include (but are not limited to) changes to:
- the researcher responsible for the conduct of the study at a study site
- the addition of an extra study site
- the design or duration of the study
- the method of recruitment
- information sheets and informed consent procedures.
Significant deviations from the approved protocol must be reported to the Committee as soon as possible.

**Annual Progress Reports and Final Reports**
The first Annual Progress Report for this study is due to the Committee by **31 January 2013**. The Annual Report Form that should be used is available at [www.ethicscommittees.health.govt.nz](http://www.ethicscommittees.health.govt.nz). Please note that if you do not provide a progress report by this date, ethical approval may be withdrawn.

A Final Report is also required at the conclusion of the study. The Final Report Form is also available at [www.ethicscommittees.health.govt.nz](http://www.ethicscommittees.health.govt.nz).

**Statement of compliance**
The committee is constituted in accordance with its Terms of Reference. It complies with the *Operational Standard for Ethics Committees* and the principles of international good clinical practice.

The committee is approved by the Health Research Council’s Ethics Committee for the purposes of section 25(1)(c) of the *Health Research Council Act 1990*.

We wish you all the best with your study.

Yours sincerely

[Signature]

Kirsten Forrest  
Administrator  
Central Regional Ethics Committee  
Email: central_ethicscommittee@moh.govt.nz
APPENDIX B

Centre for Postgraduate School of Nursing Studies.
72 Oxford Tce
Otago University
CHRISTCHURCH 8014.

Attention: Director of Nursing

To whom it May Concern,

CONSENT TO PARTICIPATE.
I am an Otago University Masters of Nursing student engaged in research aimed at exploring the context and culture of workplace based learning from the perspective of Nurse Educators in Urban district hospitals throughout New Zealand. I am seeking initial consent to your organisation to be involved in this research.

The introduction of the Health Practitioners competency Act (2003), has had implications upon nurses and organisations integrating lifelong learning strategies. This study is keen to explore how organisations plan, manage and facilitate learning within the workplace, specifically in terms of the context and the culture of learning. Urban district hospitals have been chosen because they are geographically isolated from major centres throughout New Zealand.

Brinkman, Salt and Walker (2008) found a significant eighty per cent of nurses within New Zealand relied upon and chose to participate in workplace learning to meet nursing council requirements. The Nursing profession remains a predominately female profession; many nurses wear multiple hats in any one-day and have a variety of work and lifestyle responsibilities. These responsibilities can make other forms of learning difficult to access. Therefore this research is enthusiastic to explore the context and culture of learning within these organisations.

This research is a mixed methods design and involves a questionnaire to be disseminated to Nurse educators involved in teaching nurses within the workplace. Following the completion of the questionnaire, Nurse Educators who are keen to participate further, are asked to consent to and take part in a telephone interview lasting approximately fifteen minutes. These interviews will be scheduled at a time that is convenient to the participant. All information pertaining to the identity of the participant and the organisation will remain confidential.
There are Thirteen District Health Boards that meet the requirements of the study and a total of 107 Nurse Educators. Your participation will be extremely valuable and enormously significant to the outcome of this research. Ethical approval is pending and it is hoped to start collecting data in February 2012.

Please do not hesitate to contact me if you have any queries, miljo124@student.otago.ac.nz or 03 9606 133 mobile 0277 258 237.

Yours sincerely,

Jodi Miller.
APPENDIX C

Centre for Postgraduate School
of Nursing Studies
72 Oxford Tce
Otago University
CHRISTCHURCH 8014

Attention: Director of Nursing

Dear (Participant Name),

CONSENT TO PARTICIPATE: A Study aimed at exploring the context and culture of workplace based education from a nurse educator perspective in urban district hospitals in New Zealand.

I am an Otago University Masters of Nursing student engaged in research aimed at exploring the context and culture of workplace based learning from the perspective of Nurse Educators in Urban district hospitals throughout New Zealand. I am seeking initial consent to your organisation to be involved in this research.

The introduction of the Health Practitioners competency Act (2003) has had implications upon nurses and organisations integrating lifelong learning strategies. This study is keen to explore how organisations plan, manage and facilitate learning within the workplace, specifically in terms of the context and the culture of learning. Urban district hospitals have been chosen because they are geographically isolated from major centres throughout New Zealand.

Brinkman, Salt and Walker (2008) found a significant eighty per cent of nurses within New Zealand relied upon and chose to participate in workplace learning to meet nursing council requirements. The Nursing profession remains a predominately female profession; many nurses wear multiple hats in any one-day and have various work and lifestyle responsibilities. These responsibilities can make other forms of learning difficult to access. Therefore I am keen to undertake some research to explore the context and culture of learning within these organisations.

This research is a mixed methods design and involves a questionnaire to be disseminated to Nurse educators involved in teaching nurses within the workplace. Following the completion of the questionnaire, Nurse Educators who are keen to participate further, are asked to consent to and take part in a telephone interview lasting approximately fifteen minutes. These interviews will be scheduled at a time that is convenient to the participant. All information pertaining to the identity of the participant and the organisation will remain confidential.

There are Thirteen District Health Boards that meet the requirements of the study and a total of 107 Nurse Educators. Your organisations participation will be extremely

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valuable and enormously significant to the outcome of this research. Ethical approval is pending and it is hoped to start collecting data in February 2012. Consultation has occurred in collaboration with Otago University.

I have enclosed a Locality Assessment by Locality Organisation form (this is a form essential to gain approval from the Multi-region ethics committee) and I would be grateful if you could sign and return it to me if you are happy to participate.

Please do not hesitate to contact me if you have any queries, or 03 9606 133 mobile 0277 258 237 or by email: miljo124@student.otago.ac.nz

Yours sincerely,

Jodi Miller.
 Centre for Postgraduate School of Nursing Studies  
72 Oxford Tce  
Otago University.  
CHRISTCHURCH 8014  
Attention: Director of Nursing.

To whom it may concern,

QUESTIONNAIRE FOR NURSE EDUCATORS

I am an Otago Nursing Masters student and engaged in research aimed at exploring the context and culture of workplace based education in urban district hospitals in New Zealand from a Nurse Educators perspective. I would be very grateful for your assistance in order to undertake this research.

Over the past 10 years nursing in New Zealand has experienced significant changes including introduction of the Health Practitioners Competency Act (2003) and the expectation of continuing lifelong learning to maintain competency. Brinkman (2008) study highlighted that at least 80% of nurses preferred workplace based learning to maintain their professional development. This study intends to explore workplace-based learning in terms of context and culture from the perspective of the Nurse Educator.

The Nurse Educator has been sampled because they are the facilitators of education and are the link between the organisation and the nurses experiencing the learning. Urban district hospitals have been chosen because they potentially experience more hurdles to attend other forms of continuing professional development, due to geographical distance. This distance potentially poses difficulties for a predominately female workforce with other work/lifestyle responsibilities to attend extramural learning.

The intention of this study is to inform the nursing and secondary health care organisations as to how learning is integrated into the culture of the workplace.

I would be grateful for your assistance in disseminating the following questionnaire packages to your Nurse Educators. Each questionnaire should take no longer than 15 minutes to complete, with an option to partake in a follow-up telephone interview at a time of their convenience.

Confidentiality of the participants and organisation will be maintained at all times. Feedback from the study outcomes and analysis will be disseminated once the study is complete and an opportunity for participants to respond prior to publication will be available.
Thank you very much for your time and support.

If you require any further information please do not hesitate to contact me at miljo124@student.otago.ac.nz or ph 03 9606 133 mobile 0277 258 237.

Yours sincerely

Jodi Miller
Information Sheet

A Study Exploring the Context and Culture of Workplace-Based Education from the Perspective of Nurse Educators in Urban District Hospitals.

You are invited to take part in a research project aimed at exploring the context and culture of workplace-based education within urban district hospitals in New Zealand from the perspective of Nurse Educators. This research is independent of your employment and your participation is entirely voluntary.

I have enclosed a questionnaire which is organised in a manner to gain responses from Nurse Educators, who are Registered nurses involved in facilitating learning for nurses. Following the completion of the questionnaire an opportunity is provided to the respondent to participate in a taped telephone interview. This will give the researcher an opportunity to explore, with the participant, the issues of workplace learning further. Approval from the Central regional ethics committee has been sought for this study. All information pertaining to the identity of the respondent and the organisation they work for, will remain confidential to the research team. An opportunity for the participants to respond to the outcome of the research will be provided.

What do I have to do?

- I would be grateful if you could take the time to answer all the questions provided, even if you feel the questions are slightly repetitive or your answer is the same as a previous question. Some questions are specifically designed this way.
- Your participation in the interview part of the study would be enormously helpful to my research and greatly appreciated. This interview will last approximately 20-30 minutes. It would be great if you could spare the time to talk with me. If you are willing to participate please could you fill in your name and contact information on the questionnaire, so that I can arrange a convenient time with you.

Finally once you have completed the questionnaire, please could you send it back to me in the enclosed, stamped, addressed envelope.

If you have any questions please do not hesitate to contact me at.

Jodi Miller 03 9606 133 or cell 0277 258 237 or miljo124@student.otago.ac.nz

I appreciate the time you have taken to read this information and thank you in anticipation, for participating in this research, your support and enthusiasm is gratefully received. Thank-you.
Questionnaire

A study exploring the context and culture of workplace learning from the perspective of Nurse Educators in urban district hospitals in New Zealand.

Thank you for taking the time to complete this questionnaire. Each question requires a response.

1. Are you?  Male    Female
   Age? _____  How many beds in your DHB? _____

2. Which ethnic group do you identify with? (You can tick more than one)

<table>
<thead>
<tr>
<th>Ethnic Group</th>
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<tbody>
<tr>
<td>NZ Maori</td>
<td>NZ European</td>
<td>Other European</td>
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<tr>
<td>Samoan</td>
<td>Cook Is Maori</td>
<td>Tongan</td>
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<td>Ni uean</td>
<td>Tokelauan</td>
<td>Other Pacific</td>
</tr>
<tr>
<td>South East Asian</td>
<td>Chinese</td>
<td>Indian</td>
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<tr>
<td>Other Asian</td>
<td>Other please specify</td>
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</tbody>
</table>

3. What are your completed tertiary qualifications?
   Diploma
   Non-Nursing Bachelors Degree
   Nursing Bachelors Degree
   Graduate Certificate
   Graduate Diploma
   Postgraduate Certificate
   Postgraduate Diploma
   Masters
   Doctorate
   Other(s)

4. Do you have any educational qualification(s) specifically in education? Yes/No
   If yes please specify what qualification(s) you hold

5. How many months or years do you have as a Nurse educator teaching in the workplace?

6. How many months or years experience have you as a Registered nurse?

6. Teaching nurses in the workplace can require specific skills – how many months or years have you worked in the speciality you teach?
7. In what speciality area(s) do you teach? (Please tick appropriate boxes)

<table>
<thead>
<tr>
<th>Assessment Treatment &amp; Rehabilitation</th>
<th>Intensive Care</th>
<th>Orthopaedics</th>
<th>Renal</th>
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<tr>
<td>Burns/plastics</td>
<td>Medical</td>
<td>Paediatrics</td>
<td>Surgical</td>
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<td>Cardiac/Cardiothoracic</td>
<td>Neonatal</td>
<td>Palliative Care</td>
<td>Theatre/Preoperative</td>
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<td>Cardiac Rehabilitation</td>
<td>Oncology</td>
<td>Primary Health</td>
<td>Trauma Emergency</td>
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<td>Community</td>
<td>Mental Health</td>
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<td>Other</td>
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Reflecting on your experience as a nurse educator teaching nurses in the workplace, please answer the following questions.

Place a tick in the phrase box that is most closely aligned to your experience in your role.

<table>
<thead>
<tr>
<th>Shared Vision</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
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</thead>
<tbody>
<tr>
<td>8. The organisation has a clear philosophy on lifelong learning.</td>
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<td>9. The organisation clearly communicates its learning philosophy to nursing staff.</td>
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<td>10. The organisation fosters a learning culture.</td>
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<td>11. Learning in the workplace for Nurses is a priority for my employer.</td>
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<td>12. Time for workplace learning is actively protected within the workplace.</td>
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<td>13. Staff are rostered to allow regular workplace learning to occur.</td>
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<td>Training and development needs analysis.</td>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Neutral</td>
<td>Agree</td>
<td>Strongly Agree</td>
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<td>14. Nurse participation in the development of workplace-based learning is valued in our organisation.</td>
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<td>15. Nurses in our organisation are involved in the planning of workplace-based learning.</td>
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<td>16. The organisation provides over and above the education required for mandatory service provision.</td>
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<td>17. The organisation has a framework in place that encourages and supports team learning.</td>
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</table>

<table>
<thead>
<tr>
<th>Training and development needs analysis.</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
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<tbody>
<tr>
<td>18. The organisation provides over and above the education required for mandatory service provision.</td>
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<td>19. The organisation demonstrates commitment to learning by performing annual personal development plans.</td>
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<td>20. The organisation collaborates with nurses to develop their learning goals.</td>
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<td>21. The organisation facilitates the nurse’s individual learning goals.</td>
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<td>22. Professional development in the workplace is a priority for the Nurses you work with.</td>
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<td>23. There is enthusiasm for workplace learning.</td>
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<td>24. Nurses confidently identify their learning needs.</td>
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<td>25. Participation in workplace learning is collaborative.</td>
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<tr>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Neutral</td>
<td>Agree</td>
<td>Strongly Agree</td>
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<td>26. Nurses actively participate in workplace learning sessions.</td>
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<td>27. Access to electronic information systems is available to all nursing staff.</td>
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<td><strong>Learning from mistakes</strong></td>
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<td>28. Our organisation demonstrates a blame free culture of incident reporting.</td>
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<td>29. The organisation uses incident reporting to develop learning objectives within our workplace learning.</td>
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<tr>
<td><strong>Implications of learning</strong></td>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Neutral</td>
<td>Agree</td>
<td>Strongly Agree</td>
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<tr>
<td>30. The organisation promotes the introduction of newly acquired skills and knowledge.</td>
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<td>31. The organisation welcomes and supports change to practice subsequent to evidence based learning.</td>
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</tbody>
</table>

Considering your current role as a Nurse Educator teaching nurses in the workplace please circle the most relevant number as it applies today.
(1 = Unmotivated, 5 = Highly motivated)

| 32. How motivated and enthusiastic do you feel in your role as nurse educator? | 1 | 2 | 3 | 4 | 5 |
| 33. How would you measure the level of support you have in your workplace? | 1 | 2 | 3 | 4 | 5 |

34. How satisfied are you, that nurses learning is a priority within the organisation.
(1= Unsatisfied, 5 = Extremely satisfied)

1 2 3 4 5
35. How satisfied are you in your role?  
(1 = Unsatisfied, 5 = Extremely satisfied)  

| 1 | 2 | 3 | 4 | 5 |

36. List positive and negative aspects of workplace based learning in your organisation.  
(Feel free to expand on a separate piece of paper if necessary).

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Thank you for sharing your time and experiences, please provide your name and contact details if you wish to express interest in providing further information for my study. I am extremely appreciative of you sharing your valuable experiences and knowledge.

Name: ____________________________ Organisation ____________________________

Contact details: PH: - ____________________________ Email: - ____________________________

Are there any further comments that you wish to make?

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

This survey will remain anonymous unless the participant has indicated an interest in a follow up telephone interview.

This questionnaire should be returned to Jodi Miller by post in the pre-paid envelope provided.
Thank you for taking the time to participate in this study, your knowledge and experiences are invaluable to my research. Participation may help to gather knowledge and provide valuable insight into how nursing and organisations alike have adapted to a culture of lifelong learning within the workplace for New Zealand.
APPENDIX G

Centre for Postgraduate Nursing Studies
University of Otago
72 Oxford Tce
Christchurch 8014

Dear (DON Name),

A study exploring the context and culture of workplace based learning from a Nurse Educator perspective in urban district hospitals throughout New Zealand.

Thankyou for consenting as an organisation to participate in this study, your willingness to allow me access to your Nurse Educators is much appreciated.

Enclosed are a number of research packages, which I would be grateful if you would be kind enough to distribute to your Nurse Educators. The research package consists of a letter informing them of the purpose, aims and some background to the study, an information sheet, a questionnaire and a stamped self-address envelope.

Each pack is numbered; this is to ensure the identity of participants is not revealed to the researcher. I would appreciate it if you could keep a record of who receives which numbered package.

When I receive data I can identify what numbers have not responded. Whilst maintaining anonymity, I can forward a reminder letter for you to distribute to those respondents. Surveys are notorious for low response rates, therefore a friendly letter is intended to encourage participation and improve the response rate.

It would be fantastic to get as many returned as possible, to gain an accurate, credible view of the context and culture of workplace based learning within urban district hospitals throughout New Zealand.

Your assistance in this role is gratefully received. Once all the questionnaire data is collected and analysed I will forward you a copy of the executive summary for you and your Nurse Educators. Each Nurse Educator who participates in the telephone interview will receive a confidential summarised transcript of their interviews and have an opportunity to give feedback to the researcher independently. This ensures rigor and validity to the research.

This research has gained the approval of the Multi-region ethics committee.

The identity of each participant and their organisation will remain confidential throughout the research and written process. Once the last reminder letter has been distributed I will ask you to dispose of the records identifying the allocated questionnaire numbers.
Your participation in this research is enormously appreciated and it is hoped, this study will establish a greater understanding of how our health care organisations fare as learning organisations for nurses.

Please do not hesitate to contact me if you have any queries.
miljo124@student.otago.ac.nz
Home 03 9606 133
Mobile 0277 258 237

Kind regards,

Jodi Miller.
APPENDIX H

Interview Schedule
1. Could you tell me how you became a nurse educator?
2. Can you tell me about the culture of learning in your workplace?
3. Tell me about what informs your teaching programmes?
4. How much of the planning that you do is around planning mandatory learning?
5. Are the strategies use to inform you’re planning unique to your area or are they used throughout your organisation?
6. When you are planning, once you’ve decided what you are going to do what’s the process following?
7. Tell me about any barriers you may experience when facilitating workplace learning?
8. What part of the process tends to flow easily when facilitating learning?
9. What supports do you have in your role?

Prompt; resources, time and administration support.

10. Leading by example is an important element when establishing a good culture of learning; can you tell me about the leadership within your organisation?
11. Tell me about your organisations strategies to support and encourage workplace-based learning for nurses?
12. Tell me about your organisations strategies to support and encourage wbl for overseas trained nurses?
13. Tell me about the organisations communication surrounding its philosophy of learning and lifelong learning strategies?
14. How does your organisation facilitate critical analysis within your nurse’s workplace learning and practice?

15. How does your organisation encourage nurses to explore their own experiences?

16. Tell me about how you and your organisation encourage the application of new skills and knowledge?

17. Can you tell me about any barriers or hurdles you have encountered within your role to facilitate and encourage learning?

18. Are you able to give me examples of how you overcame these?

19. If there were one thing about your learning culture that you would change, what would it be?
APPENDIX I
11 April 2011

Gill Halksworth-Smith
Department of Postgraduate Nursing
University of Otago, Christchurch

Mā te rangahau hauora e tautoko te whakapiki ake te hauora Māori
All health research in Aotearoa New Zealand benefits the hauora (health and wellbeing)
of tangata whenua

Tena koe Gill,

Thank you to you and Jodi Miller, for taking the time to meet with me at the University of Otago, Christchurch on Monday 11th April, to discuss your research study titled:

A study exploring the Nurse Educator role in urban district hospitals in the South Island of New Zealand; context, culture and setting.

I note that your research is a Masters thesis to survey the general population of nurse educators practising in urban based hospitals in the South Island.

As this is a proposed audit, it is always challenging to make comment in terms of achievement for improving health status and in particular Maori Health status however, it was apparent in your summary of the research that there could be a small number of Maori participants and that this research may have impact on Maori workforce and that is important.

(Maori health workers, Maori Health providers, Maori Health professionals) should be relatively accessible and well placed to advise you as to a relevance of your research and the outcomes which can be achieved for Maori health and the population overall.

It is also advisable that researchers review and refer to the District Health Board Annual Plan and/or the current Health Targets published by the Ministry of Health (1 July 2009).

As findings from this study could contribute to the development of future research, it is therefore appropriate that Maori researchers, Maori health providers and Maori health professionals are aware of your successful outcome. The Research Office of the University of Otago, Christchurch and in particular myself, as the Research Manager Maori, would be willing to assist in the dissemination of your findings once your project has reached a conclusion.

It is a requirement of the ethics approval process that a final report be submitted when the research is complete. A copy of the report should be provided to me at that time as findings from this project may contribute to the development of future research hypotheses or projects. It is therefore important that appropriate Maori organisations, Maori health professionals and Maori researchers are aware of your findings. The Research Office of the University of Otago, Christchurch and in particular myself as the Research Manager - Maori would be willing to assist in the dissemination of your findings once your project has reached a successful conclusion.

Research Office, Department of the Dean
University of Otago, Christchurch
PO Box 4345, Christchurch Mail Centre, Christchurch 8140, New Zealand
Tel +64 3 364 0337 • Fax +64 3 364 1490 • Email research.uoc@otago.ac.nz
www.uoc.otago.ac.nz
My suggestions do not necessarily relate to ethical issues with the research, including methodology. Other committees may also provide feedback in these areas. I hope this letter will suffice in terms of the application. Please contact me should you need any other information that may not have been included in the letter relevant to our conversation.

I wish you well in your research.

"Mo tatou a mo ka uri a muri ake nei" Ngai Tahu 2025

Ka nui tonu nga mihi

Elizabeth Cunningham
Research Manager - Maori