Perceived Learning Needs In Staff Development of Some Care Providers in Five Long-Term Care Settings in Southern Ontario

Deborah L. Millar, R.N., B.Sc.N.

Department of Graduate and Undergraduate Studies in Education

Submitted in partial fulfillment
of the requirements for the degree of
Master of Education

Faculty of Education, Brock University
St. Catharines, Ontario

Abstract

This exploratory descriptive study described what 20 care providers in 5 long-term care facilities perceived to aid or hinder their learning in a work-sponsored learning experience. A Critical Incident Technique (Woolsey, 1986) was the catalyst for the interviews with the culturally and professionally diverse participants.

Through data analysis, as described by Moustakas (1994), I found that (a) humour, (b) the learning environment, (c) specific characteristics of the presenter such as moderate pacing, speaking slowly and with simple words, (d) decision-making authority, (e) relevance to practice, and (f) practical applications best met the study participants' learning needs. Conversely, other factors could hinder learning based on the participants' perceptions. These were: (a) other presenter characteristics such as a program that was delivered quickly or spoken at a level above the participants' comprehension, (b) no perceived relevance to practice, (c), other environmental situations, and (d) the timing of the learning session.

One of my intentions was to identify the emic view among cultural groups and professional/vocational affiliations. A surprising finding of this study was that neither impacted noticeably on the perceived learning needs of the participants. Further research with a revised research design to facilitate inclusion of more diverse participants will aid in determining if the lack of a difference was unique to this sample or more generalizable on a case-to-case transfer basis to the study population.

Acknowledgements

I would like to say thanks for the financial support provided by the Research Interest Group of RNAO. Their contribution to my thesis lessened the pressures of doing a research study. I would also like to thank not only the staff who participated but also the Administrators and Directors of Care of the facilities who provided the space for the interviews and the staff the time to participate.

I also would like to thank my thesis committee, Dr. Anne Elliott, Dr. Sheryl Boblin Cummings, and most especially my thesis advisor Dr. Katharine Janzen. Katharine, whose encouragement, support and feedback was invaluable and always provided in a warm, nonthreatening manner. She made me feel like I am competent and capable.

I would also like to acknowledge the support of some special people in my life. First, Andy Langlois, who gave a damn and always believed I could do it even when I didn't.

I'd also like to thank Sarah, Jana-Leigh, and Robby, the lights in my life without whom I can't imagine there would be much sunshine -- and life wouldn't be as "adventurous." Their constant understanding, love, and encouragement to help me achieve all my dreams have been neverending. I love you guys.

Table of Contents

List Of Tables

CHAPTER ONE: INTRODUCTION

This was an exploratory study of the specific learning needs of professionally and culturally diverse care providers in five long-term care settings. Current education programs in long-term care are limited for a variety of reasons. Limitations can be classified as: (a) system-related such as insufficient funds or the lack of time to plan or support an effective program; (b) educator-specific including a lack of skills and/or knowledge in training; and (c) process-specific to education such as a lack of knowledge of the target audience and how to meet their learning needs best or a lack of direction for the staff development program because it lacks a conceptual framework. To be effective, a staff development program should (a) be established within an accepted framework designed to meet the needs of the target audience; (b) use an educator experienced in education; and (c) operate within the funding limits allocated by the Ministry of Health and Long-term Care. To maintain competency, practicing nurses must continuously upgrade their knowledge base. "As regulated professionals we have a responsibility to our clients and ourselves to stay competent" (Wansborough, 1997, p. 11). Since health care is in constant flux and advances in technology continue, nurses may find maintaining competence a challenging endeavour. Thus, effective staff development programs that meet the learning needs of care providers, as perceived by these staff, are essential.

Background of the Problem

The disabilities and the acuity of long-term care residents have increased over the last 10 years because: (a) the average age of the residents has increased to over 80 years old; (b) responsibility for elder care has shifted from acute care to long-term care; this

includes both institutions and the community setting; (c) there have been technology advances; (d) there is an increased number of persons over the age of 65; and (e) the life expectancy of the population as a whole, has increased to over 75 years of age (Mezley & Lynaugh, 1989). Although Mezley and Lynaugh's (1989) research is an American study conducted in the 1980s, their conclusions are relevant in current Ontario long-term care practice settings. In Ontario, the number of persons over age 65 was 644,410 and the total population was 8,432,100 in 1976. Therefore, the aged comprised 7.64% of the total population. In 1986, the populations were 992,700 and 9,477,200 respectively (10.47% of the total). By 1996 this percentage had increased to 11.87% (1,334,410 and 11,252,400 respectively). This is outlined in Table 1. The census figures from these periods also demonstrate the number of persons over the age 75 has increased in Ontario (Government of Canada, 1999). The fiscal constraints and closer monitoring of health care costs in the 1990s have further increased the acuity of long-term care residents.

Table 1

Population of Ontario and its citizens over 65

YEAR	TOTAL POPULATION IN ONTARIO	POPULATION OVER THE AGE OF 65	PERCENTAGE
1976	8,432,100	644,410	7.64%
1986	9,477,200	992,700	10.47%
1996	11,252,400	1,334,100	11.87%

Government of Canada. (1999). Population and Dwelling counts [On-line]. Available: http://www.statcan.ca/english/census96/dwel.htm

In my experience as a nurse, the people admitted to long-term care consist primarily of the very old and the very frail. In Ontario and elsewhere in North America, the well/less acutely ill elderly remain in the community longer than in previous generations. Despite these increases in acuity, there are a limited number of professional care providers.

In the United States, less than 2% of long-term care facilities have a physician available on site at all times (Mezley & Lynaugh, 1989). In Ontario, the Nursing Home Act (Government of Ontario, 1990) states that long-term care facilities (LTCF) are staffed by Registered Nurses (RN), Registered Practical Nurses (RPN), and Health Care Aides (HCA). The minimum requirement stated in the legislation is that a RPN be present in the facility and a RN be available on call for the LTCF. The Ministry of Health and Long-term Care's funding formula for long-term care combines both registered and direct care givers. The number of staff required is based on a workload measurement system called The Alberta Classification Tool. This tool, completed by persons from other LTCFs, provides a case mix number to determine the required number of care providers within the long-term care facility. It does not impose any specific staff mix on the facility. Thus, in a LTCF, health care can be provided using any combination of RN, RPN, or HCA as long as it meets the standards in the Nursing Home Act and the Long-term Care Facilities Programs Standards established by the Ministry of Health and Long-term Care (Government of Ontario, 1990, 1995).

When looking at the characteristics of the care providers in long-term care,

Mezley and Lynaugh (1989) found that these care providers are usually older and have completed less continuing education than nursing staff in acute care settings. Furthermore, there are fewer advanced nursing practitioners such as clinical nurse specialists available to aid with complex resident care needs and day-to-day management of resident problems. As a result, informal education through interaction with specialists and experts is limited. Consequently, internal formal educational opportunities become vital to continuously maintain and improve the quality of care provided to the institutionalized elderly. In addition, there are few timely and organized mechanisms for clinical decision-making in long-term care (Mezley & Lynaugh, 1989). For example, it is often the HCA, the least professionally prepared, who is left to detect the minute changes in a resident and the need for further interventions. The HCA reports these subtle changes to the charge nurse, often an RPN, who may lack the formal education that provides him/her with the knowledge and skills in assessment, or he/she may lack the time to evaluate the resident's condition comprehensively. Compounding this problem, the charge nurse must call the physician, who is usually off site. The physician, in turn, may not get adequate information from the LTCF staff and/or may only be covering for the resident's primary physician and not know the resident well. This situation may lead to the resident being treated inappropriately or transferred unnecessarily to the hospital for assessment, which further increases already strained health care costs and also increases client anxiety.

These issues support the importance of an effective staff development program for

caregivers. Hensley and Travis (1997) point out that "With this current and future growth comes greater responsibility on the part of each center, large and small, for a well-trained interdisciplinary (licensed and non licensed) caregiving staff" (p. 173).

Statement of the Problem Situation

Long-term care has many challenges. The staff mix in long-term care settings combines both professional, regulated staff and nonprofessional unregulated staff. Also, because of the nursing shortage of the early 1980s and subsequent Canadian immigration practices, the staff mix usually includes culturally diverse providers whose first language is often not English. Furthermore, many HCAs may have limited education (usually only a high school diploma) and limited reading and writing skills, especially in English (Yahes & Kittrick-Dunn, 1996). Canada has been very supportive of a multicultural identity and the right of Canadians to practice their culture. Consequently, Yahes and Kittrick-Dunn's (1996) conclusions based on the American experience, may also be relevant for long-term care in Canada. It is my experience that care providers in long-term care often have limited skills in English.

For these reasons, the educator needs a staff development program that is appropriate for care providers with differing levels of knowledge and skills and which respects the multicultural diversity of the care providers. In addition, the educator needs a program that promotes motivation to learn, a philosophy of lifelong learning, and a desire to attend learning opportunities within the long-term care setting.

Purpose of the Study and Research Question

The purpose of the research was to understand the participants' perspective (the emic view) of their learning needs related to staff development in long-term care. Although my study will not develop a theoretical framework related to staff development, the goal is to generate concepts and to provide a beginning point for an initial conceptual framework for a staff development program in long-term care. The research question was "What is it that care providers in five long-term care facilities perceive aids or hinders their learning in a work-sponsored learning experience?"

Glossary of Terms

Long-term care: includes institutions that provide services twenty-four hours a day to people (called residents or clients) who have physical or mental dysfunctions that do not enable them to live independently in the community (Mezley & Lynaugh, 1989).

Nurse: Under the Regulated Health Professions Act (1992) the term "nurse" can only be used for Registered Nurses and Registered Practical Nurses regulated by the College of Nurses of Ontario (CNO) (Government of Ontario, 1992b). In the literature anyone who provides nursing care is often referred to as a nurse. In this thesis the term "care provider" is used as generic terms for both regulated and nonregulated staff. The term "nursing staff" refers to only those regulated by the CNO.

Health Care Aide (HCA): Unregulated health care workers have been labelled

with a variety of terms in the acute care setting such as: generic workers, multiskilled workers, service associates, and personal services workers. These are new positions in acute care as fiscal constraints have become a reality in the 1990s. Historically, these positions have always been a part of the long-term care delivery settings and are generally called "health care aides" (personal experience). This is the term that is used in this thesis for these workers.

Staff development: This study focused on in-house training, both inservice and orientation. The term "staff development" is used in this context.

Culture: the shared values, beliefs, and practices of a particular group of people. These shared meanings are patterns that guide the thinking of group members and are passed from one generation to the next (O'Toole, 1992).

Registered staff: a RN or RPN as defined by the College of Nurses of Ontario (CNO) which includes successful completion of an accredited program of study and entrance to practice certification process (Government of Ontario, 1992b).

Theory: a creative and rigorous structuring of ideas, of concepts, and definitions that have a relationship. The theory is purposive and it is tentative and grounded in assumptions/value choices. It also includes a systemic view of the phenomena (Chinn & Kramer, 1991).

Conceptual framework: a symbolic descriptive representation of concepts into a whole (Chinn & Kramer, 1991).

Rationale

The research question is important for several reasons. First, it may be used as a tool to guide nursing practice and meet the educational needs of the care providers in long-term care. From a continuous quality improvement (CQI) perspective, the findings of this study aid in designing programs and services that promote, maintain, and/or improve care for the residents and their families. This occurs since motivational literature such as Armstrong, Clark, and Stuppy (1995), Campbell (1999), Cooper (1997) and De Silerts (1995) indicates that an education program that effectively meets the staff's learning needs is more likely to increase the learner's retention and application within the LTC work setting. In addition, contribution of the findings to adult education includes furthering the field of education and training in health care -- specifically long-term care.

Educational research provides practical applications that are broad in perspective (Gillis, 1991; Jones, Borces-Clark, Merker & Palau, 1995; Phillips & Baldwin, 1997; Werab, Alexander, Brant, & Wester, 1994; Wissmann 1996). However the findings are specific to acute care settings and may not apply in long-term care. LTC has unique challenges including a diverse cultural mosaic, diverse staff mix, as well as limited resources available for education. In addition, a culturally diverse workforce requires different perspectives for examining issues. This work-team mix changes the way within which long-term care must function. Comprehension of multicultural issues is more than understanding the various cultural traditions and includes areas such as mentoring, career development, and a feeling of well-being at work (Dunwell, 1997). Furthermore, if the

care providers are expected to function using the most current practices and knowledge base available, then the staff development program must be designed to meet their learning needs and the objectives of the organization and those mandated by government regulatory bodies.

Theoretical Framework

Research involves more than a collection of information related to a particular phenomenon. By itself, the collected data and themes have little relevance or value; thus, an attempt must be made to explain how the facts, observations, and experiences interrelate. Theory integrates the parts and provides an order to the information to make it a whole. It uses the uncovering of fundamental patterns to aid in making sense of the world (Merriam & Simpson, 1984). Without a conceptual framework or theory development the research question becomes less practical for understanding or expanding the knowledge of the practitioners of adult education in long-term care settings.

Also, Mitchell and Cody (1993) state nursing knowledge must be explicitly conceptualized from within nursing's body of knowledge to be recognized as a distinct science. A conceptual framework may be simple or complex and include abstract constructs that describe or explain specific phenomena. The framework explains the main things to be studied such as the key concepts, ideas, or variables; labels them, and describes the perceived relationship among them. Lastly, a conceptual framework provides a structure to guide the development of a study. Thus, the researcher identifies the variables and relationships that he/she believes to be most meaningful (Miles &

Huberman, 1994).

Importance of the Study

My experience as an educator and administrator in long-term care provided me with my initial conceptualization of staff development in this area. I expected there would be factors within a staff development program that would aid or hinder the learning of the participants that would be unique to the HCA or RN/RPN, specific cultures, or have no impact on either professional/vocational or cultural variables. However, there were also factors I expected to be modified by differences in professional/vocational level or cultural background. These may include the importance of participatory or visual presentations and the minimal value of lecture-type teaching strategies and especially those that emphasize written materials.

The complexities of health care, and nursing specifically, demand practitioners who are competent and who also continually update both their knowledge base and skill level. The current political and social climate has led many health care decision-makers and stakeholders to question which health care delivery system is most appropriate and best meets the needs of the aging population. As a result of the social and economic changes the role of long-term care, as a health care delivery system, has changed. Prior to long-term care reform of the early 1990s, much of the research and health care dollars focused on the acute care setting. Acute care is treatment provided over a finite period of time and includes treatment by specialists to whom a client has been referred by a primary care giver. Long-term care, on the other hand, involves health care services

provided for an extended length of time for clients unable to independently perform their own activities of daily of living (O'Toole, 1992). Not only are the foci of care different in the two care settings, but the philosophical perspectives that the treatment practices are based upon are also different. Currently, decision-makers believe that the philosophical perspectives in long-term care serve the needs of the elderly better than acute care (Government of Ontario, 1992a). In summary, staff development programs in long-term care must be appropriate, relevant, and valuable for care providers in that context. Such a staff development program enables provision of the most effective care to meet the needs of the residents whom the care providers serve.

Scope and Limitations of the Study

The scope of this research study was limited to five LTCFs within an hour's drive of a large Canadian city. These facilities were varied in both number of beds and type of staff development program. The facilities' selection was based on the professional relationship I had with either the Director of Care or the Administrator and the availability of staff to participate from the individual facility. Based on my interview with the Directors of Care for each facility, the similarities and differences among the five LTCFs were delineated.

Briefly, the first facility had 132 beds divided into four separate units. Two of the units had client care co-ordinated by RNs and two by RPNs. The staff development program/ model included sharing of an educator with another facility in the same corporate holding company. The educator position was added to the facility because of

increased funding from the Ministry of Health and Long-term Care and not through any corporate strategic directive that emphasized the need for such a role. There was no formal staff development program model nor a formal structure that included either a needs assessment or research-based educational events. The education program was generally based on audit findings – both internal and external, legislative requirements, and directives from senior corporate management. In my opinion, this staff group had difficulty trusting management. There had been six different Directors of Care in two years, each with her own management style and philosophy. Thus, the staff found educational events where sporadically presented and not always well structured.

The second, a 80-bed facility, was divided into two units: one whose residents' care was co-ordinated by a RN and one co-ordinated by a RPN. The Director of Care (DOC) included staff development in her functional duties since there was no one solely responsible for it. Consequently, this LTCF did not have any formally structured staff development program. However, the DOC selected educational events based on staff requests and Ministry of Health and Long-term Care and legislative requirements. From my perspective, this facility had an atmosphere of 'family.' The Director of Care and Administrator were married and the facility, itself, had been in the family for years. In addition, there were a number of long-serving employees who appeared very loyal and committed to the organization.

In the third LTCF, the participants were employed at a facility with 192 beds and the fourth had 282 beds. Both had three units with all RNs in charge. There was a full-

time educator; however, there was no formal staff development program. The education provided was instructor-centred, not learner-centred. In other words, there was no structure in place to identify the staff's learning needs and the education provided was assumed by the facility's management team. The differences between these facilities were in informal power. In the larger facility, the HCAs were a strong and militant group who vocalized their displeasure with any management directive through rebellion. They appeared to have minimal interest in learning and had the largest multicultural group of any of the facilities.

Lastly, the fifth facility had 60 beds divided into two units whose client care was co-coordinated by RNs. The staff development program was based on adult learning principles, research findings, learner needs, and corporately mandated. The staff educator had a Master's Degree and a long work history in staff development. She was hired to make the facility a stronger force within the LTC community through improved staff knowledge, care based on best practices, and research to develop programs and strategies that better meet the care needs of the clients served. I did not know this facility as well as the others but through meetings had met the Administrator on a number of occasions. She seemed to be a leader with a specific vision and agenda. She also appeared to place learning as a priority for the staff of the facility. I believe this is supported by her successfully 'selling' the Board on the need for such a qualified educator. Lastly, the staff group were long-time employees who appeared to be loyal and dedicated.

In all the facilities, the clients served were elderly with a variety of both

physiological and psychological impairment ailments. Most of the clients had multiple diagnoses. The facilities included four that were privately owned and one that was publicly owned and received large donations from the community served. All were funded primarily through government long-term allocation. The characteristics of the LTCFs selected to participate are outlined in Table 2.

Table 2

Summary of Participating LTCFs

LTCF #	# Of Units/ Co-Ordinator	Total # Beds	Ownership	Staff Development Model
1	4 units 2 with RNs & 2 with RPNs in charge	132	private	• shared educator. • no formal program. • based on internal and external audits, government findings.
2	2 units 1 with RN and 1 with RPN in charge	80	private	• no person designated. • use outside consultants. • no formal program. • based on staff needs, organizational strategic plan, and audits.
3	3 units all have RN in charge	192	private	• full-time educator with no work or educational experience in training. • no formal program. • based on internal and external audits, government findings.
4	3 units all with RNs in charge	282	private	• full-time educator with no work or educational experience in training. • no formal program. • based on external and internal audits, government findings.
5	2 units with RNs in charge of both	60	public	• full-time educator on site with work and educational experience in training. • formal program. • based on staff needs, organizational strategic plan, and audits.

LTCF – long-term care facility

Outline of the Remainder of the Thesis

Chapter 1 defined the purpose of the study and described the problem. A brief overview of the current economic and social climate highlighted the significance of an effective staff development program. The research question and rationale have been identified and applicable terms defined.

Chapter 2, " Review of the Related Literature," will discuss the educational and nursing literature related to professional/vocational affiliation and multicultural issues. Lastly, it will briefly describe a number of theoretical perspectives on staff development and critically analyze their relevance to this study.

Chapter 3, "Methodology and Procedures," will describe the qualitative approach used for participant selection and data collection strategies. In addition, data analysis will include rigour, ethical considerations, and the assumptions and limitations.

Chapter 4, "Findings," provides the demographics of the study sample and the findings of the content analysis. There will be supporting anecdotal information from the care providers organized by themes.

Lastly, Chapter 5, "Summary, Conclusions, and Recommendations," answers the research question. Conclusions will be based on the study's data and the literature reviewed will be used to understand the meaning and/or significance of the findings. The study's design, data collection methods, and treatment of the data are also discussed critically. Finally, implications for practice, theory, and further research will be described.

CHAPTER TWO: REVIEW OF THE LITERATURE

Introduction

This chapter describes the current staff development literature with respect to the impact of multiculturalism and vocational or professional affiliation on care providers in long-term care facilities (LTCF). A review of conceptual frameworks that may guide my research is also be presented in this chapter. The literature review was limited to English language publications, primarily Western European, North American, and Australian. Research about care providers' perceptions about their learning needs, when possible, has been limited to long-term care (LTC) and in Canada, specifically. The focus for publication years was 1990-1999 because staff development in long-term care is in its infancy and older literature would not likely be relevant to current practice or increase an understanding of the trends in theory development. However, articles that may be considered foundational thinking or a "classic" article (e.g., Brookfield, 1987; Flanagan, 1954) were also included.

Literature Review

Multicultural Issues

Understanding cultural diversity is important in the field of staff development and when planning research. An individual's cultural background influences his or her worldview and way of behaving. In my review of the literature related to cultural influence, there was an abundance of papers discussing the cultural diversity of the consumers of health care (e.g., Caminha-Bacote, Yahle, & Langenkamp, 1996; Culley,

1996) but less research and scholarly discussions related to cultural diversity within the staff group. Also, I found that few defined either the term "culture" or "cultural diversity" consistently.

Jackson (1995) stated that different parts of the world have different philosophies about topics such as health and wellness, doctor/nurse interaction, and the clients' psychosocial needs. For example, what North American nurses consider part of basic nursing care may not be basic care in the Philippines. Consequently, the educator "in looking at how nurses discern practice from one culture to another [will find it] necessary to consider how nursing is constructed in the newcomer nurse's country of origin" (Jackson, 1995, p. 33). Yahes and Kittrick-Dunn (1996) described cultural diversity and more specifically, its impact on the educational needs of staff. They found that immigrant nurses have a variety of knowledge, skills, and cultural distinctiveness. The previous environment these nurses worked in had different technologic resources, alternative treatment practices, and unique approaches to resident care compared with those commonly used in the United States. The American experience with cultural diversity is not unique to the United States. From my experience of 11 years in nursing, including 6 in LTC, I have found that this factor is also very relevant to staff development in long-term care in Canada.

Moreover, Yahes and Kittrick-Dunn (1996) found the greatest challenge for care providers educated in different parts of the world was communication, since certain words have different meanings in various cultures and languages. Accent differences

between individuals can also result in misunderstandings. Planning a staff development program must include awareness of this potential risk and educators must develop programs that take this into account.

> Another result of linguistic differences is the formation on units of cliques of like cultures speaking in their native tongue in the presence of others who don't understand them. This can cause anger, hostility, and alienation on the part of those not belonging to their culture (Burner, Cunningham, & Hatter, 1990, p. 32).

Culture influences one's therapeutic communication skills and style. In addition, there are communication variances related to verbal style, culturally determined gender roles, assertive behaviour, and nonverbal communication. For example, a doctor's order may not be questioned if the nurse's cultural value does not permit the questioning of authority figures, especially if they are males (Arleiter, 1988).

Caminha-Bacote, Yahle, and Langenkamp (1996) described cultural encounters between staff and their clients that can also be considered important aspects for staff education. The educator must not only have the academic knowledge related to various cultural groups but also have cultural encounters. Through direct engagement in cross-cultural interactions with care providers from diverse backgrounds, the educator can refine or modify existing knowledge about a specific culture, thereby reducing stereotypes. Also, a fuller understanding of cultural norms will aid the educator in developing culturally relevant staff development programs.

Alspach (1995) agrees that care providers in American hospitals are no longer a

culturally homogenous group. They are a heterogeneous mixture of varying ethnic and socioeconomic subgroups representing a variety of cultures and educational systems. Consequently, when these persons are in the same work setting, contrasting and divergent attitudes, values, beliefs, and behaviours may lead to misunderstandings, misinterpretations, and conflicts. This is also true in Canadian institutions. An effective staff development program may increase the likelihood of shared understanding, clarification, and working harmony by improving comparisons of similarities and the identification, acknowledgment, and acceptance of cultural differences. Canadian and other cultural groups must work together in long-term care. Without a comprehension of each other's perspective and the discovery of a common base for understanding among staff members, the clients in the facility, for whom the staff must provide care, will not be served.

Munet-Vilaró (1988) discussed the difficulties researchers may encounter when interviewing/observing care providers from different cultural groups. For example, unwritten traditional customs and manners are usually learned through interpersonal interactions and passed on through generations.

In summary, the Canadian tradition has always been to allow individual cultural groups to maintain their heritage. However, to make this effective for staff development, one must understand the similarities between cultural backgrounds and also what each contributes to the long-term care delivery system. Moreover, these factors must be considered in research. My review of the literature, as previously described, found that

although there is research about multiculturalism in the literature it focuses on the consumers, not the providers of health care. Yahes and Kittrick-Dunn (1996) do discuss the importance of cultural background, however, they limit their discussion to improving the communication and linguistic skills of the non-Canadian trained care providers.

Professional/Vocational Affiliation

My review of the literature did not find any research related specifically to the educational needs of RNs/RPNs and HCAs in LTC. However, Nolan, Owens, and Nolan (1995) described a pluralistic model for continuing professional education of health care workers. They designed this model to reach those care providers who may be potentially disadvantaged related to continuing education including: junior, "off shift" (e.g., night shift), and part-time care providers. Their program involves a modular, flexible, and integrated educational program that allows the learners to work at their own pace and self-select the combination of modules that may be beneficial to them. Ultimately health care providers who understand and emphasize similarities and differences among themselves -- both culturally and professionally -- will achieve better care for the clients they serve.

> The challenge for interdependent health care providers is to communicate effectively with one another especially when these individuals are members of different (and often competing) professional cultures. Health care providers from different professional cultures usually have gone through different educational and training programs, have different job titles, belong to different professional

> organizations, and have different health care duties and experiences. Because of differences in their professional training and distinct professional orientation towards health care, different providers are likely to make different decisions about which health care intervention strategies are best for treating a particular consumer's health problems. These differences of clinical judgement are important issues to consider when developing an effective multidisciplinary holistic treatment regimen (Kreps & Kunimoto, 1994, p. 75).

This is also true of holistic staff development programs. Burgio and Burgio (1990) reviewed the literature related to staff training and described methods of institutional staff training and management for nursing assistants (HCAs) but excluded registered staff. It appears, although not directly stated, that Burgio and Burgio (1990) hypothesized that changes in resident care would be possible if nursing assistants' focus changed from a custodial function and reinforcing a dependency in the residents to a therapeutic model of rehabilitation. In my opinion, a program that focuses only on HCA would not be a holistic approach to staff development. Such an approach would need to include a program that includes all staff regardless of their professional status. It is possible that registered staff may inadvertently also encourage the residents to be dependent. Long-term care has a variety of health care disciplines within its delivery model, all of which educators must take into account in staff development and in research.

Interestingly, Burgio and Burgio (1990) also found that, although institutions provided staff training, there were only a limited number that also included an evaluation

component to assess if the participants comprehended the information provided. Without comprehension it is unlikely the participants would put the information presented into practice. This can result in several possible problems including: (a) effective use of human resources (both the educator and the staff) does not occur; (b) a CQI program that does not ensure that the clients are receiving the best and most current care available; (c) reduced likelihood of any changes in practice being permanent; and (d) continued past practice of care being only skill and task oriented without consideration of a client's psychosocial needs.

In conclusion, I found only limited staff development research in the literature that dealt with multicultural diversity and none that addressed the professional diversity of care providers within long-term care. This is an identified weakness of current educational research.

Theoretical Perspective on Staff Development

Definitions of Concepts

Few studies found in the literature used, or provided any clear or comprehensive definitions related to staff education programs. Even the term "staff development" was rarely defined. Hensley and Travis (1997) defined it as "total training -- orientation, inservice, and continuing education" (p. 174). On the other hand, Alspach (1995), in her conceptual framework identified staff development as a component separate from continuing education. The inconsistency of definitions for any of the terms limits the clarity of the concepts.

In addition, Alspach (1995) used the term academic education in her model. This leads to some confusion because she illustrated it as a part of Level 3 in Benner's model (see Appendix A). Benner's (1984) Model of Skill Acquisition for Nursing described Level 3 for competent practitioners. These are nurses who are beginning to feel confident in new situations and able to apply theory in practice (Benner, 1984). Since Alspach (1995) did not outline these terms in her paper, I assume she meant academic knowledge to increase one's knowledge base rather than the initial knowledge one obtains. Furthermore, academic knowledge in Alspach (1995) appears to be consistent with Hensley and Travis's (1997) terms -- inservice and continuing education. Thus, discrepancies exist in the literature.

Conceptual Frameworks

The literature review undertaken revealed five frameworks that may have been appropriate to conceptualize my research: Alspach (1995), Schoenley (1994a), Viau (1994), Knowles (1990) and McDonald (1996).

Alspach (1995), as illustrated in Appendix A, had many components that I found valuable for my conceptualization of the problem including the notion that staff development is a progressive ladder -- from an educational foundation to the outcome of quality patient care -- through which learners move. There are two main strengths to Alspach's model. First, it has a holistic approach to learning. Also, it is similar to the CNO (1997) Quality Assurance program. Both provide mechanisms for monitoring the quality and effectiveness of various learning approaches such as staff development,

continuing education, and academic education. These mechanisms include an evaluative component to assess a nurse's skills, knowledge, and attitude. Ultimately, the programs lead to an evaluation of the quality of care provided to the client. Hypothetically, this framework can be used for both registered and nonregistered staff and for a variety of cultural groups within long-term care.

Schoenley (1994a, Appendix B) also combined a variety of theories including Benner's (1984) Domains of Learning. The primary limitation of this theory was the number of concepts included without any clear definitions. For example, the American Association of Colleges of Nursing's (AACN) essential values are a component of this model. Values -- such as truth, justice, and human dignity -- are relevant for all care providers to support and believe, regardless of diversity in education level or cultural group. They are key concepts that may be vital for a staff development program.

However, Schoenley (1994a) did not define these concepts. Consequently, the definitions are interpreted based on the personal beliefs and values of the individual worker who ascribes certain meanings to the concepts. Thus, the conceptual framework will not mean the same thing to different care providers or to different cultural groups. For example, a RN, from one culture, may feel that "a helping relationship" is one that involves the nurse providing support to a client to maximize the client's potential. On the other hand, a HCA, from another culture, may feel that a "helping relationship" is one that involves the care provider providing all the care for the client.

Viau (1994) described a collaborative teaching model. This model supports adult

learning principles and bases its framework on the unique needs of the each learner. That is, it is a learner-centred process of instruction. This model includes a sharing of decision-making between the learner and the educator specifically in curriculum development. This model is illustrated in Appendix C. Viau (1994) provided descriptions of the principles fundamental to collaborative teaching-learning in the framework and includes the various roles of staff development. I believe that this model would be more beneficial for the program planning components of staff development than for my specific research question because it is much more technique or "how-to" oriented.

Knowles (1990) described a model that identifies the adult learners' unique needs and the strategies to enhance their learning. Androgogy learning is a maturation process through which the adult learner moves from dependence on the educator to one that strengthens his/her self-directedness, including the development of an individual learning style. This model contains six basic assumptions:

1. *Timing of learning and motivation to learn*: Adult learning is based on the educational event being timed to coincide with the adult learners' developmental stage. This means that learning takes place when the learners are capable of comprehending the knowledge and skill based on their personal life experiences (readiness to learn). Adults must be mentally, emotionally, and physically ready to learn. The educator must acknowledge the learner's strengths and limitations. These learners are usually motivated by external factors such as a better salary, promotion, etc.

2. *Experiential*: Adults relate to a lifetime of experience and derive their self-identity from their life experiences. These experiences are an important aspect of their sense of being. Each individual can be a significant resource to the educator. Lastly, the adult learner must have a learning experience that leaves some type of impact. This assists with a change in behaviour, skill, and or knowledge. Adult learners learn best by doing.
3. *Belonging and security*: Adults learn when they take ownership of the process including feeling comfortable contributing, making their own decisions, and feeling respected. This includes the educator providing the educational event in an atmosphere of physical and emotional security characterized by mutual respect, acceptance, openness, and trust.
4. *Immediacy*: The adult learner must be given an opportunity to apply and practice newly acquired skills and knowledge. Adult learners need to know how the learning experience impacts on them and their practice. They will focus on how they can use the information immediately (relevancy-oriented). The learning must be able to help them perform a task or deal with problems.
5. *Self-directed/independent*: Learning is a self-activity and requires active participation. Adult learners want to participate in the choice of activities and the decisions made on how to evaluate both themselves and the educational event. As a group, they will be more heterogeneous than younger learners will be. Different learners learn at different rates and in different ways; therefore,

they learn best when learning activities and exercises are tailored to their individual needs, skills, abilities, interests, and learning styles. In addition, learning of more than one type occurs at any one time and is different for each learner.

6. *Ready to learn*: Adult learners must be given immediate feedback on performance. When they know they are doing it well it becomes a more worthwhile, satisfying learning experience. Adult learners need to have encouragement to continue to learn.

Lastly, McDonald (1996) described a conceptual model of a tree with its roots in knowledge and caring and its trunk composed of fundamental or basic content. The branches represent areas that must be considered equally in any learning environment and include the environment, socialization, and the clients served (Appendix D).

In summary, although Alspach (1995), Schoenley (1994a), and Viau (1994) illustrate their models, none are described completely. It appeared none of these conceptual frameworks were an appropriate model for staff development in long-term care. Knowles' (1990) model is based on general adult learning principles and McDonald's model is curriculum based. Therefore, initially it was difficult to decide whether any one, none, or a combination of them was relevant to my research question.

I reviewed the findings from my research study to determine if there is any congruence between any of these models and the findings. There is no one model that is a perfect fit. Consequently, I combined Knowles' (1990) Principles of Adult Learning with

McDonald's (1996) conceptualization of staff development; I found a tree metaphor to be congruent with my findings.

CHAPTER THREE: METHODOLOGY AND PROCEDURES

Overview

This chapter describes the qualitative research approach. It includes both the theoretical basis and the theory's application to my study. Qualitative research faces specific challenges to maintain rigour and ethical standards. Measures taken to protect the participants' rights are identified. In addition, the data collection methods, utilizing the critical incident tool (CIT) and face-to-face interviews are discussed in detail. These research methods support the purpose of the research study to understand the participants' perspective (the emic view) of their learning needs related to staff development in long-term care (LTC).

Lastly, the process for treatment of the data for this study provides a structure for possible auditability or replication by other researchers.

Research Methodology

The research design was exploratory and descriptive in nature based on a qualitative approach.

Qualitative research is a systematic inquiry which involves understanding individuals' interactions with themselves and their environments. It can be defined as "multi-method in focus, involving an interpretive, naturalistic approach to its subject matter. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them" (Britten, Jones, Murphy, & Stacy, 1995, p. 104). Although there are other definitions (e.g., Field & Morse, 1985; May, 1996; McLaughlin & Marascuilo, 1990) the

key elements, such as maintaining the environment as lived by the research participants and interpreting the phenomena related to the meaning for the participants, are similar.

Nursing is a very hands-on, clinically based profession and to develop research and do experiments outside of clinical practice limits the value of the results and conclusions reached.

> The opportunity to explore issues in the "real nursing world" where the context is part of the research itself is a significant advantage of the research. The many variables within nursing practice, although problematic, can be taken into consideration to produce a richer picture. When empirical research is conducted away from clinical settings, the findings can be idealistic and estranged from the reality of clinical constraints. This highlights the importance of conducting research in the subjects' natural environment where the researcher becomes aware of the problems surrounding practice (Marrow, 1996, p. 45).

In addition, qualitative research is appropriate when researching a previously unexplained topic, or one that is poorly understood or defined (McLaughlin & Marascuilo, 1990). For these reasons, a qualitative research methodology was more appropriate for my research question than a quantitative methodology.

The emic perspective allowed me to examine education from the point of view of the participant rather than myself, the researcher, or the facility's educator. It allowed me to discover the common meaning that care providers use to organize their behaviour and interpret their experiences -- implicitly and explicitly.

Furthermore, each person has his or her own perception of reality related to staff development. The importance of issues will vary from one individual to another. Therefore, it was necessary to study the same phenomena, as experienced by care providers in long-term care, from the viewpoint of a variety of persons. There was a similarity in the areas discussed by each individual participant but the relative importance of these varied from one individual to another. When the individual experiences were summarized, analyzed, and compared, then a pattern of experiences and the development of shared meanings emerged (Ferguson, 1996; Patton, 1990). Qualitative analysis does not attempt to analyze compartments of the human experience but rather it is holistic in its orientation, attempting to investigate the totality of an experience within a given culture and contextual situation (Hamill, 1994, p. 510). Each theme developed must be part of the whole phenomenon of staff development in long-term care. Together the ideas expressed constitute the holistic view of the lived experience.

To identify themes, I carefully studied the concrete examples provided by the participants to gain insight into the essential meanings they attributed to the experiences. Recommendations of Moustakas (1994) were used to analyze the data. The steps of intuiting, analyzing, and describing were used.

Briefly, Moustakas (1994) described a methodology that obtains a core of the common lived experiences of the participants. First, I reviewed the data thoroughly and smaller units of meaning were pulled out. I based the selection of a unit of meaning on the research question. These units had to be able to stand alone (i.e., they were

understandable with no explanation except knowledge of the focus of the inquiry). A unit of meaning was either a few words or whole paragraphs. I reviewed them one at a time to uncover their essences. For each, I re-read the unit of meaning and asked myself, "What are the recurring words, phrases, or topics?' 'What are the concepts that the participants use to explain what the staff educator says or does?' 'Are there any emerging themes?' 'Are there any patterns?' I grouped the participant's experiences (units of meaning) into common themes or essences and labelled each with an abstract descriptor, that is, I formulated of the units of meaning within a provisional category.

After all units of meaning had been categorized I reviewed each category for the properties or characteristics of the group of cards clustered together. I wrote a general statement that conveyed the essence of the participants' lived experience in that specific category. According to Norman et al (1992) categories should have self-explanatory titles with descriptions that are rich though not lengthy and vividly convey a picture of the kind of incidents included in the category. Lastly, they must enhance the distinctiveness of the category. The category descriptions use vivid and suggestive words and/or terms using a more abstract formulation to express common themes.

Upon completing the initial list of categories, I reviewed each. I eliminated all concrete, vague, or overlapping expressions and developed more exacting descriptive terms.

Lastly, I synthesized all identified patterns and concepts into a descriptive narration of the overall conceptualization of staff development as perceived by care

providers in long-term care. I then studied all the themes to try to clarify the meaning and relate them to the whole experience (Appendix E).

In conclusion, the reasons that qualitative analysis was appropriate for my study included: (a) I found limited knowledge about the experiences of staff development for care providers in long-term care, (b) the findings have implications for a broader more holistic staff development program from the viewpoint of the participants for whom the program is intended, and (c) it may generate possible theories, related concepts and hypotheses that have not been studied and are worth studying (adapted from Leininger, 1985).

Instrumentation

Interviews

Both the interview guide and the skill of the interviewer affect the quality of the data collected. Also each type of qualitative research method has specific needs that must be considered when developing an appropriate interview guide. For example, phenomenological interviewing is concerned with uncovering knowledge that is embedded in cultures, incorporating shared language, practices, and important practical knowledge about day-to-day experiences included in these responsibilities (Sorrell & Redmond, 1995). Phenomenological interviews provide the researcher with data regarding the participants' shared meanings. This is accomplished by encouraging the participants to provide a vivid, in-depth picture of their lived experiences, including the context of the experience that shaped the participants' perspectives, and to retain the

integrity of the data. To accomplish this, the interviewer uses both active listening and a narrative approach in a supportive environment. My interviewing style was open, empathetic, and included active listening. In addition, I made sure my probes were more "how" than "why"-formatted to facilitate capturing the meaning or essence of the participants' lived experiences.

The semistructured interview process is an interactive experience in which both the interviewer and participant influence the outcome. The questions are open and the interviewer may ask the participant to clarify his or her responses as the interview progresses. The researcher must encourage the participant to describe his or her unique perspective of an experience. Sorrel and Redmond (1995) emphasized the necessity for the researcher to carefully frame the opening question to ensure the data gathered answers the specific research question. Furthermore, the researcher develops questions that guide the participants to describe rather than interpret the experience to obtain a holistic understanding of the perceptions of the participants.

The conclusion of the interview is participant-driven and usually occurs when the person being interviewed believes that he/she has exhausted his/her descriptions of the experience(s).

The challenges of interviewing ESL participants. Marshall and While (1994) reviewed the challenges of interviewing participants with ESL. They found that most researchers omitted ESL subjects from participation in studies. However, they believed "recruitment of participants with ESL to research is essential if their unique and valid

data are to be collected" (p. 566). Consequently, they identified strategies to include ESL participants in research studies. Although based on a literature review related to consumers and not providers of health care, Marshall and While (1994) believe that these strategies are valid for ESL providers of health care.

Upon review of the strategies I arrived at the conclusion many were important to keep in mind when I interviewed the participants since cultural diversity, as previously identified, was such a large component of long-term care. The first strategy identified was personal contact. The literature described by Marshall and While (1994) supports personal contact to aid in reducing anxiety and demonstrating empathy that would not be possible if questionnaires were mailed or distributed for completion. Furthermore, personal contact increases validity and reliability. These could be at risk since cultural groups and even individuals within these cultures may attribute different meanings to words or concepts used. Also the cultural bias of the researcher, who interprets the words or concepts of the participants, may change the intent of what was said. Lastly, Marshall and While (1994) suggest that personal contact aids in communication because of the nonverbal interaction. Nonverbal communication by the researcher can reassure participants and nonverbal communication of the participants helps the researcher assess participant comprehension and/or fatigue level. I set up interviews at the times and in the venues negotiated with each participant. Ongoing validation with the participants was done at the time of the initial interview and further validation was done at follow-up interviews. This validation included a review of themes I had found to ensure I had not

added or deleted any and that I had described the meaning of their experiences accurately.

In summary, interviewing plans of action included: (a) the use of subtle probes and different words without changing the meaning to aid comprehension, (b) probes that only used the active voice and simple sentence structure, and (c) an audiotaped record of all interviews (with participants' consent). This helped me interpret the responses of the participants with a strong accent, ensure vocal nuances were not lost, and also provided a record of any clarifications I used to ensure my understanding of what the participants said.

Chavez and Oeiting (1995) emphasized that

> It is absolutely necessary that we as researchers continue gathering data on culturally different groups. These populations are growing in numbers, and it is necessary that we have the data to inform policy...it is necessary that we have appropriate cultural knowledge of the group being studied and an understanding of the cultural and language issues which might influence our results (p. 870).

Critical Incident Tool

The critical incident tool (CIT) was the stimulus used for uncovering the participants' reflections on their experiences with staff development. "Critical incident studies are particularly useful in the early stages of research because they generate both exploratory information and theory or model-building. As such, they belong to the discovery rather than to the verification stage of research" (Woolsey, 1986, p. 252). The CIT is narrative and provides a format for the participants to structure their stories.

Brookfield (1987) described critical incidents as brief written or verbal descriptions of vividly recalled situations that, for some reason, were of particular significance to the person recalling the event. The tool would guide the participant through past experiences related to staff development and then cue the participant to answer questions about the remembered event -- both a factual description and a reflection upon it. The critical incident technique was first described by Flanagan (1954) and was initially used in the Aviation Psychology Program of the Army Air Forces during the Second World War to identify effective pilot performance.

Norman, Redfern, Tomalin, and Oliver (1992) stated that the key to the CIT is that participants summarize their overall experience within their description of the incident. Validity can be established since participants recount what they actually saw and felt and what was important to them. Through these reflections the researchers found that "happenings' revealed by the incident the participant chose identified the meanings of the lived experience for them.

The CIT was appropriate for my research question because it provided examples of experiences. The reflections aided me to comprehend the reasons for specific behaviours. Furthermore, the study's findings provided information for the facility's educator through an increased awareness of the current realities in long-term care for care providers. Similarly, critical incidents revealed the values and assumptions of the reflective participants. I did not ask the participants directly to explain rationales or underlying beliefs or values. Therefore, the responses were more likely to be true

reflections of the participants. "Educators know that workplace realities, beliefs, values, and assumptions are strongly linked to learning, growth, and change" (Rosenal, 1995, p. 118). Lastly, I believed CIT to be appropriate for a culturally diverse group with potentially limited English comprehension skills. The CIT emphasizes specific situations, events, and people rather than abstract concepts, broad judgements, or underlying assumptions.

In conclusion, critical incidents, using an interview technique that I audiotaped after obtaining written consent from each participant, limited the necessity for care providers surveyed to be proficient in the English language.

Interview Guide

The interview guide was based on my own experiences in LTC and the themes identified in the literature. It contained questions that sought to focus the interview on critical incidences and the meanings attributed to them by the care providers.

Appendix F describes the interview guide, based on critical incident reflection, used to facilitate the interview process and provide me with suggested probing questions to understand the essences of the participants' experiences.

The guide had three sections. The first part was a brief introductory statement on the study and myself. In the second part on demographics, the participants were asked to identify their position in the facility (i.e., RN/RPN or HCA), the length of time they had worked there, the primary language they spoke outside of work and how they would rate their verbal skills and their reading, writing, and understanding of the English language.

The third section was based on CIT. The participants were asked a set of questions to identify their beliefs and values related to their own learning needs. Both incidents were to have occurred in the previous six months. The only difference was that the first situation described a learning experience the participant enjoyed and learned from whereas the second described one the participant did not enjoy and did not learn from. Both incidents were to be described in detail and the questions to probe for further information were identical. These probes included questions on: (a) details such as the day and time of the learning experience, the location of the event, other attendees, the topic, etc.; (b) specifics regarding the presenter including how the information was presented (lecture, overhead, videos, etc.), the amount of English written material, etc.; (c) factors that helped or hindered their learning; (d) the usefulness of the information provided to their work practices; (e) description of what the participant liked and disliked and if the information changed his or her practice; and (f) questions related to whether the presenter did any follow-up to ensure the participant understands or if there was any additional thing the learner required.

Selection of Participants

The population pool consisted of registered staff and HCA staff within long-term care facilities. The sample included 20 people working in five LTCFs within a 1 hour's drive from a large metropolitan area. The sample included four staff from each of a selection of five nursing homes -- two HCAs and two RNs or RPNs.

Registered Nurses (RNs) function to assess, co-ordiantge, and evaluate care for clients

with more complex care needs or have a less stable medical condition. Registered Practical Nurses (RPNs) function under the direction of an RN, although there is no direct reporting relationship, and provide care to clients who have less complex care needs and a more stable medical condition (Government of Ontario, 1992b). However, for the purposes of this study the role differentiation was assumed to have no impact on their educational learning needs. The five LTCFs were selected based on my professional relationship with the Administrator and/or Director of Care. As previously described, each setting selected was diverse in a number of areas: (a) served a different group of clients, (b) had a different bed capacity, that is, were of various sizes, (c) differed in ownership, either publicly or privately owned, and (d) developed their staff development programs differently. This was illustrated by the educator status within each long-term care facility, which may have included an in-house educator, an externally hired one on a need-to basis to provide educational sessions, or by a number of facilities sharing one educator.

Sampling Strategy

This study used purposive convenience sampling to identify participants. Sampling strategies were deliberate in their intent to choose participants who were most likely to have participated in staff development and to describe their experience for the researcher. Although, it is important to ensure that some persons possessing each of the salient characteristics of the population be included, it is more important to include settings and participants who will provide rich details of the phenomena studied. In

general, the characteristics of the participants and settings determine to whom the results will be relevant. Therefore, it is helpful to gather relevant demographic data about each participant and background information about each setting (Woolsey, 1986). The purpose of the collection of demographic data is to facilitate applicability to other persons of similar cultural or professional backgrounds. Accordingly, only as many persons from a specific cultural background or professional affiliation are included in the research as is necessary to obtain the information. Thus, the sample becomes informationally representative such that the findings of the care providers' perceived learning needs, on a case-to-case basis, can represent other care providers with similar characteristics within similar long-term care settings (Sandelowski, 1995).

Purposive sampling provides information-rich cases for in-depth study. Information-rich cases are ones from which the researcher can learn a great deal about the issues of central importance to the purpose of the research. The participants chosen were those most likely to indicate and reveal the phenomenon in detail (Patton, 1990). Specifically, the individuals selected best depicted the differing characteristics of the long-term care facilities and care providers. The sample was also broad and the perspective inclusive to be able to identify the development of any emerging theory.

The selection of participants was determined by those who had special characteristics or knowledge that may have added to, supported, or refuted any emerging themes. The special characteristics included selecting persons with: (a) varied work experience, (b) a diversity of cultural backgrounds, (c) an understanding of oral English,

and, (d) who had participated in an educational event at the workplace in the previous six months. This increased my understanding of the relevant concepts found through analysis (Field & Morse, 1985).

Recommendations of Cheeks, O'Brien, Ballantyne, and Pincombe (1997) were used to obtain a reasonable number of volunteers to allow purposeful selection of participants in the study. Their suggestions included: (a) circulating a notice throughout the study setting, (b) attending change of shift reports to provide further information, and (c) attending staff meetings to continue to provide information.

Originally, I intended to personally approach staff to determine their interest in the study. Upon further reflection I felt this might put the study at risk of researcher bias and/or influence and I decided not to approach staff directly. Although, the availability of written material can be beneficial in some settings, I believed that because my population included individuals for whom English was not a first language this would be an inappropriate strategy and was eliminated.

Pilot Studies

Prior to implementation, the interview guide was pretested in a two-step process (Berg, 1989). Initially, the guide was given to three Registered Nurses of diverse cultural backgrounds to critically examine for face validity and bring legitimacy to the interview guide for data analysis and conclusion development. This review of the guide indicated that the questions appeared to be simple, logical, and would likely provide the information needed to complete the study. No changes to the guide were indicated at Step

1 of the pretesting.

Following the initial critical examination, the interview guide was presented to two RN/RPNs and two HCAs who, although similar to the population, were not a part of the study sample (i.e., they were from long-term care facilities not a part of the five homes that would provide the sample of staff). These specific staff did not have Englishe as their first language and were interviewed as though they were a part of the sample.

After the interviews I questioned each one regarding clarity of the questions and I also critically reviewed the responses to determine if the responses obtained would answer the research question.

The four persons interviewed found the questions clear with minimal clarification required. There was some indication that those interviewed in the pilot study tried to be more positive than negative. Thus, I tried to reassure them regarding both anonymity and confidentiality. Through this pilot phase I realized the staff were likely to describe more positive than negative experiences. Thus, I was constantly vigilant to reduce bias through any verbal or non-verbal encouragement of positive examples expressed by the participants.

Data Collection

Initially, data collection and analysis were done simultaneously (an iterative approach) as recommended in the literature reviewed. The two processes were believed to be inseparable. The intention included to generate data saturation, that is, when no new themes emerged from the participants and the data were repeating (Streubert & Carpenter,

1999) I would stop the process. However, this strategy led to some interviewer bias (i.e., I began to anticipate participant responses and felt that my questions became more leading). Thus, after the fourth participant was interviewed, the rest were transcribed and set aside for critical review after the completion of all the interviews.

Purpose and Approach

"Data collection is influenced by the knowledge level, experiences, biases, and perspectives of the researcher, as well as by what information the participants are willing or able to provide and what sources of data are available to the researcher" (Downe-Wamboldt, 1992, p. 315). I identified persons (sources) who had experienced the staff development and also were willing to express their inner feelings and to describe psychological experiences that occurred with these feelings.

Data collection included contacting those who agreed to participate in the research before the actual interview. Sorrell and Redmond (1995) suggested that the researcher provide the participants with introductory material prior to the interview so they can come prepared about the topic and answer any preliminary questions the participants may have. In addition, the interviewing tool should be a guide that the researcher uses to assist the participants to describe their experiences without leading the discussion. This can be assured by using a semistructured interview guide that includes open-ended questions to begin the interview process. Researchers can help participants explain things in more detail by including clarifying or probing questions to facilitate the participants' ability to recall the lived experience (Streubert & Carpenter, 1999).

In summary, interviewing "allows the inclusion of (persons) who might be reluctant or unable to provide written information and it maximizes opportunities to elicit the co-operation of participants and clarify meanings" (Norman et al., 1992, p. 594). I selected an inductive, interpretative interview approach because it gave me the opportunity to understand human experiences by going to the participants themselves. They had the chance to discuss learning experiences. I tried to discover the meanings which were attributed to these lived experiences.

Data Processing and Analysis

Analysis

Interpreting the data collected involved decisions based on what had been collected and relating these findings to the research objectives and nursing practice. Reinharz (1983) described a systematic phenomenological approach that transforms the care providers's critical incident descriptions of their perceived learning needs into the lived experience descriptions of staff development in long-term care. This includes transforming:

1. *the participants' experiences into language*. Through verbal interaction with the participants and CIT as the stimulus, an opportunity for sharing the lived experience of staff development in long-term care was provided.
2. *what is seen and heard into an understanding of staff development in long-term care.* Verbatim transcription of the participants' critical incidents recorded a description of the participants' lived experience. Demographic data

about the participants and the background information about the settings were summarized in a narrative descriptive tabular format.

3. *what is understood about care providers's perceptions of their learning needs into conceptual categories*. These categories are essences of the original experiences and became the units of meaning.
4. *Perceptions discovered into a written recorded document*. The draft initial document captured what I thought about the experience of staff development in long-term care and what I reflected about the participants' descriptions. Validation occurred by having the participants review the descriptions of their perceived learning needs to ensure the information was correctly stated and nothing had been added or deleted.
5. *written document into a formally recorded thesis.* My thesis synthesizes and captures the shared meanings of the care providers's perceived learning needs in staff development in long-term care settings with minimal, if any, distortion or loss of the data's richness.

Qualitative analysis is an inductive process that begins with coding of the data (units of meaning). More progressively inductive steps include: clustering or classifying the units of meaning (provisional categories), gathering the clusters into themes or essences, and the interpretation of those essences. An analytical approach adapted from Moustakas (1994) was used for this process.

The initial step *intuiting* required that I become absorbed in the description of the

perceived learning needs of care providers in long-term care and that I began to know about their experiences as described by the participants. During data collection, I documented any ideas, feelings, or responses that emerged, whether participants' or mine, in my journalling log. During each phase of the research, I was cognizant of my personal biases and assumptions and set these beliefs aside to obtain the most accurate description possible of the care provider's learning needs in long-term care.

Analyzing identified the perceived learning needs and was based on the data obtained and how the participants presented the data. It included distinguishing the specific elements (units of meaning) and exploring the relationships and connections with other units of meaning until common themes were noted. I also treated each unit of meaning equally with all other units of meaning.

First, I reviewed the data thoroughly and smaller units of meaning were pulled out. I based the selection of a unit of meaning on the research question. These units had to be able to stand alone (i.e., they were understandable with no explanation except knowledge of the focus of the inquiry). A unit of meaning was either a few words or whole paragraphs. The units were identified with a code to protect the identity the anonymity of the participants.

Lastly, *describing* included descriptions of the critical elements of the experiences. These critical elements -- textural descriptors, structural descriptors, and an overall description -- were based on the classifications or groupings of the units of meanings and also the units of meaning taken individually. I reviewed textural descriptors

of the participants' experience (including verbatim examples) one at a time to uncover their meanings. For each, I re-read the unit of meaning and asked myself, "What are the recurring words, phrases, or topics?" "What are the concepts that the participants use to explain what they say or do?" "Are there any emerging themes?" "Are there any patterns?" I wrote notes that used a key word or phrase that accurately reflected the unit's meaning.

Structural descriptors seek all possible meanings and divergent perspectives and construct terms that aptly describe how something was experienced. Thus, simultaneously I listed and prepared a rough preliminary grouping of every expression presented by the participants. These were the initial provisional categories. I placed the unit of meaning in the provisional categories it appeared to fit. I used as many provisional categories as necessary to reflect all perspectives of all the participants. Each unit was grouped (categorized and coded) with similar units. If the unit did not fit with currently identified provisional categories then a new provisional category was formed. This process was consistent with that described by Maykut and Morehouse (1994) "The researcher seeks to develop a set of categories that provide a reasonable reconstruction of the data she or he has collected" (p. 134).

Lastly, an overall description of the meaning and essence of the experience are documented and brought to written form. After all units of meaning had been categorized I reviewed each category for the properties or characteristics of the units of meanings clustered together under that specific provisional category. These common relevant

constituents were brought together. I wrote a general statement that conveyed the meaning contained in that specific category. According to Norman et al (1992), categories should have self-explanatory titles with descriptions that are rich though not lengthy and vividly convey a picture of the kind of incidents included in the category.

Consequently, the titles must enhance the distinctiveness of the category. I reviewed my initial categories of recurring themes and concepts. I eliminated all vague or overlapping expressions and developed more exacting descriptive terms. The category had to be explicitly expressed in the description and the units of meaning had to be explicitly or implicitly expressed as a component of the specific essence. The units of meaning found to be incompatible with any of the provisional categories were removed and placed in the provisional category that more accurately reflected their meaning. Once the category had been saturated with data and was as holistic and as objective as possible I synthesized all identified patterns, concepts, transitions, and units into a descriptive narrative that ensured the accuracy of the perception of the participants' lived experience. I then studied all the coded categories to try to clarify the meaning and relate them to the whole experience.

Next, I identified two experts (key informants) from long-term care facilities not in the study. The selection was based on their experiences with staff development in long-term care and general consensus within the long-term care community that these persons were "experts". These persons were selected based on their interest and willingness to be a part of the process. The key informants verified, based on their practice as educators,

the emerging themes. They also identified additional themes, questioned established themes, and suggested changes where they saw fit. I then reduced the categories by eliminating overlapping themes or vague or intricate categories. I then reverified these with my key informants. This was done since the research literature has shown that multiple interpretations of the data reduces unsubstantiated meanings and inaccurate interpretations (Jasper, 1994).

Through the research process, there is a professional obligation to seek ongoing clarification, or elaboration of meaning and/or intent from the participants. The researcher must also validate evolving interpretations of the data collected (Sandelowski, 1995). I asked the participants in my study, during the interview process, if this is what they meant or to elaborate on what they had just said. Furthermore, I had a second interview with them to verify some emerging concepts or themes identified from the data collection and key informants.

Assumptions

The key assumption for my study, as identified by Patton (1990), was that the world is patterned and those patterns are knowable and explainable. In other words, the world is configured in set ways and those configurations can be discovered and explained. Thus, the assumption that individuals can recall and describe their learning experiences was established. I assumed the participants' capability to take part in the research study if: (a) the participants were able to sign a consent form written in English, (b) I had informed the participants about the research study, and (c) I obtained their

voluntary consent. Furthermore, since the participants' knowledge of the English language had to be sufficient enough to read a consent form in English it was assumed they could speak it and I assumed that their verbal English skills were adequate and a translator was unnecessary. Also due to the necessity for informed written consent, the sample selected necessitated that the participants had a good understanding of English in order to be able to sign the consent form. Based on my experience I assumed that this level of English is not likely common to all long-term care providers.

Not only did I assume that culture and professional/vocational affiliation would make a difference to care providers and their perceived learning needs but also that care providers in LTC had learning needs that were important and different from staff in acute care.

Limitations

My study had a number of limitations including author, sampling, participant, and interview biases. My biases as the researcher and author of this study related to my cultural background. I am a white, Anglo-Saxon female. I was cognizant of my cultural background and consciously minimized my own biases when interviewing persons from other cultures by being cognizant of how I phrased things or the probes I used. Additional factors that may have biased me included my professional experience as both an administrator in long-term care and also as an educator. Both provided me with prior knowledge that could have influenced my interviewing or data analysis if I had not consciously monitored these risk factors by choosing my words carefully and through the

use of the participants' own words.

Sampling biases such as sample size, selective bias, self-selection, and the inclusion criteria will be discussed next. Sampling in qualitative research differs from quantitative research sampling and the measure of generalizability also differs. The sample size could have been a limitation if I did not obtain sufficient data to develop the richness and detail of the phenomena being studied. This factor was noted to be a limitation with regarding to the negative learning experiences. Although much support and assurance of confidentiality and anonymity were provided, I found that a number of participants denied having any negative experiences. I do not believe that this area had data saturation. However, due to time constraints and the scope of this study I did not attempt to recruit further volunteers.

Selective bias means that the findings will not be generalizable from sample to population but from case to case. Although I attempted a variety of methods to select persons who typify varied cultural backgrounds, participation depended on the nurses' voluntary consent and was not similar to the total population. Thus, this self-selection reduced the richness of the data collected. An attempt was made to obtain as large a variety of cultural backgrounds as possible. However, it is assumed that there is still a segment of the population who did not volunteer for whatever reasons. This may have occurred since some cultures believe to volunteer denotes some type of expertise and the participant may not feel "qualified" to answer the questions (Chavez & Oeiting, 1995). Conversely, various cultures may attribute different meanings to a situation or behaviours

and I had to be careful during data collection and analysis not to infer my meanings to the participants' beliefs and values.

When I collected and analyzed the data I kept in mind the individual's perspective and interpretation of an experience may be dissimilar from mine. I analyzed all data based on the participants' learning experiences as articulated by them and the meanings they attributed to them. However, care providers who voluntarily consented to participate were not necessarily representative of the entire LTC population.

In addition, scholarly and ethical standards mandated a written English consent. Furthermore, the decision that the participants are care providers with a good understanding of oral and written English employed in specific long-term care facilities within a limited geographical area limited the population pool. Consequently, these factors reduced the generalizability of the findings to the population as a whole. Specifically this research may be generalizable not from sample to population but from case to case. However, the findings are informative since this topic has not been adequately addressed in the literature.

Participant bias describes biases such as social desirability, "true experiences," and cultural variation. Social desirability describes what the participant believes the researcher wants to know (Sandewlowski, 1993). I have a background in long-term care and I knew some of the participants superficially. There had never been a direct reporting relationship between myself and any of the participants, nor did I work directly with any of them. However, because we had a professional relationship in the past, the participants

may have unconsciously distorted information to present what they believed I wanted to hear or was more favourable to themselves. Also, the participants may have excluded parts of the experience that were painful or confidential; therefore, the description may not be the complete and true experience. However, I made every effort to overcome this by fostering an environment of safety, trust, and acceptance through my accepting nonverbal cues and calm, soothing voice I used.

Cultural variations further emphasized the importance of personal contact between myself and the participant. For instance, Zane (1994), cited in Chavez and Oeiting (1995), emphasized that in many Asian cultures self-effacing behaviour and modesty are sought-after values. Thus, if the individual volunteered for something it implies that she/he is more of an expert than other persons. This would reduce the likelihood of the individual volunteering. Consequently, as a researcher, I was aware of cultural variations. Although a risk, I do not believe cultural background, as described above, was a limitation for participation by the various cultural groups.

Lastly, interview bias may include time lapse considerations and salience of events. The longer between the event being investigated and the actual interview, the greater the inaccuracy of the data. The participants' perceptions are important in the interview process to minimize interview bias. The participants were asked to recall events that had occurred no more than 6 months prior to the interview. It was noted that even with the timeline, some participants had difficulty recalling a situation. However, Woolsey (1986) stated if the event is relevant and significant to the participant, the

reporting is likely to be more thorough and accurate. This was found in my study. Once the participants recalled an event, the description of the situation and their feelings was detailed and fairly thorough.

Methodological Rigour

Applying criteria from one research method to another inevitably favours the research tradition that generated them. Thus, rigour in qualitative research cannot be measured by the same criteria as quantitative research (Sandelowski, 1986). Guba's and Lincoln's (1985), as cited in Sandelowski (1993), framework describes a rigourous standard for qualitative research. The components of this framework included: truth value, applicability, consistency, and neutrality.

Truth value measures credibility. In quantitative research this is measured using internal validity. To achieve truth value, the qualitative researcher must report sufficient details of the data collection and the processes of analysis to permit others to judge the quality of the final product. To demonstrate truth value, the results must include findings that make sense and are credible to the reader, and which authentically portray staff development in long-term care as perceived by the care providers. I used an initial conceptual framework to guide data collection, analysis, and interpretation; in-depth descriptions and direct quotes to report the findings; and conceptually clustered units of meaning to illustrate and interpret the data collected. Furthermore, I attempted to find other plausible explanations for the findings and describe negative cases (i.e., the "exceptions" to the rule) -- those cases that did not fit the emerging pattern (Patton,

1990).

Secondly, applicability is a key measure of rigour. In quantitative research this can be assessed when measuring external validity. Qualitatively, applicability is measured through congruency or fittingness. The analysis of the data must fit the lived experience of the participants within a given situation or context. The objective of qualitative research is that the persons having the experience will have an "aha" when reading the analysis of the findings. Generalizability, in the quantitative sense is not emphasized. Alternatively, qualitative philosophy describes collecting data in a particular situation. Consequently, the research can assess a practice or proposition in that setting only, that is, qualitative approaches observe effects in context (Denzin & Lincoln, 1994). Qualitative researchers argue that "generalizability is itself something of an illusion since every research situation is ultimately about a particular researcher in interaction with a particular subject in a particular context" (Sandelowski, 1986, p.3).

Firestone (1993) described three levels of generalizability in research including: (a) sample to population (more useful in quantitative research), (b) analytic (theory-based) where connections made are beyond the immediate study to links with other theoretical frameworks; and (c) case-to-case transfer. Case-to-case transfer is appropriate for my research.

Case-to-case transfer, according to Firestone (1993), occurs when an individual in a specific setting considers selecting a program or idea from another setting to be a part of his/her setting. Evaluation includes comparing the two settings and the generalizability of

the findings in the first setting to the second one. Thus, rich descriptions of the setting of the initial research site must be complete enough to allow the comparison. Lastly, the reader compares the two settings and makes the determination if the findings are transferable to his/her specific setting -- not the researcher of the initial setting.

Schofield (1993), as described in Firestone (1993), supports case-to-case transfer. She emphasized that researchers analyze the degree to which their specific setting matches the setting being described in the research setting being evaluated. If the two scenarios are reasonably similar then the findings can be transferred from the initial research setting to the potential setting. I have included rich descriptions of both the settings and the participants to assist other researchers to determine if the findings are appropriate in their specific setting or research milieu. Therefore, the findings are more likely to be viewed as meaningful and applicable to the readers of my research and in terms of their own experiences.

Sandelowski (1986) described the next measure of rigour as consistency. In the quantitative paradigm, this refers to the reliability, stability, and dependability of a given circumstance. Inherent in reliability is repeatability. Another researcher should be able to replicate the findings. Guba and Lincoln (1985), as cited by Sandelowski (1993), proposed that auditability is the criterion to measure consistency in qualitative research. This researcher follows the "decision trail' and arrives at the same or comparable findings that are not contradictory to those of the original researcher. I used two measures for auditability: my journalling log of decisions made and a chronology of events, and my

detailed outline of the methodology of this study.

Finally, neutrality refers to the minimizing of bias in the research. Quantitatively, the criterion measure is objectivity and is believed to have occurred when reliability and validity are established. Andersson and Nilsson (1964) as cited in Woolsey (1986) found that the CIT is valid and that using additional data collection methods provided no new information. They found the number and structure of the incidents were only slightly affected by other methods of data collection and by different interviewers. Thus, it is also a reasonably objective tool for qualitative research so other data collection tools are unnecessary. In addition, the identification of my assumptions prior to the beginning of the data collection contributed to the neutrality of my research.

Qualitative researchers measure neutrality on the merit of the study's confirmability. Truth value, applicability, and auditability establish confirmability. Complete objectivity, qualitative researchers believe, cannot occur because true separation between researcher and participant is not possible and that the investigation of a phenomenon will change it (Sandelowski, 1986).

In conclusion, there are specific strategies I used to maintain methodological rigour. These were: (a) data collection across a range of settings, (b) key concepts identification with clarity, (c) audit trails so any person could understand the progression of events and their rationale, (d) a holistic approach to data collection, (e) a journalling log that documented information about the research process including all decisions made and their rationales and the impact the researcher and participants had on each other, (f)

identification and reporting of both typical and atypical cases, (g) a description of the process used to categorize and code the data collected and how the different elements of the data were linked, and (h) validation from the participants by clarifying what the participants said during the initial interview and confirming concepts discovered at the follow-up interviews.

> Qualitative research is a representation in the same sense that an artist can, with a few strokes of a pen, create an image of a face that we would recognize if we saw the original in a crowd. The details are lacking but a good "reduction" not only selects and emphasizes the essential features, it retains the vividness of the personality of the rendition of the face (Tesch, 1990 cited in Sandelowski, 1993, p. 3).

Consequently, good qualitative research does not include so much data/phenomena that the details overwhelm the perceptions of the situation/experience itself. Just as one artist's view of the face is no less valid than another artist's, one researcher's analysis of a participant's lived experience is as valid as another's. However, disciplined subjectivity helps to increase shared understanding.

Ethical Considerations

Ethical considerations are important to any research but are more so in qualitative research because the researcher and the participant are not always at "arm's length" from each other. The key ethical concerns with this study included the right to privacy, the right to know, informed consent, nonmalifience, responsible reporting, and credibility.

These ethical principles are also inherent in my knowledge bases as a health care practitioner (College of Nurses of Ontario, 1995).

The right to privacy means the individual has the right to be protected from identification. Each participant was informed orally and in writing that all information discussed during the interview process would remain confidential and that anonymity was assured because identification will not be possible for anyone reading the results. All audiotapes are in a secure location to maintain the anonymity of the participants. Furthermore, only I had access to the raw data. Additionally, protection of the privacy for the individual increases if the findings have been interpreted according to established rules, structures, and guidelines and through the use of a conceptual framework (Rothe, 1993).

The principle of the right to know outlines that any person affected by the research should be able to obtain information about it while preserving the confidentiality of the research study's participants. To provide knowledge of the findings, of this study I have developed a structured, documented plan for disseminating the information. Participants will be offered a summary copy of the results and have been provided with a name and phone number to contact if they have any questions about the study.

Informed consent means the researcher receives agreement from the participant to be in the study after he or she has been carefully and truthfully told about the study. Informed consent involves three characteristics: (a) knowledge and understanding, (b) ability of the participants to consent freely, and (c) documentation of the participant's

consent. Knowledge and understanding becomes difficult when a potential participant's comprehension of English is limited. Thus, I took my time and explained the study in detail. I repeated myself as often as necessary to ensure understanding. Since the participant had to give his/her consent freely there was no coercion nor any reward for participation. I provided information to the participant regarding the option to withdraw at any time from the study without explanation or any repercussions. Lastly, the participant was asked to sign a written consent form. The written consent documented that informed consent had been obtained. The information outlined on the written consent provided all the information about the study, the participant's right to withdraw without penalty, and that no coercion, subtle or otherwise, was used to influence the individual to participate. The consent also included permission to audiotape the interview. Without informed consent a significant breach of ethics would have occurred. The consent form is in Appendix G.

Nonmalifience, as an ethical principle, protects the individual from physical or emotional harm. There was not any known untoward psychological or physiological fallout. However, this area had to be considered in case something unexpected did occur. Instead of trying to determine participants at risk, I gave all participants reassurance related to confidentiality, anonymity, and debriefing on the process. I documented in my journalling log all decisions made, how I handled issues, and the rationale for decisions. There were no unanticipated events and participants did not appear to be nor did they verbalize any physiological or psychological untoward effects from the study.

Furthermore, I do not have a position of authority or responsibility with respect to any of the participants. That is, I was a neutral, external researcher.

Responsible reporting is a presentation of a complete and balanced view. My analysis of the findings addresses conflicting points of view and presents a comprehensive picture of what was discovered representing the various viewpoints.

Lastly, to maintain credibility only questions related to my research question were asked to eliminate extraneous information. As well, I interpreted all findings according to proper phenomenological inquiry, as described by Reinharz (1983), including immersion in the data and the coding of the data. Data analysis, as adapted from Moustakas (1994), identifies the essences of the participants' lived experiences using thematic descriptions that depict these experiences succinctly and accurately. Ethically, all typical and atypical cases were reported.

CHAPTER 4: DATA ANALYSIS AND INTERPRETATION

Introduction

This chapter presents the findings obtained from my analysis of the data. This includes the learning needs of the care providers in the select long-term care facilities (LTCF) as perceived by them.

Participant Descriptions

Ten HCAs from five LTCFs were interviewed. These staff had been working in their respective facilities between 7 and 17 years with a mean of 11.3 years. The primary languages spoken were: Canadian or British English (4), Jamaican English (1), Punjabi (1), Ewe – an African language (1), and Filipino (3). There were nine females and one male. The participants rated their own skill in English as excellent for seven of the interviewees and good for the remaining three.

The 10 Registered staff were not separated into RNs and RPNs since for the purpose of this study they were taken as a cohort. They were from the same five LTCFs as the HCAs. They had been working in their respective facilities between 2 and 20 years with a mean of 9.5 years. The RN/RPN spoke the following languages as their primary language: Canadian or British English (5), Jamaican English (1), French (1), Polish (1), and Filipino (2). This sample also included nine females and one male and they rated their skills in English as excellent for nine of the interviewees and good for one. This information is summarized in Table 3. Participants were not selected based on their proficiency in English being good or excellent.

Table 3

Participants' Professional/Vocational and Cultural Backgrounds

AFFILIATION	M/F	YEARS OF EXPERIENCE	FIRST LANGUAGE	ENGLISH SKILL
HCA	M	14	English	excellent
HCA	F	10	English	excellent
RPN	F	20	English	excellent
RPN	F	19	English	excellent
HCA	F	14	Punjabi	good
RPN	F	2	English	excellent
RN	F	10	French	excellent
HCA	F	7	Ewe (South African)	good
HCA	F	17	English (Jamaican)	excellent
HCA	F	15	Filipino	excellent
HCA	F	10	Filipino	good
HCA	F	12	English	excellent
HCA	F	13	English	good
HCA	F	8	Filipino	good
RN	F	5	Polish	good
RPN	F	12	Filipino	excellent
RPN	F	3	English	excellent
RN	F	7	Filipino	excellent
RPN	M	9	English	excellent
RN	F	8	English (Jamaican)	excellent
TOTALS – HCA	9-F 1-M		English – 5 Other – 5	Good – 5 Excellent – 5
TOTALS – RN/RPN	9-F 1-M		English – 6 Other – 4	Good – 1 Excellent – 9

Analysis of the Critical Incidents

The findings obtained did not demonstrate any large differences in responses related to either professional/vocational affiliation or cultural background based on the primary language spoken. The sampling strategy utilized did not support any comparisons. Thus, further researchers must revise the strategy prior to data collection. All participants' responses could be categorized within similar themes for both the positive and negative learning experiences. Therefore, other than identifying numerically the variability of the professional/vocational affiliations, I did not subcategorize the findings. I approached identifying concepts and patterns within the units of meanings by counting the number of respondents who described that specific theme. Counting is a "crucial further step of interpreting the pattern" (Morgan, 1993, p. 115). Thus, counting aids in data analysis (in qualitative research) whereas in quantitative research it is used to describe and summarize, not interpret, what is known about the data. Briefly, interpretation began initially with obtaining a core of common lived experiences as described by the participants. These experiences (units of meaning) were grouped into common themes and labelled with a descriptor that is an abstract formulation of the units of meaning within that provisional category. Lastly, all identified patterns and concepts were synthesized into a descriptive narration of the overall conceptualization of staff development of care providers in long-term care. These concepts were divided into themes of positive learning experiences and negative learning experiences for the registered and nonregistered staff.

Themes of the Positive Learning Experiences

The analysis of the care providers' responses regarding their positive learning experiences identified six themes. These themes are: (a) experiential learning, (b) humour, (c) specific characteristics of the presenter, (d) environmental factors, (e) relevance to practice, and (f) decision-making authority within their LTCF. The percentages of respondents for each theme are identified in Table 4.

Table 4

Common Themes from Positive Learning Experiences

THEME	RN/RPN RESPONSES (x/10, %)	HCA RESPONSES (x/10, %)
hands on/practical application	8, 80%	8, 80%
humour	7, 70%	7, 70%
presenter characteristics	7, 70%	6, 60%
environment	7, 70%	6, 60%
relevance to practice	5, 50%	8, 80%
decision-making authority	2, 20%	1, 10%

Experiential learning. Both RN/RPNs and HCAs responded in 80% of the interviews (16/20) that an opportunity to utilize the information in a hands-on application increased the value of the learning experience. This could be seen through the use of a simulated patient. However, for some learners the simulated patient might be anxiety producing and intimidating and did not provide a supportive environment.

1. "I liked the use of the simulated patient. It allowed me to practice my skills on someone I can't hurt and in a learning situation. The debriefing afterward allowed me to understand how what I did or said made the patient feel" (Participant T3/7).
2. "The simulated patients are scary. I feel like I am always being evaluated by the educator. I am afraid that if I do something wrong they will think that I am doing those things with my patients and they may not think I am a good nurse" (Participant T5/13).

Other types of experiential learning were also beneficial to the learner. This may include hands-on practice for new skill development or being able to manipulate products that may be used in the LTC setting. This theme is evident in the following comments:

1. "Different companies, selling their products…liked the hands-on. Actually able to use all of the equipment and find out which was the best" (Participant T2/6).
2. "There were no activities just talking. A lot of hands on. It was like a product fair as well. You got to go around and check and test a lot of different products. Put on by a number of companies. About 12 I think. That was the good part about it. It wasn't just one company. Therefore it wasn't biased. A lot to choose from, a lot to

look at" (Participant T3/8).

3. " . . .Had to feed each other – pudding and other things with different consistencies. Liked feeding each other. She <the presenter> had us feed each other quickly and then slowly so we could see how the residents feel. We used big spoonfuls and then smaller spoonfuls. We couldn't use our hands if we were the resident. It gave me a good idea of how the residents felt when I feed them. Made me more aware of how important it was to feed them in a certain way" (Participant T3/10).
4. "No activities to do. Showed us all the parts of the machine. Demonstrated on an actual one. Then we got the chance to practice using the oxygen cylinder so that when we had one at work we were more comfortable with it" (Participant T7/5).
5. Fire drills teaches you how to cope with a fire -- how to put it out and how to evacuate the residents. When I started here it used to be a fireman that comes and demonstrates. But now for the past 4-6 years I haven't seen the fire department come. Now it is just the management here that do it and we watch a video. Before they used to show how to use the fire hose and the fireman would light up something and they would make you hold the fire hose and put out the fire. Now it is more pretend…I liked the practice because someday there could be a problem and you know how to deal with it. Some time these things are going to happen and if I don't learn from it how can I apply it to the situation? It is good to have it regularly because the more you often you get taught the correct way when things

come, you never know, you apply them in the proper way. There is no panic or whatever" (Participant T7/20).

Case studies or role playing of a situation that may occur in LTC was another type of experiential learning that the participants found to be a positive learning experience. This theme was described as follows:

1. "Case studies were helpful. Provided a chance for group feedback and discussion. Putting residents' behaviours in the Resident Care Plan and making sure they are precise is a lot of work. The practice setting helps a lot" (Participant T2/1).

Humour. Many participants (70% of both the HCAs and of the RN/RPNs (14/20) described humour as a key component of any positive learning experience. Although humour can be one component of the presenter's characteristics. I chose to identify it separately since it was discussed as an important component so frequently. The humour may be presenter initiated or participant driven. However the key appeared to be that it was an accepted part of the learning experience and encouraged.

This theme is illustrated in the following comments:

1. "A sense of humour is important. A little joke or story breaks the monotony of the speaker" (Participant T2/3).
2. "Sometimes if the topic is very detailed a laugh helps break the heaviness in the air and makes it easier to get back into the subject" (Participant T4/15).
3. "Laughing makes the learning more fun and relaxed. The less stressful the

environment the more likely I am to learn the information. I like to have fun at work especially during an inservice" (Participant T4/12).

Presenter characteristics. Both HCA and Registered staff described many factors that can be considered related to presenter characteristics. This theme includes such factors as ability to explain a topic containing the use of simple language, enthusiasm when presenting, encouraged the learners to ask questions. The theme of presenter characteristics was evident in 60% (6/10) of the HCAs' positive learning experiences and 70% (7/10) of the RN/RPNs'. The following excerpts from their comments illustrate this theme:

1. "He came and explained to us all about oxygen tanks and how to use them. He explained it really well" (Participant T4/5).
2. "His style of teaching made it a better learning experience because he spoke loud, very clear, simple words. If any of us did not understand we asked him questions. He had a sense of humour and was enthusiastic. It made a difference on how much I learned" (Participant T5/2).
3. "WHMIS (a positive learning experience). The guy explaining it was really good. He used simple words that we could understand. He didn't use any big words to explain it. When we were answering questions he would give you a hint and that would help trigger something. You know the stuff you know but you don't really remember until someone says a keyword or something" (Participant T1/17).
4. "I liked the teaching style because there was enough time for questions and then

discussions. That kind of thing. So it helped you to learn too…I mean questions about what you don't understand and then have a few discussions regarding it. And then also the video was left for us. You could stay and watch it on your own free time, if you wanted to" (Participant T6/19).

5. "Heimlich Maneuver. It was done in a group setting. The instructor was very informative, clear. She also made it fun. There was a fair amount of humour involved. So I think that was what, I think, helped me learn. It also drew you in. If she was relaxed and comfortable and explained it very basic, very basic that helped. There was no big words or anything" (Participant TT1/14).

Environment. Key factors that make the environment conducive to learning are not only being a day off but also even more beneficial to be at another facility (away from the place of employment). Of the first critical incidents interviews, 60% (6/10) the HCAs and 70% (7/10) of the RN/RPNs felt that time off benefited their learning. This theme is highlighted in the following quotations:

1. "Easier because away from work" (Participant T5/2).
2. "Relaxed, humour, informal, in the evening. Everyone came in street clothes. Seemed to be meeting as friends, not coworkers. Added that little extra, more cohesiveness. Everyone chose to be there" (Participant T3-12).

Relevance to practice. Many staff needed to know how the information presented would help them in their day-to-day practice. Although an important component for both staff groups, I found that the learning experience was more likely to be positive if it was

relevant to the work setting for the HCAs (80%; 8/10). Fifty percent of the RN/RPNs (5/10) expressed this as important. This theme is seen in the following comments:

1. I liked it because I do the job. It helped me put it more into perspective what I have to do and refined the things I have done before" (Participant T3/9).
2. "Used case studies involving our own residents so we got to problem solve difficult behaviours we were experiencing" (Participant T 4/6).
3. "What I liked best was that I could come back here and apply it. I could use it, the things that I learned that day. It was all about ulcers and wound care. It was practical. I could apply it to my job. Treatments are the focus of my job here (Participant T7/11).
4. "Helps you understand much better people who have suffered stroke, go into stroke recovery. You know, because some are cognitively impaired and there those who are not. Actually, it explained a lot because you might be thinking why is this person not doing this and every day getting frustrated with them . . . (Participant T7/1).
5. "Helped me understand a whole lot of things about caregiving you might be blaming someone for not doing this or that. But that person may not have any control over what is going on. It is this person's condition due to whatever diagnosis the person has got not the particular person. It helps me answer why is that person doing that today and not tomorrow. Changed the way I work with the residents because I am able to understand what is happening much better

(Participant T3/16).

Decision-making authority. Although it was not mentioned by many participants, for those that did discuss it (10% of HCAs (1/10) and 20% (2/10) of RN/RPNs) it was a significant issue that made the learning experience more enjoyable and one that they learned from. The following comments from the first critical incident represent this theme:

1. "Different companies, selling their products. We decided which one was the best one and we purchased it. Once we decided which one we wanted the company rep came into the nursing home and went from resident to resident to see if they would qualify for the sit-stand lift" (Participant T1/16).
2. "There was a new product that was just recently introduced in the nursing home. They'd used it in a lot of other different nursing homes so they brought it here. The Director of Care (DOC) gave me permission to try it. Because I have the background and knowledge the DOC trusts my judgement, that makes it more beneficial to me. It made the learning about the treatment more valuable because the decision to use the product and which residents to use it on are up to me" (Participant T5/8).

Themes of the Negative Learning Experiences

This was much harder for the participants to answer. Originally, nine (64.3%) out of the total group of participants indicated that there were no problems in the learning experiences at their facility. Many explanations were given including: (a) management

always tried to plan good learning experiences and the participants emphasized their appreciation, (b) they could not think of any, and (c) even if they had prior knowledge of the topic they felt they still could learn more about it.

In order to obtain further negative incidents I re-iterated that this was confidential and anonymous. I also explained that a negative experience was not a reflection of a poor program and actually helped the education co-ordinator to develop learning experiences that better meet staff's needs. However, even with this support and encouragement six (42.9%) continued to deny any negative experiences (Table 5).

Table 5

Negative Experiences: No Answer

PROBE	RN/RPN RESPONSES (x/10, %)	HCA RESPONSES (x/10, %)
prior to encouragement	4, 40%	5, 50%
after researcher encouragement	2, 20%	4, 40%

One HCA put it the most eloquently,

> There wasn't any inservices I didn't like. No matter what the situation is, there might be something you don't know or something that you already know that can be reconfirmed. Whatever the information it is worth hearing the information again, even if you know something. From my viewpoint we all need a roof over out head and meals on the table but the residents need our help. If not, then you are just doing the job and not helping the residents. Going to short courses helps you learn. As a part-time worker it may be difficult but as a human being you may be passing them <the residents> one day and you don't just look at them and think it is not happening to me. Because one day it could happen to you, a friend or your family. You would want someone who knows and understands to be taking care of you. (Participant T11/5).

The themes for the second critical incident included: (a) relevance to practice, (b) timing of the inservice, (c) presenter characteristics, and (d) the learning environment (Table 6).

Table 6

Common Themes from Negative Learning Experiences

THEME	RN/RPN RESPONSES (x/8, %)	HCA RESPONSES (x/6, %)
Timing	8, 100.0%	6, 100.0%
Presenter characteristics	5, 62.5%	5, 83.3%
Relevance to practice	4, 50.0%	2, 33.3%
Environment	1, 12.5%	1, 16.7%

Timing. This theme was identified as a hindrance to all the care providers who provided negative learning experiences. There were a number of variations to the theme but the key was the lack of time to attend. Some of the variations were: (a) using break/lunch time to attend, (b) there were no replacement staff to cover the unit and there was a lot of work to be done on the unit, (c) the time of day, and (d) care providers feeling that they should attend on their own time (without compensation). This theme is clearly illustrated in the following excerpts from the interviews:

1. "Inservice on lifts and transfers. Information I already knew. It was during work time. That made it harder because I had to go back to work. Always in my mind that I wanted to do 'this' and 'this' and that I wanted to complete 'that' before I leave (for the day)" (Participant T10/10).
2. "Inservice at 2pm. Bad time for day shift because we are up at 5 so by 2 if you sit us down we are usually nodding off" (Participant T12/16).
3. "Knowing I had to stay after the end of my shift to catch up on the work I left upstairs made it harder to pay attention" (Participant T17/17).
4. "I work steady afternoons. So when there is an inservice booked for 2pm I will come in for it but that also means I have to leave the inservice early because I start at 2:45 to go and get report. It is also harder because it makes it a longer day. It is very rushed. Don't get to see the end of the inservice, miss the questions, hard to get mine answered" (Participant T13/12).
5. "Inservices done at the supper hour. I have to leave early because I have to make

sure I get upstairs to get the medication done or I won't be out of here on time. It's a time element. Time is your worst enemy" (Participant T9/3).

6. Time of the day doesn't matter much to me. Once I am there I am there. But it is harder because I was working because I felt like I was rushed for time and I was always watching the clock" (Participant T4/7).
7. "What I didn't like about it was that it was at break time. Had to go then and learn something. I don't think I should have to use my break time. The timing was bad. Although any time is bad if you are working that day" (Participant T5/4).
8. "Don't like when they are at 9:00 or 1:30. Busiest times of the day. Because if I don't get my work done then I don't get off the floor on time and it makes it harder. Inservices are very time consuming and not everybody can attend. I try to send the HCA because I already know a lot of stuff and it gives them a chance" (Participant T15/9).
9. "Pay me to come in on my time off to attend because if I have to leave the floor things don't get done. Self directed would be okay but I like direct learning. I love to read but I have to be in the mood. I like to learn in a social setting" (Participant T11/20).
10. "Some things they have to discuss them in more detail. Sometimes you come in there, like one time I attended WHMIS and it was the first time in 20 years I had ever heard about it. The time was difficult. It was on your break time and by the time they finished it break time was over. It was kind of rushing things. If it was a

little longer, say another half hour, it would not be rushed and it would explain it properly but then I'd think 'Oh I have to get back to the floor. I have a job there and I have to be fair to my coworkers too" (Participant T11/19).

11. "It was about 3:15 which is okay. When you are on afternoons you have a little more time than on days but workload is still an issue. It actually makes it difficult because we are thinking of going back on the floor to have your work done so you won't be late for the next, I mean, mealtime. That is supper time which is just so close by. But it is a bit, ummmm, better compared to working day shift. I guess it's a bit okay at that time" (Participant T17/4).
12. "Don't like inservices that are too late in the day and the later in the day the shorter they should be. An inservice should last no more than thirty minutes anyway" (Participant T12/15).

Presenter Characteristics. Of the RN/RPNs who responded 62.5% (5/8) and 83.3% of the HCAs who responded (5/6) wrote how they felt about the presenter's style and characteristics that made the learning experience less enjoyable and valuable. The following excerpts from their comments in the second critical incident illustrate this theme:

1. "Didn't like the speaker. Had a monotone voice and he wasn't very interactive" (Participant T16/4).
2. "It was long and drawn out. Tried to stretch it into an all-day thing. They talked fast but there was not a lot of information. Too little information, talking too fast,

stretched. All kinds of professors and doctors came up to say how some people can be reformed, trained again from brain injury. They all said the same thing all day" (Participant T1/18).

3. "Mostly lecture. Large words. A lot of large words that we did not understand half of. And too fast" (Participant T11/20).
4. "Not able to break it down to the person who has the lowest knowledge level. Need to individualize teaching. Not everyone learns the same way. I can learn six different ways but some people can't they need you there to walk them through it six different times. Teachers have to remember the audience they are focusing on" (Participant T10/3).
5. "Unable to answer our questions" (Participant T6/15).

Relevance to practice. Fifty percent (4/8) of the Registered staff and 33.3% of the HCAs (2/6) described the theme relevance to practice in the second critical incident. This theme is reflected in the following comments:

1. "Went to an inservice in Toronto on abusive behaviour. No, it wasn't on abusive behaviour; it was on brain injury and better ways to cope with it. I found it to be totally useless for our group of clients. Didn't teach us enough about how to deal with the elderly, abusive, brain injured that we have. Focused on the families and how to deal with their issues. Not focused on health care providers" (Participant T15/18).
2. "Went to an inservice on feeding techniques it did not interest me. I do not feed

the residents. It is good knowledge to have but...."(Participant T9/11).

3. "Maybe some of the topics did not quite apply to me, being in a nursing home setting. Some of the focus was more on hospitals. May have been better if given only to nursing homes because the hospital part did not interest me at all" (Participant T9/8).

Environment. The theme of environment was evident in 12.5% (1/8) of RN/RPN responses and 16.7% (1/6) of HCA responses in the second critical incident. this theme can be seen in the following descriptions:

1. "the room was in the basement and dimly lit. I felt cold and damp down there. I did not feel very comfortable. Besides the room was small and was not made for inservices – it use to be a storage room and still felt like one" (Participant T).
2. "don't like the bird chirping in the background" (Participant T5/8).
3. "room was too cold and the chairs were borrowed from the residents' dining room and were very uncomfortable" (Participant T16/9).

Evaluation Component of the Learning Experience

Twenty participants described 34 learning experiences. Of those 34, two (0.5%) critical incidents discussed the evaluative component of the learning experiences and a further eight (ten in total or 29.4%) responded to the probes in the interview guide. The responses included three (8.8%) that the presenter did not explicitly request any feedback on the learning experience nor provide any indication of how the participant could obtain clarification if necessary. The other seven (20.6%) indicated that the presenter did not

directly ask them or return to the facility to determine if they required any clarification. However, these participants voluntarily told me that they were sure the presenter of the material was available if needed. None of the participants described any formal evaluation that had to be completed for the presenter regarding the quality of the learning experience.

Supplementary Themes

Of the 34 critical incidents, there were 24 (60%) that described the use of supplementary tools. These were as follows: overheads with primarily words, five (20.8%), overheads with both words and diagrams, three (12%), two (8.3%) that used videos that were primarily pictorial, four (16.6%) had videos that were a combination of words and pictures, and eight (33.3%) presenters provided handouts or pamphlets that were principally words. One of the learning experiences included a compulsory test and one was an in-depth case study on documentation. Thus, English language skills were essential. None of the presenters appeared to be cognizant of the possibility of any of the learners might have limited English skills.

Practical Applications of Data Analysis

Humour as a teaching strategy has been the subject of many articles regarding staff education (Ackerman, Henry, Graham, & Coffey, 1994; Parrott, 1994; & Robbins, 1994). Parrott (1994) described the many benefits of laughter in all human spheres -- physiological, cognitive, and psychosocial -- and indicates that although there is no empirical evidence to support its use in education there are a number of indicators of its

potential to make the learning experience a positive one. She describes benefits of increased attention and interest, increased comprehension of the subject, reduced learner stress and/or anxiety and also reduced monotony.

Parrott (1994) recommended a number of teaching strategies that employ humour as a component of its successful implementation. The criteria to determine appropriateness are if it reduces learner anxiety and/or if it aids in retention and transfer of the knowledge or skill presented. Robbins (1994) emphasized that humour must be relevant to the topic. Any unrelated humour has unpleasant effects on the educator-learner relationship and detracts from the learning environment. McDonald (1996) stated that humour is a valuable tool; however, the caveat she emphasizes is that "humour is only funny when self-esteem is not threatened" (p. 34).

As found in the critical incidents described, the participants indicated that humour did make the learning experience more effective as a strategy to aid in their learning. The data I collected are consistent with findings of my literature review.

Practical applications within the learning environment were also a component of positive learning experiences, as described the participants. Knowles (1990) and Schoenley (1994b) support this outcome. Schoenley (1994b) described role-playing as a valuable teaching strategy since it provides learners with a safe environment to explore human interactions within. It allows the learner to apply new or revised knowledge or a new skill in a controlled setting without risk or harm to the clients.

Simulated patients are a specialized form of role-playing. Simulated patients are a

teaching strategy that provides participants with a "client." The "client" has been trained regarding the medical/psychosocial condition being portrayed. The care provider uses the opportunity to role-play a situation that may include any of interviewing skills, physical assessment, or health care management. The "client" acts the role-playing as a real client would in the same situation. The other benefit for the learner is that the "client" will provide feedback on how the care provider made him/her feel during the scenario. Although in my experience this teaching strategy is not common in LTCFs within the geographical area studied, it is a common strategy used in many university health care programs such as medicine and nursing. The assumption of such a strategy represents the expectation that the learner will be able to practice the new knowledge or skill in a safe environment prior to dealing with the real client. The "patient" is so rehearsed in his/her role that the learner becomes absorbed in the setting and it begins to appear real. Many learners are able to function in a simulated patient environment as if it were really happening. However, as previously described, some learners do find it stressful and feel their job performance is being assessed. This anxiety may interfere with learning.

Both the characteristics of the presenter/educator and the environment in which the expected learning is to occur can have either a positive or negative effect on the learning experience. Much has been written regarding the importance of the presentation of the information (Bender, 1999; Klarman & Mateo, 1994; Wachs, 1994;). Knowles (1990) stated that the educator sets the initial climate of the group and the learners will develop their impression of the learning experience based on the setting provided by the

educator. Learners respect an educator who is fully knowledgeable about the topic and presents it effectively. The educator should be truly enthusiastic and believe in his/her topic. Bender (1999) described four critical elements for any educator's presentation: to inform, to entertain, to touch emotions, and to move to action. These are similar to those identified by the participants.

Providing information to the learners includes the relevance of the topic to them and to be sure that enough information is presented that demonstrates the educator's credibility and competence. Entertaining the learners describes specific presenter characteristics that increase the likelihood of the learning experience being a positive one such as a dynamic speaking voice, enthusiasm, word selection, vocal variety, speaking loudly and clearly enough for the learner to hear, regular breaths and pauses help control the pace of the participation, and lastly, having a powerful opening and closing that will have a lasting impact on the learners.

Wachs (1994) described the importance of the environment to the learning experience specifically, the resource of time. Kelly (1992) continued by discussing how compromise and collaboration benefit the learners and reduce the impact of lost time on the clients served. Mutual success can be achieved for all stakeholders. Possible areas the educator should consider when designing an educational program include if: (a) whether the learning experience should be done over a short or long period of time or incorporated into a regular ongoing staff development program; (b) if it should be offered on the "off-shifts" or provisions should be made for those care providers to attend during the day. To

determine this the educator needs to have a clear understanding of the facility's expectation of the learners' responsibility for their own learning and any possible costs to the LTCF to financial support the staff development program; and (c) are there less costly methods of disseminating the information (e.g., self-directed learning packages) that will provide the same or comparable learning opportunities for care providers.

Although this study did not demonstrate a strong difference based on cultural background I assume this could still have an effect on the learning experience. Further research in this area will support or refute this assumption. In the literature, Phillips and Baldwin (1997) support this assumption. They emphasized any training program must support the development of teaching strategies that take into account that adult learners have a broad range of reading and writing skills (specifically in English). Therefore, any activity that uses these linguistic skills should be kept to a minimum. The presenter must encourage the learners to interact with each other rather than take notes. In addition, written materials such as handouts should be kept to a minimum. When used, the handouts should contain only diagrams or very simple words. They should augment discussion but not be relied on to accomplish essential learning objectives. Phillips and Baldwin (1997) also found that role-playing activities allowed the learners to incorporate new information in a practice setting prior to using it with the clients they serve.

Although evaluation of the educational program was not an objective of this thesis it was a by-product that appeared to have an impact on the value of the learning for the participants. As found in this study, it also appears to be the weakest component of the

learning experiences. Although the participants did not identify this lack as a hindrance to their learning, it is a deficit from an organizational perspective. The importance of evaluation, as a key component of any comprehensive staff development program is supported in the literature (Holzemer, 1988; Jenkins, Baxter, Dowton, Gibbs, & Partridge, 1998). Knowles (1990) described evaluation as "getting inside the skulls of the participants -- and inside the social systems in which they are performing -- and finding out what is happening in their way of thinking, feeling, and doing" (p. 139).

Kirkpatrick (1971), as cited in Knowles (1990), formulated that evaluation had four components to be valuable part of a comprehensive staff development program and also best support androgogical principles. These components are: reactive, learning, behavioural, and results-oriented. Reaction evaluation obtains information from the learners regarding the experiences as it happens such as what they like or don't like.

Learning evaluation includes methods of measuring the amount of learning that has occurred and may be accomplished using pre- and post-tests to assess knowledge acquisition or performance tests to determine skill acquisition. Learning is not valuable without a change in behaviour.

Consequently, behavioural evaluation assesses for a change in the care providers' practice following the learning experience. This may include a practical application of the newly acquired knowledge or skill or a demonstrated change in the care providers' attitude within the LTC setting.

Lastly, results evaluations are the more administrative areas that need to be

evaluated including cost-benefit analysis, and staff turnover.

Relationship of the Results to the Androgogical Model

The participants described themes very similar to Knowles (1990) Androgogical Model of Learning. As previously discussed, Knowles believed adult learning was based on six fundamental principles. These assumptions improved the likelihood of learning. These components were: timing of learning and motivation to learn, experiential, belonging and security, immediacy, self-directed and independent, and ready to learn. The professional/vocational affiliation of the participant had no bearing on the areas that helped or hindered their learning. The only identified difference in this study between the HCAs and the RN/RPNs was the relative importance of the theme. For both staff groups the themes identified were similar yet, each group emphasized different themes. For example, the learning experience "relevance to practice" was described by 80% of HCAs and 70% of RN/RPNs as a factor that made the learning experience positive and 50% of RN/RPNs and 28.57% of HCAs that responded described that the lack of relevance made the learning experience a negative one.

Conceptualization of the Results Within an Educational Framework

McDonald (1996) described a conceptual framework that took into account many of the factors found in my study. She illustrated her framework like a tree because it "represents a living thing that receives nourishment from roots in an ancient wisdom of knowing and caring" (McDonald, 1996, p. 32). Appendix D illustrates the complete framework. McDonald indicated that the concepts of health, interventions, accountability,

and adaptation are continually interacting and integrated with the branches of the tree (client, socialization, and environment). Appendix H focuses on McDonald's (1996) conceptualization of the teaching/learning component of the tree. The three key areas are environment, teacher, and learner. In order for the environment to be conducive to learning it must include: (a) comfort -- comfortable seating, good lighting, temperature control, refreshments, and other such amenities, (b) openness to promote interaction between educator and learner including a circular seating plan when possible, (c) mental stimulation thorough the use of a variety of teaching strategies, (d) safety -- describes an environment in which the learner may express opinions without consequences, and (e) humanness which emphasizes an approach that is person-centred and includes valuing others, genuineness, and empathetic understanding.

The learner component of this model is similar to Knowles (1990) Androgogical Model of Learning. The learner components include life experience, competence, motivation, culture, and values and beliefs.

Lastly, the teacher components describe such areas as: being a facilitator, role model, resources, expert, and an assessor of both the learners' needs and the effectiveness of the training program.

Summary

This chapter has presented a discussion of the findings and interpretation of the data analysis in this qualitative research. The study population was described and the CIT interview answers reviewed and interpreted.

CHAPTER 5: SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Introduction

This chapter summarizes the findings in relation to the research question. In particular, the study design, CIT, data collection methods, and process of data analysis are also reviewed and critically evaluated. Finally, implications for practice and theory development are described. Recommendations for further research are a component of the final conclusions.

Study Summary

This qualitative study explored and described both HCA and Registered staff's perceptions of their learning needs in five long-term care facilities (LTCFs) within a defined geographical area. There were 10 HCAs, including 9 females and 1 male, and 10 RN/RPNs, including 9 females and 1 male, purposively selected from a pool of volunteers. This selection included 2 HCAs and 2 RN/RPNs from each facility. All 20 were able to describe positive learning experiences. However, 6 of the 20 (30%) could not identify any negative learning experiences for a variety of reasons.

Demographic data on each participant related to position, length of service, primary language spoken outside of work, and ability to communicate in English. The data obtained regarding the learning experiences were then analyzed for themes according to an adaptation of Moustakas' (1994) research approach. The positive learning experiences were analyzed separately from the negative ones. Analysis of the

participants' responses based on professional/vocational affiliation demonstrated few differences Consequently, to get a sense of the impact of these characteristics the themes were discussed together and the variability between the two groups was identified. Cultural background did not have any perceivable differences. These were not specifically analyzed separately.

Answers to the Research Question

The research question was "what do care providers in five long-term care facilities perceive aids or hinders their learning in a work-sponsored learning experience?" As outlined in Tables 4 and 6, the analysis of the data indicates the care providers described similar themes that may help or hinder their learning. The key appears to be how the learning experience is structured. For example, the participants, in both the first and second critical incidents described "presenter characteristics." Specific components, such as simple language or an enthusiastic manner, made the learning experience more enjoyable and one from which learning occurred. Other areas, such as flat affect or using language the participants did not comprehend, had a negative impact on the learning experience.

The most meaningful theme described that affected the learning experience, positively or negatively, was time. Positively, if the pace was moderate, the participants did not feel rushed, if it was done on off-time, or away from the facility then the learning experience was more valuable. Conversely, if the pace was too slow or too fast, the educational event occurred at break/lunch time, or during a busy part of the already hectic

workday then the participants felt that the learning experience was hindered and less enjoyable.

Evaluation of the Research Process

This qualitative study explored and described the perceptions of care providers in LTC that would aid their learning. The CIT focused on face-to-face interviews to guide the interview process and to aid in possible probes that increased the complete description of the participants' experiences.

The demographic section of the CIT asked questions that did not identify the participants but provided data regarding the type of staff interviewed. In the sections that specifically asked for information on the learning experiences -- the critical incidents -- I interviewed each participant individually and recorded the information on an audiotape after permission from the volunteer had been obtained. I did not achieve my goal of determining how much of a confounding variable comprehension of English was for the care providers interviewed. In hindsight, and with more time and other resources, it may have been more valuable to have: (a) a written consent in other languages, (b) co-researchers from cultural backgrounds dissimilar to mine to aid in recruitment and interviewing, and (c) an interview guide developed in the native tongue of the participant and have a translator available for interviews. Thus more comprehensive data could have been obtained regarding the importance of cultural background within the learning environment.

Critical Appraisal of the Methodology

Upon reflection, using CIT for data collection was the most appropriate for this study. It was found that simultaneous data collection and analysis was an approach that risked some researcher bias and was discontinued after the fourth interview. Moustakas' (1994) guidelines for a structured analysis worked effectively and aided me in my thought processes during the analytic phase of the study.

Sorrell and Redmond (1995) recommended contacting the interview participants prior to the interview. Although they did not identify the best method to contact participants, the objective of the pre-interview included a detailed explanation of the study and possibly to give them the topic or theme of the critical incidents. This component of the interview was not done due to time commitments on the part of the participants and myself, as researcher. Since comprehension of English did not have an impact on the participants' understanding of the research process or the questions I asked them, this did not appear to have any detrimental effects on the study's results. However, if the participants had a less proficient understanding of English this component of the interview process should be included. Conversely, pre-interview information for the participants may have facilitated recall of learning experiences, especially negative ones.

As previously articulated, there were some noted differences between Registered Staff and HCAs but none among the various cultural groups. It is not possible to determine if this occurred because there was no difference or because the process of data collection had some unintended deficiencies.

Critical Appraisal of the Study Results

Based on the literature reviewed, I expected to find: (a) variations in learning needs based on professional/vocational affiliation and cultural background, (b) that participatory or more visual presentations would be the teaching strategy of choice for both groups, (c) that there would be minimal educational value of lecture type programs, (d) role- playing/ case studies would be valuable for all staff regardless of professional affiliation, (e) written materials would be less valuable for HCAs, (f) staff with more limited reading skills in English would prefer visual presentations, (g) participation from specific cultural groups would be difficult to obtain, (h) the modular system that allowed the care providers to work at their own pace and self-select the combination of modules that most benefited their learning, as described by Nolan et al. (1995), would be a good teaching strategy, and (i) that few programs, as supported in the literature by Burgio and Burgio (1990), would have an evaluation component.

The findings of this study did not support any differences in learning style based on cultural background and limited variation based on professional/vocational affiliation. Teaching strategies the participants described included more participatory strategies such as role playing and other types of experiential learning. The study participants found lecture-type strategies to be of minimal benefit. Based on the good to excellent English skills of the study participants, no difference was observable among cultural groups regarding written versus visual presentations. In addition, it was found that obtaining participants from a variety of cultural backgrounds was difficult. The modular learning

program may be of benefit if combined with more direct teaching strategies. I assume this, as supported in my study, since the learners describe the importance of a social, camaraderie-type atmosphere. This is further supported through the description of humour as an important strategy to facilitate the development of a positive learning experience.

Lastly, there was no formal evaluation of any of the learning experiences described by the participants. From the CIT responses it appears that any follow-up would be done only if the participants, themselves, actively pursued this area of the learning experience.

Implications of the Study

This study has a number of implications for nursing in the areas of practice, theory development, and further research. Its objective to further nursing knowledge through the generation of concepts and to provide a beginning point for an initial conceptual framework for a staff development program in long-term care has been achieved.

For Practice

For LTC, this study can be practical in a number of ways. This study can assist care providers to apply new knowledge and skills learned in the clinical setting through the development of an educational program that enhances their learning and increases their confidence level in their own abilities. The staff educator can incorporate the research findings into the curriculum and use the information as supporting evidence for

the teaching strategies employed.

Rosenal (1995) described other potential uses of critical incidents in staff development for educators. She stated that such uses include: determining the efficacy of a specific skill or knowledge, development of a learning needs assessment, or to acquire examples useful in teaching. Since critical incidents describe both positive and negative situations they allow the educator to identify both specific learning needs and conceptual information related to the staff person's mental processing. They are credible teaching strategies for the learners because other nurses write them. Also, the examples can be used to raise unspoken or sensitive issues during group discussions. They reduce barriers to learning, according to Rosenal (1995), if the educator explains that feelings are not unique to the individual; but are felt by other staff members also. Examples provide a demonstration of what other nurses are feeling.

The management team in LTC needs to promote and support the education process through development of a more formal staff development program run by a person who has this task as his or her primary responsibility. The program must take into account the learners' needs and incorporate them into the strategic directives of the organization. In addition, management needs to foster a climate of intellectual curiosity and provide support -- financial, emotional, or resources -- to care providers. Without management support many staff may see acquiring new knowledge and/or skill as a luxury, not a necessity. The commitment from the management team ultimately results in better care for the clients served.

Finally, there must be an evaluation component to the program. Without this component there is no objective measurement therefore, it is not possible to determine if the goals and objectives of the educational session are being met. As has been described, this study found that evaluation was not done very effectively.

For Theory Development

This research study had several outcome objectives for staff development in long-term care. These include: to improve the use of limited resources, to develop an initial conceptual framework, and to determine an overview of the structure of a program.

Long-term care has historically had a limited number of staff functional positions within its organization structure. Effective and efficient uses of these resources in a cost-effective manner will aid the facility to be fiscally responsible with both human and monetary resources.

In my literature review I did not find a theoretical model or clearly defined concepts in staff development specifically related to long-term care. This makes it difficult for the educator to develop a staff development program that meets the needs of the culturally diverse care providers and also relates to the professional/vocational affiliation of the staff mix. There will be instances when both Registered and HCA staff will be required to have the same information and there will be other times when education will be provided for each group separately relevant to their practice. Thus, a conceptual framework will guide the educator in the development of the appropriate educational delivery system. The findings provide a foundation for an initial framework

of a staff development program in long-term care. Knowles (1990) Androgogical Model and McDonald's (1996) tree conceptualization must be critically appraised for their value to LTC care providers as the educator develops his/her staff development program.

Lastly, because of the limited research related to staff development in long-term care, it is necessary to develop a data base. This data base should include a variety of teaching strategies that are effective for staff within long-term care. There are several literature sources that discuss teaching strategies (Irvin, 1996; Kuhn, 1995; Modic & Harris, 1994; Petersen, 1994). In summary, an effective staff development program must be based on a framework grounded in research before an educator can determine the most appropriate teaching strategy for a given learning need of the diverse care providers in long-term care.

For Further Research

There are a number of areas other researchers can address to expand on this study. As this study was limited to care providers in five LTCFs within one geographical area, a replication study in different populations and geographical areas would increase the credibility and generalizability of the results. In addition, there may be other cultural variables that aid in determining the cultural group one identifies with. Using these variables, rather than skill in English, the researcher may be able to determine if cultural group has an impact on care providers' learning needs in a work-sponsored educational event.

A sample of care providers with lower skills in English than this study group

could be beneficial for furthering the development of appropriate strategies in a LTC staff development program. Previously, suggestions including translating interview guides and consents and also having interviewers from other cultural groups were recommended to widen the range of cultural backgrounds that a sample may be obtained from.

Conducting the study at a different point in time can be a purpose of other studies. The effectiveness of a more structured educational program implemented to enhance care providers' knowledge and skill and that takes into account the themes expressed by the study participants needs to be researched. Longitudinal studies can also be implemented to examine the professional development program after the implementation of these strategies to determine if they made any difference.

Further research can be done later related to specific teaching strategies that are actually effective for learning for the nursing population in long-term care. The hope is that these strategies would be selected based on their congruency with the phenomena discovered through this research study. Pre- and post-intervention studies would evaluate various teaching strategies that may be effective.

It is too premature to do a cost-benefit analysis of the educational program. Further exploratory research data is required. However, such information would be one method of supporting a staff development program. For example, this is especially important if the theme of time is considered an important component of the staff development program. Its efficacy and effectiveness must be measured to assess, if staff is paid for their attendance at an educational event, does this have a positive outcome

including better health or care practices for the facility's residents? This research may be done through evaluation studies.

In addition, I have recommended a staff development model that combines Knowles (1990) Androgogical Model and McDonald's (1996) tree conceptualization. I believe it can be practically implemented into practice and meets the needs of the professionally and cultural diverse care providers. Research into this assumption must be done to support or refute this hypothesis.

Lastly, it is the responsibility of any researcher to collaborate with practitioners. Research that is not grounded in practice has limited value. If, the LTC providers' learning needs are not addressed then the quality of care provided to the residents they service and the problems they encounter in their day-to-day practice may not be resolved. In order for the research to be of value it must be applicable to LTC practitioners and the clinical implications disseminated.

Dissemination

I believe the most valuable method to inform key stakeholders about the results of the study is to use a multifaceted approach. My plan is to inform interested persons by providing for all participants, upon request, a copy of the findings and setting up a date and time to be available at an information session at all participating long-term care facilities for questions about the data analysis. I will supplement this session with a poster presentation for those staff unable to attend the information session.

Secondly, after completion of the data analysis and my thesis defense, the written

portion of the defended thesis will be bound and made available for any interested persons through the Brock University Library. This will include a willingness to present the thesis at the Graduate Conference at Brock University in September, 2000.

Lastly, I will fax all long-term care facilities within 50 km of the researcher's home and offer to present my findings to the appropriate persons. I will also prepare a short synopsis for circulation in Perspectives, a journal provided by the Canadian Gerontological Association.

Conclusion

In summary, I found that staff development in long-term care has not been adequately addressed in the literature. Historically, there have been many studies, as previously identified, on teaching strategies and learning theories related to staff but few that focus on cultural and professional or vocational variables.

Furthermore, there are a limited number of papers regarding my proposed research problem. The literature that is available has several limitations including: (a) it is not related to long-term care, (b) it does not take into account the cultural diversity of the staff, (c) it does not take into account the diverse professional affiliation of the staff, (d) it does not clarify definitions for key concepts in staff development.

Thus, the unique needs of care providers within long-term care are not clearly delineated within the literature. Both the concept of CQI and the Quality Assurance Program from the CNO discuss the importance of continuing to increase one's knowledge base. The lack of a theoretical framework and a structure to frame an inservice/staff

development program within limits the effectiveness of an educator. I believe that this demonstrates a gap and a need for my research question -- to contribute to the development of a conceptual framework for staff development in long-term care that identifies and addresses the professional and nonprofessional status and the multicultural characteristics of the staff.

References

Ackerman, M.H., Henry, M.B., Graham, K.M., & Coffey, N. (1994). Humor won, humor too: A model to incorporate humor into the healthcare setting (revised). Nursing Forum, 29(2), 15-21.

Alspach, J. (1995). The educational process in nursing staff development. St. Louis, MO: Mosby Yearbook.

Arleiter, J.S. (1988). The facts about foreign nurses. RN, 51(9), 56-63.

Armstrong, M.L, Clark, D.W., & Stuppy, D.J. (1995). Motivational orientations of urban- & rural-based RNs: Implications for staff development educators. Journal of Nursing Staff Development 11(3), 131-137.

Bender, P. (1999). Secrets of power presentations. Toronto, ON: The Achievement Group.

Benner, P (1984). From novice to expert: excellence and power in clinical nursing practice. Redwood City, CA: Addison Wesley Publishing.

Berg, B.L. (1989). Qualitative research methods for the social sciences. Boston, MA: Allyn & Bacon.

Britten, N., Jones, R., Murphy, E., & Stacy, R. (1995). Qualitative research methods in general practice and primary care. Family Practice, 12(1), 104-13.

Brookfield, S. (1987). Developing critical thinkers: Challenging adults to explore alternative ways of thinking and acting. San Francisco, CA: Jossey-Bass Publishers.

Burgio, L.D., & Burgio K.L. (1990). Institutional staff training and management:

A review of the literature and a model for geriatric, long-term care facilities. International Journal of Aging and Human Development, 30(4), 287-302.

Burner, O.Y., Cunningham, P., & Hatter, H.S. (1990). Managing a multicultural nurse staff in a multicultural environment. JONA, 20(6), 30-34.

Caminha-Bacote, J., Yahle T., & Langenkamp, M. (1996). The challenge of cultural diversity for nurse educators. Journal of Continuing Education in Nursing, 27(2), 59-64.

Campbell, L.N. (1999). Adult education. Helping adults begin the process of learning. AAOHN Journal 47(1), 31-42.

Chavez, L.L., & Oeiting, E.R. (1995). A critical incident model for considering issues in cross-cultural research. Failures in cultural sensitivity. The International Journal of Addictions, 30(7), 863-874.

Cheeks, J., O'Brien, B., Ballantyne, A., & Pincombe, J. (1997). Using the critical incident technique to inform aged and extended care nursing. Western Journal of Nursing Research, 19(5), 667-682.

Chinn, P.L., & Kramer, M.K. (1991). Theory and nursing: A systematic approach (3rd ed.) St. Louis, MO: Mosby Yearbook.

College of Nurses of Ontario (1995). Ethical Guidelines For Professional Practice. Toronto, ON: Author.

College of Nurses of Ontario (1997). Professional profile. Toronto, ON: Author.

Cooper A. (1997). Responding to poor inservice attendance. Canadian Nurse,

93(4), 26-30.

Culley, L. (1996). A critique of multiculturalism in health care: The challenge for nurse education. Journal of Advanced Nursing, 23, 564-570.

De Silerts, L.D. (1995). Assessing registered nurses' reasons for participating in continuing education. Journal of Continuing Education in Nursing, 26(5), 202-208.

Denzin, N.K., & Lincoln, Y.S. (Eds.) (1994). Handbook of qualitative research. Thousand Oaks, CA: Sage Publications.

Downe-Wamboldt, B. (1992). Content analysis: Method, application, and issues. Health Care for Women International, 13, 313-321.

Dunwell, L. (1997). Respect and open conversation are key to managing staff diversity. The Brown's University Long-term care Quality Advisor, 9(21), 1-4.

Ferguson, D.S. (1996). The lived experience of clinical educators. Journal of Advanced Nursing, 23, 835-41.

Field, P.A., & Morse, J.M. (1985). Nursing research: The application of qualitative approaches. Kent, UK: Croom Helm.

Firestone W.A. (1993). Alternative arguments for generalizaing from data as applied to qualitative research. Educational Research, 22(4), 16-23.

Flanagan, J. (1954). The critical incident technique. Psychological Bulletin, 51, 327-358.

Gillis, D.M. (1991). Strategies to promote positive behavior toward elderly patients. Clinical Nurse Specialist, 5(3), 165-168.

Government of Canada (1999) Population and dwelling counts [On-line], Available: http://www.statcan.ca/english/census96/dwel.htm.

Government of Ontario (1990). Nursing Home Act (Rev. ed). Toronto, ON: Queen's Printer.

Government of Ontario (1992a). Long-Term Care Act. Toronto, ON: Queen's Printer.

Government of Ontario (1992b). Regulated Health Professions Act. Toronto, ON: Queen's Printer.

Government of Ontario (1995). Long-Term Care Facilities Program (Rev. ed.). Toronto, ON: Queen's Printer.

Hamill, C. (1994). Changing emphasis in nursing research. British Journal of Nursing, 3(10), 510-512.

Hensley, A.D., & Travis, S.S. (1997). The provision of staff development programs in adult day care centers. Journal of Continuing Education in Nursing, 28(4), 173-180.

Holzemer, W.L. (1988). Evaluation methods in continuing education. Journal of Continuing Education in Nursing, 19(4), 148-157.

Irvin, S.M. (1996). Creative teaching strategies. Journal of Continuing Education in Nursing, 27(3), 108-114.

Jackson, P. (1995). Constructing nursing practice: Country of origin, culture, and competency. International Journal of Nursing Practice, 1, 32-36.

Jasper, M.A. (1994). Issues in phenomenology for researchers of nursing. Journal of Advanced Nursing, 19, 309-314.

Jenkins, C., Baxter, L., Dowton, J., Gibbs, C., & Partridge, J. (1998). When staff training isn't enough: An evaluation of a collaborative evaluation approach. International Journal of Language and Communication Disorders, 33, Suppl: 409-414.

Jones, S., Borces-Clark, V., Merker, C.A., & Palau, D. (1995). Changing behavior: nurse educators and clinical nurse specialists design a discharge planning program. Journal of Nursing Staff Development, 11(6), 291-295.

Kelly, K.J. (Ed.)(1992). Nursing staff development: current competencies, future focus. Philadelphia, Participant T: J.B. Lippincott Co.

Klarman, K.L., & Mateo, M.A. (1994). An approach to presentation skill development of nurses. Journal of Nursing Development, 10(6), 307-311.

Knowles, M. (1990). The adult learner: Neglected species (4th ed.). Houston, TX: Gulf Publishing Co.

Kreps, G.L., & Kunimoto, E.N.(1994). Effective communication in multicultural health care settings. Thousand Oaks, CA: Sage Publications.

Kuhn, M.A. (1995). Gaming: A technique that adds spice to learning? Journal of Continuing Education in Nursing, 26(1), 35-39.

Leininger, M. (Ed.). (1985). Qualitative Research Methods in Nursing. Miami, FL: Grune & Stratton.

Marrow, C. (1996). Using qualitative research methods in nursing. Nursing

Standard, 11(7), 43-45.

Marshall, S.L., & While, A.E. (1994). Interviewing participants who have English as a second language: challenges encountered and suggestions for researchers. Journal of Advanced Nursing. 19, 309-314.

Maykut, P., & Morehouse, S. (1994). Beginning qualitative research, London, UK: The Falmer Press.

McDonald, N.C. (1996). Teaching from a treetop. Nurse Educator, 21(1), 32-36.

McLaughlin, F., & Marascuilo, L. (1990). Advanced Nursing And Health Care Research: Quantification Approaches. Philadelphia, PA: W.B. Saunders Company.

Merriam, S.B., & Simpson, E.L.(1984). A guide to research for educators and trainers of adults. Malabar, FL: Robert E. Kriger Publishing.

Mezley, M.D., & Lynaugh, J.E. (1989). The teaching nursing home program: Outcomes of care. Nursing Clinics of North America, 24(3), 769-789.

Mitchell, G.J., & Cody, W.K. (1993). The role of theory in qualitative research. Nursing Science Quarterly, 6(4), 170-178.

Modic, M.B., & Harris, R. (1994). A reinforcement technique: The goody bag. Journal of Continuing Education in Nursing, 25(3), 143-144.

Morgan, D.L. (1993). Qualitative content analysis: A guide to paths not taken. Qualitative Health Research, 3(1), 112-21.

Moustakas, C. (1994). Phenomenological research methods. Thousand Oaks, CA: Sage Publications.

Munet-Vilaró F. (1988). The challenge of cross cultural nursing research. Western Journal of Nursing Research. 10(1), 112-16.

Nolan, M., Owens, R.G., & Nolan, J. (1995). Continuing professional education: Identifying the characteristics of an effective system. Journal of Advanced Nursing. 21, 551-560.

Norman, I.J., Redfern, S.J., Tomalin D.A., & Oliver, S. (1992). Developing Flanagan's critical incident technique to elicit indicators of high and low quality nursing care from patients and their nurses. Journal of Advanced Nursing. 17, 590-600.

O'Toole (Ed.). (1992). Miller-Keane encyclopedia and dictionary of medicine, nursing, and allied health (5th ed.). Philadelphia, PA: W.B. Saunders Co.

Parrott, T.E. (1994). Humor as a teaching strategy. Nurse Educator, 19(3), 36-38.

Patton, M.Q. (1990). Qualitative evaluation and research methods (2nd ed.). Newbury Park, CA: Sage Publications.

Petersen, J. (1994). Increasing standards awareness through fortune cookie contest. Journal of Continuing Education in Nursing. 25(3), 157-62.

Phillips, R.M., & Baldwin B.A. (1997). Teaching psychosocial care to long-term care nursing assistants. Journal of Continuing Education in Nursing. 26(3), 130-134.

Reinharz, S. (1983). Phenomenology as a dynamic process. Phenomenology and Pedagogy, 1(1), 77-79.

Robbins, J. (1994). Using humour to enhance learning in the skills laboratory. Nurse Educator, 19(3), 39-41.

Rosenal, L. (1995). Exploring the learner's world: Critical incident methodology. Journal of Continuing Education in Nursing, 26 (3), 115-118.

Rothe, J.P. (1993). Qualitative research: a practical guide. Toronto, ON: PDE Publications.

Sandelowski, M. (1986). The problem of rigor in qualitative research. Advances in Nursing Science. 8(3), 27-37.

Sandelowski, M.(1993). Rigor or rigor mortis: the problem of rigor in qualitative research revisited. Advances in Nursing Science 16(2), 1-8

Sandelowski, M. (1995). Sample size in qualitative research. Research in Nursing & Health, 18, 179-183.

Schoenley, L. (1994a). Curriculum design in staff development. Journal of Nursing Staff Development, 10(4), 187-90.

Schoenley, L. (1994b). Teaching in the affective domain. Journal of Continuing Education in Nursing, 25(5), 209-212.

Sorrell J.M,.& Redmond, G.M. (1995). Interviews in qualitative nursing research: differing approaches for ethnographic and phenomenological studies. Journal of Advanced Nursing, 21, 1117-22.

Streubert, H.J, & Carpenter, P.R. (1999). Qualitative research in nursing: advancing the humanistic imperative (2nd ed.). Philadelphia, PA: J.B. Lippincott Co.

Timms, J., & Ford, P. (1995). Registered nurses' perception of gerontological education needs in the UK and the USA. Journal of Advanced Nursing, 22, 300-307.

Viau, P.A. (1994). Collaborative teaching-learning: A potential framework for a staff development educator. Journal of Nursing Staff Development, 10(4), 195-201.

Wachs, J.E. (1994). Professional presentations: transmitting information with polish and flair, part I: Preparing the presentation. AAOHN Journal, 42(3), 141-143.

Wansborough, G. (1997). The whys and hows of competence assessment. College Communique, 22(1), 11.

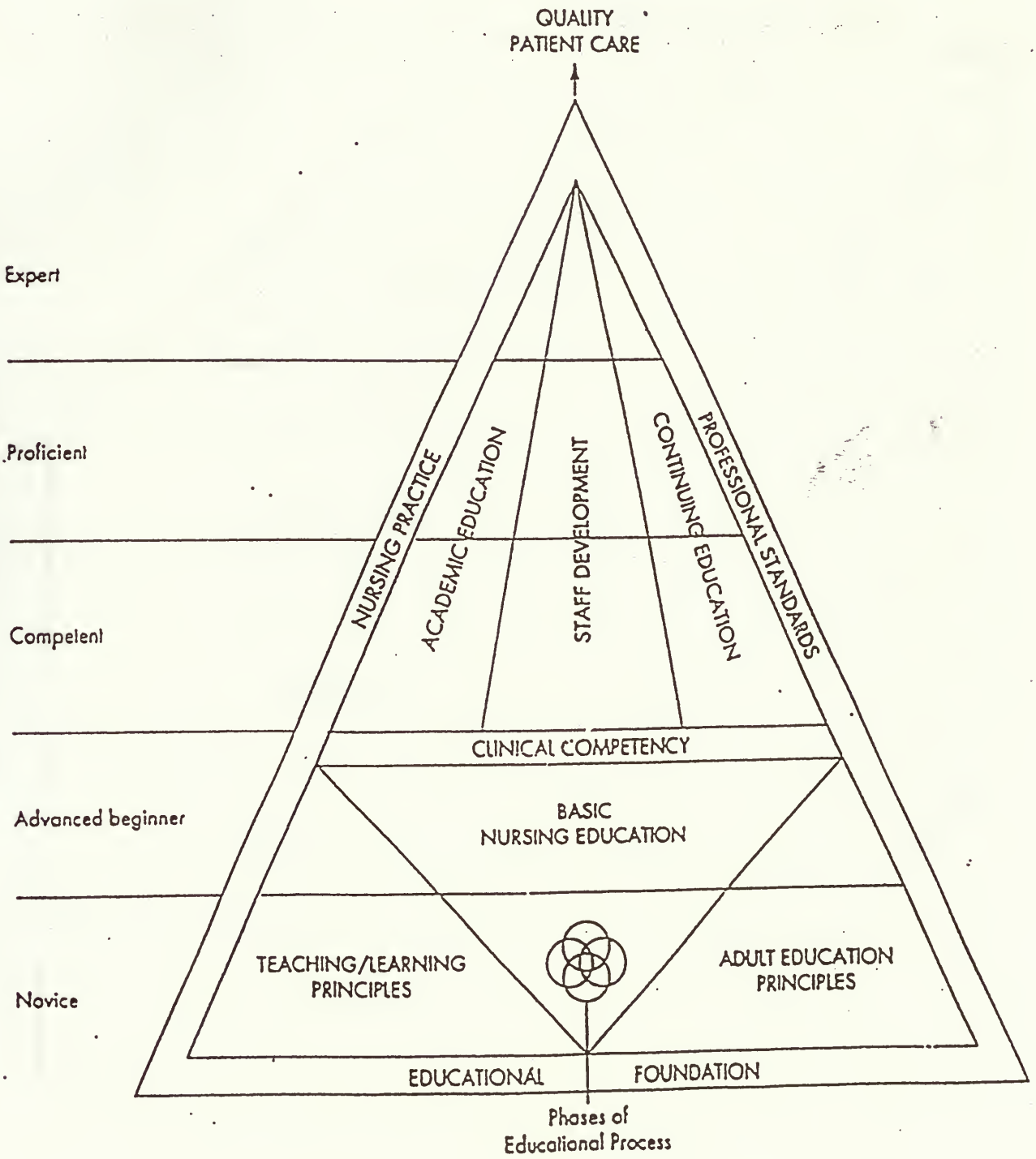
Werab, B., Alexander, C., Brunt, B., & Wester, F. (1994). The use of medication modules for medication administration errors. Journal of Nursing Staff Development, 10(1), 16-21.

Wissmann, J.L. (1996). Strategies for teaching critical thinking in pharmacology. Nurse Educator, 21(1), 42-46.

Woolsey, L.K.(1986). The critical incident technique: an innovative qualitative method of research. Canadian Journal of Counselling. 20(4), 242-54.

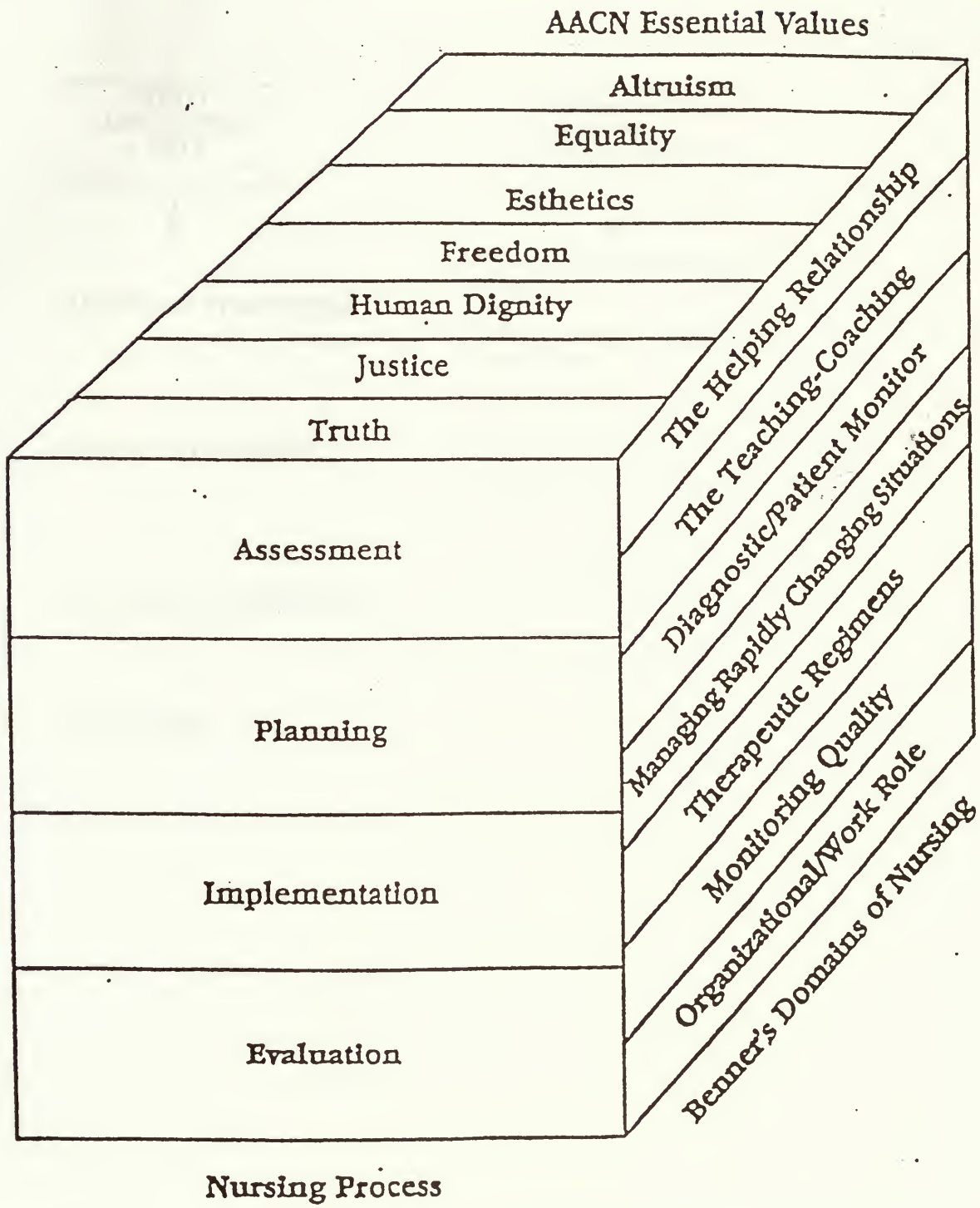
Yahes, E., & Kittrick-Dunn, A.(1996). Enculturation of foreign nurse graduates: An integrated model. Journal of Continuing Education in Nursing. 27(3), 120-123.

Appendix A: Theoretical Foundations of Staff Development



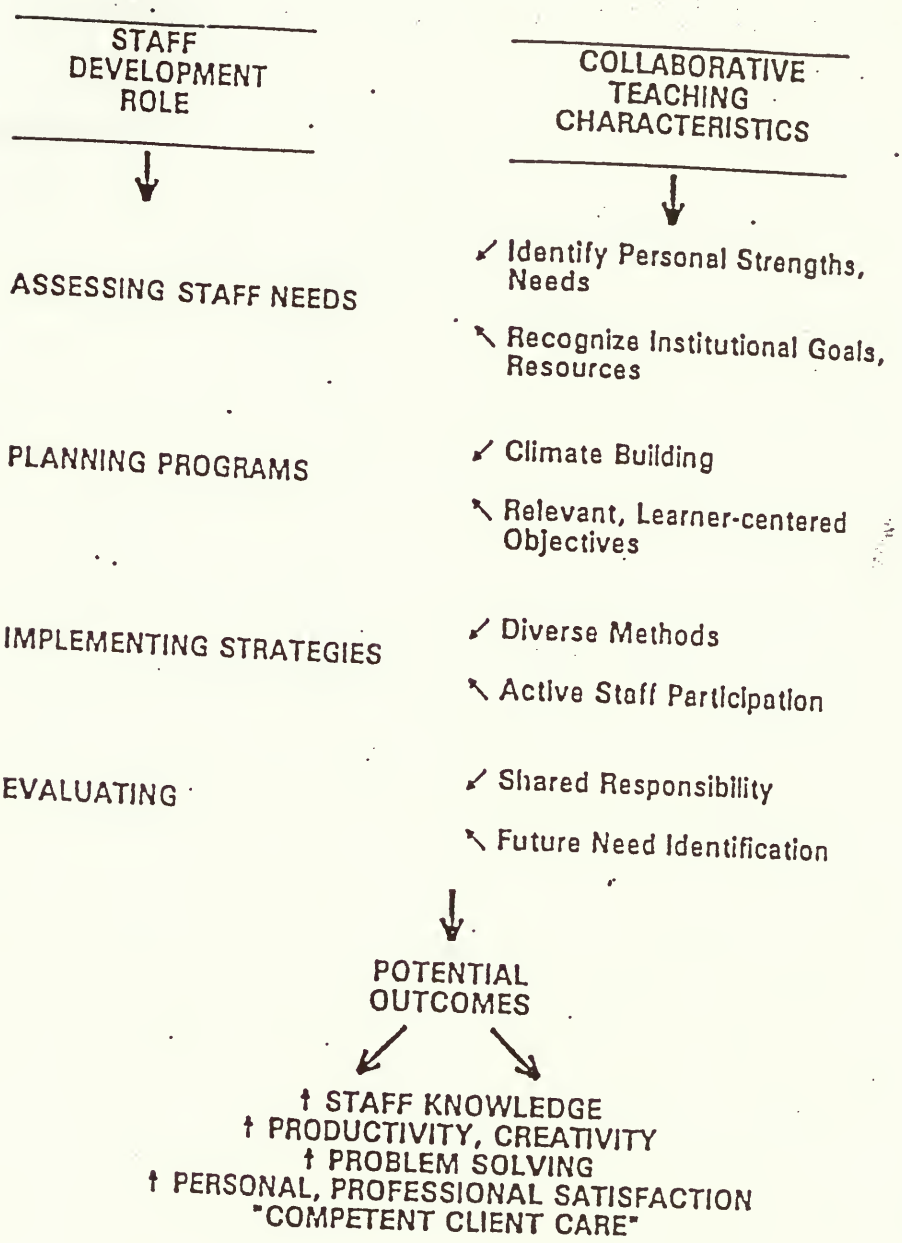
Alspach J. (1995). The educational process in nursing staff development. St. Louis, MO: Mosby Yearbook.

Appendix B: Curriculum Model Crossgrid



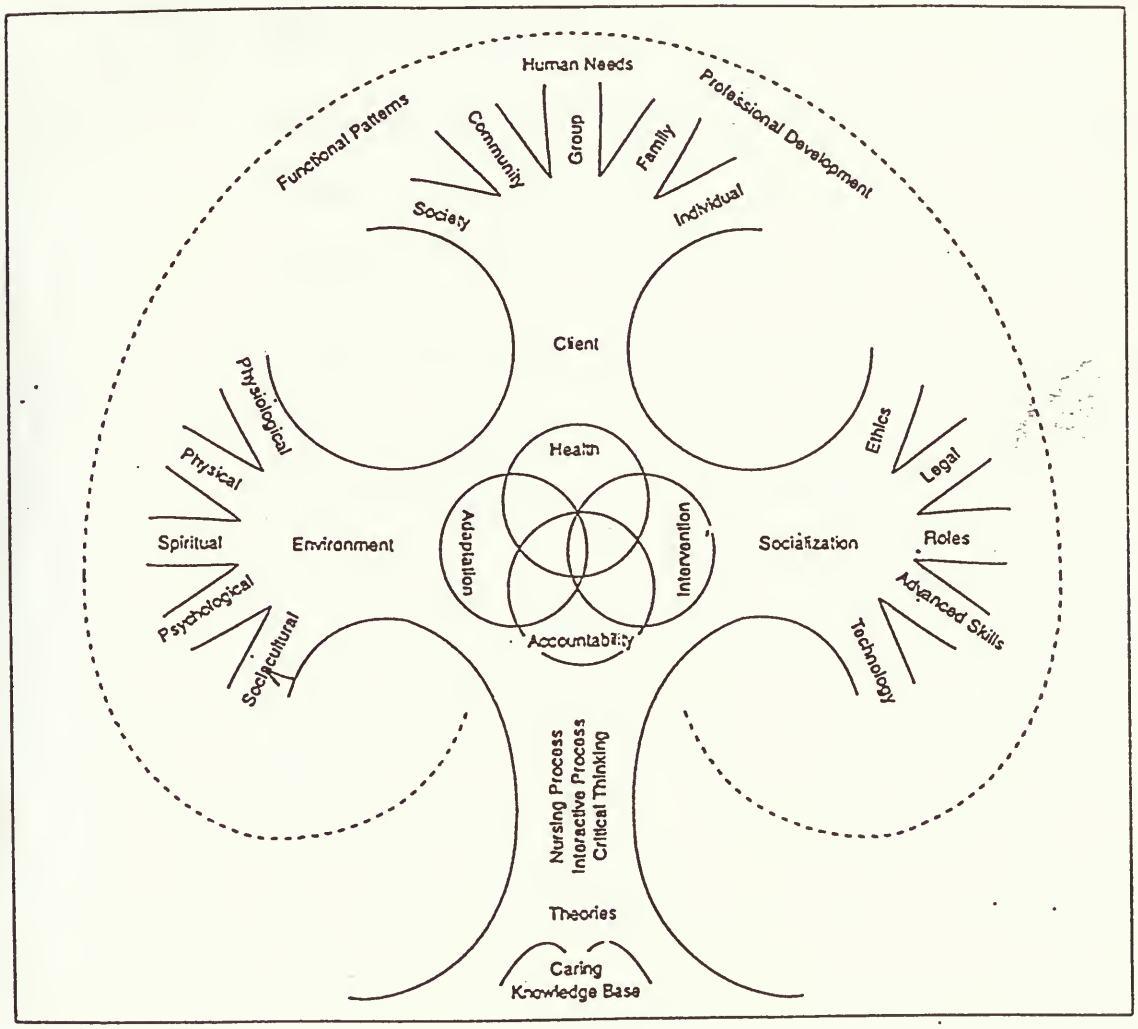
Schoenley, L. (1994a). Curriculum design in staff development. Journal of Nursing Staff Development, 10(4), 187-190.

Appendix C: Collaborative Teaching-Learning



Viau, P.A. (1994). Collaborative teaching-learning: A potential framework for a staff development educator. Journal of Nursing Staff Development, 10(4), 195-201.

Appendix D: Conceptual Framework for Curriculum Development



McDonald, N.C. (1996). Teaching from a treetop. Nurse Educator, 21(1), 32-36.

Appendix E: Data Analysis Strategies

1. During data collection, I documented any ideas, feelings, or responses that emerged, whether it be mine or the participants, in my journalling log. I, during each phase of the research, I was cognizant of my personal biases and assumptions and set these beliefs aside to obtain the purest description of care provider's learning needs in long-term care.
2. Audiotaped interviews were transcribed verbatim using Corel WordPerfect 7. I then listened to the tapes while reading the transcriptions for accuracy.
3. After data transcription, in the upper right corner of each page of data, I included information based on the type of data collected, the source of data, and the page number. The type of data & corresponding codes were: interview transcripts (T), field notes or documents (F), follow-up interview transcripts (FT), and key informants (K). The participants and primary source of the data had a numerical value assigned to maintain confidentiality. The page number followed a backslash. Thus, an example code would be T1/5.

4 Each page of data was photocopied single sided. The original was set aside.

5. I assembled the photocopies into separate piles, sorted by question and subquestion. All the demographic data was kept in one complete package.

6. Identification of meanings then began. First, I reviewed the data thoroughly reviewed and smaller units of meaning were pulled out. I based the selection of a unit of meaning on the research question. These units had to be able to stand alone. i.e., they were understandable with no explanation except knowledge of the focus of the inquiry. A unit of meaning was either a few words or whole paragraphs.

7. I cut out each unit of meaning and taped it to a 4x6 index card, folded it to make it fit, if necessary. On the bottom right corner of the index card I wrote the identifying code as written from procedure #1. I did not use a computer to cut and paste because I am a more visual learner. I preferred having a hard copy in front of me that I shifted the categories manually until I satisfied with the outcome.

8. After all units of meaning had been placed on an index card I reviewed them one at a time to uncover their essences. For each index card, I re-read the unit of meaning and asked myself, "what are the recurring words, phrases, or topics?' "What are the concepts that the participants use to explain what they say or do?' are there any emerging themes?' "are there any patterns?' In the top left I wrote the key word or phrase that indicated the essence of the unit's meaning.

9. Simultaneously I listed and prepared a rough preliminary grouping of every expression presented by the participants. These were the initial

provisional categories. I placed the unit of meaning in as many provisional categories as it appeared to fit into appropriately.

10. Upon completion of categorizing of the unit of meaning I had reviewed I selected another unit of meaning and compared it to units of meaning already analyzed. I used as many provisional categories as necessary to reflect all perspectives of all the participants. Each unit was grouped with similar units. If the unit didn't fit with currently identified provisional categories then a new provisional category was formed. "The researcher seeks to develop a set of categories that provide a reasonable reconstruction of the data she or he has collected" (Makut and Morehouse, 1992, p.134).

11. After all units of meaning have been categorized I reviewed each category reviewed for the properties or characteristics of the group of cards clustered together under that specific provisional category. I wrote general statement that conveyed the meaning contained on the index data cards in that specific category. According to Norman et al (1992) categories should have self-explanatory titles with descriptions that are rich though not lengthy and vividly convey a picture of the kind of incidents included in the category. Lastly, and they must enhance the distinctiveness of the category.

12. I reviewed my initial categories of recurring themes and concepts. I

eliminated all concrete, vague, or overlapping expressions and developed more exacting descriptive terms.

13. I re-evaluated each indexed unit of meaning individually. The provisional category had to be explicitly expressed in the description and the units of meaning had to be explicitly or implicitly expressed as a component of the specific essence. The units of meaning found to be incompatible with any of the provisional categories were removed.

14. On a sheet of paper I brainstormed the essential relationships as they intuitively came to me and related them to categories of recurring themes that the various units of meaning had evoked in me. I wrote down the ideas using the language of the participants.

15. Lastly, once the category was holistic and as objective as possible I synthesized all identified patterns, concepts, transitions, and units into a descriptive narrative. I then studied all the categories to try to clarify the meaning and relate them to the whole experience.

Appendix F: Interview Guide

PART ONE: INTRODUCTION

My name is Debbie Millar and I would like to talk with you about how you best learn at work. So I can listen better to what you are saying, may I tape our conversation? The only person who will listen to this tape will be me. My teacher from school is a resource to me but will not know any identifying characteristics about you. I will now ask you a few questions. If you don't understand or want anything repeated just let me know.

PART TWO: DEMOGRAPHICS

1. What is your job here?
2. Years worked?
3. Is English your first or second language?
4. What language do you primarily speak outside of work?
5. How would you rate your skill in English in these area?
   a) reading
   b) writing
   c) speech
   d) understanding

choices: none, limited, good, excellent

PART THREE: CRITICAL REFLECTION

Section one: Recall an important learning experience you attended at work in the last six months that you enjoyed and learned from. Describe it in detail.

1. Tell me about the specific situation:
   a) approximately what was the day and time?
   b) where was the event held (location within the facility)?
   c) besides you, who attended?
   d) who was the person presenting the information?
   e) what was the topic?

2. Tell me how the person gave you the information:
   a) did she/he give you any activities to do?
   b) did the person just talk to you?
   c) did you watch any videos?
   d) were the overheads mostly pictures or were there a lot of words?
   e) did she/he give you any handouts to take with you?

3. Tell me about the factors from that experience that helped or made it harder to learn. For example,
   a) did the time of the event matter? Why?
   b) were you working or did you come in on your time off?
   c) if applicable, did the fact that you had to work on the unit make a difference? Why?
   d) did your skill reading or understanding English make it easier or harder to learn?
   e) did the person's style of teaching the information make a difference in your learning? How?
   f) did you already know something about the topic?

4. How useful was the information you were given that day in your job?

5. Sometimes people we work with either already use the information we just learned or sometimes they make fun if we try to use it. Did your co-workers make it harder or easier to use this information in your job?

6. Tell me about the experience including:
   a) what did you like?
   b) what did you dislike?
   c) what were the best parts?
   d) what were the worst parts?
   e) is there anything you would do differently?

7. Did the information you were given change:
   a) the way you feel about yourself?
   b) the way you feel about the other people you work with?
   c) the way you feel about the residents?
   d) your personal and job satisfaction?

8. Did the person providing the information come back later to see if:
   a) you had any further questions or comments about the information?
   b) you needed more time to learn?
   c) she/he could help you use the information?
   d) you had any suggestions to improve the learning experience?

Section two: Recall an important learning experience you attended at work in the last six months that you did not enjoy and did not learn from. Describe it in detail.

1. Tell me about the specific situation:
   a) approximately what was the day and time?
   b) where was the event held (location within the facility)?
   c) besides you, who attended?
   d) who was the person presenting the information?
   e) what was the topic?

2. Tell me how the person gave you the information:
   a) did she/he give you any activities to do?
   b) did the person just talk to you?
   c) did you watch any videos?
   d) were the overheads mostly pictures or were there a lot of words?
   e) did she/he give you any handouts to take with you?

3. Tell me about the factors from that experience that helped or made it harder to learn. For example,
   a) did the time of the event matter? Why?
   b) were you working or did you come in on your time off?
   c) if applicable, did the fact that you had to work on the unit make a difference? Why?
   d) did your skill reading or understanding English make it easier or harder to learn?
   e) did the person's style of teaching the information make a difference in your learning? How?
   f) did you already know something about the topic?

4. How useful was the information you were given that day in your job?

5. Sometimes people we work with either already use the information we just learned or sometimes they make fun if we try to use it. Did your co-workers make it harder or easier to use this information in your job?

6. Tell me about the experience including:
   a) what did you like?
   b) what did you dislike?
   c) what were the best parts?

d) what were the worst parts?
e) is there anything you would do differently?

7. Did the information you were given change:
   a) the way you feel about yourself?
   b) the way you feel about the other people you work with?
   c) the way you feel about the residents?
   d) your personal and job satisfaction?

8. Did the person providing the information come back later to see if:
   a) you had any further questions or comments about the information?
   b) you needed more time to learn?
   c) she/he could help you use the information?
   d) you had any suggestions to improve the learning experience?

Appendix G: Consent Form

CONSENT FORM

BROCK UNIVERSITY DEPARTMENT OF EDUCATION

Title of Study: Staff Development in Long-term care
Researchers: Katharine Janzen and Deborah Millar
Name of Participant: (please print): _____

I understand that the study I have agreed to participate in involves answering some questions about what I learned at work in the last six months. The purpose of the study is to find out what styles of teaching help me learn best. The study will be an interview format and will be audiotaped. I also understand that I will be able to see the data before it is completed. At any time, upon request, I will be given a copy of the results of the study.

I understand that my participation in this study is voluntary and that I may withdraw from the study at any time and for any reason without penalty.

I understand that there is no obligation to answer any question or participate in any aspect of this project that I may consider invasive.

I understand that all personal data will be kept strictly confidential and that all information will be coded so that my name is not associated with my answers. I understand that only the researchers named above will have access to the data.
Participant Signature: _____ Date: _____

If you have any questions or concerns in the study, you can contact Debbie Millar at (905) 521-4465 or Professor Katharine Janzen at (416) 491-5050, extension 2080.

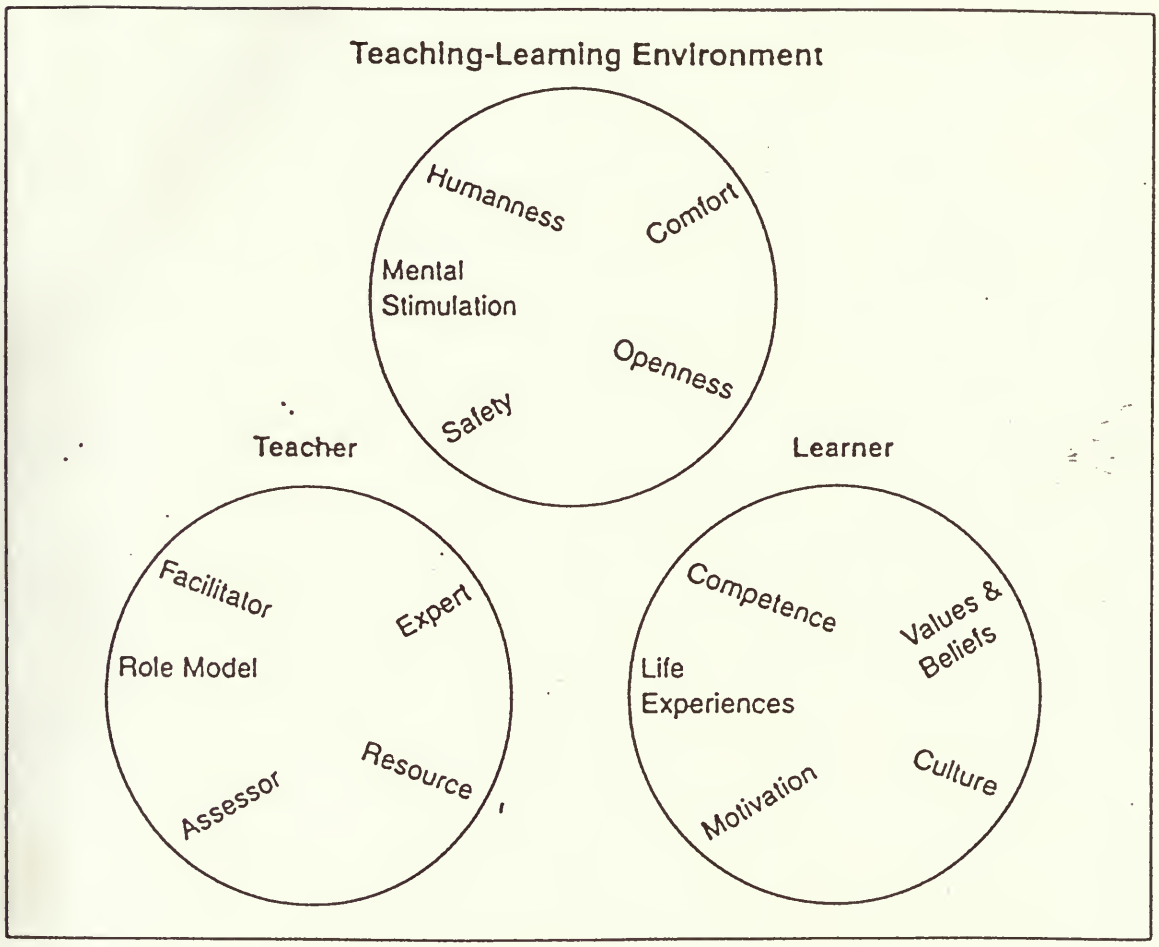
Feedback about the use of the data collected will be available during the month of February, 2000 at this long-term care facility. A written explanation will be provided for you upon request.

Thank you for your participation. Please take a copy of this form with you for future reference.

I have fully explained the procedures of this study to the above volunteer.

Researcher Signature: _____ Date: _____

Appendix H: Components of Teaching-Learning Environment



McDonald, N.C. (1996). Teaching from a treetop. Nurse Educator. 21(1), 32-36.

2775