



**UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA**

Faculty of Health Sciences
School of Health Care Sciences
Department of Nursing Science

**STRATEGIES TO ENHANCE CONTINUING PROFESSIONAL
DEVELOPMENT (CPD) PROGRAM FOR REGISTERED NURSES IN
UNITED ARAB EMIRATES (UAE): A MIXED METHOD STUDY**

Thesis for the degree of Doctor of Philosophy in Nursing

by

Mohamad A. El Najm

Supervisor: Professor Mavis Mulaudzi

Co-supervisor: Dr. Varshika Bhana-Pema

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ABSTRACT

Introduction: In the rapidly growing and evolving healthcare systems, Continuing Professional Development (CPD) has become essential for nurses to update their knowledge and skills, achieve and maintain their competencies, and elevate their clinical functioning with the aim of providing a high standard quality of healthcare to the public as the ultimate goal. Moreover, CPD has been mandated as a licensure renewal requirement for nurses in the UAE. However, despite its importance, there is a lack of empirical studies about the effectiveness of CPD programmes in the UAE.

Aim: This study explores and investigates the perspective of registered nurses (RNs), regarding the effectiveness of the Continuing Professional Development (CPD) in the UAE in order to develop CPD strategies.

Research design: Advanced Multiphase Mixed Method.

Methods: The study constitutes three phases:

- Phase one is qualitative; data was collected through four exploratory focus group interviews with RNs from all geographical areas in Abu Dhabi. They were selected through expert purposive sampling strategy from the same selected facilities as per the sampling of phase two. Data was analysed by “Thematic Analysis Style” using QSR NVivo software.
- Phase two is quantitative descriptive; a modified questionnaire Q-PDN (Questionnaire-Professional Development for Nurses) was used to collect data from RNs. The sample was selected from a population of 18,910 RNs through probability stratified sampling, utilising the probability proportional to size (PPS)

sampling due to the unequal size of the units. The sample size was 400 with a 655 response rate. Data was analysed by using the SPSS software yielding descriptive and inferential statistics.

- Phase three is qualitative Appreciative Inquiry where meeting(s) were conducted with nursing “key players” in the Abu Dhabi, adopting the 5-D Cycle. The nursing ‘key players’ represent the role of the nursing leaders in Abu Dhabi. Data was analysed using simultaneous targeted participatory thematic analysis.

Results and conclusion: The CPD strategic recommendations were developed based on the RNs’ needs and perceptions and aligned with the benchmarked international CPD practices. The main consideration was the evidence of an existing relationship between the perceived influencing factors and the RNs’ participation in CPD. The study has numerous implications towards developing CPD strategies and policies, contribution to body of knowledge, and benefiting the nurses.

Keywords: Continuing Professional Development, Strategy Development, Nursing

LIST OF ABBREVIATIONS / ACRONYMS

Abbreviation / acronym	Meaning
AI	Appreciative Inquiry
ANA	American Nursing Association
CC	Continuing Competence
CE	Continuing Education
CME	Continuing Medical Education
CND	Continuing Nursing Development
CNE	Continuing Nursing Education
CPD	Continuing Professional Development
CPE	Continuing Professional Education
CRN	Clinical Resource Nurse
CQ	Closing Question
DHA	Dubai Health Authority
DOH	Department of Health
EC	European Commission
GAHS	General Authority for Health Services
HAAD	Health Authority – Abu Dhabi
HBB	Helping Babies Breathe

HCPC	Health and Care Professions Council
ICN	International Council of Nurses
IOSH	Institution of Occupational Safety and Health
IPA	Interpretive Phenomenological Analysis
IQ	Introductory Question
IRB	Institutional Review Board
KI	Key Informant
KQ	Key Questions
LLL	Lifelong Learning
MOHaP	Ministry of Health and Prevention
NCLS	Nursing Career Ladder System
OCLC	Online Computer Library Center
OQ	Opening Question
PD	Professional Development
PDRP	Professional Development and Recognition Programme
PICD	Participant's Information and Informed Consent Document
PPS	Probability Proportional to Size
PQR	Professional Qualification Requirements
QDA	Qualitative Data Analysis
Q-PDN	Questionnaire – Professional Development for Nurses
RCN	Royal College of Nursing
RCS	Royal College of Surgeons
REC	Research and Ethics Committee
RN	Registered Nurse
RSA	Republic of South Africa

SDT	Self-Determination Theory
SOAR	Strengths, Opportunities, Aspirations, and Results
SQ	Sub-Question
TA	Thematic Analysis
TQ	Transition Question
UAE	United Arab Emirates
UAENMC	United Arab Emirates Nursing and Midwifery Council
UK	United Kingdom
UP	University of Pretoria
USA	United States of America
WHO	World Health Organization

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CHAPTER 1: INTRODUCTION

1.1 INTRODUCTION

This study explores and investigates the perspective of registered nurses (RNs) with regards to the effectiveness of Continuing Professional Development (CPD). The findings of the study prompted the development of strategies to ensure effectiveness of the nursing CPD programmes in the Emirate of Abu Dhabi within the United Arab Emirates (UAE). The American Nurses Association (ANA) describes CPD as *“a lifelong process of active participation by nurses in learning activities that assist in developing and maintaining their continuing competence, enhance their professional practice, and support achievement of their career goals”* (ANA & NNSDO, 2010:1).

This chapter introduces the background, significance, problem statement, aim, questions, and objectives, concept clarification, paradigm and philosophical assumptions, theoretical underpinning, and research design and methods.

1.2 BACKGROUND

Healthcare complexities, advancements, and continuous evolution, in response to the populations' changing needs and demands, have resulted in the expansion of existing knowledge and techniques. Consequently, nurses who are core in the healthcare system and are the largest healthcare workforce, are expected to maintain up-to-date professional competence. As such, nursing bodies have a responsibility to develop and maintain effective CPD programmes, in order to build nurses' capacity to perform in alignment with the continuous changes and to provide safe, qualitative, efficient, effective, timely, and patient-centered care (Feldacker, Pintye, Jacob, Chung, Middleton, Iliffe et al., 2017; Ni, Hua, Shao, Wallen, Xu and Li, 2014; Nsemo, John, Etifit, Mgbekem and Oyira, 2013; Prialux, Margaret, Rachael, Lisa, Annette and Rae, 2014).

Over the years across the globe, reforms and improvements have passed the nursing profession. Despite these efforts, pre-qualifying education is only enough as an initial

preparation for nurses. However, it cannot prepare them for all the changes and updates that will certainly occur during their professional careers. It is estimated that knowledge has a half-life of 2.5 years and needs to be updated within that period (Clark, Draper and Rogers, 2015; Chong, Sellick, Francis and Abdullah, 2011). Therefore, CPD has become essential in order for nurses to update their knowledge and skills, achieve and maintain their competencies, and elevate their clinical functioning (Billett, 2010; Ebrahimi, Mohammadi Hosseini, Amirnia, Mehraee, Jamali and Hejazi, 2012; Pool, Poell and ten Cate, 2013; Chong et al., 2011).

CPD is important in developing nurses' experiential and educational competencies with the aim of providing high quality standards of healthcare services to the public, which is the ultimate goal (Aboshaiqah, Qasim and Abualwafa, 2018). It has been emphasised that CPD is key to improving skills and adapting and applying new technologies in the provision of care (Hamzehgardeshi and Shahhosseini, 2013). CPD will provide nurses with new evidence-based knowledge, justifications, and updates of what does and does not work in practice (Nsemo et al., 2013). Due to its importance, the investment in CPD has increased significantly all over the world in the last few decades (Clark et al., 2015).

The International Council of Nurses (ICN) defines CPD as *“the establishment of higher levels of competence in the range of knowledge, skills and abilities needed to perform duties or support interventions... in clinical practice, management, education, research, regulation or policy-making”* (ICN, 2005). In the same breath, ANA refers to CPD as *“a process of planned activities based on performance review and setting of explicit targets for good clinical practice with the aim of improving actual quality of patient care”* (Bynum, Irwin and Cohen, 2010). However, the Dubai Health Authority (DHA) describes it as *“a range of learning activities through which healthcare professionals maintain and develop their knowledge and skills throughout their career to ensure that they retain their capacity to practice safely, effectively and legally within their evolving scope of practice”* (DHA, 2014). This study holds the opinion that addressing the CPD as a “process” rather than as “a range of activities” would put it in the right developmental scope. As such, it aims to develop effective CPD strategies.

The importance of CPD is to improve nurses' knowledge, skills, and attitudes to improve patient care and job satisfaction and retain a competent and motivated workforce (Nsemo et al., 2013; Skår, 2010). Nurses perceive CPD as an extremely important and helpful tool to further develop and measure professional competency (Ni et al., 2014; Priaulx et al., 2014). It has been evidenced that CPD activities increase nurses' theoretical knowledge and psychomotor skills and confidence in performing designated tasks and procedures (Kasine, Babenko-Mould and Regan, 2018). Moreover, CPD helps nurses to meet patients' needs, maintain professional competence, develop new skills, and retain their jobs (Nsemo et al., 2013).

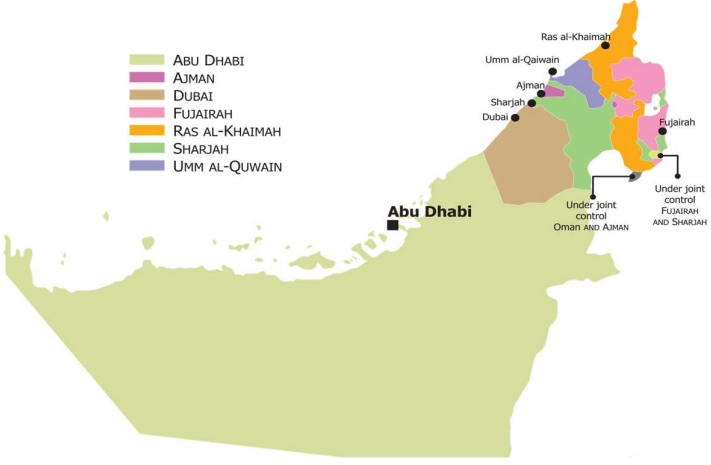
The healthcare sector in the UAE has witnessed rapid growth in the last decade, to meet both the evolving needs of a growing population, and to achieve the "Health for All" strategic priority of the UAE vision 2021 (USUAE_Business_Council, 2016). It was anticipated that the healthcare market would grow at 7% annually between 2015 and 2020 (RNCOS, 2015) and would increase to \$19.5 billion (Emirates247, 2016a). The underlying reasons that will trigger this growth, would be the increasing local population (Emirates247, 2016b) The increasing numbers of expatriates (TheNational, 2016), and sedentary lifestyle has led to the prevalence of numerous chronic diseases (Sulaiman, Elbadawi, Hussein, Abusnana, Madani, Mairghani et al., 2017). Therefore, having the appropriate skilled workforce is key to achieving this strategic priority (Brownie, Hunter, Aqtash and Day, 2015). Although training of nurses at undergraduate and postgraduate basic levels is up to standard, it is critical to keep nurses in practice up to date with knowledge and skills to manage the rapidly evolving technological changes and disease profiles. As such, CPD is regarded as a key enabler for nurses to maintain high standards of competence (COT, 2007).

The UAE was formed as a country in 1971. The country has three regulatory bodies that cover the seven Emirates (Table 1.1). These are the Department of Health (DOH) in Abu Dhabi, DHA in Dubai, and Ministries of Health and Prevention (MOHaP) in the other five Emirates. CPD was implemented as a mandatory requirement for nursing licensure renewal by the three regulatory bodies at separate times between 2005 and 2008. This was done in an attempt to unify the healthcare standards and practices among the three regulatory bodies. In 2014, a Unified Healthcare Professional Qualification Requirements (PQR) document was published by the UAE Nursing and Midwifery Council (UAENMC) established

in 2009. However, the regulations and legislations are still under the authority of the regulatory bodies.

Table 1.1: UAE Health Professions Regulatory Bodies Overview

#	Emirate(s) (Area)	Regulatory Body	Established	Historical Remarks
1	Abu Dhabi	DOH	2007	<ul style="list-style-type: none"> • MOHaP was the regulatory body in UAE from 1971 to 2001. • In 2001, General Authority for Health Services (GAHS) took over the regulatory responsibilities in Abu Dhabi • In 2005, GAHS took over the operations management of the facilities in Abu Dhabi • In 2007, DHA was established and took over the regulatory and operations responsibilities in Dubai • In 2007, GAHS was re-structured into 2 organisations. <ol style="list-style-type: none"> 1. Health Authority of Abu Dhabi (HAAD) responsible for the regulations 2. SEHA responsible for the facilities operations • In 2009, UAENMC was established • In 2017, HAAD's name changed to DOH
2	Dubai	DHA	2007	
3	Northern Emirates (Sharjah, Ajman, Umm Al Quwain, Ras Al Khaimah, and Fujairah)	MOHaP	1971	



Possible underlying causes and solutions for the ineffectiveness and inefficiency of some CPD programmes are addressed by several studies in the reviewed literature. The review concluded that understanding the CPD's role in developing the nursing practice is a key factor that affects the nursing workforce development (Wang, Wei, Li, Deng and Luo, 2013). Similarly, it has been found that CPD should be relevant, purposeful, and include a variety of activities to cover personal/professional development, work-based learning, or formal education (Holloway, Arcus and Orsborn, 2018). This approach is supported by several studies which indicate that the effectiveness of CPD should be based on the nurses' real needs and expectations (Haywood, Pain, Ryan and Adams, 2013; Holloway et al., 2018;

Jones, Michael, Butt and Hauck, 2016; Pool, Poell, Berings and ten Cate, 2016; Pool, Poell, Berings, ten Cate and info:eu, 2015; Weglicki, Reynolds and Rivers, 2015) and their view of facilitators and barriers to participation (Aboshaiqah et al., 2018; Feldacker et al., 2017; Hamzehgardeshi et al., 2013; Haywood et al., 2013; Kasine et al., 2018; Ni et al., 2014; Nsemo et al., 2013; Shahhosseini and Hamzehgardeshi, 2014; Brekelmans, Maassen, Poell, Weststrate and Geurdes, 2016). The importance of nurses' opinion was highlighted in terms of identifying key factors influencing their participation in CPD (Brekelmans, Poell and van Wijk, 2013; Davis, Taylor and Reyes, 2014; Brekelmans, Maassen, Poell and van Wijk, 2015).

1.3 SIGNIFICANCE

The significance of this study is anticipated to be in three different respects; implications of developing CPD strategies and policies, contribution to the CPD knowledge and understanding, and benefits for nurses. Therefore, examining the understanding of the CPD concept needs influencing factors and programme effectiveness from the perspective of the nurses. Nurses' opinion, which are highly affected and driven by their values and attitudes, are crucial in matters that affect their career and professional development (Billett, 2010; Davis et al., 2014; Brekelmans et al., 2015).

Firstly, the study enables the achievement of effective CPD strategies for nurses and consequently, will be useful in developing new policies and/or amending the existing policies (Haywood et al., 2013; Holloway et al., 2018; Jones et al., 2016; Pool et al., 2016; Pool et al., 2015; Weglicki et al., 2015). Secondly, the findings would contribute to the local and international body of knowledge in terms of delivering effective CPD programmes, especially since no studies have been published on the effectiveness of CPD in the UAE. Finally, in addition to creating baseline data for Abu Dhabi and the UAE regarding the nursing CPD programmes, the expected implications of the proposed study on nurses are to increase their awareness of how and why they have to develop professionally. The study will also help employers, decision makers, and regulatory bodies to adopt approaches and strategies that would better fit nurses' needs (Aboshaiqah et al., 2018; Brekelmans et al., 2013; Feldacker et al., 2017; Hamzehgardeshi et al., 2013; Kasine et al., 2018; Ni et al., 2014; Nsemo et al., 2013; Pool et al., 2013; Prialux et al., 2014; Shahhosseini et al., 2014;

Brekelmans et al., 2016; Holloway et al., 2018; Jones et al., 2016; Pool et al., 2016; Weglicki et al., 2015).

1.4 PROBLEM STATEMENT

Little is known about the CPD programmes in the UAE since the regulatory bodies and UAENMC do not publish detailed documents/manuals about the CPD programmes. The only published information is a CPD guidelines manual by one regulatory DHA, and brief guidelines by the other bodies. The UAENMC mentioned CPD as an item under the licensure renewal requirements in the PQR document. However, the regulatory bodies launched an approval system for the accredited CPD hours and promoted several CPD activities. In the UAE, the CPD concept is frequently used interchangeably with Continuing Medical Education (CME) and Continuing Nursing Education (CNE).

Since the launch of CPD, numerous areas of development and inquiry have been identified. First, the inability to find a published study about the effectiveness of the nursing CPD. Second, the limitation of CPD requirements to the number of the hours without specification of relevancy to the field of specialty and without identifying the different needs of nurses, according to their expertise, specialty, performance, and/or quality of care. Third, nurses' informal comments and questioning about the value and benefits of attaining any CPD hours within the current context. Therefore, the connection between CPD hours and CPD programme is not evident and is questioned, and this triggered the first inquiry in this study; to explore and investigate the effectiveness of the programme.

Enormous efforts have been made by the regulatory bodies, nursing experts, leaders, managers, and educators to develop effective CPD programmes and frameworks. These efforts were boosted by mandating the CPD as a prerequisite for the nursing licence renewal in many countries, including the United States of America (USA), United Kingdom (UK), Canada, Australia, and the UAE. Nevertheless, reviewing the findings of the empirical studies indicated a gap in nurses' understanding of the CPD process; as such CPD does not always achieve the desired effectiveness (Brekelmans et al., 2013). Priaulx et al. (2014) categorised the reasons into three areas: (a) institutional characteristics and their influence on nurses' participation in CPD; (b) nurses' attitudes towards CPD; and (c) nurses' actual concerns about participation in CPD. Taking this into consideration, this study addresses

the effectiveness of the CPD programmes in the UAE in terms of knowledge, skills, and attitude from the nurses' perspective and hopes to develop the effective CPD strategies. These strategies aim to deliver a CPD programme that will increase nurses' awareness of the importance of CPD, identify and meet their needs in terms of content and delivery, address the hindering and facilitating factors that influence their participation, and subsequently, achieve the desired outcomes.

1.5 AIM, OBJECTIVES, AND QUESTIONS

The aim of this study is to explore and investigate the perspective of registered nurses (RNs) regarding the effectiveness of the Continuing Professional Development (CPD) in the UAE in order to develop inclusive CPD strategies.

To achieve this purpose, this study was conducted in three phases. Questions, objectives, and hypotheses were posed as follows:

Phase 1 (qualitative focus group interviews with the RNs):

1. What is the perception of RNs on the effectiveness of the CPD programme?
 - *Objective 1.1:* explore and describe the perception of RNs about the effectiveness of the CPD programme on their performance.

Phase 2 (quantitative self-reported questionnaire for the RNs)

2. What are the intrinsic and extrinsic hindering and facilitating factors that influence RNs' participation in the CPD programme?
 - *Objective 2.1:* identify and determine the intrinsic and extrinsic hindering factors that influence RNs' participation in the CPD programme.
 - *Objective 2.2:* identify and determine the intrinsic and extrinsic factors that facilitate RNs' participation in the CPD programme.
 - *Objective 2.3:* Identify the most important CPD activities.
 - *Objective 2.4:* identify any perceived differences in the hindering factors, facilitating factors, important activities, and actual activities undertaken in terms of the region, governor, and type of facility.

The main hypotheses about the correlation between hindering factors (conditions), facilitating factors (motives), important activities, and actual activities undertaken are as follows:

- **Hypothesis (H1):** the motives, conditions, and importance associated with CPD have a significant effect on the CPD activities performed by RNs in Abu Dhabi.
- **Null Hypothesis (H0):** the motives, conditions, and importance associated with CPD have no significant effect on the CPD activities performed by RNs in Abu Dhabi.

The sub-hypotheses that examined which of the sub-factors within each construct i.e. motives, conditions, and importance significantly contributes to CPD activities are presented in chapter three.

Phase 3 (Appreciative Inquiry meeting with the nursing leaders)

3. How can an effective CPD programme that meet the needs of RNs be developed?

The objectives are based on the 5-D Cycle of the Appreciative Inquiry (AI) which are “Define”, “Discovery”, “Dream”, “Design”, and “Destiny” phases (Cooperrider, Whitney and Stavros, 2008). As per the study’s aim, to develop CPD strategies, the study reached the “Design” phase of the 5-D Cycle where the best CPD strategies were developed. The “Destiny” phase, which is the implementation phase will be carried out in the future, during the postdoctoral study.

a) *Define Phase*

- *Objective 3.1:* define the affirmative topic CPD and clarify the focus of inquiry; based on the findings of phases one and two.

b) *Discovery Phase*

- *Objective 3.2:* explore and describe what is working effectively in the existing CPD programmes and strategies.

c) *Dream Phase*

- *Objective 3.3:* identify areas of improvement in the existing CPD programmes and strategies.

- *Objective 3.4:* describe the expected CPD programme activities in terms of content, provision, and outcomes.
- d) *Design Phase*
- *Objective 3.5:* develop the best CPD strategies that would contribute to the improvement of the CPD programme.

1.6 OVERVIEW OF THE CPD CONCEPT AND CLARIFICATION OF RELATED TERMS

1.6.1 Historical Overview of the CPD Concept

Most literature on the history of lifelong learning (LLL) extends to the early 1920s, although some unreliable sources extend it to an earlier period. According to Simpson (1994), there are six influential adult education theorists who presented separate visionary works about adult learning, when it was realised that education is not limited to children. Three theorists from the UK are Albert Mansbridge, Basil Yeaxlee, Richard Tawney, while three from the USA are Edward Thorndike, John Dewey, and Eduard Lindeman. Among them, Basil Yeaxlee and Eduard Lindeman discuss LLL in a specific period with a serious societal need; during the economic depression that had hit Europe during and after the war.

At an earlier time, Florence Nightingale used to encourage her followers to continue learning, however, this would not be considered as CPD as nursing was not a profession at that time. Nevertheless, the first recorded nursing CPD course dates back to 1894 in the USA (Stein, 1998). Recently, LLL became more associated with adult learning, especially with the emerging economical needs and skills agenda (Scales, Pickering, Senior, Headly, Garner and Boulton, 2011).

1.6.2 Lifelong Learning (LLL)

Clarifying the CPD concept would be incomplete if not set in the context of LLL. Alsop (2013) maintains that LLL is the underpinning philosophy for all personal learning and development; formal and informal.

The European Commission (EC) incorporated the formal and informal learnings in the definition of the LLL by stating that it:

“encompasses all learning activities undertaken throughout life with the aim of improving knowledge, skills and competences, within personal, civic, social or employment-related perspectives” (EC, 2019).

This definition does not specify the learning that occurs for or in employment. It aims for all stages of life rather than just to meet professional competence requirements. Laal and Salamati (2012) present a similar definition when they state that it *“covers the whole range of learning that includes formal, informal and non-formal learning”*.

The benefits of LLL are enormous and resemble those of the CPD. However, most important, it contributes to the development of knowledge and skill in nursing and allows for critical thinking, supports reflection and self-assessment, and improves the quality of patient care (Eason, 2010).

1.6.3 Continuing Professional Development (CPD)

In continuum with LLL, ANA described CPD as:

“a lifelong process of active participation by nurses in learning activities that assist in developing and maintaining their continuing competence, enhance their professional practice, and support achievement of their career goals”
(ANA&NNSDO, 2010:1).

The ANA’s definition is very useful as it incorporates several aims of CPD and focuses on the career goals. Within the same context, CPD is also defined as:

“a term commonly used to denote the process of the on-going education and development of health care professionals, from initial qualifying education and for the duration of professional life, in order to maintain competence to practice and increase professional proficiency and expertise” (Alsop, 2000:1).

In continuum with the above definitions, but with the exclusion of the undergraduate and postgraduate education, the Royal College of Surgeons (RCS) defines CPD as:

“any learning outside of undergraduate education or postgraduate training that helps to maintain and improve their performance. It covers the development of

knowledge, skills, attitudes and behaviours across all areas of professional practice and includes both formal and informal learning activities” (RCS, 2019).

A complementary definition describes CPD as:

“a process by which individuals take control of their own learning and development, by engaging in an on-going process of reflection and action”

(Megginson and Whitaker, 2007:3).

From these definitions, it can be concluded that CPD is an individual nurse’s responsibility. However, from a different perspective, since nurses should work under certain regulatory bodies, they should comply with the requirements where definitions of CPD may differ slightly. An example of such definitions is the Health and Care Professions Council (HCPC) which defines CPD as:

“as the way in which registrants continue to learn and develop throughout their careers so they keep their skills and knowledge up-to-date and are able to practice safely and effectively” (HCPC, 2019).

Taking into consideration patients and quality of care but with less personal motive, the Royal College of Nursing (RCN) in the UK describes CPD as:

“fundamental to the development of all health and social care practitioners, and the mechanism through which high quality patient and client care is identified, maintained and developed” (RCN, 2009:2).

Additionally, the Institution of Occupational Safety and Health (IOSH) published a definition that encompasses most of the precedent elements with more emphasis on the reflection and states:

“CPD helps you create a structured career path, as well as safeguard your professional status. CPD is about your skills, knowledge and expertise, and reflecting on what you’ve gained or achieved” (IOSH, 2019).

Lastly, it has been found that the World Health Organisation (WHO), in affiliation with the Capacity Plus, published the most comprehensive definition of CPD that satisfies the needs of most of the nurses, regulatory bodies, and healthcare providers. It states that CPD is:

“part of as a systematic and ongoing process of education, in-service training, learning, and support activities that build on initial education and training to ensure continuing competence, extend knowledge and skills to new responsibilities or changing roles, and increase personal and professional effectiveness” (Giri, Frankel, Tulenko, Puckett, Bailey and Ross, 2012).

In the UAE, there is no published definition of CPD by the MOHaP and UAENMC. However, the DOH in Abu Dhabi defines CPD as an:

“ongoing systematic maintenance and growth of the knowledge and skills required for a health professional to remain competent in his/her occupation for the benefit of that particular profession” (DOH, 2019).

While the DHA adopted a definition that encompasses the same concepts of the DOH's definition that states that CPD is:

“a range of learning activities through which healthcare professionals maintain and develop their knowledge and skills throughout their career to ensure that they retain their capacity to practice safely, effectively and legally within their evolving scope of practice” (DHA, 2014:4).

After reviewing such wide variety of CPD definitions, it can be concluded that CPD:

- is a systematic and ongoing process
- requires active participation in learning/educational activities; includes both formal and informal
- covers the development of knowledge, skills, attitudes, and behaviours
- requires reflection on practice
- aims to maintain competence to practice and increase professional proficiency and expertise
- supports achievement of their career goals
- supports provision of high-quality patient and/or client care
- allows nurses to retain their capacity to practice safely, effectively and legally within their evolving scope of practice

1.6.4 Continuing Professional Development and Interchangeable Terms

In nursing literature, numerous terms are often used interchangeably (Laal et al., 2012). In this study, such phrases are grouped together under two categories; the “Development” and the “Education” terms. The “Development” terms are the most common term used for “Continuing Professional Development” (CPD) and the least used term is “Continuing Nursing Development” (CND). The “Education” terms are Continuing Professional Education (CPE), “Continuing Nursing Education” (CNE), and “Continuing Education” (CE). The major difference among both groups of terms is that the “Education” group is more focused on didactic principles and formal learning, while the “Development” group is more focused on self-directed learning where nurses have full control of their professional development (Grant and Stanton, 1998 in Brekelmans et al., 2013). This difference does not deny the fact that the “Education” forms a significant element of “Development” (Murphy, Cross and McGuire, 2006).

ANA refers to the CPD as a lifelong process and CE as a systematic learning experience and defines the CE as:

“Those systematic professional learning experiences designed to augment the knowledge, skills, and attitudes of nurses and therefore enrich nurses’ contribution to quality healthcare and their pursuit of professional career goals” (ANA&NNSDO, 2010:43).

Another definition of CE, that put emphasis on the quality of patient care, states that it is:

“a process of planned activities based on performance review and setting of explicit targets for good clinical practice with the aim of improving actual quality of patient care” (Bynum et al., 2010).

Whereas a similar, but more comprehensive definition of CE, took the organisational goals as an umbrella of the process, when it stated that it is:

“a process that prepares the staff members for improvement and better efficacy in current or future positions, modifies their thinking and action, and furnishes them with professional information they need to achieve organizational goals” (Ebadi, Vanaki, Nehrir and Hekmatpou, 2007).

In the UAE, the Continuing Medical Education (CME) is used as an interchangeable term to CPD (DHA, 2014). The DOH states that CME:

“helps those in the medical field maintain competence and learn about new and developing areas of their field. It is designed to enhance health professionals’ knowledge and skills, which will result in better health services provided”
(DOH, 2019).

As such, it can be concluded that the published definitions of the “Education” group does not differ from the “Development” group”. Most of the organisations which necessitate agreements on consistent definitions of different terminologies work to ensure that end-users are not confused. This highlights the importance of agreements on the common language among professionals.

1.7 PARADIGMS AND PHILOSOPHICAL ASSUMPTIONS

Since paradigms are fundamental in the scientific research and provide a conceptual framework for viewing the social world (Patterson and Williams, 1998), this study was conducted from the perspective of the pragmatic paradigm which views as an alternative, the presence of single and multiple realities, which are open to empirical inquiry and are applicable towards finding practical solutions to problems in the real world (Creswell and Plano Clark, 2018). A detailed discussion of the paradigms and philosophical assumptions is explained in chapter three.

1.8 THEORETICAL UNDERPINNING

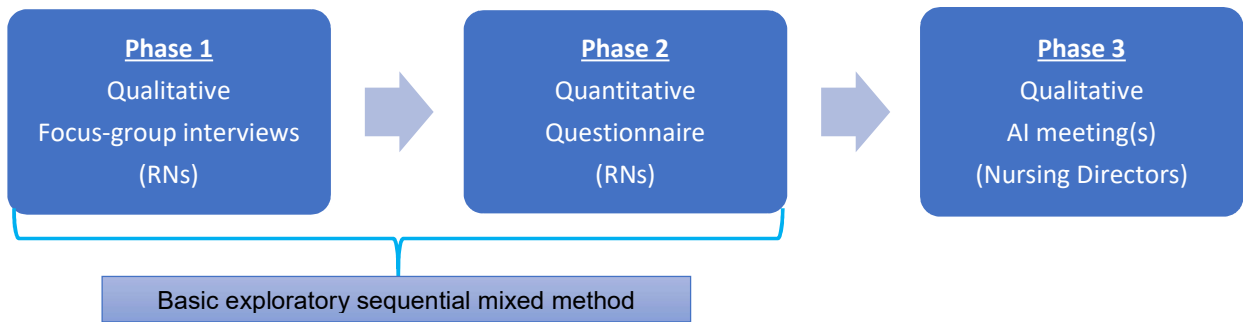
The theoretical foundation that guided the “basic exploratory sequential mixed method”, phases one and two, is based on three theories and/or models; Self-Determination Theory (SDT), Kanter’s Structural Empowerment Model, and Bloom’s Taxonomy of Learning Domains. These are manifested in the questionnaire’s constructs; motives, conditions, activities, and undertaken activities. More details about the theoretical underpinning is explained in chapter three, as part of the questionnaire’s modification process.

1.9 RESEARCH DESIGN AND METHODS

Design and methods are the pillars of research and are defined as “*plans and the procedures for research... that involve the intersection of philosophy, strategies of inquiry, and specific methods*” (Creswell, 2009:3, 5). The approach to this study is an “advanced multiphase mixed method”. The mix of the quantitative and qualitative approaches in one design contributes to the provision of a more complete picture of the research problem and enhances the significance and reliability of the study (De Vos, Strydom, Fouché and Delpont, 2011:435). This mix represents the pragmatic paradigm; taking a value-oriented approach to research (Johnson and Onwuegbuzie, 2004). As an advanced multiphase mixed method design, the study is based on the basic exploratory sequential mixed method design (Qualitative-Quantitative) which is followed by a qualitative Appreciative Inquiry phase. As illustrated in figure 1.1, phase one used the qualitative, explorative, descriptive, and contextual method where data was collected through focus group interviews with RNs for exploratory purposes (Bryman and Bell, 2007). The findings of phase one were used to inform phase two, which resulted in the modification of the drafted “Questionnaire – Professional Development of Nurses” (Q-PDN) (Johnson, Onwuegbuzie and Turner, 2007; O’Cathain, Murphy and Nicholl, 2010). Phase two employed the quantitative cross-sectional descriptive method where data was collected from RNs about the extrinsic and intrinsic influencing factors to participate in the CPD in Abu Dhabi, using the modified questionnaire; based on the Q-PDN questionnaire and the findings from the first phase. Finally, using the findings from phases one and two, the third phase was qualitative Appreciative Inquiry (AI) with the nursing key role players as a powerful research and change tool (Kristin, Jane, Mary, Bonnie, Mélanie, Mary et al., 2012). Eventually, the AI’s outcome was the proposed CPD strategies.

More details about the research design and methods in addition to the population, sample, sampling, data collection, ethical considerations, validity and reliability, trustworthiness, and data analysis are explained in chapter three.

Figure 1.1: CPD Advanced Multiphase Mixed Method Roadmap



1.10 ORGANISATION OF THE DISSERTATION

- Chapter 1: Introduction
- Chapter 2: Literature Review
- Chapter 3: Methodology
- Chapter 4: Qualitative Focus Groups Findings
- Chapter 5: Quantitative Questionnaire Findings
- Chapter 6: Data Integration and Discussion of the Core Design
- Chapter 7: Qualitative Appreciative Inquiry Findings and Discussion
- Chapter 8: Conclusions, Limitations, Implications, and Recommendations

1.11 SUMMARY OF THE CHAPTER

Nursing practice should be aligned with the continuous advancements and evolution in the healthcare industry in order to provide safe, efficient, effective, timely, and patient-centred care. Hence, nurses are expected to maintain up-to-date professional competence through contemporary and effective CPD programmes that meet their needs. This study was conducted in three phases from the pragmatic perspective as an advanced multiphase mixed method. It explored and investigated the perspective of RNs regarding the effectiveness of the CPD in the UAE where new CPD strategies were developed. The study hopes that the new strategies will contribute to the nurses' developmental and educational needs in order to provide the ultimate goal of providing high quality healthcare service.

CHAPTER 2: LITERATURE REVIEW

Chapter one outlined the thesis and presented an overview of the study, this chapter presents the literature reviewed from two different aspects. The first aspect is the integrative literature review that contributes to the in-depth understanding of the CPD by addressing the current gaps and finding evidence by reviewing, critiquing, and synthesising the representative literature (Richard, 2016). The integrative literature review is popular in dynamic topics and has experienced rapid growth (Richard, 2016) and the researcher believes that CPD is one such topic. The second aspect is the comparison of international CPD programmes from selected countries across the globe, representing a benchmark from which to develop strategies for an effective CPD programme.

2.1 INTEGRATIVE LITERATURE REVIEW

2.1.1 Search Strategy

A search strategy was carefully planned and continuously refined to conduct the integrative literature review and facilitate rigour (Cooke, Smith and Booth, 2012). The search question and inclusion criteria were foundational in the search strategy. Other important aspects included the selection process, the quality assessment and data analysis in order to bring the most frequent and rich emerged themes from the findings.

2.1.1.1 Search Question

The search question that guided the integrative literature review was developed in accordance to the SPIDER mnemonic. SPIDER was proposed by Cooke et al. (2012) as a tool for the qualitative and mixed method studies in a more timely and sensitive manner than the PICO that is used for the quantitative studies. SPIDER mnemonic stands for

“Sample”, “Phenomenon of Interest”, “Design”, “Evaluation”, and “Research type”. The SPIDER for the integrative literature review is presented in table 2.1.

Table 2.1: SPIDER of the Integrative Literature Review

Sample	RNs
Phenomenon of interest	CPD
Design	Focus groups and questionnaire
Evaluation	Perception/experiences
Research type	Mixed method

The emerged search question from the SPIDER is “*what is the RNs perception of the CPD?*”

2.1.1.2 Inclusion Criteria

After formulating the search question, the search inclusion criteria were set to include the required relevant publications as per the search question and to exclude any irrelevant and unjustified publications. Strict inclusion criteria contribute to unbiased findings of the integrative literature review. The inclusion criteria addressed key elements such as the sample/participants, phenomenon of interest, type of publications, key words and their synonyms, timeframe and publication language (Aromataris and Riitano, 2014).

Participants referred to as sample in the SPIDER, are RNs, regardless of their specialty and setting. Identifying them as a keyword facilitated the search process and contributed to the exclusion of the significant number of articles about the same phenomenon of interest but in a different setting, such as undergraduate nursing studies. In addition to RNs, midwives’ studies were taken into consideration as their work conditions resemble that of RNs and both fall under the same category in many settings.

The phenomenon of interest, CPD, was another strict inclusion criterion. Articles should have investigated the CPD phenomenon based on RNs in order to qualify and to be included. Thus, all articles that addressed the CPD from the any other aspect were excluded. Several synonymous keywords for the CPD were used.

The search criteria also included journal articles with empirical studies only about nursing CPD. The studies were not restricted to any type; they include the qualitative, quantitative, and mixed method studies. The search was limited to full text peer reviewed content with articles format. The WorldCat (OCLC catalog of books and other materials in libraries worldwide), the world's most comprehensive database on information about library collections (OCLC, 2018) was used as a database. OCLC (Online Computer Library Center) is a global library co-operative that provides shared technology services, original research, and community programmes for its members, and the library community at large. In addition to the WorldCat, the Google Scholar search engine was also used to find any other eligible articles.

The keywords were “nursing” and “continuing professional development” and their synonyms. Preliminary keywords were not narrowed and restricted to get a wide view of the available literature. The keyword for RNs was “nurs*”. The star (*) allowed for the inclusion of all nursing related terms such as nurse, nurses, registered nurses, registered nursing, nursing and clinical nurses. Synonymous keywords for the CPD were “contin* professional development”, “contin* professional education”, “contin* education”, “contin* nursing development”, “contin* nursing education”, “lifelong learning” and “in-service education”. The star (*) in the (contin*) allowed for the search to include “continuing” and “continuous”.

The initial timeframe for the search was identified as a five-year period, from 2013-2018. However, the literature review was updated by one year to include 2019, even though this was the case, 2013 articles could not be excluded due to the significant findings. Thus, the final timeframe became a six-year period from 2013-2019. The included papers in the first five years were 21 and four were added according to the same search protocol, making the total number of studies 25.

The last inclusion criterion taken was the publication language. The search language was not limited to English; this was done to avoid excluding any significant findings from recent studies in other languages. However, in addition to the 25 included articles, two more

were found in Portuguese. Their abstracts were also in Portuguese and had to be translated to English through the “Google Translate” services. However, it was discovered that the content was not relevant to the study’s scope. Hence, both papers were excluded. If they had been found to be relevant, the intention was to officially translate them to English or request the English versions from authors if available.

2.1.1.3 Selection Process

The selection process of the included articles was adopted from the PRISMA 2009 flow diagram (PRISMA, 2015). The process started by searching for potential articles using the identified keywords and then filtering them to include the peer reviewed full text articles with a timeframe of six years from 2013-2019. Afterwards, the titles of the retrieved articles were screened for inclusion and checked for duplication. Finally, a total of 42 full text articles were carefully assessed for eligibility by reading the full texts. Thereafter, 25 articles were included for the integrated literature review (Figure 2.1).

2.1.1.4 Quality Assessment and Data Synthesis

Data was extracted from articles and summarised in a grid (Table 2.2) that displays the required data in an organised manner to allow comprehensive data synthesis and discussion of the themes. However, the availability of the data does not imply its validity and reliability. To evaluate the validity and reliability of the studies, a critical appraisal of the studies was conducted. The researcher adopted the framework of DePoy and Gitlin (1994) that is represented in a set of general questions that enquires about all aspects of a published study.

Afterwards, the data was analysed and grouped into themes according to the findings of the reviewed papers. Nine themes emerged from this process. However, only three themes were considered for the literature review according to their frequency and depth. The frequency of the three themes ranged from 8 to 14 whereas the other three were not as frequent nor as common; most of them appeared once (Table 2.3). The three main emerged themes are (1) “nurses’ perception on the importance and benefits of CPD”, (2)

“factors (facilitating and hindering) influencing participation in CPD”, and (3) “needs analysis and expectations”. A discussion of the themes is presented in the next section.

Figure 2.1: Articles Selection Process (adopted from PRISMA 2009 Flow Diagram)

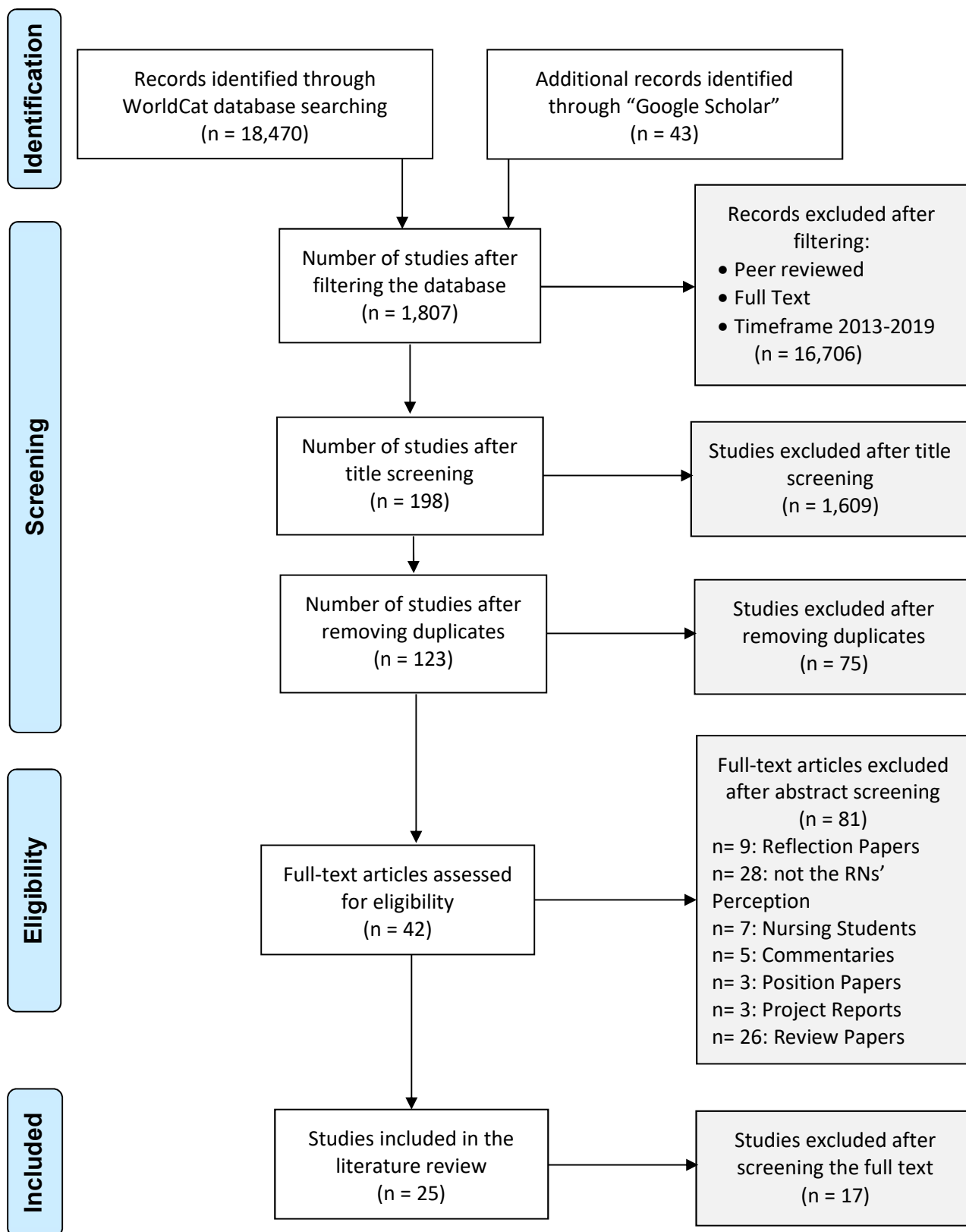


Table 2.2: Literature Review Grid

#	Source	Purpose/ Research Question	Methodology, Population and Sampling	Data Collection and Analysis	Major Findings, Contributions	Themes
1	Nsemo et al. (2013)	To determine the perception of nurses on various aspects of CPE	Mixed method design <u>Quantitative</u> 155 nurses and midwives (76% of the population) Stratified random sampling 2 hospitals in Calabar, Nigeria Response: 150 (96.8%) <u>Qualitative</u> 150 interviews	<u>Quantitative</u> self-explanatory, semi-structured questionnaire Analysis Predictive Analytical Software for Social Sciences (PASW 18.0). <u>Qualitative</u> Unstructured (in- depth) interviews Analysis Thematic Analysis	Participants generally perceived that CPE is valuable and worthwhile for practice 99.3% perceived that CPE helps practitioners to retain their job 82.0% said it helps them meet patients' needs 74% CPE allow nurses to maintain professional competence 67.3% said it develops new skills Motivation factors 1) 100%: mandatory 2) 67.3%: professional responsibility 3) 54%: personal interest and self-development Hindering Factors organisational & physical 1) 80.7%: busy shift and scheduling 2) 67.3%: family responsibilities 3) 39.3%: geographic distance to venue 4) 12.7%: high cost of course 5) 45%: Attitude of nurse managers especially when programmes are organised	Importance/Ben efits of CPD Motivating Factors Hindering Factors CPD provision and content

					outside the health facility. Perception of how CPE serves as a tool for quality service delivery; participants perceived that CPE enables nurses to provide quality care in terms of effectiveness (100%), efficiency (100%), relevance (98.0%), safety (92.0%) with only 12.7% for consistency of care	
2	Ni et al. (2014)	To explore the attitudes and perceptions of Chinese nurses regarding the attributes of current CE practice and the major factors that affect their participation in these educational offerings	Quantitative cross-sectional survey 2727 hospital-employed Chinese nurses from 10 general hospitals multi-stage, stratified random cluster sampling	Self-administered questionnaires Analysis: Software package SPSS 17.0. Categorical data was reported as frequencies, and the continuous data as means with standard deviations	Chinese nurses considered CE an extremely important measure to further develop their professional competency 92.8% thought CE was necessary and important 92.2% considered CE helpful Motivating factors (5 main factors) 1) to update their knowledge of the newest nursing development and procedures 2) to improve their skills in clinical practice 3) to improve the quality of their comprehension 4) to obtain the knowledge necessary to achieve professional status 5) to raise their level of scholarship (to receive an academic degree)	Importance/Benefits of CPD Motivating Factors Hindering Factors Expectations and needs analysis Attributed of Current CE practices

					Hindering Factors (5 main factors) 1) time constraints 2) work commitments 3) a lack of opportunity 4) cost of the courses 5) previous negative experiences with CE programmes	
3	Haywood et al. (2013)	To explore the perceptions of CPD held by people who have MSK conditions	Interpretive phenomenological analysis (IPA) Focus group methodology Nurses, physiotherapists, podiatrists and occupational therapists who work in musculoskeletal (MSK) services; managers of these services; and people who use MSK service Purposive sample	Three focus groups and two conference calls varying locations 1.25–1.5 hours' duration Audio-recorded Analysis coded by the researchers using a priori and inductive coding Coded directly using NVivo software	Views of people with MSK conditions demonstrated an emphasis on communication skills and that was raised by managers and clinicians Challenges (key to facilitating CPD activity for nurses and AHPs working in MSK services) Sufficient time Funding Provision of study leave (critical role of managers and organisations) Lack of policy made it difficult for one manager to obtain the CPD opportunities for her staff, while another organisation's CPD policy enabled a manager to give her staff time to pursue CPD	Hindering Factors Expectations and needs analysis CPD provision and content
4	Feldacker et al. (2017)	To identify barriers and enablers of effective	Qualitative Evaluation 52 key informant interviews (KIIs)	Key informant interviews (KIIs) and focus group discussions (FGDs)	Barriers 1. Lack of sustainable financial resources 2. Limitations in coordination of CPD result in poor accountability	Hindering Factors

		HIV/TB-related CPD	<p>were conducted: 17 in Malawi, 19 in Tanzania and 16 in RSA.</p> <p>89 HCWs (24 from Malawi, 38 from Tanzania and 27 from RSA) completed questionnaires and participated in focus group discussions (FGDs)</p>	<p>Each HCW completed brief, semi-structured questionnaires and participated in a FGD</p> <p>Analysis: KII and FGD results were combined into key themes spanning countries</p> <p>Verbatim transcription was completed for all recorded KIIs and FGDs</p>	<p>for CPD oversight and reduce CPD quality assurance</p> <p>3. Healthcare worker shortages limit CPD opportunities, creating disparities in CPD access</p> <p>4. CPD irrelevance and imbalance between HCW-identified CPD needs and current programmes reduce enthusiasm for CPD</p> <p>5. Facility-level constraints, including poor infrastructure and weak supply chains, restrict implementation of CPD skills and knowledge</p> <p>Challenges are more severe in rural settings</p> <p>Challenges to CPD implementation: Individual level</p> <p>1. Lack of self-motivation</p> <p>2. Money for attendance</p> <p>3. Country-specific challenges</p>	
5	Priaulx et al. (2014)	To ascertain the current understanding, practice and future continuing professional development (CPD) needs of nurses and midwives employed in a	<p>Quantitative</p> <p>289 public and private hospital nurses and midwives responded</p> <p>A total response rate (RR) of 39% was achieved from the 750 surveys</p>	<p>A paper-and-pencil survey</p> <p>Extreme responses to survey scale items, or outliers, were identified using standard data screening methods</p>	<p>Participants:</p> <p>1) Understood the new requirements</p> <p>2) Valued ongoing learning</p> <p>3) Preferred education to occur within work hours</p> <p>4) Considered their workplaces as accepting of change</p> <p>Two-thirds of participants believed CPD should be shared between them and their</p>	<p>Importance/Benefits of CPD</p> <p>Motivating Factors</p> <p>Hindering Factors</p> <p>CPD provision and content</p>

		regional area of Queensland, Australia.	(450 public) distributed across the two hospitals, with individual service RRs of 42% (public) and 33% (private)	After outlier deletion, 289 responses were included for analysis Cronbach's alphas were 0.69, 0.48, 0.77, & 0.55	employers Barriers Understaffing The concern that CPD would interfere with time outside work Positive Organisational support positively influenced attitudes to CPD Future CPD activities 1. Most common suggestions: related to technical nursing procedures such as learning the latest in wound care, or advanced life support 2. Preferences for the process of professional development (conferences and workshops) and access to higher degree studies 3. Leadership and management skills such as learning how to mentor and how to delegate	Organisational readiness for change scales
6	Brekelmans et al. (2016)	To present an inventory of expert opinions on the factors that influence the participation of registered nurses in CPD activities	Delphi study 38 Dutch experts	Data collection comprised three rounds: experts completed two consecutive rounds of questionnaires and participated in a discussion meeting	Main influencing factors were: 1) A CPD registration system showing the attractiveness of the nursing profession 2) Nurses' identification with the nursing profession 3) Opportunities for workplace learning 4) The line manager as a role model Attractive education	Influencing factors (Hindering and Facilitating Factor)

					programmes Inquisitive/analytical ability, initiative, flexibility and critically reflective work behaviour were the most important Characteristics of the nurse profession mentioned by the experts	
7	Pool et al. (2013)	To explore nurses' and their managers' perceptions of the differences in continuing professional development between younger and older nurses	A qualitative study Large academic hospital in the Netherlands 22 nurses in three age groups (20–34 years, 35–49 years and 50–65 years) and 10 nurse managers participated in four focus groups Convenience sampling method	Focus groups The interviews were analysed using a thematic analysis strategy	The concept of continuing professional development has three dimensions: purpose, level of formality of learning activities, and scope of development. Participants in all groups perceived nurses who develop continually as up to date, equipped to gain in-depth knowledge, enrolling in courses, having an intrinsic desire to develop, and open to feedback. They were seen as innovative, critically reflective, and were perceived to be key contributors to the development of the hospital ward	Expectations and needs analysis Perceptions of CPD associated with three dimensions
8	Hamzehgardeshi et al. (2013)	To investigate these factors from the point of Iranian nurses	Quantitative cross-sectional study 361 Iranian nurses Convenience sampling	The questionnaire used consisted of two parts Statistical Package for Social Sciences for Windows	Facilitators "Update my knowledge" Barriers "Work commitments" Personal and structural barriers	Influencing factors (Hindering and Facilitating Factor)

				version13.0 (SPSS Inc., Chicago, IL, USA)	were significantly higher than the interpersonal	
9	Shahhosseini et al. (2014)	To investigate the facilitators and barriers of nurses' participation, to explore nurses' perception of the most common facilitators and barriers.	An explanatory sequential mixed methods design with follow up explanations variant were used, and it involved collecting quantitative data (361 nurses) first and then explaining the quantitative results with in-depth interviews during a qualitative study.	Semi-structured in depth interviews The qualitative and conventional content analysis approach was used A computer- assisted program (MAXQDA 10) was used for data management Questionnaire Statistical Package for Social Scientist version 16 for windows (SPSS Inc., Chicago, USA).	Facilitators "Update my knowledge" - updating information and professional skill Barriers 1) Lack of support 2) Work commitments 3) Time commitment	Influencing factors (Hindering and Facilitating Factor)
10	Aboshaiqah et al. (2018)	To identify factors that RNs perceive as barriers to CPD in Saudi Arabia	A descriptive/ correlation design Convenience sample of 600 RNs	A researcher- constructed instrument	Three major barriers: 1) 38.2% agree that financial support was the major barrier 2) Commitment/ scheduling problems to attend the educational activities with 29.7% 3) the ability to attend the class regularly with a 19.6% Recommendations - Staff development co-	Hindering Factors

					<p>ordinators are advised to assess learning needs, and CPD activities should be outcome driven and patient centred.</p> <ul style="list-style-type: none"> - Creation of a supportive atmosphere in the clinical environment that promotes CPD activities - Planning CPD activities should be done in consultation with the target group 	
11	Kasine et al. (2018)	Explore nurses' experiences of translating continuing professional development (CPD) education utilising the HBB© course to nursing practice in Rwanda	<p>Qualitative descriptive design</p> <p>A purposive sample of 10 nurses</p>	<p>Individual interviews</p> <p>NVIVO computer software was used to manage qualitative data</p> <p>Content analysis was used for generating categories from the data</p>	<p>Three categories emerged from the analysis:</p> <ol style="list-style-type: none"> 1) application of competencies acquired from education sessions to practice 2) benefits of CPD 3) facilitators and barriers to the application of competencies into practice <p>Nurses' perceived confidence in performing newborn resuscitation improved after taking part in HBB© courses</p> <p>Perceived an increase in their theoretical knowledge and psychomotor skills pertaining to newborn resuscitation</p>	<p>Importance/Benefits of CPD</p> <p>Factors influencing the application of competencies into practice</p> <p>Application of competencies</p>
12	Holloway et al. (2018)	To identify the level and content of training required by	<p>Descriptive approach</p> <p>45 RNs all potential</p>	Hicks-Hennesseu Training Needs Analysis (H-TINA) questionnaire.	The purposeful and effective development of nursing workforce capability requires an	Expectations and needs analysis

		local primary care nurses in relation to reducing ASH rates and ED admissions	candidates with 40% response rate (18 nurses)	Descriptive statistical approaches	evidenced based professional development strategy	
13	Jones et al. (2016)	To explore Tanzanian midwives' perceptions of their professional role in the context of their clinical working environment and provide recommendations for the development of CPD education for Tanzanian midwives	A qualitative, descriptive design 16 Tanzanian midwives in 3 hospitals (3 focus groups)	Focus group interviews Ritchie and Spencer's (1994) 'framework analysis' method	Midwives' overwhelming focus was on saving lives of women and newborns Urgent need for CPD education to improve their professional image and ability to save women and newborns The need for improved detection of unwell women and newborns and to prioritise care is recognised	Expectations and needs analysis
14	Pool et al. (2016)	To explore the relationship between nurses' motives and activities for continuing professional development	Qualitative study 21 nurses in academic and general Dutch hospitals	Semi-structured interviews analysed using a literature-based framework on motives and learning activities for CPD	The relationship between 9 motives and 4 activities were identified where nurses could use these findings to increase their awareness of why and how they develop professionally	Expectations and needs analysis
15	Pool et al. (2015)	To explore continuing professional development	A qualitative study 21 nurses in three age groups from	Semi-structured interviews, from a biographical perspective	In all age groups, daily work was an important trigger for professional development on the ward. Performing extra or new	Expectations and needs analysis

		strategies among younger, middle-aged, and older nurses	general and academic hospitals in the Netherlands	Data were analysed using a vertical process aimed at creating individual learning biographies, and a horizontal process directed at discovering differences and similarities between age groups	tasks appeared to be an additional trigger for undertaking learning activities external to the ward. Learning experiences in nurses' private lives also contributed to their continuing professional development. Besides these similarities, the data revealed differences in career stages and private lives, which appeared to be related to differences in continuing professional development strategy; 'gaining experience and building a career' held particularly true among younger nurses, 'work-life balance' and 'keeping work interesting and varied' to middle-aged nurses, and 'consistency at work' to older nurses	
16	Brekelmans et al. (2016)	To investigate the nature of the relationships among those factors that influence nurse participation in CPD in the Netherlands	An exploratory descriptive cross-sectional study A convenience sample of 5500 RNs working at one Dutch university hospital and several general hospitals (response 1226 nurses)	Questionnaire Professional Development of Nurses (Q-PDN).	"Conditions" was found to be moderately related to "Motives", which itself was strongly related to "Importance", which itself was very strongly related to "CPD activities pursued". If nurses considered a CPD activity important they were highly likely to pursue it; however, the importance attached to specific CPD activities was influenced by the presence of particular motives, which depended in part	Expectations and needs analysis

					on the way CPD conditions were perceived	
17	Weglicki et al. (2015)	To ascertain the aspirations, priorities and preferred mode of CPD for non-medical prescribers	Qualitative phenomenological approach 16 allied health professionals working in primary and secondary care settings	Semi-structured in-depth interviews and a focus group A topic guide was used to cover clinical decision-making (including difficult decisions), legal aspects of prescribing and diagnostic issues A content analysis of the verbatim transcripts enabled four key emerging themes	The four key emerging themes identified are the following: Theme 1: "Personal anxiety undermining confidence to prescribe", Theme 2: "External barriers and other factors that exacerbate anxiety", Theme 3: "Need for support identified through coping strategies", and Theme 4: "Preferred mode or style of learning"	Expectations and needs analysis CPD provision and content
18	Purfarзад, Bahrami, Keshvari, Rafiei, Sivertsen and Cert (2019)	To identify factors influencing the development of gerontological nursing competence in Iranian hospitals	Qualitative Twenty-six participants (nine nurses, 12 nurse managers, four clinical instructors, one physician) Four teaching hospitals and nursing schools affiliated with Arak, Isfahan, and Tehran Universities of	Semi-structured Interviews Conventional content analysis	2 major categories & 7 subcategories <u>Management Factors</u> 1. Meritocracy in Gerontological: competencies of gerontological nursing need to be identified (competencies should be identified first in the specialty) 2. Educational System: no ongoing and continuing education and orientation programmes in the field of gerontological nursing (Specialty) 3. Performance Management:	Expectations and needs analysis Influencing factors

			<p>Medical Sciences in Iran</p> <p>Chosen by use of purposive and snowball sampling</p>		<p>lack of evaluation criteria for the specialty</p> <p>4. Leadership Style of Nursing Managers: focus on tasks only (task-oriented); no motivation and no coaching</p> <p>5. Quality of Working Life: The quality of working life is influenced by a lack of safety and job security, nursing managers' inappropriate and unproductive communication with the staff, lack of promotion opportunities, lack of decision-making power and professional independence of the nurses, lack of a balance between work and family responsibilities, the need for fair and adequate payment, performance reviews, less than satisfactory performance, lack of psychological comfort in the workplace, and the necessity of using capable managers</p> <p><u>Organisational factors</u></p> <p>6. Organisational Learning: the presence of a professional gerontological nurse in each section can serve as a role model for the professional training and development of other nurses</p> <p>7. Organisational support</p>	
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19	Steven, Larkin, Stewart and Bateman (2018)	To explore the impact and perceived value of multi-disciplinary Continuing Professional Development workshops for Health Visitors who support families with children with complex health needs	Realistic Evaluation principles guided the research Workshop attendees were invited to participate (n.21), 81% (n.17) agreed Setting: One North of England Health Service Trust	Observation (field notes) Questionnaire Interviews	Participants suggested the <u>interactive teaching strategy, encouraged sharing of experiences and ideas, getting to know one another and learning together</u> Many <u>valued the opportunity to network</u> and the resulting ability to place a face with a name. This human contact was important in enhancing confidence to subsequently contact services and in facilitating communication The main <u>inhibitory factor</u> in applying learning from the workshops appeared to be <u>workload pressures</u> . These included limited time and dealing with competing demands	Influencing factors CPD provision and content
20	Abebe, Bender and Pittini (2018)	This study describes the in-service training experience of perioperative nurses from the SickKids-Ethiopia Paediatrics Perioperative Nursing Training Programme in	Qualitative The first author led qualitative in-depth interviews with nine perioperative nurses who participated in training in September 2016 9 participants out of 65 who	Interviews Systematically developed descriptive codes and themes to analyse the data.	Participants experienced improved knowledge, skills, confidence, and job retention related to perioperative nursing practice after participating in Paediatrics Perioperative Nursing Training Participants also stressed key challenges including lack of access to ongoing perioperative in-service training and problematic staffing policies that impact perioperative nurses'	Importance/Benefits of CPD Hindering Factors Expectations and needs analysis

		Addis Ababa, Ethiopia	completed the training		ability to fully utilise and share new knowledge gained during CPD training	
21	Hariyati and Safril (2018)	To identify the correlation between nurse's perceptions of the continuing professional development (CPD) and the satisfaction of nursing career ladder system (NCLS) implementation	A descriptive quantitative approach A non-experimental survey design Proportional random sampling technique with the total sample size of 149 nurses in a hospital in Indonesia	Questionnaire Descriptive Statistics	Results: There was a moderate, positive correlation between the CPD and the NCLS satisfaction (R: 0.42, p= 0.0001)	Importance/Benefits of CPD
22	Teekens, Wiechula and Cusack (2018)	To explore the perceptions and experiences of nurses and midwives in undertaking continuing professional development	Systematic Review The review considered studies that include those nurses and midwives who are required to participate in any type of CPD	JBI SUMARI	The benefits of undertaking CPD are that it can: 1) Enable professionals to meet their obligation to provide ethical, effective, safe and competent practice in the nursing profession 2) Enables an individual to apply attention to areas of development and take appropriate action to reduce any shortfalls in knowledge 3) Enables the development of reflective and flexible workers who can both initiate and respond to innovations in healthcare	Importance/Benefits of CPD

					CPD aims to assist nurses and midwives to respond to the changing needs of the healthcare system and their patients to ensure the best possible health outcomes	
23	Perry and Azulay Chertok (2018)	To evaluate a continuing education intervention on nurses' knowledge and perceived competency regarding the care of hospitalised patients with substance use disorder	Quantitative A pre-test/post-test design was utilised to assess changes in knowledge and perceived competency immediately before and after the intervention for 31 hospital nurses using evidence-based tools and measures	Demographic data survey Knowledge-based quiz SPSS	Directly following the intervention, knowledge and perceived competency scores were significantly improved among the nurse participants There was no statistical significance noted between the demographic characteristics and the pre-test/post-test results.	Importance/Benefits of CPD
24	Clark et al. (2015)	To identify the processes that key stakeholders perceive to be most important in facilitating a positive impact of CPE on practice	A qualitative design Setting: Two acute trusts, one primary care trust and two higher education institutions in one geographical region in England Participants: Representatives	Two rounds of semi-structured interviews A total of 35 interviews were conducted in the first round and 31 interviews in the second round (n = 66)	Four overarching themes were identified that illuminate stakeholders' perspectives of the important factors affecting the process of CPE: organisational structure, partnership working, a supportive learning environment and changing practice	Importance/Benefits of CPD

			from four stakeholder groups—students, managers, educators and members of each healthcare organisation's governing board	Template analysis techniques.		
25	Eslamian, Moeini and Soleimani (2015)	To explore the challenges of nursing continuing education in Isfahan University of Medical Sciences hospital	<p>A descriptive explorative qualitative study</p> <p>The sampling begun with a purposeful method and continued with snowball method. Thirty-nine participants were selected among the nurses of three hospitals, nursing and midwifery faculty, continuing education centre, and the vice-chancellery for treatment</p> <p>Isfahan, Iran</p>	<p>Interviewed 39 participants in five focus group and five individual interviews</p> <p>Semi-structured interviews and field notes for data gathering, and members checking, triangulation (data and method), peer debriefing, and peer review to increase the strength of data</p> <p>Data was analysed with thematic analysis method</p> <p>Data analysis produced 175 initial codes, 8</p>	<p>The five main themes included: learners related factors, teachers related factors, educational process related factors, inadequate facilities, and defective evaluation</p> <p>Learners related factors: Lack of participants' preparation for learning Inadequate motivation for learning Lack of human resources</p> <p>Teachers related factors: Inappropriate teachers and defective knowledge transfer methods Teachers' inadequate motivation</p> <p>Educational process related factors Imprecise need assessment Improper planning Inappropriate implementation</p> <p>Inadequate facilities</p>	Hindering factors

				subthemes, and 5 main themes	Defective evaluation Participants pointed to lack of a pre-test post-test in some classes, lack of giving feedback to the learners even in classes with a pre-test post-test, lack of educational evaluation of the personnel in relation with the held education programme, lack of supervision on the educational content of continuing education by the authorities, and lack of efficacy of the education.	
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Table 2.3: Themes Frequency among the Reviewed Papers

#	Themes	Articles (numbers from 1 to 25 as per the articles sequence in table 2.2)																								Total	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24		25
1	Importance/benefits of CPD	x	x			x						x									x	x	x	x			8
2	Influencing factors	x	x	x	x	x	x		x	x	x								x	x	x				x	x	14
3	Expectations and needs analysis		x	x				x					x	x	x	x	x	x	x		x						11
4	CPD provision and content	x		x		x												x		x							5
5	Attributes of current CPD practices		x																								1
6	Organisational readiness for change scales					x																					1
7	Perceptions of CPD associated with three dimensions							x																			1
8	Factors influencing the application of competencies											x															1
9	Application of competencies											x															1

2.1.2 Themes

2.1.2.1 Theme 1: Nurses' Perception on the Importance and Benefits of CPD

The importance of CPD comes from its vital role of improving patient care and job satisfaction, and maintaining a competent and motivated workforce (Nsemo et al., 2013; Skår, 2010).

Ni et al. (2014) surveyed 2727 hospital-employed Chinese nurses from 10 general hospitals, as part of a quantitative cross-sectional study in China. The study explored nurses' attitudes and perceptions regarding the attributes of current CE practices and factors affecting their participation. Nurses perceived CE as an extremely important measure to further develop their professional competency, 92.8% thought that CE was necessary and important and 92.2% considered it helpful. However, the sampling of the study would affect the generalisability as it did not include nurses in community settings and other specialised areas. A similar study conducted in Australia had similar limitations (Priaux et al., 2014), the majority of nurses valued the benefits of ongoing learning and took up opportunities for CPD.

The findings from a different qualitative descriptive study (Kasine et al., 2018), conducted in Rwanda matched the Chinese study findings in terms of the importance and helpfulness where the nurses perceived an increase in their theoretical knowledge and psychomotor skills and confidence in performing newborn resuscitation after taking part in HBB© courses. The Rwanda study interviewed 10 nurses with the aim of exploring their experiences of CPD education utilising the Helping Babies Breathe (HBB©) course to nursing practice. However, a major limitation observed in the study was that HBB© was offered to nurses and other health professionals, but only nurses were interviewed.

Before both studies, a mixed method study was conducted in two public hospitals in Calabar, Nigeria by Nsemo et al. (2013) with the aim to determine the perception of nurses and midwives on various aspects of CPE. The findings indicated that participants perceived CPE as a valuable and worthwhile tool for practice. They specifically

maintained that CPE helps them to retain their jobs and meet patients' needs, and allows them to maintain professional competence, and develop new skills. In the same study, nurses considered CPE as a tool for quality service delivery. They maintained that it enables nurses to provide quality care in terms of effectiveness (100%), efficiency (100%), relevance (98.0%), safety (92.0%), while only 12.7% said it helped with consistency of care.

From a different qualitative study (Abebe et al., 2018) that was conducted to describe the in-service training experience of perioperative nurses in Ethiopia, the findings of nine interviews with participants who had completed the training revealed that they experienced improved knowledge, skills, confidence, and job retention after participating in the programme. Despite the positive findings, the small sample of the study and the very specific training programme limits the generalisability of the findings. On the same page, findings of another quantitative, pre-test/post-test design study (Perry et al., 2018) which was conducted to evaluate a CE intervention on nurses' knowledge and perceived competency regarding the care of hospitalised patients with substance use disorder, showed that intervention, knowledge and perceived competency scores were significantly improved among the 31 participants. Despite the significant findings, their generalisability would be limited due to the small sample size within a single hospital. Moreover, it studied the short-term effect (study conducted one week after the intervention).

In a descriptive quantitative study conducted in 2018 at an Indonesian hospital and aiming to identify the correlation between nurse's perception of the CPD and the satisfaction of Nursing Career Ladder System (NCLS) implementation, the findings showed that there is a moderate to positive correlation between the CPD and the NCLS (Hariyati et al., 2018). However, the nature of the sampling technique adopted limit the generalisability of the findings.

Lastly, the benefits of CPD were concluded from a systematic review that explored the perceptions and experiences of nurses and midwives in undertaking CPD (Teekens et al., 2018). It has been found that it can enable professionals to meet their obligation of

providing ethical, effective, safe, and competent practice in responding to the changing needs of healthcare, ensure best possible health outcomes for patients, enable the development of reflective and flexible workers who can both initiate and respond to innovations in healthcare, and enable professionals to pay special attention to their areas of practice and take appropriate action to fill knowledge gaps. Despite the strength of systematic reviews in evidence-based practice, the study has a limited generalisability as it only included qualitative approach studies.

2.1.2.2 Theme 2: Factors Influencing Participation in CPD

Factors influencing participation in CPD became key elements examined in most of the studies even though the main purpose was not to identify them. The factors are categorised as facilitators and barriers and some researchers categorised them as individual and structural factors, see table 2.4. Facilitators are also referred to as “motivators”, “motives”, “incentives”, and “enablers” whereas the barriers are referred to as “hinders”.

2.1.2.2.1 Facilitators to Participate in CPD

In a study surveying nurses’ perception in public and private hospitals in a region of Queensland, Australia, the perceived incentives were measured as part of the study, and it was found that the organisational support positively influenced attitudes to CPD (Priaux et al., 2014). In the same context, Nsemo et al. (2013) identified three different major motivating factors, where 100% of the nurses reported mandatory, 67.3% professional responsibility and 54% personal interest and self-development. In another study by Ni et al. (2014), it was reported that nurses perceived five main motivating factors for CPD participation as, to update their knowledge of the newest nursing development and procedures, to improve their skills in clinical practice, to

Table 2.4: Factors Influencing Participation in CPD

Type		Factors	Nsemo et al., 2013	Ni et al., 2014	Haywood et al., 2013	Feldacker et al., 2017	Priault et al., 2014	Brekelmans et al., 2013	Hamzehgardeshi et al., 2013	Shahhosseini et al., 2014	Aboshaqah et al., 2018	Purfarzad et al., 2019	Steven et al., 2018	Abebe et al., 2018	Clark et al., 2015	Eslamian et al., 2015	
Facilitators	Structural	Mandatory	•														
		Organisational support					•										
		Managers as a role model						•									
	Individual	Professional responsibility and/or Nurses' identification	•						•								
		Raise the level of scholarship		•													
		Networking											•				
Personal interest		•															
		Self-development, Update Knowledge, and/or Improve Skills	•	•					•	•							
Barriers	Structural	Scheduling, understaffing and work commitment	•	•		•	•		•		•		•	•	•		
		Managers' attitude and/or leadership	•									•					
		Geographic distance	•														
		Lack of support, opportunity, and/or preparation		•		•			•		•	•				•	•
		Lack of policy			•										•		
		Partnership between managers and educators														•	
		Infrastructure, human resources, and/or teaching staff				•										•	•
		Lack of planning and/or evaluation process				•							•				•
		Lack of specialty											•				
		CPD registration system							•								
	Individual	Attractiveness and/or previous negative experiences		•					•								
		Personal Motivation				•										•	•
		Time constraints and family responsibilities	•	•	•		•				•	•		•		•	
		Cost and funding	•	•	•	•	•					•					

improve the quality of their comprehension, to obtain the knowledge necessary to achieve professional status and to raise their level of scholarship.

A three-round Delphi study among 38 Dutch nursing experts (Brekelmans et al., 2013) aiming to identify and prioritise factors that influence the participation of RNs in CPD activities found that the main positive influencing factors are identification with the nursing profession and the line manager as a role model. However, the findings would be biased since the RNs were not asked for their opinions. In a mixed-method study (Steven et al., 2018) that was conducted in London with the aim to explore the impact and perceived value of multi-disciplinary CPD workshops where participants valued the opportunity to network and human contact was regarded as important in enhancing confidence and facilitating communication. The study may have limited generalisability due to the fact that it contributes to practice improvement rather than seeking generalisable findings. In addition, the study was conducted on a small scale geographically.

The specific facilitators that were examined in Iran, which is also in the Middle East, and has common characteristics with the UAE, were no different to the international factors. Hamzehgardeshi et al. (2013) surveyed 361 Iranian nurses and found that the most important facilitator was "Update my knowledge". However, participants' sincerity in answering the questions was a major limitation that would bias the results. Again in Iran, Shahhosseini et al. (2014) conducted a mixed method study that was conducted to investigate the facilitators and barriers of nurses' participation; it was found that the most highlighted facilitator was "Update my knowledge" as well.

2.1.2.2.2 Barriers to Participate in CPD

Through the literature review, it was found that the investigations/studies on barriers to participate in CPD was much broader and more common than investigations on the facilitators. All studies that examined facilitators examined the barriers, but not vice versa.

In a study that was guided by the Interpretive Phenomenological Analysis (IPA) (Haywood et al., 2013) explored the CPD needs and issues for a group of clinicians that included

nurses and other professionals in musculoskeletal areas found that the main barriers to participate in CPD are funding and time. In addition, lack of policy made it difficult for managers to obtain CPD opportunities for staff. However, generalising the results of the study would be questioned as it was conducted in a very specific setting and included allied health professionals. Lack of access to CPD activities and policy issues were also highlighted in the qualitative study (Abebe et al., 2018) that was conducted in Ethiopia, where participants stressed the problematic staffing policies that impact perioperative nurses' abilities to fully utilise and share new knowledge gained during CPD training.

Nsemo et al. (2013) identified several hindering factors where 80.7% of nurses reported busy shifts and scheduling, 67.3% family responsibilities, 39.3% geographic distance to venue, while only 12.7% reported high costs. 45% reported that attitude of nurse managers as a hindering factor especially when programmes are organised outside the health facility. Ni et al. (2014) reported almost similar hindering factors such as time constraints, work commitments, lack of opportunities, costs, and previous negative experiences. In addition, (Priault et al., 2014) also identified similar hindering factors such as understaffing and time. In the Delphi study (Brekelmans et al., 2013), summarised three negatively influencing factors as CPD registration system, opportunities, and attractive education programmes.

In a more recent study, (Steven et al., 2018) conducted in London, it was concluded that the main inhibitory factor is workload pressures. These includes limited time and dealing with competing demands. Another study also conducted in England in hospitals, primary care centres and educational institutes in one geographical area (Clark et al. (2015) came up with more comprehensive findings. The qualitative study was implemented over two rounds and aimed to identify the processes that key stakeholders perceive to be most important in facilitating a positive impact of CPE on practice. The findings revealed four main themes including organisational culture, working partnerships, a supportive learning environment, and changing practice. First, participants agreed on the importance of a positive, supportive organisational culture in maximising the impact of CPE. Second, they stressed the importance of working partnerships between educators and managers in the

integration of service needs, education commissioning, and the availability of relevant training. Third, they acknowledged the importance of, and challenges associated with, creating and maintaining a supportive learning environment, especially with the demands of a busy workplace. Fourth, they highlighted the importance of improving practice by developing and sharing knowledge and skills.

A more specific study with qualitative evaluations was conducted by Feldacker et al. (2017) to identify barriers and enablers of effective HIV/TB-related CPD in three African countries; Malawi, Tanzania, and the Republic of South Africa (RSA). The 52 Key Informant (KI) interviews, the questionnaires and focus groups with 89 healthcare workers revealed five major structural barriers; lack of financial support, limitations in CPD co-ordination, staff shortage, lack of needs analysis, and limited facility resources. Moreover, these challenges were more severe in the rural areas. At the healthcare workers' individual level, the lack of motivation and financial support were the two major identified barriers.

Similarly, the two Iranian studies (Hamzehgardeshi et al., 2013; Shahhosseini et al., 2014) reported three barriers: work commitments lack of support, and time. A third study in the Middle East was conducted in Saudi Arabia (Aboshaiqah et al., 2018) as a descriptive/correlational approach with the aim to identify factors that RNs perceive as barriers to CP, and three major barriers identified where 38.2% financial support, 29.7% commitment and scheduling problems, 19.6% the ability to attend classes regularly. The findings do not represent a majority in perceiving the barriers and challenges and the sampling would limit the generalisability as it was in one hospital only.

In a descriptive explorative qualitative study that was conducted in Iran (Eslamian et al., 2015) with the aim of exploring the challenges of nursing continuing education, the findings of the five focus-group and five individual interviews with nurses, educators, and administrative from hospitals and CE centres revealed five main themes concerning the hindering factors. First, learners-related factors such as lack of participants' preparation for learning, inadequate motivation for learning, and lack of human resources. Second,

teachers-related factors such as inappropriate teachers, defective knowledge transfer methods, and teachers' inadequate motivation. Third, educational process related factors such as imprecise need assessment, improper planning, and inappropriate implementation. Fourth, inadequate facilities that are convenient for the desired education. Finally, defective evaluation where there is lack of pre-tests and post-tests in some classes, lack of feedback to the learners even during classes with pre-tests and post-tests, lack of educational evaluation of educators, and lack of supervision on the educational content. The generalisability of the findings would be limited due to the qualitative nature of the study and due to the very specific location of Asfahan.

In a more recent qualitative study that was conducted in four teaching hospitals in Iran (Purfarzad et al., 2019) with the aim to identify factors influencing the development of gerontological nursing competence in Iranian hospitals, the conventional content analysis of the 26 semi-structured interviews with nurses, nurse managers, clinical instructors and a physician revealed that there are two major categories of hindering factors that affect nurses' participation in CPD and those are management and organisational factors. The management factors are lack of specialty, gerontological nursing, continuing education programmes, lack of evaluation criteria for the specialty, and the task-oriented leadership style of the nurse managers that excludes motivation and coaching. On the other hand, the organisational factors are organisational support and the organisational learning through the presence of a gerontology specialised nurse in the units to serve as a role model for other nurses. Despite the transferability of the findings, they are questionable due to the nature of the study.

2.1.2.3 Theme 3: Needs Analysis and Expectations

The studies emphasised the importance of needs analysis and nurses' expectations, adopting evidence-based approaches, age-differences, and the relationship between the CPD activities and the motives, conditions, and/or importance.

In a qualitative descriptive study conducted in Tanzania (Jones et al., 2016) with the aim to explore midwives' perceptions of their professional role in the context of their clinical

working environment through three focus groups in three hospitals, concluded that midwives' overwhelming focus was on saving lives of women and newborns. As such, there is an urgent need for CPD education to improve their professional image and ability to save women and newborns as there is a need for improved detection of unwell women and newborns. These findings could be biased for this proposed study as participants were midwives. Another qualitative phenomenological study (Weglicki et al., 2015) was conducted among 16 allied health professionals working in primary and secondary care settings with the aim to ascertain the aspirations, priorities, and preferred mode of CPD for non-medical prescribers. The study concluded that anxiety and lack of confidence in non-medical staff poses a significant challenge for CPD. It was suggested that strategies that are most likely to improve prescribing confidence are blended into the learning. The findings of both studies could be biased for this study, however, both indicate the importance of conducting needs analysis.

From a different perspective, in a study conducted by Haywood et al. (2013), on the CPD needs and issues for a group of clinicians in musculoskeletal areas, patients' perception of CPD were also explored. Patients' view demonstrated an emphasis on communication skills that was seldom raised by managers and clinicians.

Additionally, age has been found as key factor on nurses' perception about CPD. In a qualitative study using focus groups in a large academic hospital in the Netherlands, 22 nurses in three age groups and 10 nurse managers participated in four focus groups (Pool et al., 2013) with the aim of exploring nurses' and their managers' perceptions of CPD between younger and older nurses. Participants perceived differences in CPD between younger and older nurses. The data suggested that the purpose of CPD and the learning activities might change over the years. It was concluded that a 'one size fits all' approach to CPD will not work. The limitations of the study are the qualitative design and convenience sampling methods which restrict the generalisability of the findings.

Building on the previous research findings, Pool et al. (2015) interviewed 21 nurses in three age groups from the Netherlands with the aim of exploring CPD strategies among

younger, middle-aged, and older nurses. Some similarities were found among all age groups in terms of their daily work which was an important trigger for professional development in terms of the effect of their private lives' experiences. On the other hand, the findings showed differences in career stages and private lives, which appeared to influence differences in the CPD strategy.

Since needs analysis does not stand alone, Pool et al. (2016) conducted another qualitative study among 21 nurses in Dutch hospitals with the aim to explore the relationship between nurses' motives and activities for CPD. The relationship between nine motives and four activities were identified where nurses could use these findings to increase their awareness of why and how they can develop professionally, and how managers and human resource development professionals could develop approaches that would better suit nurses' needs.

Studying the relationship between the CPD activities and contributing variables was expended in another exploratory descriptive cross-sectional study by Brekelmans et al. (2016) where 5500 Dutch RNs (1226 responded) were surveyed. The study identified three variables which are "Conditions" were found to be moderately related to "Motives", which were strongly related to "Importance", which was very strongly related to "CPD activities". If nurses considered a CPD activity important they were highly likely to pursue it; however, the importance attached to specific CPD activities was influenced by the presence of particular motives, which depended in part on the way CPD conditions were perceived.

Emphasising the used instrument, Holloway et al. (2018) conducted a descriptive study using the Hicks-Hennessey Training Needs Analysis (H-TINA) questionnaire among primary health care nurses in New Zealand with the aim of identifying the level and content of training required. The study concluded that purposeful and effective development of the nursing workforce capabilities requires an evidenced-based CPD strategy.

Identifying the CPDs content was another need where a mixed method study, that was conducted by Nsemo et al. (2013), examined nurses' perception about the content of the CPD. The study showed that the adequacy of coverage of content was lacking or not adequate at all. When they were asked about who should be responsible for the CPDs content determination, 42.7% perceived it should be the nurses while 40.7% perceived it should be the regulatory body. Along with the content, the mode of delivery was another expectation element for nurses. A mixed-method study was conducted in London where the data was collected through filed notes, a questionnaire, and interviews (Steven et al., 2018) with the aim to explore the impact and perceived value of multi-disciplinary CPD workshops. Participants suggested that the interactive teaching strategy is a very effective mode of delivery as it encourages sharing of experiences and ideas, getting to know one another, and learning together. In addition, online resources were seen as a solution for funding constraints and an effective way of managing time.

The nursing specialty is also a concern in terms of the CPD for nurses. The findings of a qualitative study that was conducted in four teaching hospitals in Iran (Purfarзад et al., 2019), with the aim to identify factors influencing the development of gerontological nursing competence in Iranian hospitals show that the findings indicated lack of identified competencies for the specialty in gerontological nursing. Another qualitative study (Abebe et al., 2018) that was conducted to describe the in-service training experience of perioperative nurses in Ethiopia, recommended that building educational leadership in specialty areas will help in staff retention. Most importantly, it was highlighted that there is a need to shift from a generalist view of the nursing to one of specialisation.

2.1.2.4 Conclusion and Implications

The purpose of this review was to attain an in-depth understanding of the CPD issue from the RNs' perception. Understanding specific nurses' opinion and perceptions about CPD is crucial for the success of any programme as it has to impact on the nurses' professionalism and confidence and positive patient outcomes (Ni et al., 2014). Identifying nurses' understanding, attitude, influencing factors that affect their participation, and needs analysis of the CPD are significant gaps to be addressed in the UAE. Moreover,

more comprehensive research is required internationally to investigate RNs' perceptions on this dynamic profession where there is a need to keep abreast with the latest developments.

2.2 COMPARISON OF INTERNATIONAL CPD PROGRAMMES

This section presents a comprehensive review and analysis of the current nursing CPD practices in certain countries across the globe. These practices are demonstrated in different forms such as programmes, frameworks, and guidelines. Such review would enrich the understanding of the CPD's scope and role in terms of effectiveness. This comparison represents a solid benchmarking that contributes to the strategy development in the third phase of this study. Benchmarking has been defined by Camp (2007), as *"the search for organizations best practices that lead to superior performance"* and as the *"key to become the best of the best"*. Jetmarová (2012) referred to benchmarking as *"measurement via comparison"* and concluded that it is *"a management tool for attaining or exceeding the performance goals by learning from best practices and understanding the process by which they are achieved"*. This comparison extends from the CPD requirements to the processes.

The reviewed CPD practices are from eight countries; Australia (NMBA, 2019), New Zealand (NCNZ, 2018), Alberta (CARNA, 2019) and Ontario (CNO, 2019b, a) in Canada, UK (NMC, 2018), USA [California (CBRN, 2019) and Texas (TBON, 2019)], RSA (SANC, 2018), France (EC, 2013), and Germany (EC, 2013). The reviewed data (summarised in table 2.5) included and was grouped under the following eight elements; terminology, mandatory versus optional, linkage to licensure, required hours, type of activity, relevance of activity to the specialty, alignment with the profession's scope of practice, and adoption of a model or framework. It has been noticed that not all countries reported complete and/or specific requirements for nursing CPD in addition to the inconsistency of the used terminology. Moreover, there are noticeable differences among the different states and provinces within the same country, such as Canada, USA, and Germany.

2.2.1 Terminology

Most of the countries use the term Continuing Professional Development (CPD) except for the state of Texas in USA that uses the term Continuing Nursing Education (CNE) and Alberta province in Canada uses the term Continuing Competence (CC) which is also used in New Zealand in addition to Professional Development (PD). In reflecting on the definition of the CPD concept and the benchmarking, CPD is the most convenient and representative term used in this study.

2.2.2 Mandatory versus Optional

Regardless of the penalties and consequences of not meeting the requirements, there is a trend of mandatory CPD in all reviewed bodies. However, in Germany, it is mandatory in four out of sixteen states. In addition to the mandatory programmes, there are also optional CPD programmes in Germany.

2.2.3 Linkage to Licensure

Despite the CPD being mandatory in most of the countries, this it is not stipulated as a nursing licensure requirement in countries such as Germany, France, and Ontario in Canada. Also, penalties are not clearly identified, except in Germany where a financial penalty is set on nurses who do not meet the requirements.

2.2.4 Required Hours

The required hours are inconsistent and not justified in any of the programmes. The identified period ranges from one to three years where some countries require 20 hours per annum, however others require 60 hours every three years without specifying the distribution of number of hours in each year. In France, nurses can accumulate the hours for a period of six years. Based on an annual rate, the required hours range from a minimum of 10 hours to a maximum of 20. On the contrary, the number of hours is not specified in Canada where two learning objectives based on self-assessment learning needs are specified as a requirement for all RNs.

2.2.5 Type of Activity

The type of CPD activity is another area of inconsistency among the reviewed bodies. The proposed model in RSA and the frameworks of Canada do not specify the type of activities to be completed by RNs while France specifies courses without any clarifications. However, other countries present detailed lists of activities such as diversity of courses' types (physical and virtual), conferences, workshops, seminars, discussion groups, workplace learning activities and self-directed learning, to mention a few. There is an emphasis on the nature of these learning activities to be undertaken. Moreover, Australia, New Zealand, and USA list organisations that are certified to offer learning activities. In a unique case, the proposed framework in RSA specifies certain thematic and categorised activities to be completed.

2.2.6 Relevance of Activity to the Speciality

The relevance of CPD activities to the nursing area of speciality is inconsistent among the countries. Despite the CPD in Canada being linked to the learning objectives that are based on self-assessment, it is not specified if the CPD activities should be relevant to the area of speciality. In the same context, UK, California in USA, Germany and France do not specify the relevance to speciality as a requirement. On the other hand, Texas in USA, RSA, Australia, and New Zealand clearly identify the relevancy to area of speciality. This element is very difficult to specify as the area of expertise is not identified and verified along with the licensure for RNs.

2.2.7 Alignment with the Profession's Scope of Practice

The CPD is clearly required to be aligned with the nursing profession's scope of practice either directly or indirectly except in the case of France where it is unspecified. Failure to do so would question the reliability of the programme.

2.2.8 Adoption of a Model/Framework

Lastly, all countries have a shape of framework for the CPD practices. However, the UK, the USA, Germany, and France do not specify what is expected in previously presented elements such as the required hours and obligation. Similarly, Australia and New Zealand

present frameworks in the form of published guidelines with an additional initiative in New Zealand which is represented by the “Professional Development and Recognition Programme” (PDRP) which is based on an individual practice portfolio for participating nurses. On the contrary, the model presented by Canada is unique despite the fact that it does not identify the number of required hours and its linkage to the licensure. It is based on the self-assessment of RNs where they are expected to conduct self-reflection on practice and develop a certain number of learning objectives that should be met through CPD. The learning objectives should be aligned with specific standards from the scope of practice. From a different perspective, the proposed model in the RSA presents some unique features. It specifies the themes and categories of the learning activities according to five domains of ethical and legal, area of practice, leadership and management, teaching, and research. Certain number of hours are specified for each domain in a total of 15 hours. In addition to that, RNs are required to develop a portfolio, however, no details are available about its components.

2.2.9 Summary of the Comparison

In conclusion, the diversity of the reviewed CPD programmes would present a solid benchmark for developing an effective CPD programme. A successful programme would be developed by adopting or contextualising a framework that shapes the CPD practices with a highlight on the RSA’s proposed programme due to its breakdown of the required hours according to RNs’ scope of practice which takes into consideration the area of specialty. This would be complemented with the Canadian model which is based on self-assessment and reflection as a way of identifying the needs and CPD activities within each theme. Within the framework of identifying the required hours on a range of 15-20 per annum, mandating the CPD, and linking it to the licensure renewal would contribute to its standardisation and effectiveness. With regards to the type of activities, the solid programme would go beyond identifying the type of activities as it would be within an evaluation or audit framework that covers all aspects relevant to the CPD activities as in the case of the PDRP in New Zealand which was presented as an alternative to the “recertification audit”. Finally, aligning the CPD to the scope of practice should not be debatable and should be mapped properly rather than just stating.

2.3 CONCLUSION

This chapter presented the literature review from two aspects; the integrative literature review and the comparison of the international CPD programmes. The integrative literature review discussed three emerged themes as synthesised findings and documented the search strategy. While on the other hand, the comparison presented a multidimensional perspective of identified CPD programmes and practices from different countries.

Table 2.5: International Comparison of CPD Programs

Country	Terminology	Mandatory	Linkage to licensure	Required Hours	Type of Activity	Relevant to speciality	Aligned with scope of practice	Model
Australia	CPD	Yes	Yes	20 per annum	<ul style="list-style-type: none"> • tertiary, vocational and other accredited courses including distance education (should relate to context of practice) • conferences, fora, seminars and symposia • short courses, workshops, seminars and discussion groups through a professional group or organisation that may issue a certificate • mandatory learning activities in the workplace in area of practice • self-directed learning, and • any other structured learning activities not covered above 	Yes	Yes (with learning needs)	Guidelines; published as a fact sheet on the NMBA website
New Zealand	PD CC	Yes	Yes	60 in 3 years	<ul style="list-style-type: none"> • degree courses • short courses • seminars • conferences • in-service education • online learning and Internet-based courses 	Yes	Yes (in the context of scope of practice and work context)	Yes <ul style="list-style-type: none"> • Recertification Audit • Professional Development and Recognition Programme (PDRP)
Canada (Ontario)	CPD	Yes	No	Not Applicable	Unspecified	No	Yes	Yes (practice reflection based on self and peer assessment) <ul style="list-style-type: none"> • RNs required to develop two learning goals each year

								based on learning needs. <ul style="list-style-type: none"> • RN must select a college practice standard or guideline relating to each learning goal.
Canada (Alberta)	CC	Yes	Yes	Not Applicable	Unspecified			Yes (practice reflection based on self and peer assessment) <ul style="list-style-type: none"> • Select a practice standards indicator based on a self-assessment of nursing practice. • Create a learning objective based on the chosen practice standards indicator. • Engage in CPD • Evaluate Influence
United Kingdom	CPD	Yes	Yes	35 in 3 years (20 of them as participatory learning)	<ul style="list-style-type: none"> • No particular type of CPD • Participatory learning: an activity that involves interaction with one or more other professionals. This can be a physical environment or a virtual one. Examples: conferences, workshops, or relevant training course. 	No	Yes	No particular model
United States of America (California)	CPD	Yes	Yes	30 in 2 years	<ul style="list-style-type: none"> • Home study courses • Continuing Medical Education • College Courses <p>A list of unacceptable courses is provided</p>	No	Yes	No
United States of America	CNE	Yes	Yes	20 in 2 years	<ul style="list-style-type: none"> • List of approved organisations offering the courses 	Yes	Yes	No

(Texas)					A list of unacceptable courses is provided	(area of practice)		
South Africa (Proposed Framework)	CPD	Yes	Yes	15	Unspecified	Yes	Yes	Yes Thematic categorised activities and portfolio: <ul style="list-style-type: none"> • Ethical and Legal Domains • Area of Practice • Leadership and Management • Teaching • Research
France	CPD	Yes	N/A	20 (can be cumulated for a period of 6 years)	Courses	Unspecified	Unspecified	Unspecified
Germany	CPD	Yes in 4 out of 16 states	N/A	10-20	Case presentations, clinical audit, clinical care discussions, clinical hands-on courses, conferences and seminars, informal practice-based learning, international and national events, eLearning, mobile learning (mLearning), self-study (scientific journals, etc.), peer to peer, employer based, multi-professional, research based, study groups and video presentations.	Unspecified	Yes	Unspecified

CPD: Continuing Professional Development

PD: Professional Development

CC: Continuing Competence

CNE: Continuing Nursing Education

CHAPTER 3: METHODOLOGY

3.1 INTRODUCTION

Mandating the CPD as a pre-requisite for the nursing licence renewal in the UAE, especially in Abu Dhabi, by the beginning of the millennium, boosted the awareness of the need to develop effective CPD programmes and practices. However, the effectiveness of the programmes is still not evident due to several factors. The most important observed factor is the limitation of the CPD requirements to the number of the hours with specification of relevancy to the field of specialty, without identifying the different needs of nurses according to their expertise, specialty, performance, and/or quality of care. Additionally, RNs' concern about the value and benefits of attaining any CPD hours within the current system has been observed informally. Therefore, the connection between the continuing education hours and the continuing professional education is not evident and is questioned and this triggered the first inquiry of this study which aimed to explore and investigate the effectiveness of the programme.

Nevertheless, reviewing the findings of the empirical studies indicated a gap in the nurses' understanding of the CPD process and in CPD achieving the desired effectiveness (Brekelmans et al., 2013). Priaulx et al. (2014) categorised the reasons into three areas: (a) institutional characteristics and their influence on nurses' participation in CPD; (b) nurses' attitudes towards CPD; and (c) nurses' actual concerns about participation in CPD. Therefore, the study was aimed at exploring and investigating the perspective of RNs regarding the effectiveness of the CPD in the UAE in order to develop CPD strategies.

To achieve this purpose, this study was conducted on three phases as an "advanced multiphase mixed method" representing the pragmatic paradigm. In this regard, the questions and objectives were posed:

Phase 1 (qualitative focus group interviews with RNs):

1. What is the perception of RNs about the effectiveness of the CPD programme?
 - *Objective 1.1:* explore and describe the perception of RNs about the effectiveness of the CPD programme on their performance.

Phase 2 (quantitative self-reported questionnaire for the RNs)

2. What are the intrinsic and extrinsic hindering and facilitating factors that influence the RNs' participation in the CPD programme in their perception?
 - *Objective 2.1:* identify and determine the intrinsic and extrinsic hindering factors that influence the RNs' participation in the CPD programme.
 - *Objective 2.2:* identify and determine the intrinsic and extrinsic factors that facilitate the RNs' participation in the CPD programme.
 - *Objective 2.3:* Identify the important CPD activities.
 - *Objective 2.4:* identify any perceived differences in the hindering factors, facilitating factors, important activities, and actually undertaken activities in terms of the region, governor, and type of facility.

The main hypotheses about the correlation between hindering factors (conditions), facilitating factors (motives), important activities, and actual undertaken activities are as follows:

- ***Hypothesis (H1):*** the motives, conditions, and importance associated with CPD has a significant effect on the CPD activities performed by RNs in Abu Dhabi.
- ***Null Hypothesis (H0):*** the motives, conditions, and importance associated with CPD has no significant effect on the CPD activities performed by RNs in Abu Dhabi.

The sub-hypothesis is presented in phase 2 within this chapter.

Phase 3 (Appreciative Inquiry meeting/s with the nursing leaders)

3. How can an effective CPD programme, that meets the needs of registered nurses, be developed?

The objectives are based on the 5D cycle of the AI which are “Define”, “Discovery”, “Dream”, “Design”, and “Destiny” phases (Cooperrider et al., 2008). As per the aim, to develop CPD strategies, the study reached the “Design” phase of the 5D cycle where the best CPD strategies were developed. The “Destiny” phase, which is the implementation phase will be carried out at a later stage during the postdoctoral phase.

a) *Define Phase*

- *Objective 3.1:* define the affirmative topic, CPD, and clarify the focus of the inquiry; based on the findings of phases one and two.

b) *Discovery Phase*

- *Objective 3.2:* explore and describe what is working well and effectively in the existing CPD programmes and strategies.

c) *Dream Phase*

- *Objective 3.3:* identify areas of improvement in the existing CPD programme and strategies.
- *Objective 3.4:* describe the expected CPD programme activities in terms of content, provision, and outcomes.

d) *Design Phase*

- *Objective 3.5:* develop the best CPD strategies that would contribute to the improvement of the CPD programme.

3.2 PARADIGMS AND PHILOSOPHICAL ASSUMPTIONS

The study was conducted from the perspective of the pragmatic paradigm, using the “advanced multiphase mixed method”. Understanding the background of the paradigms and philosophical assumptions of the study is crucial in understanding the pragmatism and approach of choice - the mixed method approach.

Paradigms are fundamental in scientific research and provide a conceptual framework for viewing the social world (Patterson et al., 1998). Different definitions of the paradigm exist in the literature. It was defined as a “*cluster of beliefs and dictates... what should be studied, how research should be done, and how results should be interpreted*” (Kuhn, 1970 cited in Bryman et al., 2007:25). The philosophy or paradigm is also defined as “*a model or pattern containing a set of legitimated assumptions and a design for collecting and interpreting data*” (Baker, 2003:312). According to Lincoln and Guba (1985), a paradigm comprises four elements; ontology, epistemology, axiology, and methodology. These elements represent the philosophical assumptions that identify the research paradigm. Ontology is concerned with the nature of reality and how the researcher views the world. Epistemology is concerned with the nature of knowledge and how we know reality or the truth. Axiology refers to the ethical considerations taken when conducting research. Methodology is about how the desired knowledge is obtained including the research design, approaches, and procedures used (Botma, Greeff, Mulaudzi and Wright, 2010; Bryman, 2006; Bryman et al., 2007; De Vos et al., 2011).

Paradigms can be grouped in three main categories; Positivism, Interpretivism, and Critical (Candy, 1989 cited in Kivunja and Kuyini, 2017). In addition, a fourth evolutionary paradigm is pragmatism and it comprises elements from the three paradigms (Tashakkori and Teddlie, 2003). Therefore, it is important to understand the four paradigms and their interconnectedness with the philosophical assumptions. This study was conducted from the perspective of the pragmatic paradigm which is viewed as an alternative that accepts, philosophically the presence of single and multiple realities towards finding practical solutions to the problems in the real world (Creswell et al., 2018).

3.2.1 Positivism

Positivism was first proposed by a French philosopher, Auguste Comte (1798 – 1857), (Babbie, 2011). It is a systematic way of conducting research that emphasises the importance of observable facts (Botma et al., 2010; Bryman et al., 2007).

In terms of ontology, the positivist researchers believe that an objective reality exists, and which can be discovered and perceived by senses and can be explained, controlled, and predicted by means of natural laws; this is referred to as Realism. In terms of epistemology, the researcher should not be part of that reality, he/she should be detached from the studied object; this is referred to as Objectivism. The researcher should not be influenced by the object and vice versa to prevent bias. This would be achieved by “control”. In terms of axiology, the research should aim to maximise the good outcomes of the research, humanity, and participants; this refers to the beneficence. In terms of methodology, it is experimental and manipulative to determine whether changes in one variable cause changes in another, with the focus on quantitative methods (Babbie, 2011; Botma et al., 2010; Creswell, 2009; Creswell et al., 2018; Lincoln et al., 1985; Tashakkori and Teddlie, 2010; Bryman et al., 2007; De Vos et al., 2011). Positivism has been criticised for its inappropriateness for all settings. There is no doubt about its fit when studying natural objects, however, this is not applicable in studying the social phenomena (Grix, 2010; Richards, 2003).

3.2.2 Interpretivism

The interpretive paradigm is also called the phenomenological approach and is referred to as constructionism (De Vos et al., 2011:8). It has been described as a response to the over-dominance of positivism (Grix, 2010). Thus, it focuses on the people’s role and how they interact with the studied phenomenon (Alqatawneh, Siddiqi, Akhgar and Btoush, 2009). Its central endeavour is understanding the subjective world of human experience (Guba & Lincoln, 1989 cited in Kivunja et al., 2017).

In terms of ontology, its assumption is relativist, where the researcher believes that the phenomenon has multiple realities and reality is socially constructed. These realities can be explored to attribute a meaning through human interactions between the researcher and the subjects, and among participants. In terms of epistemology, its assumption is subjectivist, where researchers make meaning through their cognitive processing of data informed by their interactions with participants. In terms of axiology, its assumption is balanced, assuming that the outcome of the research will reflect the researcher’s values

and it is their duty to make sure that the findings are balanced. In terms of methodology, it relies on qualitative methods (Babbie, 2010, 2011; Botma et al., 2010; Creswell, 2009; Creswell et al., 2018; Kivunja et al., 2017; Tashakkori et al., 2010; Bryman et al., 2007; De Vos et al., 2011). Interpretivism has been criticised for its limited generalisability as it does not generate theories and also for investigators' involvement in the process which affects the study's objectivity (Grix, 2010). On the other hand, Richards (2003) believes that such issues can be overcome by being careful, rigorous, and being systematic.

3.2.3 Critical Research

This is sometimes referred to as a transformative paradigm. The critical paradigm is concerned with social justice issues (Kivunja et al., 2017). Despite the importance of understanding and studying the society, it emphasises critiquing and changing the society; researchers should be both critical and reflective to actively engage with the powerless and oppressed (Botma et al., 2010; De Vos et al., 2011).

In terms of ontology, it assumes historical realism where reality is shaped by social, political, cultural, economic, and gender values (Guba & Lincoln, 1994, p.110 cited in Scotland, 2012). In terms of epistemology, its transactional assumption allows the researcher to actively interact and engage with participants. In terms of axiology, it respects the cultural norms (Kivunja et al., 2017). In terms of methodology, its assumption is dialogical. It fully acknowledges its context and promotes dialogical relations of equality between researchers and participants (Babbie, 2011; Scotland, 2012).

As each paradigm, both positivism and interpretivism, try to explain the phenomena from their view of the world, they are criticised by critical research as they do not have an interest in changing the world (Scott and Usher, 2010). However, instead of only generating knowledge, critical researchers aim to transform the phenomena in a collaborative manner (Guba and Lincoln, 2005).

3.2.4 Pragmatism

Pragmatism is derived from the work of Peirce, James, Mead, and Dewey in the United States of America (USA) around 1870 (Cherryholmes, 1992). The pragmatism arose when many philosophers argued that a mono-pragmatic approach, either positivism or interpretivism, is not enough to understand and construct the truth where a more appropriate worldview is needed. This worldview should combine methods to address participants' behaviour, and their beliefs (Kivunja et al., 2017). According to Creswell (2009), pragmatism arises out of actions, situations, and consequences rather than antecedent conditions. Its importance comes from focusing on the research problem and then using pluralistic approaches to derive knowledge about the problem. Therefore, it is not committed to any single system of the previously discussed philosophies (Creswell et al., 2018; Morgan, 2007; Tashakkori et al., 2010) whereas researchers emphasise the research problem and use all possible approaches to understand the problem (Rossmann and Wilson, 1985 cited in Creswell, 2009).

In terms of ontology, pragmatism assumes a non-singular reality where the world is not seen as an absolute unity and different individuals view and interpret the reality differently (Kivunja et al., 2017; Morgan, 2007). In terms of epistemology, pragmatism's relational assumption gives the researcher the freedom to choose what best suits the study (Babbie, 2011; Creswell et al., 2018). In terms of axiology, pragmatism's value-laden assumption indicates that the researcher should put all possible efforts into benefitting the people (Kivunja et al., 2017). In terms of methodology, mixed methods research is the approach of choice, where researchers adopt both quantitative and qualitative assumptions (Creswell et al., 2018; Morgan, 2014; Tashakkori et al., 2010). A great advantage of the pragmatic approach is its emphasis on the connection between epistemological concerns about the nature of knowledge that we produce and technical concerns about the methods that we use to generate the knowledge (Morgan, 2014).

Reflecting on this study, the researcher adopted the mixed method design in the belief that non-singular reality exists in the world. Therefore, the researcher believes that CPD in the UAE requires both objective and subjective perspectives to attain deep

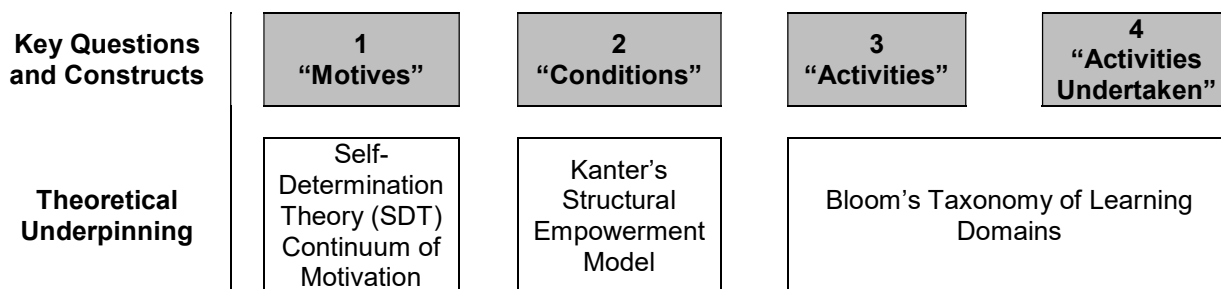
understanding of the issues and in seeking the desired change by developing strategies for an effective CPD programme. This is represented in mixing the qualitative and quantitative approaches in an advanced multiphase sequential manner prior to conducting the qualitative appreciative inquiry with nursing key players. First, the researcher tried to understand the human experiences through his interaction with participants via the focus group interviews in the exploration phase. This provided multiple perspectives that yielded multiple realities of the situation. Then, the researcher used the concluded findings to inform the next phase where truth discovery was by means of collecting objective data in a systematic manner but without interaction with subjects to avoid any chance for influence on and by the subjects. By observing the facts through the questionnaire's objective findings, the researcher discovered the objective single reality. Finally, the researcher used the previous findings to come up with solid and feasible CPD strategies for the UAE. This mix of approaches points to the researcher's pragmatic belief that what works best to attain the study's specific aim is to utilise the multiphase mixed method that would yield precious benefits for all CPD stakeholders in the UAE, knowing that what works for this study, might not work in another.

3.3 THEORETICAL UNDERPINNING

The theoretical foundations that guided the “basic exploratory sequential mixed method”, phases one and two, is based on three theories and/or models; Self-Determination Theory (SDT), Kanter's Structural Empowerment Model, and Bloom's Taxonomy of Learning Domains. They were manifested in the focus group's guide and the questionnaire. The first four key questions in the focus groups' guide were aligned with the four constructs of the Q-PDN questionnaire; (1) “motives”, (2) “conditions/barriers”, (3) “activities”, and (4) “activities undertaken”. In this context, the constructs were aligned with the identified theories/models and were modified according to the concluded gaps in comparison with the elements of the theories/models. The “motives” construct was aligned with the “continuum of motivation of the SDT, the “conditions” construct with Kanter's Structural Empowerment Model, and the “activities” and “activities undertaken” with Bloom's Taxonomy of Learning Domains. Thus, the three theories/models represent a theoretical underpinning that guides this part of the study and to understand the factors

influencing RNs' participation in the CPD activities (Figure 3.1). The theories are discussed in the following sub-sections.

Figure 3.1: Theoretical Underpinning of the “Basic Exploratory Sequential Phases”



3.3.1 Self-Determination Theory (SDT)

The “motives” construct in the current study was aligned with the continuum of motivation of the SDT. The SDT was developed in the mid-1980s as a general framework of human motivation (Deci and Ryan, 1985) that proposed a taxonomy of five major dimensions of motivation; one intrinsic and four extrinsic dimensions (Figure 3.2). The first dimension is “inherently autonomous” (intrinsic) and it originates from within the person, whereas the sources of motivation are the interest and enjoyment of the activity itself. The second dimension is also “autonomous” (extrinsic) and is defined as an “Integrated Regulation” the source of motivation is the congruency between behaviour and identity, goals, and values. The third dimension is “moderately autonomous” (extrinsic) and is defined as an “Identified Regulation” and the source of motivation is the importance of goals and values. The fourth dimension is “moderately controlled” (extrinsic) and is defined as an “Introjected regulation” since the source of motivation is performance-contingent self-worth and ego. The fifth and last dimension is “controlled” (extrinsic) and is defined as “External Regulation” since the source of motivation is reward and punishment. The “Amotivation” was identified within the continuum as a sixth dimension, but it was not considered in this study as it is the lack of motivation and subsequently does not encompass any sources (Deci and Ryan, 2000; Gagné and Deci, 2005).

Figure 3.2: The Self-Determination Theory (SDT) Continuum of Motivation

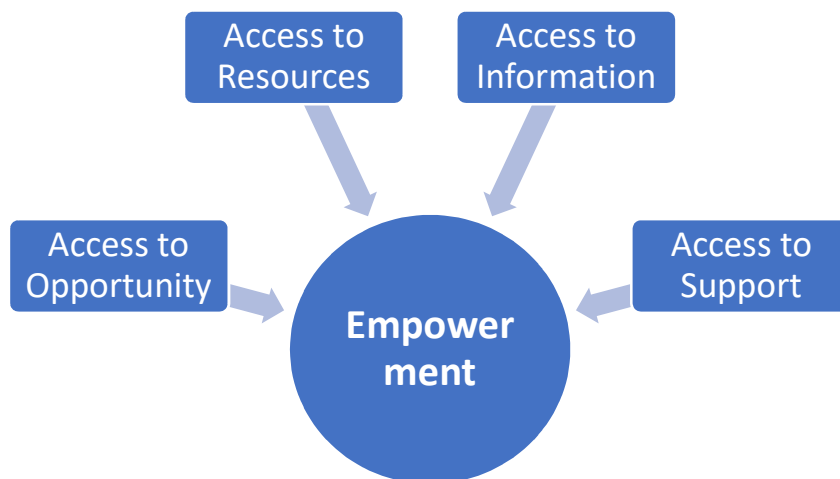
	<u>Amotivation</u>	<u>Extrinsic Motivation</u>				<u>Intrinsic Motivation</u>
Motivation	Lack of Motivation	Controlled Motivation	Moderately Controlled Motivation	Moderately Autonomous Motivation	Autonomous Motivation	Inherently Autonomous Motivation
Type of Regulation		External Regulation	Introjected Regulation	Identified Regulation	Integrated Regulation	
Motivational Source	Absence of Intentional Regulation	Contingencies of reward and punishment	Self-worth contingent on performance; ego involvement	Importance of goals, values, and regulations	Coherence among goals, values, and regulations	Interest and enjoyment of the task

Adopted from (Deci et al., 2000; Gagné et al., 2005).

3.3.2 Kanter's Structural Empowerment Model

The “conditions” construct was aligned with Kanter's Structural Empowerment Model (Figure 3.3). Kanter (1993) defined power as the “ability to mobilise resources to get things done”. To activate the power, the employees should have access to four structures; lines of information, support, resources, and opportunities to learn and grow. These lines represent the sources of structural empowerment (Laschinger, Finegan, Shamian and Wilk, 2001). Access to opportunity refers to the possibility for growth and movement and the opportunity to increase knowledge and skills. Access to resources refers to the employee's ability to attain the financial means, materials, time, and supplies required to accomplish the work. Access to information refers to having the formal and informal knowledge that is necessary to be effective in the workplace including the technical knowledge and expertise required to accomplish the work and an understanding of organisational policies and decisions. Access to support involves receiving feedback and guidance from subordinates, peers, and superiors (Kanter, 1993; Laschinger et al., 2001).

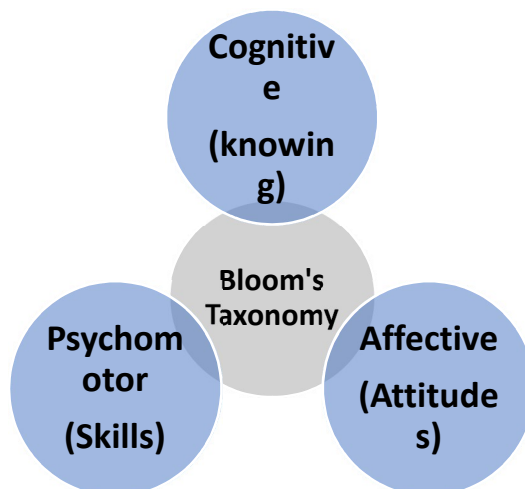
Figure 3.3: Kanter's Structural Empowerment Model



3.3.3 Bloom's Taxonomy of Learning

The “activities” and “undertaken activities” were aligned with Bloom's Taxonomy of Learning (Anderson and Krathwohl, 2001). The taxonomy's three learning domains are cognitive (thinking) that involves development of mental skills and knowledge acquisition, psychomotor (physical/kinesthetic) that involves utilising motor skills and co-ordinating them, and affective (emotion/feeling) that involves attitude (Figure 3.4). The taxonomy's domains represent the professional development domains that concern RNs and any well planned CPD programme. Bloom's taxonomy has been used in professional development in terms of the progression of the level of expertise and the level of performance (McKimm and Swanwick, 2009). However, this study utilised it to frame and conceptualise the different types of activities within CPD programmes and practices.

Figure 3.4: Bloom's Taxonomy of Learning Domains



The theoretical underpinning that comprises the three theories together contributed to guiding and answering the questions of phases one and two through exploring the RNs' perception about the value of CPD and the influencing factors that affect their participation in the CPD activities. The focus groups and the questionnaire were effective tools to investigate the CPD phenomenon from RNs' perception as they accommodated the intrinsic and extrinsic motivations of the continuum of motivation of the SDT, the opportunity, information, support, and resources lines of access of Kanter's Structural Empowerment model, and the cognitive, psychomotor, and affective learning domains of Bloom's taxonomy.

The explanation of the theories' application to the study is extended to the Instrument (Q-PDN questionnaire) modification section of phase two where further explanations are presented.

3.4 RESEARCH DESIGN

As explained in chapter one, the approach to this study is an "advanced multiphase mixed method". This mix contributes to viewing the complete picture of the CPD phenomenon and enhances the significance and reliability of the study (De Vos et al., 2011:435). Due

to the complexity of the CPD issue for nurses in Abu Dhabi where several factors and variables contribute to the issue, a mixed method approach has been adopted as a solid choice to understand the issue and to obtain a satisfactory answer to the question (Botma et al., 2010). Specifically, the quantitative approaches serve the generalisation of the findings whereas the qualitative approaches aim to explore complex dynamic phenomena. Therefore, in addition to enhancing the value of the research (Bryman, 2006), the integration of the strengths of both approaches leads to a richer and deeper understanding and the bias of any one of them could neutralise the bias of the other (Creswell, 2009:14; Zhang and Creswell, 2013). On the other hand, the inclusion of the multiphase is a very effective approach, among the mixed method, in terms of the programme evaluation due to its dynamic features. It encourages the incremental development of the questions, facilitates further exploration of unexpected qualitative results, and allows involving the key informants in the evaluation process (Creswell and Plano Clark, 2007; Jack, Tony, Judith and Sandra, 2014).

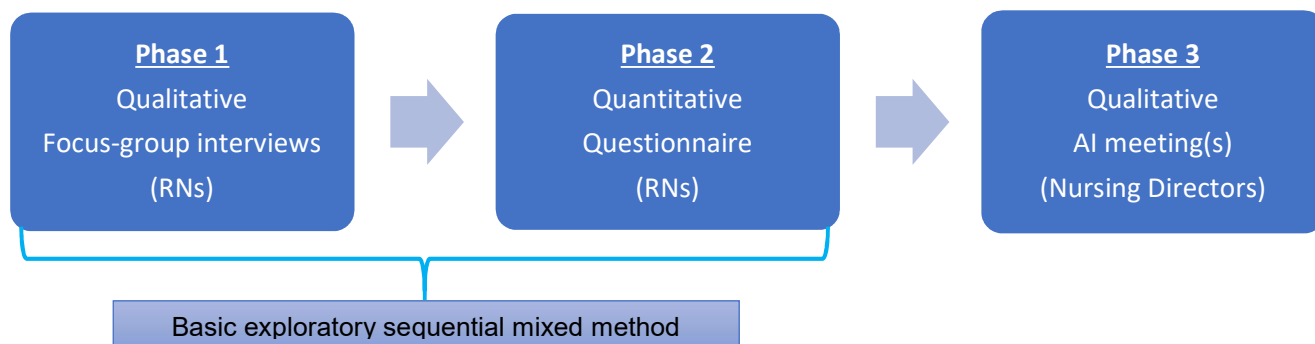
In this multiphase mixed method design, quantitative and qualitative methods are mixed and used from the perspective of two different paradigms representing the pragmatic paradigm; taking a value-oriented approach to the research (Johnson et al., 2004). First, the positivism, in phase two, is represented by the deductive quantitative approach which is a "*systematic way of doing research that emphasizes the importance of the observable facts*" (Botma et al., 2010:42). The researcher collects information on instruments based on measures completed by participants where methods and conclusions must be examined for bias in order to maximise the validity and reliability (Creswell, 2009). Second, the interpretivism, in phases one and three, is represented by the inductive qualitative approach where the emphasis is on human beings' experiences that construct the meaning through their involvement (Creswell, 2009). Subsequently, this contributes to more accurate results (De Vos et al., 2011).

Creswell (2009) emphasised that the mixed methodology in pragmatism enables the researcher to look at "what" and "why" to provide the best understanding of the research problem. Moreover, it was highlighted as a fundamental principle that the mix should have

complementary strengths and non-overlapping weaknesses (Johnson and Turner, 2003). Therefore, the integration of the approaches at the design, data collection, and data analysis levels serves the achievement of the study's aim.

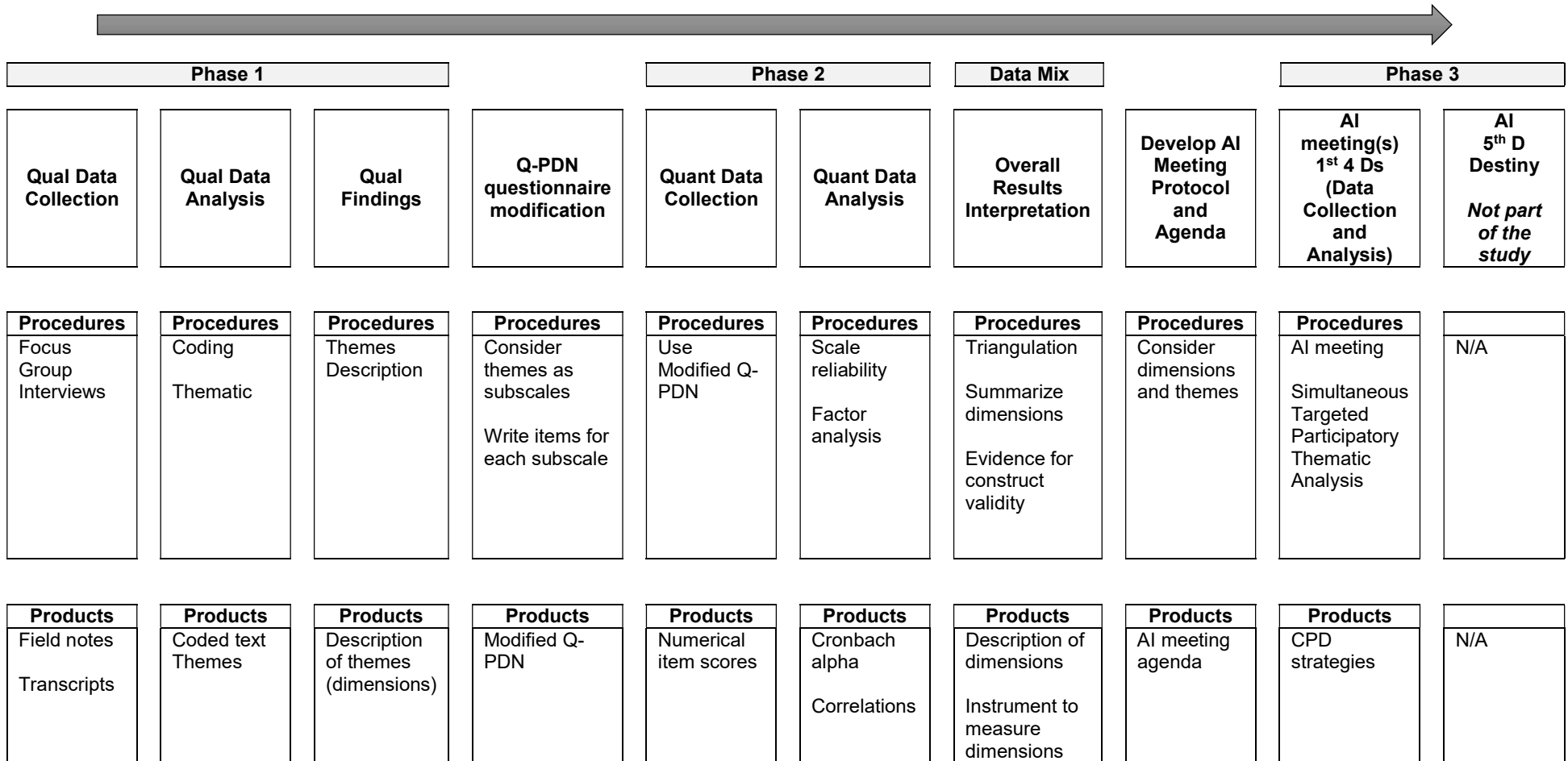
The advanced multiphase mixed method design was based on the basic exploratory sequential mixed method design (Qualitative-Quantitative) which is followed by a qualitative Appreciative Inquiry phase (Figure 3.5). Phase one is a qualitative, explorative, descriptive, and contextual method. Phase two is a quantitative cross-sectional descriptive method. Finally, using the findings from the previous phases, the third phase is a qualitative Appreciative Inquiry with nursing directors as a powerful research and change tool (Kristin et al., 2012). An overview of the data collection, data analysis, and interpretation is illustrated in figure 3.6. The following sections describe the design of each phase.

Figure 3.5: CPD Advanced Multiphase Mixed Method Roadmap



The design and methods of each phase is presented in the following consecutive sections.

Figure 3.6: Overview of Data Collection, Analysis, and Interpretation



Diagram's idea was adopted from Creswell et al. (2007)

3.5 PHASE ONE: QUALITATIVE DESIGN AND METHODS

3.5.1 Design

The research question for phase one was “what is the perception of RNs about the effectiveness of the CPD programme?” It was answered by attaining the following objective:

- Explore and describe the perception of RNs about the effectiveness of the CPD programme on their performance.

For this, the qualitative, explorative, descriptive, and contextual method was adopted as a phenomenological approach to explore and describe the lived experiences and perception of RNs about the effectiveness of the CPD programme. The phenomenological approach is described as an inquiry where the researcher explores and describes the essence of human experiences about a certain phenomenon as described by participants through an extensive and prolonged engagement (Creswell, 2009). The engagement with participants over four focus group interviews yielded unique appreciation of the reality of the participants' experiences (Munhall, 2012).

First, qualitative research is inductive in nature where the researcher explores meanings and insights in certain situations (Corbin and Strauss, 2015; De Vos et al., 2011). Creswell (2009) described it as an effective approach that occurs in a natural setting and enables the researcher to develop a level of detail from high involvement and engagement in the actual experiences. Burns and Grove (2009) stated that it is a systematic and subjective approach to highlight and explain daily life experiences and to further give them proper meaning. This approach enabled the researcher to be highly involved and extensively engaged with RNs through the focus group interviews and to understand their lived experiences and concerns about the CPD programme.

Second, the exploratory approach was defined as an effective method when limited knowledge is known about the phenomenon where the researcher has to get new insights and/or discover new ideas (Burns and Grove, 2005; Nieswiadomy, 2014). The nature of

the focus group interviews was explorative as the researcher had no precedent evidence-based knowledge about RNs' perception where exploring their lived experiences was key in this study and prepared a solid ground for phase two.

Third, the descriptive approach aims to create an accurate description of a phenomenon and its characteristics, this approach is more concerned with "what" rather than "how" or "why" something has happened, especially when limited information is available about the phenomenon (Hosseini, 2015). The question of phase one is a typical "what" question about the RNs' perception which gave the researcher a clear idea about the needs and expectations of RNs regarding the CPD programme.

Fourth, the contextual study has been described as "*one in which the phenomenon under investigation is studied in terms of its intrinsic and immediate contextual significance*" (Mouton, 1996:133). Klopper (2008) states that "*qualitative studies are always contextual, as the data is only valid in a specific context*". Therefore, the researcher avoided detaching RNs from their setting, as the main concern was to view the RNs' perception in the context of Abu Dhabi.

3.5.2 Population, Sampling, and Sample

3.5.2.1 Population

The population has been defined as "*the totality of persons, events, organization units, case records, or other sampling units with which the research problem is concerned*" (De Vos et al., 2011:223). The target population is all RNs working in the Emirate of Abu Dhabi. RNs in Abu Dhabi number 18,910 RNs working in more than 1,154 healthcare facilities (HAAD, 2017).

The nursing population in Abu Dhabi is characterised by a very low number of national nurses whereas the expatriate nurses represent 98.5% (WHO, 2016 in Paulo, Loney and Lapão, 2019). These figures are aligned with the distribution of the population where the national population represents 18.1%, whereas expatriates represent 81.9% of people

living in the Emirate of Abu Dhabi. The regional distribution of RNs within Abu Dhabi is also affected by the regional distribution of people who numbered 3,037,937 in 2016; 53.3% in Abu Dhabi, 41% in Al Ain, and 5.7% in Al Dhafra (DOH, 2018). The distribution of the healthcare facilities and RNs in terms of the region, governor (government and private), and type of facility (hospitals and clinics or centres) are summarised in tables 3.1 and 3.2 (HAAD, 2017).

Table 3.1: Distribution of Registered Nurses in the Emirate of Abu Dhabi

Region	Government		Private		Total
	Hospitals	Clinics & Centres	Hospitals	Clinics & Centres	
Abu Dhabi	5012	460	4776	3063	13311 (70.4%)
Al Ain	1897	361	1553	1034	4845 (25.6%)
Al Dhafra	278	20	210	246	754 (4%)
Total	7187	841	6539	4343	18910

Table 3.2: Distribution of Healthcare Facilities in the Emirate of Abu Dhabi

Region	Government		Private		Total
	Hospitals	Clinics & Centres	Hospitals	Clinics & Centres	
Abu Dhabi	7	35	28	708	778
Al Ain	3	27	12	281	323
Al Dhafra	6	8	1	38	53
Total	16	70	41	1027	1154

3.5.2.2 Sampling

The population groups and subgroups were levelled to three stages (illustrated in figure 3.7) according to the geographical distribution (three regions), type of governor (government and private sector), and type of facility (hospitals and clinics and centres) respectively.

Figure 3.7: Sampling Stages (groups and subgroups)

Stage 1 Geographical Distribution	Abu Dhabi	Al Ain	Al Dhafra
Stage 2 Governor	G P	G P	G P
Stage 3 Type of facility	H C H C	H C H C	H C H C

G: Government facility
P: Private facility
H: Hospital
C: Clinic or Centre

In phase one, the data was qualitative and was collected through focus group interviews with knowledgeable participants about the CPD perceptions, influencing factors, and needs and expectations. Participants were selected purposively to acquire a deep understanding of the issue and to yield cases that are “information rich” (Patton, 2015). Since they have experienced the central phenomenon, their experiences were explored to obtain themes that were vital to build in-depth understanding of the CPD issue in the UAE and to modify the questionnaire of phase two that assisted in the interpretation of the findings from phase one (Creswell, 2009). In addition to their knowledge and experience, their availability and willingness to participate were other important factors that were addressed during the selection process (Bernard, 2002 cited in Palinkas, Horwitz, Green, Wisdom, Duan and Hoagwood, 2015). This sampling is common in qualitative studies with exploratory descriptive purposes, especially at this stage, before conducting the study, where little is known about the issue under study (Botma et al., 2010).

At this exploratory stage of the multiphase mixed method research, participants were recruited according to the “expert purposive sampling” strategy, as little was known about the CPD in Abu Dhabi where the data could form the basis of this research and inform

the subsequent quantitative phase (Morse and Niehaus, 2009). To acquire the maximum understanding of the population's perception, the Directors of Nursing or their representatives of the government and private facilities, who were selected in phase two (refer to sampling in phase two) in each segment in stage three in the sampling stages were asked to nominate experienced and knowledgeable nurses in CPD. This included experienced nurses, nurse managers, clinical resource nurses, and in-service education nurses.

The inclusion/exclusion criteria for the sample was concise but beneficial to avoid any misleading information. The inclusion criterion was limited to all RNs who are practicing nursing in Abu Dhabi and had renewed their nursing licence at least once in Abu Dhabi. This provides an assurance that participants have experienced the mandatory CPD process which is a prerequisite for the licence renewal. On the other hand, the exclusion criteria excluded facilities with 10 RNs and less. This criterion was very effective in the data collection process as it saved time and money that would be spent on hundreds of facilities that are distributed over a huge geographical area.

Another concern behind the exclusion criterion is the researcher's knowledge about the logistics and ethical approval process in the UAE. The ethical approval is required from each facility as a requirement to conduct research where the management approval is not enough. The approval process required more than five months at some facilities and no response was received from others, even after closing-up the research project.

3.5.2.3 Sample

As a qualitative phase, the sample size depends on two criteria; data sufficiency and saturation (Botma et al., 2010). However, the sample size cannot be determined accurately before conducting the study to achieve the desired saturation as it is affected by several factors, such as quality of data (amount and degree of complexity), sample heterogeneity, available resources, and the number of people involved in the analysis and interpretation of the data (Guest, Bunce and Johnson, 2006).

Generally, the sample size is typically small and usually 30 cases or fewer in total (Teddlie and Yu, 2007). Nevertheless, Tashakkori et al. (2010) have summarised the sample size recommendations of the focus groups as 6-12 participants (Bernard, 1995) or 8-12 participants (Baumgartner, Strong and Hensley, 2002) in each group with a range of 3-6 focus groups (Krueger, 1994).

In this phase, four focus group interviews were conducted and distributed over the three geographical areas with a total of 31 RNs (see table 3.3). Taking into consideration the apologies, the invitations were sent to 12 participants for each interview. However, the attendance was 12 participants in interview one, six participants in interview two, seven participants in interview three, and six participants in interview four. The first intention was to conduct three preliminary interviews on the basis of one interview in each geographical area (Krueger and Casey, 2015). The data analysis revealed satisfactory data sufficiency, but not all themes were saturated where the researcher decided on the fourth interview to attain data saturation and make sure that all CPD concerns were addressed. The location of the fourth interview, Al Dhafra, was decided due to the researcher's knowledge of the participants' background as rich informants who were working in the segments of the governmental hospitals and private clinics/centres to attain the desired data saturation.

Table 3.3: General Profile of Focus Group Interviews

Focus Group Interviews	Region	Duration	Sent Invitations	Attendees	Total Attendees
1	Al Ain	60 minutes	12	12	31
2	Al Dhafra	106 minutes	12	6	
3	Abu Dhabi	66 minutes	12	7	
4	Al Dhafra	77 minutes	12	6	

Participants were chosen purposively from the facilities that granted ethical approval for the study. The approval process was a major challenge in the study as several facilities did not respond which reduced the recruitment as the researcher was hoping to include a wider variety of rich informants. The non-response was treated as a "no approval" after

waiting for two months with frequent reminders during that period. Participants were selected according to the Directors of Nursing or their representatives' knowledge about their RNs. They nominated candidates with rich information about the CPD phenomenon and the researcher checked their eligibility according to the inclusion/exclusion criteria. In addition, the researcher suggested a couple of candidates based on his knowledge about their background as resourceful participants. Participants were selected from the three regions, taking into consideration the governor and the type of the facility. More details about the recruitment process and participants' profile are explained in the next section.

3.5.3 Data Collection

This phase has a great weight due to its relationship with and input into the second phase, which was quantitative in nature, thus, forming together the basic exploratory sequential design. The data was collected through focus group interviews. The interviews focused on the RNs' experiences and perception about the effectiveness of the CPD programme.

The in-depth focus group interviews were exploratory for an average of 77 minutes (see table 3.3) for each of the four groups of RNs; 60 minutes for interview one, 106 minutes for interview two, 66 minutes for interview three, and 77 minutes for interview four. Participants' represented all segments that were identified in the sampling methods (see table 3.4). Participants had very rich information about the CPD concerns and requirements in Abu Dhabi, regardless of their job title; staff nurses, charge nurses, nurse managers, clinical resource nurses, and nursing quality officers.

Table 3.4: Participants of Focus Group Interviews' Segments Representation

Interviews	Location	Government		Private	
		Hospital	Clinic/Center	Hospital	Clinic/Center
Interview 1	Al Ain			•	•
Interview 2	Al Dhafra	•	•		
Interview 3	Abu Dhabi		•		
Interview 4	Al Dhafra	•			•

3.5.3.1 Procedures and Participants' Recruitment

Participants were mainly recruited through their Nursing Directors or their representatives as per the common practice in Abu Dhabi. Specifically, the researcher sent official e-mails to the contact person in the facilities where the purposively selected participants work. The e-mails were followed by a phone call to confirm the request and to answer any inquiries. The e-mails included the ethical approval, the focus group protocol, and "Participant's Information and Informed Consent Document" (PICD) (Annexure A – Focus Group Interviews PICD). Afterwards, the interview's date, time, venue, and any other logistic arrangements were agreed on through different means of communication; e-mails, phone calls, and in-person visits. The agreement was based on the convenience of participants, especially with the venue, as most focus groups included participants from two or more facilities. Participants' location and distance to the venue are illustrated in table 3.5. The distance was calculated using "Google Maps".

The researcher was not able to provide much incentive to participants as the study is mainly self-funded. However, sharing opinions, enjoyable, convenient and easy to find meeting location, involvement in an important research project as it was conducted at the Emirate level, building professional connections, and refreshments and snacks were very convenient incentives to participants who showed interest and professionalism during the interviews (Krueger et al., 2015; Stewart and Shamdasani, 1990). The venue facilities were provided by the facilities reflected their co-operation and support, in addition to the convenience factor for most participants.

Table 3.5: Venue and Participants' Convenience of Focus Group Interviews

Interview	Region	Participants' Facility	Interview's Venue	Distance to Venue	Remarks
Interview 1	Al Ain	Facility 1	Facility 1	0 km	Same facility
		Facility 2		1.6 km	Walking distance
Interview 2	Al Dhafra	Facility 3	Facility 3	0 km	Same facility
Interview 3	Abu Dhabi	Facility 4	Facility 4	0km	Same facility Facility 4 arranged transportation as all facilities fall under the same governor
		Facility 5		17.3 km	
		Facility 6		22.6 km	
		Facility 7		20.4 km	
Interview 4	Al Dhafra	Facility 8	Facility 8	0 km	Same facility
		Facility 3		5.4 km	Transportation was offered but participants used their own pool car

On the day of the interview, the researcher met participants in the designated venue, conducted informal conversation with them for rapport purposes, and made sure that they received the PICD. Extra copies of the PICD were prepared in case they were required. Just before commencing the interviews, the researcher collected the signed PICDs and made sure that participants understood that participation was confidential and anonymous and that they had the right to withdraw at any time in addition to all other ethical considerations and precautions; as per the PICD.

During the interviews, the researcher played the role of the moderator/facilitator. The environment was comfortable, and seating arranged in a circle. The researcher and each participant wrote their names, as per their preference, on cards to facilitate communication during the discussion as calling people by their preferred name contributes to the desired comfortable environment. The language of discussion was the official business language in Abu Dhabi, English, translation was not needed.

All interviews were recorded by audiotape and the researcher's hand-written notes. For the audiotaping, the researcher used two high-tech electronic devices; a professional "Sony" audiotaping device and a smart phone that was used as a plan B in case any

misfortune happened. The audio recording was copied from the professional audiotaping device to the researcher's laptop and then copied to a cloud service to avoid any unintentional loss of the data. After securing the audio recording and checking its clarity, the recording on the smart phone was deleted. The recording devices were tested and familiarised with in advance. The hand-written notes included first, a discussion note about the key themes and new ideas to build on them during the interview. Second, a flipchart to summarise the identified elements of each question and to refer to them during the interview and to rank the most important factors by participants.

3.5.3.2 Data Collection Instrument

3.5.3.2.1 Introduction and Historical Overview

The "ideal" data collection instrument for this phase was the focus group interview as it examined people's experiences, opinions, needs, and concerns (Kitzinger, 2005). Moreover, focus groups are very useful in gathering information to modify a large-scale quantitative tool; a questionnaire (Krueger et al., 2015). It has been referred to also as a group interview and group depth interview (Liamputtong, 2011).

3.5.3.2.2 Characteristics of Focus Groups

Krueger et al. (2015) identified a unique combination of five characteristics of the focus groups and these characteristics has also been identified by several authors (Hennink, 2007; Hollander, 2004; Liamputtong, 2011; Wilkinson, 2004). First, focus groups' size should be small, 5-8 people, but the range can be expanded from 4 to 12. This range is considered small enough to give the chance to participants to share their insights whereas it is considered large enough to reach diversity in perceptions. Higher than this range would lead to fragmentation of the group whereas smaller than this range would result in few ideas and subsequently fewer themes. Second, participants should possess certain common characteristics. The homogeneity of the focus groups is identified according to the study's purpose. Third, focus groups provide qualitative data that is of interest to the researcher. The qualitative data comes from the comparison and contrast of the opinions

from the different groups. For this purpose, a minimum of three groups are required. Fourth, the discussion should have a focused scope which could not be achieved without careful phrasing and sequencing of the questions. These sets of questions are also known as the “questioning route” or “interview guide”. Participants should understand them easily and perceive them as logical inquiries where they should appear spontaneous and natural. Fifth, focus group interview’s ultimate goal is to help in the understanding of the topic (Hennink, 2007; Krueger et al., 2015; Liamputtong, 2011; Wilkinson, 2004).

3.5.3.2.3 Critique of the Focus Groups

Krueger et al. (2015) identified six criticism areas of the focus groups where addressing them is critical for the trustworthiness of the findings.

First, participants tend to intellectualise and represent themselves as thoughtful, rational, and reflective individuals, especially when they discuss their behaviour. However, behavioural experts indicate the opposite about the human behaviour. This problem was minimised by using another inquiry method in this mixed method study (Krueger et al., 2015).

Second, in a continuum with the first criticism, participants, human beings, are often unaware for what actually drives and influences their behaviour. Therefore, the moderator needs to have insight on these emotions which can be enabled by asking projective questions that inquire about the feelings and the interview setting should be appropriate for sharing emotions as some people might become tense and/or even cry (Hopkins, 2007; Krueger et al., 2015; Liamputtong, 2011).

Third, focus group participants might make the answers up, especially when they tend to avoid embarrassment if they have limited or no experience in the topic. The same strategies to illicit intellectualisation should be adopted by the researcher (Hollander, 2004; Hopkins, 2007; Krueger et al., 2015; Liamputtong, 2011).

Fourth, focus groups might produce superficial trivial results especially when the topic is complicated and large. Therefore, the group size and the duration of the interview should be planned carefully where invited participants should not exceed 12, taking into consideration the possibility of apologies (Krueger et al., 2015; Wilkinson, 2004).

Fifth, dominant participants might influence the results. To overcome this challenge, the moderator should be skilled to reduce this risk and even convert it to a beneficial learning experience where he/she should serve as a levelling force that allows reflection and comment on various arguments without pressure (Hollander, 2004; Krueger et al., 2015; Liamputtong, 2011).

Sixth, the subjectivity of the findings of the focus groups affects their validity and reliability. Therefore, using another inquiry tool, questionnaire, in the mixed method would eliminate this critique that would lead to bias (Krueger et al., 2015; Liamputtong, 2011; Creswell et al., 2018).

In addition to the identified criticism areas, there are two main reasons behind the failure of group experiences; unclear purpose or inappropriate processes (Krueger et al., 2015). These reasons might have a direct impact on the value of the focus groups in terms of obtaining an understanding that requires a clear purpose and how participants interact and discuss the topic that requires appropriate processes (Conradson, 2005). To overcome the identified areas of criticism and reasons of failure, the researcher should understand that focus groups work best when participants are in a comfortable, respectful, and non-judgemental setting (Conradson, 2005; Hennink, 2007; Krueger et al., 2015; Liamputtong, 2011).

3.5.3.2.4 The Focus Group's Design

Krueger et al. (2015) and Morgan (1995), in separate works, have identified five different designs of focus groups from a diversity perspective of participants' categories. The designs are single-category design (traditional), multiple-category design, double-layer design, broad-involvement design, and large-scale design. The design of this study is the

traditional single-category design as it is the ideal design to conduct focus groups until achieving theoretical saturation; the point where no new insights are gained. In this design, the number of groups varies but should not be less than the initial three to four groups with a specific category of participants. It is used when the researcher does not require comparison and contrast with different category of participants and according to other features. In this study, all participants fell in the category of RNs within the scope of the CPD inquiry.

Despite this, RNs could fall under different geographical categories and the researcher could have compared among these categories in the data analysis, however, this was not the aim of the study or the phase. However, the comparison was within the study's scope to identify the explored geographical range of the CPD issues (Merton, Lowenthal and Kendall (1990). Therefore, the decision omitted the multiple-category and double-layer designs that require a minimum of two categories whereas the broad-involvement and large-scale designs were omitted as they are concerned with the widespread public topics and convey a sense of widespread listening (Krueger et al., 2015).

3.5.3.2.5 The Moderator

The researcher's role in the focus groups of this study was represented in the form of a moderator or facilitator. It was considered as a key influential role in the focus groups in terms of collecting rich and valid data. The main task was to stimulate participants to engage actively in the discussions (Krueger et al., 2015; Liamputtong, 2011; Stewart, Shamdasani and Rook, 2007). Playing this role was influenced by a number of factors, including personal characteristics, educational background and training, experience as a moderator, and certain situational characteristics such as the sensitivity of the topic, the scope and required depth, and the venue and time (Stewart et al., 2007).

Stewart et al. (2007) emphasised the fact that the moderator represents a leadership role in the focus groups through the motivation, direction, and power as a social influential. However, Liamputtong (2011) argued that the moderator is not only a leader but a

navigator as well. As a navigator, in alignment with the main task, the moderator “*can use an analogy of exploration*” (Gates and Waight, 2007).

Most importantly, the moderator should be neutral. However, from a practical perspective, the moderator could not be a neutral spectator. Therefore, the moderator should be reflexive when sharing any experiences and this should be to serve the main aim of the focus group; to encourage the discussion (Liamputtong, 2011). This has been referred to as self-disclosure (Reinharz and Chase, 2002 cited in Liamputtong, 2011).

Besides, the issue of control, positioning has been highlighted as a major factor (Hollander, 2004; Krueger et al., 2015; Liamputtong, 2011). However, Stewart et al. (2007) have connected it to the leadership attributes of the moderator where the groups require social influence to direct them to the core discussion.

Lastly, the good focus groups’ moderator should be (Hennink, 2007; Hollander, 2004; Krueger et al., 2015; Liamputtong, 2011; Stewart et al., 2007):

- Emotionally intelligent in terms of being sensitive to participants’ needs, a good observer, and a good communicator as an active listener and clear expresser of thoughts
- Non-judgemental about the participants’ responses
- Knowledgeable about the topic
- Represent leadership role
- Patient and flexible
- Admitting own bias
- Having a sense of humour

Therefore, in this study, the researcher was prepared to play the moderator’s role by understanding the research problem, being familiar with focus groups’ settings, knowing the groups’ backgrounds and dynamics. Additionally, being the person who prepared the questioning route and strategy was a positive factor for the researcher. Lastly, the

researcher's experience and knowledge in leadership and management, by profession and academia, was a positive in managing the groups.

3.5.3.2.6 Questioning Route

The focus group's protocol, namely the questions guide, is a critical element in determining the success of the focus group (Hesse-Biber and Leavy, 2011; Liamputtong, 2011). The questioning route has been defined as "*a list of sequenced questions in complete, conversational sentences*" (Krueger et al., 2015:43). The good questioning route have **four major characteristics**: (1) it starts with an easy question to ease smooth engagement of all participants, (2) it is sequenced to allow the conversations to flow naturally, (3) it starts with general questions and narrows to more specific and important questions, and (4) it uses time logically and wisely (Krueger et al., 2015).

Therefore, this section explains the number and categories of questions, qualities of good questions, and the process of developing questioning route.

3.5.3.2.7 Number and Categories of Questions

There is no typical number of questions in the literature, however, Krueger et al. (2015) indicated that the typical questioning route includes around 12 questions for a two-hour focus group. These questions would be answered in minutes in an individual interview but asking them in a group environment, the discussion would last for many hours due to the nature of questions and participants' cognitive processes. Participants' answers and responses would spark ideas and trigger memories and thoughts of others. The questioning route of this study included a total of 18 questions of different types (Annexure B – Focus Group Guide); one opening question (OQ), one introductory question (IQ), two transition questions (TQ), two key questions (KQ), and 12 sub-questions (SQ), and one closing question (CQ). This number of questions is considered acceptable taking into consideration the diversity and that four of the 18 questions are not typical conversation-evoking questions.

As stated previously, different types of questions were used during the focus group for different purposes and at different times. The level of importance of the question is key in determining the time spent on it and its analysis intensity. There are five essential categories of questions: opening, introductory, transition, key, and ending (Krueger et al., 2015; Morgan, 1995; Stewart et al., 1990).

1. Opening Question

The opening question is designed to be quick (about 30 seconds) and easy to answer. It is expected to be answered by all participants at the beginning of the interview as it is aiming to have everyone talking early on. The opening question usually asks about facts rather than opinions and attitude that require a long time to answer and discuss. The opening question is not a discussion question but strictly a process of engaging all participants at an early stage and helping them to feel comfortable. Analysis of opening questions is usually not required as it is not aiming to get information. It is crucial for the success of the focus group that the opening question does not highlight power or status differences among participants (Halcomb, Gholizadeh, DiGiacomo, Phillips and Davidson, 2007; Krueger et al., 2015; Morgan, 1995; Stewart et al., 1990). The opening question was the first question where participants were asked to introduce themselves and their speciality. It avoided indicating their position to eliminate any possibility of highlighting the power of the position. The question was:

- OQ: Please share your name and speciality.

2. Introductory Questions

Introductory questions introduces the topic or issue and triggers participants' thinking about their experiences and connection with the topic. At this stage, the researcher starts to get clues about participants' views about the topic (Halcomb et al., 2007; Krueger et al., 2015; Morgan, 1995; Stewart et al., 1990). The IQ of the focus groups was about participants' view of the CPD which facilitated introducing the topic and gave the researcher some clues about their views. The question was:

- IQ: What do you think about the value of the CPD in terms of the development of knowledge, skills, and attitude for nurses?

3. Transition Questions

Transition questions play an important role in transitioning the conversation from the introductory questions to the key questions and in setting the stage for productive key questions. At this stage, the discussion reaches more depth than the surface introductory questions about participants' experiences where they become aware of the others' views of the topic. These questions require a few minutes (Halcomb et al., 2007; Krueger et al., 2015; Morgan, 1995; Stewart et al., 1990). The focus groups included two TQs at the beginning of the in-depth discussion. The two questions were more specific than the IQ that asked about the value of the CPD and with less depth than the KQs. The questions were:

- TQ: How do you see the CPD programme in the UAE?
- TQ: How do you feel about the CPD as a licensure renewal requirement in UAE?

4. Key Questions

Key questions drive the study. They are also referred to as focus questions. These questions are the first to be developed by the researcher as they are based on the research question. They need sufficient time (10 to 20 minutes each) for full discussion and require the greatest attention during the analysis. These questions usually begin one-third to halfway into the interview. During this stage, the moderator is expected to use more pauses and probes than the other stages of the focus group (Halcomb et al., 2007; Krueger et al., 2015; Morgan, 1995; Stewart et al., 1990). The focus group included five KQs which were linked to the phase's research question and to the constructs of the questionnaire of phase two. The questions were:

- KQ: What CPD activities do you usually attend?
- KQ: What are your motives to attend CPD activities?
- KQ: What are the barriers to attend a CPD activity?
- KQ: Which CPD activities do you consider important in terms of the knowledge, skills, and attitude competencies respectively?
- KQ: What are your CPD needs and expectations?

In addition to the five KQs, the focus group included additional eight SQs, six open-ended and two close-ended, to get the maximum range of the CPD issue. The eight questions were:

- SQ: Which mode of delivery do you prefer in terms of the knowledge, skills, and attitude competencies respectively?
- SQ: What is the content of the CPD activities?
- SQ: How do you see the content of the CPD activities in terms of the knowledge, skills, and attitude competencies respectively?
- SQ: How do you see the impact of the CPD activities on the nurses' knowledge, skills, and attitude competencies?
- SQ: How do you identify these needs?
- SQ: How do you recognise that these needs and expectations are met?
- SQ: Are the CPD activities connected to your performance appraisal?
- SQ: Are they mandatory?

5. Ending Questions

Ending questions set the closure of the discussion, allow participants to reflect on their comments, and are critical to the discussion. Generally, there are three types of ending questions: the 'all things considered' questions, the summary question, and the final question.

The 'all thing considered' question is useful in determining participants' final position on the critical areas. It asks each participant to reflect on the discussion and to identify the most important aspects in one minute. This question is very helpful in the analysis because it allows interpretation of the conflicting comments and assigns weight to what they say (Halcomb et al., 2007; Krueger et al., 2015). These questions are asked by the end of each critical point such as the motives, barriers, and activities. The questions are in the form of an exercise to re-list and highlight the main points and give them a rate and/or rank according to their importance and/or frequency. For example, by the end of the discussion about the "motives" question, the motives were summarised and listed on a flipchart where the participants were asked to rank them according to their importance.

The summary question is asked after the short oral summary (about two minute) by the moderator. It asks about the adequacy of the summary and is critical for the analysis (Halcomb et al., 2007; Krueger et al., 2015). The summary questions were embedded with the 'all thing considered questions' of each critical point in order to get concise responses about those points. For example, in the same exercise of the "motives" question, participants were asked to confirm their summarised responses.

The final question is an insurance question. It is also referred to as a closing question. It has a unique purpose to ensure that all critical aspects are covered. It starts with a short overview about the purpose of the study and then the moderator asks whether anything is missed. It requires several minutes and it could include feedback comments about the moderating skills and any other improvement suggestion (Halcomb et al., 2007; Krueger et al., 2015; Morgan, 1995; Stewart et al., 1990). The final question was as follows:

- CQ: Are there any other questions/information/issues you want to ask/share about the CPD in UAE?

3.5.3.2.8 Qualities of Good Questions

The questions of this focus group were developed carefully and were of a good quality. Therefore, the questions (1) were conversation evoking, (2) avoided uncommon technical terms, (3) were easy to use, clear, and short, (4) were mostly open-ended with very clear key terms, and (5) included engagement activities (Krueger et al., 2015; Schaeffer and Presser, 2003).

3.5.3.2.9 The Process of Developing a Questioning Route

In developing the questioning route, the researcher adopted the concepts of Schaeffer et al. (2003) and embedded them in the process of Krueger et al. (2015) that consists of seven steps: (1) brainstorm, (2) sequence the questions, (3) phrase the questions, (4) estimate time for each question, (5) get feedback from others, (6) revise the questions, and (7) test the questions.

1. *Brainstorm*

The researcher conducted a brainstorming session with three of his colleagues who were oriented to the study's purpose and targeted participants. The colleagues are familiar with the nursing environment and CPD in Abu Dhabi. The colleagues are two nursing academics with previous experience as RNs in Abu Dhabi and a clinical resource nurse. The meeting lasted about an hour. All members wrote down their thoughts about the questions that could be asked in the focus group. Generating ideas for questions was a very effective group activity, however, the group was not efficient refining the questions. The researcher took the set of questions to step two for refining and sequencing (Krueger et al., 2015; Liamputtong, 2011).

2. *Sequence the Questions*

The sequence of the questions is the key reason behind using the term "focus" in the "focus groups". Proper sequencing of the questions gives participants a fair opportunity to express their opinions and views and build on them (Krueger et al., 2015; Schaeffer et al., 2003). For an efficient sequencing, the researcher took into consideration four major aspects.

First, key questions, then work backwards. The researcher first sequenced the key questions in a logical flow then placed the question that immediately precedes the first key question. This question opens the discussion and leads to the key question (Krueger et al., 2015).

Second, general questions before specific questions. To achieve this, the moderator adopted the funnelling concept in order to move the discussion from the general ideas to a more specific and critical discussion (Krueger et al., 2015).

Third, positive questions before negative questions. Asking about the positive before the negative questions is a successful strategy to get both aspects discussed and explored. On the contrary, with human beings asking negative questions first would make it very

difficult to move to the positive ones. For instance, the “motives” question preceded the “barriers” question (Krueger et al., 2015).

Fourth, un-cued questions before cued questions. The researcher asked the un-cued questions first then asked questions with cues to prompt additional discussions. For example, the researcher asked participants about the intrinsic and extrinsic motives and barriers of the CPD activities without giving cues. After answering this question, the researcher gave them some cues in order to get comments (Krueger et al., 2015).

3. Phrase the Questions

After sequencing the questions, the researcher reviewed them and identified the key questions in order to phrase them appropriately. Then, the researcher added more questions in order to build the questioning route (Krueger et al., 2015). The researcher took into consideration six major aspects.

First, **open-ended questions** are a very effective choice in the focus group as they allow participants to respond freely without limiting their answers. Participants’ responses would be based on their situations and experiences. The open-ended questions should be written in a way that begs more information and explanation and avoid limiting the answers. For example, asking participants “how satisfied?” does not yield rich information. On the contrary, asking them “how do you feel?” would open the discussion and give detailed description and explanation (Krueger et al., 2015).

Second, asking participants to think back and reflect on certain situations would yield more reliable information. Without specifying certain situations, participants might respond to the most recent experience or the best experiences only. For example, as part of the probing questions, participants were asked to reflect on a CPD activity that they have attended recently (Krueger et al., 2015).

Third, avoid asking “why”. The why questions are very sharp and confronting questions. Despite being open-ended, participants would intellectualise their answers in a defensive

behaviour and the moderator will not be able to reach the deep discussion about their motivating behaviours and emotions. Instead, using the “what” and “how” questions about the CPD would lead to the desired exploration of participants’ feelings (Krueger et al., 2015).

Fourth, simple questions are essential for the success of the focus group. Complex questions were avoided as they might delay the answer and confuse participants which would affect their engagement negatively and/or the questions would be interpreted differently by different participants (Krueger et al., 2015).

Fifth, make the questions conversational. The rule of thumb of the conversational questions is that their language should be common and comfortable for participants (Krueger et al., 2015). The set of questions were checked carefully to avoid any uncommon terms or acronyms. Participants did not have any difficulty with the technical terms as the nursing CPD topic is a common and popular topic.

Sixth, being cautious while using examples as this would limit participants’ thinking and direct the discussion to specific areas without exploring their feelings and experiences. Subsequently, this prevents other dimensions and aspects from emerging. Examples were used minimally and carefully as probes only after participants finished their answers (Krueger et al., 2015).

4. Estimated Time for Each Question

The typical focus group interviews last for about two hours. This is considered convenient physically and psychologically for participants. Out of the 120 minutes, 15 minutes were planned for the start-up and waiting for enough participants to arrive and another 15 minutes were spared for the ending and summarising questions. However, the researcher faced some difficulties with the last 15 minutes as participants, as is human nature, were rushing the process. This left about 90 minutes for the opening, introductory, transition, and key questions with a range between 5 and 20 minutes to be spent on each question. Many factors affected the estimated time, including the complexity and category of the

questions, level of participants' expertise, size of the group, and duration of the activities (Krueger et al., 2015).

Therefore, the interviews included four primary stages. Stage one was the introduction where the researcher welcomed participants, presented an overview of the discussion and its purpose, and presented the guidelines and ground rules, and then participants introduced themselves. It lasted for about 10 minutes. Stage two was characterised by rapport building where the researcher asked easy questions to start the conversation. It lasted for about 10 minutes also. Stage three was the core of the focus group interviews as it is where the in-depth discussion happens, and the key data is collected. The questions were about the main purpose and constructs of the study and yielded powerful information. The researcher's role was key in this stage in encouraging participants to express their thoughts and feelings. It lasted for about 50-90 minutes. Interviews consumed about 50 minutes in stage three, as there was sufficient data. Stage four is the close-up where the researcher summarises the discussion and participants either confirm or clarify the information. However, several critical points were summarised immediately after their designated questions. Then, the researcher answered any remaining questions, thanked participants, and indicated the next steps. It lasted for around 5-10 minutes.

5. *Get Feedback from Others*

Upon completing the questioning route, the set of questions was shared with the brainstorming team for feedback. This feedback could be sought via e-mail with a due date within a week, however, the researcher sought it via a meeting as it was convenient for all (Krueger et al., 2015). Before this meeting, another means of feedback was sought from the IRB committee during the preparation of the proposal.

6. *Revise the Questions*

After the feedback, the questions should be revised and sent back to the feedback team. This cycle can happen a few times until either the team is comfortable, or they start to

nitpick. However, this step was unnecessary as the final version was confirmed during the feedback meeting. Then, it is time to test the questions (Krueger et al., 2015).

7. Test the Questions: Pilot Study

Stewart et al. (2007) indicated that, regardless of any factor, “*there is no substitute for trying out an interview guide prior to its use*”. The questions were tested orally on a small group of people, four RNs, who have similar characteristics to participants. Initially, testing the questions looked to many aspects such as how easy is asking the question, clarity, structure, and check for meaning. Additionally, it helps in learning about the effectiveness of the moderator in order to identify any need for modification to the level of engagement (Breen, 2006; Krueger et al., 2015).

As a result of the pilot study, the questioning route was not modified as it had been found that it was easy to ask, clear, well structured, and with a very clear meaning. Additionally, the moderator was satisfied with the level of involvement with the different types of questions. However, a different issue arose during the testing of focus group as the digital recording device did not record the interview and the researcher had taken only a few notes. In order to avoid such unfavourable situations, as a corrective action, the researcher used two different digital recording devices, in addition to the flipchart to record the key points in the actual focus groups.

3.5.4 Data Analysis

The analysis of phase one started simultaneously with the data collection. To stay within the scope of the study, the direction, depth, and intensity of the analysis were guided by the study’s aim and phase’s specific question and objectives. This was an important factor to avoid being distracted by the large amount of gathered data (Breen, 2006; Krueger et al., 2015; Liamputtong, 2011). The QSR NVivo software was used as a tool. The qualitative data was transcribed verbatim and analysed according to the “Thematic Analysis” (TA) style.

For a quality focus groups analysis, the researcher took into consideration four critical qualities. First, as it is discussed in this section, the analysis process was systematic. Being systematic means that the researcher followed a reliable process to avoid missing critical factors. Second, the analysis should be verifiable by preparing sufficient data to develop solid evidence about the analysed data. Third, the systematic process should be sequential, starting with the planning phase, passing by the recruitment of the right participants, building an appropriate questioning route, and ending with the researcher's role as a moderator, and concluding with the data analysis. Fourth, the analysis should be continuous, starting from the moment of data collection in the first focus group. Then the analysis continues in the same manner taking into consideration the schedule of the interviews and transcription before moving to the next one.

3.5.4.1 Data Analysis Style

There are a number of qualitative data analysis styles. However, the style of choice in this study was the TA style which has been used widely and seen as a foundational method for qualitative analysis (Braun & Clarke, 2006). TA has been connected to the phenomenological approach as it focuses on the human experience subjectively (Braun and Clarke, 2006; Guest, MacQueen and Namey, 2012).

Its name, "thematic", refers to its focus to examine themes within data. TA has been defined as "*a method for systematically identifying, organizing, and offering insight into patterns of meaning (themes) across a data set*" (Braun and Clarke, 2012:57). Therefore, TA emphasises on finding a meaning across a "data set". The seen meanings or experiences should be common, collective, or shared; rather than a unique personal experience. On the other hand, not all common patterns are meaningful or important as they should be within the scope of the study's aim (Braun et al., 2012).

TA is commonly used due to its characteristics as flexible and accessible where it has been viewed as only a method of data analysis, rather a qualitative research approach. This is considered as a strength as it allows the researcher to analyse the data in different ways; either to find a meaning across the "data set" or to conduct in-depth analysis of a

particular issue (Braun et al., 2012). “Data set” refers to the data, from the corpus data, used for a particular analysis whereas the corpus data refers to all data collected for the study. On the other hand, the TA has been seen as a useful method to generate suitably analysed data for policy development (Braun & Clarke, 2006).

3.5.4.1.1 Thematic Analysis Approaches and Decisions

For an appropriate and delimited TA, the researcher’s position should be identified clearly among three main continua; inductive versus deductive coding and analysis, experiential versus critical orientation to data, and realist versus constructionist theoretical perspective (Braun et al., 2012). However, from a pragmatic perspective, the researcher’s position is in no position in any of the three continua, especially in the second and third continua.

However, in the first continuum, where the inductive, a bottom-up, approach is driven by the content of the collected data and the deductive, a top-down, approach is driven by the concepts and ideas that are brought by the researcher to the data. From a pragmatic perspective, the researcher used a combination of both approaches; inductive and deductive. This choice has been confirmed from the reality where this combination is often used due to the impracticality to be purely either deductive or inductive in the coding and analysis process (Braun et al., 2012). However, the inductive approach was predominant in the coding and analysis since the coding and analysis were driven by the content of the data except for identifying the categories of the content as per the questions and ideas from the focus groups’ guide, such as motives, barriers, and activities.

In the same context, coding has been identified as the primary process for developing themes from the analysed data by identifying the common and important meanings and encoding these. This process prepares the data for interpretation (Boyatzis, 1998), whereas the themes themselves denote a certain level of patterned response or meaning from the data. This process should be guided by the study’s aim and question(s) to obtain precise understanding of the “big picture” (Braun et al., 2006). The levels have been identified as either “semantic” or “latent”. Semantic, explicit level, themes present explicit and surface meaning as stated by participants. This produces a rich description of the

entire data. Then, the researcher summarises and interprets the semantic content (Patton, 2015). On the other hand, latent, interpretive level, themes are deeper than the semantic. They identify the ideas and assumptions through comprehensive interpretation of specific areas of interest across the majority of the data set. This produces theorised data rather than descriptive (Boyatzis, 1998; Braun et al., 2006). TA usually focuses on one of them. Therefore, the researcher focused on the semantic themes that help in attaining the descriptive approach of phase one.

3.5.4.1.2 Critique of Thematic Analysis

Despite the highlighted and acknowledged advantages of the thematic analysis, it has been critiqued for a number of reasons. First, it might miss some nuanced data. Second, its flexibility might affect the focus on what data to analyse (Braun et al., 2006; Guest et al., 2012). Additionally, some authors viewed thematic analysis as a general tool rather than a specific approach by itself (Boyatzis, 1998; Ryan and Bernard, 2000), however, the pioneers in thematic analysis, Braun et al. (2006), and an endless list of researchers and authors argue that it is a method on its own.

3.5.4.2 Computerised Data Analysis

The researcher used the QSR NVivo 12 (Windows version) computer software, which was released in March 2018, as a tool for organising, coding, and preparing the data for thematic analysis. NVivo is a qualitative data analysis (QDA) computer software package produced by QSR International. It has been designed for qualitative and mixed method researchers working with very rich text-based and/or multimedia information (QSR, 2019). The use of computerised data analysis software facilitates the analysis of the time-consuming and exhaustive task and contributes to providing verifiable and systematic data (Stewart et al., 2007).

3.5.4.3 Data Analysis Process

To conduct systematic analysis and to avoid “anything goes” analysis of the TA (Antaki, Billig, Edwards and Potter, 2003), the researcher adopted the guidelines that were

developed by Braun et al. (2006). This six-phase step-by-step guide was developed from the perspective that the analysis is a recursive process that develops over time (Anzul, Downing, Ely and Vinz, 2003; Braun et al., 2006).

1. Phase One: Familiarising Yourself with Your Data

The researcher became familiar with the data starting from the focus group interviews as the researcher was the moderator. Afterwards, the researcher verbatim transcribed the four interviews accurately which added more familiarisation with the data. Finally, the researcher got immersed in the data by reading the verbatim transcription repeatedly and actively after transferring them to the Nvivo 12 software.

2. Phase Two: Generating Initial Codes

After and during being familiarised with the data, the researcher organised the data in a more structured manner by dividing it into segments as per the focus group's guide structure. Then, the researcher started producing initial codes under each segment of the data to group them meaningfully.

3. Phase Three: Searching for Themes

After producing the list of grouped codes, the researcher re-focused on, sorted, and combined them to find the potential and then the identified themes. Eventually, some codes were combined to form main themes, others formed sub-themes, and another set was discarded. However, the themes were not confirmed at this stage yet.

4. Phase Four: Reviewing Themes

At this stage, the researcher refined the identified potential themes. The data within themes was checked for its meaningful coherence while the data between the themes was checked for its clear distinction. Considering the validity of the themes in relation to the data set, a thematic map was used and checked for its accurate reflection of the meaning in the data set, the study's aim, and the phase's objective.

5. Phase Five: Defining and Naming Themes

After being satisfied with the thematic map, the researcher defined and further refined the themes. For each theme, a detailed analysis was written, telling its story and how it fits within the overall data in relating to the study's aim and phase's objective. The large complex themes were clarified and structured by identifying their sub-themes. As a final test for the clarity and definition of the themes, each theme's scope and content were described precisely and briefly.

6. Phase Six: Producing the Report

At this stage, the researcher prepared the finding's report that showed the merit and validity of the analysis by providing sufficient evidence from the data. They were presented in a narrative analytical manner that described the story and presented argument in relation to the study's aim and phase's objective.

3.6 PHASE TWO: QUANTITATIVE DESIGN AND METHODS

3.6.1 Design

The research question for phase two is "what are the intrinsic and extrinsic hindering and facilitating factors that influence RNs' participation in the CPD programme from the RNs' perception?" It was acknowledged by answering the following objectives:

- Identify and determine the intrinsic and extrinsic hindering factors that influence RNs' participation in the CPD programme.
- Identify and determine the intrinsic and extrinsic factors that facilitate the RNs' participation in the CPD programme.
- Identify the important CPD activities.
- Identify any perceived differences in the hindering factors, facilitating factors, important activities, and actually undertaken activities in terms of the region, governor, and type of facility.

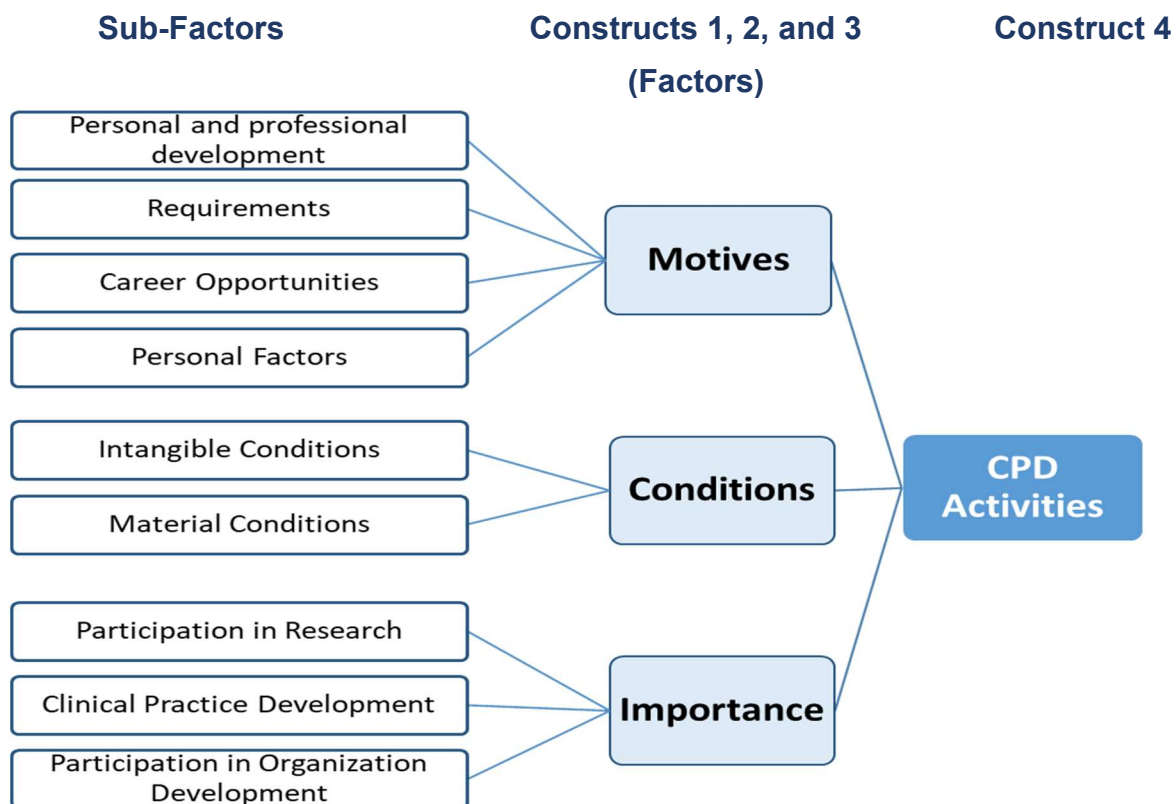
The main hypotheses about the correlation between hindering factors (conditions), facilitating factors (motives), important activities, and actually undertaken activities are as follows:

- **Hypothesis (H1):** the motives, conditions, and importance associated with CPD has a significant effect on the CPD activities performed by RNs in Abu Dhabi.
- **Null Hypothesis (H0):** the motives, conditions, and importance associated with CPD has no significant effect on the CPD activities performed by RNs in Abu Dhabi.

As illustrated in the diagram below (Figure 3.8), the sub-hypothesis, that examined the sub-factors within each construct i.e. motives, conditions, and importance, significantly contribute to CPD activities. This allows the validation of the main hypothesis and tests the additional new sub-factors in the modified Q-PDN. The sub-hypotheses are as follows:

- H-A1: The motives (construct 1) of RNs in Abu Dhabi have a significant influence on the actual undertaken CPD activities (construct 4).
- H-A2: The conditions (construct 2) surrounding RNs in Abu Dhabi have a significant influence on the actual undertaken CPD activities (construct 4).
- H-A3: The importance perceived of CPD activities (construct 3) by RNs in Abu Dhabi has a significant influence on the actual undertaken CPD activities (construct 4).

Figure 3.8: Factors and Sub-Factors Influencing Nurses' "actual" undertaken CPD activities (four Constructs)



For this, the quantitative cross-sectional descriptive method was adopted to identify and determine the facilitators, barriers, and importance of the CPD activities which influence RNs participation in the CPD programme in Abu Dhabi. As part of this mixed method study, it is important to look to the objective reality in order to identify the influencing factors. This is represented by choosing a quantitative approach to survey these factors through a self-reported questionnaire from the perspective of RNs. This approach is a strong driving force towards generalising and transferring the findings to other settings and situations or making claims about the population (Creswell et al., 2018).

The descriptive design aims to gather information about certain variables without changing the environment or manipulating them and consequently, without looking at possible cause and effect. What differentiates it from the observational designs is that it does not include comparison groups (Drummond and Murphy-Reyes, 2018). Grove,

Burns and Gray (2013) stated that the descriptive designs “*may be used to develop theory, identify problems with current practice, justify current practice, make judgements, or determine what others in similar situations are doing*” (p.125). Examining the intrinsic and extrinsic factors that influence RNs is a way of identifying the problems with the current CPD programmes in a descriptive manner without manipulating any variable, changing the environment, or conducting any sort of correlation to study the relationship between variables.

On the other hand, the cross-sectional design involves collecting data at one point of time regardless of the period that might vary according to the context of the study. The randomised cross-sectional design is utilised for the needs assessment of research dealing with the development and evaluation of a programme which is the case in this study as the aim of the study is not targeting studying the changes over the time longitudinally (De Vos et al., 2011). The most common advantages of the cross-sectional study is that it is inexpensive, can estimate the trend of the RNs’ perception, and do not have much to follow up (Drummond et al., 2018).

3.6.2 Population, Sampling, and Sample

3.6.2.1 Population

The population of phase two is the same population accessed in the first qualitative phase.

3.6.2.2 Sampling

Similar to phase one, the population groups and subgroups of phase two were staged in three levels according to the geographical distribution (three regions), type of governor (government and private sector), and type of facility (hospitals and clinics and centres) respectively (Figure 3.7).

In this quantitative phase, the data was descriptive and collected cross-sectionally through a constructed questionnaire. To achieve the maximum representation of the very large and distributed population across Abu Dhabi, probability stratified sampling was the

choice to attain the successive random sampling. It has the advantage of concentrating on the CPD issue in specific sections of the geographical areas and consequently, saves cost and time (Levy and Lemeshow, 2013; Botma et al., 2010; De Vos et al., 2011). The units, RNs, were grouped in strata according to three levels (illustrated in figure 3.7).

The selection of participants in the probability stratified sampling was based on “Probability Proportional to Size” (PPS) sampling which is referred to as a “Proportionate Stratified Random Sampling”. The PPS is very effective in settings where the units within the strata have unequal sizes in order to attain more precise estimators of the population parameters (Alam, Sumy and Parh, 2015).

The inclusion/exclusion criteria for the sample aims to include all RNs who have renewed their nursing licence in Abu Dhabi at least once to guarantee that participants have experienced the mandatory CPD process which is a pre-requisite for the licence renewal. On the other hand, due to the huge number of healthcare facilities with either a very small number of RNs or nil, the sampling purposively excluded all facilities with 10 RNs or fewer and eventually excluded RNs employed by those facilities.

Thus, in stage one of the multistage sampling, the included facilities in the sampling process were reduced from the total population (N), 1,154 facilities, to 165 facilities. The 165 included facilities that accounted for the majority of RNS; 16,770 out of 18,910. However, the number of the included RNs who had renewed their licence at least once, within the included facilities, was not identified by the researcher due to the conservative manner of most of the facilities and their reluctance to share the RNs’ information. Therefore, the researcher requested the facilities to exclude the RNs who had not renewed their nursing licence at least once and guided them on the proper randomisation procedures (Annexure C – Randomization Technique and Procedure) as per the selected sample from the facility.

In stage two, a stratified proportional to size sampling was used to determine proportional sample size within the facilities in each region. Stratified random sampling examines the

characteristics of a population group and breaks the population down into strata. Dividing the population by strata helped the researcher to easily choose the appropriate number of RNs from each stratum, based on proportions of the population. This was achieved by adopting a method proposed by Barreiro and Albandoz (2001) which is based on the following formula:

$$n_i = n \cdot \frac{N_i}{N}$$

Where,

n_i = sample size for each stratum

n = required sample size

N_i = population size for each stratum

N = size of the population

The proportional sample size for each stratum with the number of facilities used in this study is illustrated in table 3.6.

Table 3.6: Sampling and Sample Overview of Phase Two

Sampling	Abu Dhabi				Al Ain				Al Dhafra			
	G		P		G		P		G		P	
	H	C	H	C	H	C	H	C	H	C	H	C
All Facilities	7	35	28	708	3	27	12	281	6	8	1	38
Facilities with >10 RNs	7	13	28	63	3	11	12	18	6	1	1	2
N	5012	460	4776	3063	1897	361	1553	1034	278	20	210	246
N_i	5012	400	4776	1633	1897	269	1553	588	278	14	210	140
Actual n_i (378)	112	9	108	37	43	6	35	13	6	1	5	3
$n_{i(400)}$ including non-response	116	12	111	41	26	10	38	16	10	4	5	7
Pilot n_i	12	1	11	4	3	1	4	2	1	0	1	1

G: Government facility

P: Private facility

H: Hospital

C: Clinic or Centre

The third stage of sampling was to randomly select one health care facility to be used for stratum in each region.

Furthermore, a simple random sampling without replacement was used as the last stage of sampling to select participants from the 16,770 population. This process ensured that each nurse in the population has a known and equal probability of being selected and being part of the study. The simple random sampling was done for RNs in the selected facility in each stratum using the Microsoft Office Excel spreadsheet as a powerful tool to run randomisation features.

3.6.2.3 Sample

To determine a representative sample size, the study adopted a sample size table suggested by Gill, Johnson and Clark (2010). At 5% precision level, where confidence level is 95% and degree of variability is 50%, an appropriate sample size for 25,000 population of nurses is 378 RNs. In order to cover for unavailability of respondents and non-response in this study, a sample of 400 nurses was targeted (table 3.1) (Gillham, 2015).

3.6.3 Data Collection

Due to the nature of this mixed method study as exploratory descriptive, the data collection tool in the quantitative phase was a cross-sectional self-reported questionnaire. The questionnaire was very effective in gathering a large amount of data from a large sample in a relatively short time (Gillham, 2015). The data from the quantitative phase was used to assist in the interpretation of the qualitative data obtained in phase one (Creswell, 2009).

The self-reported modified questionnaire was based on the Q-PDN (Annexure D – modified Q-PDN). The original questionnaire was developed in the Netherlands in 2014 by a group of four researchers who conducted several studies about the nursing CPD (Brekelmans et al., 2015). The questionnaire tests the effectiveness of nursing CPD in terms of four constructs; motives, conditions, important activities, and “actually”

undertaken CPD activities. The reliability analysis showed satisfactory to good Cronbach's alpha scores on the four factors; ranging from 0.7 to 0.89. The same researchers used the same questionnaire later in 2016 in an exploratory cross-sectional study in the Netherlands. Permission to use and modify the Q-PDN questionnaire was granted by Dr Brekelmans in 24 July 2018 via Email.

3.6.3.1 Development of the Instrument

The original validated Q-PDN questionnaire was modified according to four aspects; theoretical underpinnings, literature review, findings of phase one, and Abu Dhabi local setting and context. The original Q-PDN consists of two parts; general characteristics and CPD questions. The general characteristics include questions about eight elements; gender, age, employment status, work experience, current unit, level of education, certification, and current main position. On the other hand, the CPD questions consists of four constructs with a total of 54 items; motives (12 items), conditions (12 items), important activities (15 items), and undertaken activities (15 items; similar to the important activities). The modifications are affected in all parts of the questionnaire, including the title, by adding the term "modified" to become "modified Q-PDN".

3.6.3.1.1 Part One: General Characteristics

The eight elements of the original questionnaire are "gender", "age", "employment status", "work experience", "current unit", "level of education", "certification", and "current main position". The modified questionnaire includes 11 elements as follows: "gender", "age", "nationality", "total years of experience", "years of experience in Abu Dhabi", "level of education", "facility's region in Abu Dhabi", "facility's type", "facility's governor", "current unit/ward", and "current main position". The modifications and their justification are according to the UAE local setting and context (summarised in table 3.7).

3.6.3.1.2 Part Two: CPD Questions

The second part of the original questionnaire includes four constructs; motives, conditions, important activities, and undertaken activities (Figure 3.9). The developers of

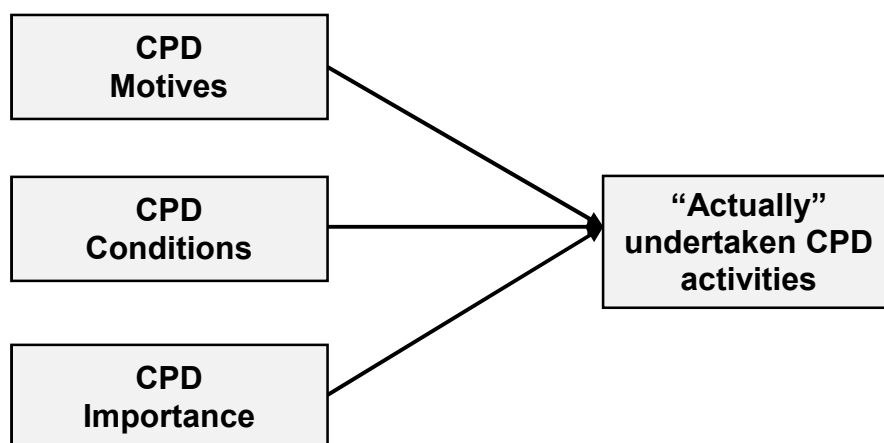
the original questionnaire built the four constructs on the conclusion of Hemmington (2000) stating that:

“the actual participation in CPD activities is influenced by at least three factors; motives of nurses, the importance they attached to CPD, and the conditions that they need to see in place in the work environment to participate in CPD activities”
(Brekelmans et al., 2015:232).

Table 3.7: Questionnaire's Modifications of Part One

Original Questionnaire's elements	Modified Questionnaire's elements	Modification	Justification
Gender	Gender	<ul style="list-style-type: none"> No changes Two options; male or female 	No changes
Age	Age	<ul style="list-style-type: none"> No changes on the element Replaced typing the number of years with 5-year age range options 	The 5-year age range presents the trends in a clear manner
None	Nationality	<ul style="list-style-type: none"> The nationality was added 	To identify the educational and experience background of participants as more than 97% of RNs in Abu Dhabi are expatriates with different backgrounds
Employment status	None	<ul style="list-style-type: none"> Employment status was removed 	All RNs in Abu Dhabi are full-time employees as per the local manpower by-laws
Work experience	Total years of experience as a Registered Nurse	<ul style="list-style-type: none"> The work experience was replaced by a clearer title "total years of experience" Replaced typing the number of years with 5-year experience range options 	Work experience might include other elements than the years of experience such as specialty
	Years of experience as a Registered Nurse in Abu Dhabi	<ul style="list-style-type: none"> "The years of experience in Abu Dhabi" element was added The years are identified in the form of 5-year experience range options 	To identify how much experience RNs have in the CPD system in Abu Dhabi
Level of education	Level of education	<ul style="list-style-type: none"> No Changes on the element The "associate degree" was replaced by a diploma degree 	"Diploma degree" is very common in Abu Dhabi
None	Facility's region in Abu Dhabi	<ul style="list-style-type: none"> The three elements were added 	To compare among the different strata of participants according to: <ul style="list-style-type: none"> Region (three regions) Type of facility (hospital and clinic/centre) Governor (government and private)
None	Type of Facility		
None	Type of governor		
Current unit	Current unit/ward	<ul style="list-style-type: none"> No changes 	No changes
Current main position	Current main position	<ul style="list-style-type: none"> No changes on the element The list of positions was modified 	According to the recognised positions in Abu Dhabi
certification	None	<ul style="list-style-type: none"> The certification was removed 	Its irrelevancy to the study and the setting as certification is not a requirement in Abu Dhabi.

Figure 3.9: Factors Influencing Nurses' "actually" undertaken CPD activities (four Constructs)



The developers formulated the items based on the literature review where they adopted several single items from two existing instruments. The first one was a questionnaire investigating CPD issues relevant to RNs and midwives. It examined their CPD activities, career choices, competency achievement, and maintenance, with relevance to personal and professional needs (National Council for the Professional Development of Nursing and Midwifery, 2004). The second instrument was a questionnaire, developed by the Dutch Institute for Health Care Research, which was an investigation into the nurses' opinions about CPD (Speet and Francke, 2004).

In the modified questionnaire, the four constructs were not changed as they represent a solid base for the study's inquiry. The items within the constructs were modified according to three perspectives; theoretical underpinnings, literature review, and findings of phase one. The "Motives" construct was aligned with the Continuum of Motivation of the Self-Determination Theory (SDT), the "Conditions" Construct was aligned with Kanter's Structural Empowerment Model, and the "Activities" and "Actually Undertaken Activities" constructs were aligned with the Bloom's Taxonomy of Learning Domains. The constructs, theoretical underpinning, emerged factors, and number of items are illustrated in figure 3.10.

Figure 3.10: Diagram of the Theoretical Underpinning of the Constructs

Constructs	1 "Motives"	2 "Conditions"	3 "Activities"	4 "Activities Undertaken"
Emerged Factors in Q-PDN	3 factors	2 factors	3 factors	3 factors
Emerged Factors in modified Q-PDN	4 factors	2 factors	3 factors	3 factors
Theoretical Underpinning	Self-Determination Theory (SDT) Continuum of Motivation	Kanter's Structural Empowerment Model	Bloom's Taxonomy of Learning Domains	Bloom's Taxonomy of Learning Domains
Q-PDN Items	12	12	15	15
Modified Q-PDN Items	16	13	16	16

Same items in Constructs 3 and 4

The original and modified Q-PDS sought a response on a five-point Likert scale with ratings from 1 to 5. The Likert scale is the most common scale to measure the scores from a quantitative survey. The scores are utilised to differentiate among the respondents' categories according to their experiences in certain phenomena (Oppenheim, 2000; Gillham, 2015). The range of meaning of the rating scale in each construct is explained in table 3.8 whereas the detailed description is explained within each construct. The meaning of the scores has been modified partially, with more definite terms to add more differentiation among the scores.

Table 3.8: Explanation of the Positions' Meaning on the Likert Scales for Each Construct in the Original and Modified Q-PDN

Construct	Meaning of Likert Scale 1-5 in the Original Q-PDN	Meaning of Likert Scale 1-5 in the Modified Q-PDN
Motives	Mainly Disagree to Mainly Agree	Strongly Disagree to Strongly Agree
Conditions	Mainly Disagree to Mainly Agree	Strongly Disagree to Strongly Agree
Important Activities	Not Important at all to Very Important	Not Important at all to Very Important
Activities Actually Undertaken	Never to very often	Never to Very Frequently

3.6.3.1.2.1 Construct One: Motives

The “motives” construct included 12 items over three factors that emerged from the analysis of the original questionnaire. The three factors are “personal and professional development”, “requirements”, and “career opportunities”. However, the questionnaire’s developers did not identify a theoretical underpinning for developing the items. In the modified questionnaire, the construct was re-built in alignment with the continuum of motivation of the Self-Determination Theory (SDT). In addition to the “amotivation” dimension that is not considered in the questionnaire as it does not have any source of motivation, the taxonomy encompasses five major dimensions (one intrinsic and four extrinsic) of motivation dimensions with different regulations and sources (Deci et al., 2000; Gagné et al., 2005).

The modifications included removing one item, partially amending two items, and adding five new items resulting in a total of 16 items. In details, the original 12 items were aligned to the continuum of motivation of the SDT where it has been found that none of the items cover the intrinsic motivation which would bias the findings of the study. The modifications and alignments are summarised in table 3.9.

For this, three new items were added to the motives construct. The same three items that were concluded from the analysis of the previous qualitative phase and from the literature review were used. The three items are concerned with interest in the activity itself, enjoyment, and networking. The fourth added item is about updating and/or gaining new knowledge which falls under the professional and personal development factor and is aligned with the “Integrated Regulation”. This item was concluded from the analysis of phase one. The last added item is to meet the requirements of the nursing licensure renewal which falls under the requirements factors and is aligned with the “External Regulation”. Like the fourth item, it was concluded from the analysis of phase one.

On the other hand, the removed item is concerned about developing the leadership abilities where it falls under the career opportunity factor and is aligned with the “Introjection Regulation”. It was removed due to its inconvenience as it covers one specific

competency that is already covered under the many other developmental items disregarding the other nursing competencies. Finally, the modification of the two items aimed to add more clarification to the meaning. The meaning of the five-point Likert scale rating in the “motives” construct is explained in table 3.10.

Table 3.9: “Motives” Construct’s Modifications and Alignment with the SDTs’ Continuum of Motivation

Q-PDN Factors	#	Q-PDN Items	SDT Type of Regulation
I take part in CPD activities to:			
Personal and professional development	1	...because further professional development is important to me	Integrated
	2	...to improve my current qualifications	External
	3	...to carry out my work better	Identified
	-	<u>... to update/refresh my knowledge, and/or gain new knowledge</u>	Integrated
	4	...to increase the quality of healthcare	Identified
	5	...to make a positive contribution to nursing practice	Identified
Requirements	6	...to meet the requirements of the organisation where I work	External
	-	<u>... to meet the requirements of the licensure renewal</u>	External
	7	...to prove to my employer that I am professionally competent	External
	8	...because this is considered highly important in my professional environment	Introjected
Career opportunities	9	...to increase promotion opportunities	External
	10	...to achieve a higher level of training	Introjected
	11	...to support my career <u>potential/choices</u>	Identified
	12	...to improve my leadership abilities	Introjected
<u>Personal Factors</u>	-	<u>... because I am interested in the activity itself</u>	Intrinsic
	-	<u>... to entertain and relieve the stress of my job</u>	Intrinsic
	-	<u>... to network with health professionals</u>	Intrinsic

Font: Original items

Font: Added item/text

~~Font:~~ Removed Item/text

Table 3.10: Explanation of the Positions' Meaning on the Likert Scale for the "Motives" Construct

Likert Scale Rating	Meaning in the Original Q-PDN	Meaning in the Modified Q-PDN
1	Mainly Disagree	Strongly Disagree
2	Partially Disagree	Disagree
3	Neither Agree nor Disagree	Uncertain
4	Partially Agree	Agree
5	Mainly Agree	Strongly Disagree

3.6.3.1.2.2 Construct Two: Conditions

The "Conditions" construct included 12 items over two factors that emerged from the analysis of the original questionnaire. The two factors are "intangible conditions" and "material conditions". However, the questionnaire's developers did not identify a theoretical underpinning for developing the items. In the modified questionnaire, the construct was re-built in alignment with Kanter's Structural Empowerment Model. The model indicates that empowerment requires having access to four structures; lines of information, support, resources, and opportunities to learn and grow (Kanter, 1993; Laschinger et al., 2001).

The modifications included partial amendment of four items and the addition of one new item resulting in a total of 13 items. No items were removed from the original questionnaire. In details, the original 12 items were aligned to Kanter's Structural Empowerment Model. The modifications and alignment are summarised in table 3.11.

Thus, one new item was added to the conditions construct. The item is concerned with organisation's policy about CPD. It falls under the "intangible conditions" and is aligned with the "access to information" line of power. On the other hand, the modification of the four items aimed to add more clarification to the meaning. The meaning of the five-point Likert scale rating in the "conditions" construct is explained in table 3.12.

Table 3.11: “Conditions” Construct’s Modifications and Alignment with Kanter’s Structural Empowerment Model

Q-PDN Factors	#	Q-PDN Items	Kanter’s Model Structures
I take part in CPD activities:			
Intangible conditions	1	...if I receive career guidance	Support
	2	...if I receive an annual appraisal	Support
	3	...if my colleagues coach me	Support
	4	...if taking part in CPD activities allows me to have a say in ward/team policy	Opportunity
	5	...if I gain more independence <i>in my work</i>	Opportunity
	6	...if the CPD activities have a clear career perspective	Information
	-	<i>... if the organisation’s policies support nurses CPD</i>	Information
	7	...if my immediate supervisor coaches me	Support
	8	...if other positions are offered within my organisation	Opportunity
9	...if I receive support from my supervisor	Support	
Material conditions	10	...if the expenses are fully reimbursed <i>or funded</i> by the employer	Resources
	11	...if suitable supplementary training courses are offered by my immediate supervisor <i>the organisation (suitable in terms of time, location, and relevancy)</i>	Resources
	12	...if my supervisor provides me <i>I am provided</i> with the necessary time <i>and/or convenient work schedule</i>	Resources

Font: Original items

Font: Added item/text

~~Font:~~ Removed Item/text

Table 3.12: Explanation of the Positions’ Meaning on the Likert Scale for the “Conditions” Construct

Likert Scale Rating	Meaning in the Original Q-PDN	Meaning in the Modified Q-PDN
1	Mainly Disagree	Strongly Disagree
2	Partially Disagree	Disagree
3	Neither Agree nor Disagree	Uncertain
4	Partially Agree	Agree
5	Mainly Agree	Strongly Disagree

3.6.3.1.2.3 Constructs Three and Four: Important Activities and Actually Undertaken Activities

The “Important Activities” and “Actually Undertaken Activities” constructs have similar items as both cover the activities. The constructs included 15 items over three factors that emerged from the analysis of the original questionnaire. The three factors are “participation in research”, “clinical practice development”, and “participation in organisation development”. However, the questionnaire’s developers did not identify a theoretical underpinning for developing the items. In the modified questionnaire, the constructs were re-built in alignment with Bloom’s Taxonomy of Learning (Anderson et al., 2001). The taxonomy’s three learning domains are cognitive (thinking), psychomotor (physical/kinesthetic), and affective (emotion/feeling).

The modifications included removing two items, partially amending one item, and adding four new items, resulting in a total of 17 items. In detail, the original 15 items were aligned to Bloom’s Taxonomy of Learning where it has been found that none of the items cover the psychomotor domain which would bias the findings of the study. The modifications and alignment with Bloom’s Taxonomy are summarised in table 3.13.

Thus, two items were removed from the construct concerned with “training courses” and “serving on the editorial board of a professional journal”. Both items fall under the “participation in research” factor. The “training courses” were removed as this categorisation does not fit the factor’s theme and does not clarify the context. The second item was removed because it is inconvenient to, and uncommon in, the Abu Dhabi context.

On the other hand, three new items were added to both constructs. They were concluded from the analysis of the previous qualitative phase and from the literature review. Two items fall under the “clinical practice development” factor where they are concerned with “attending hands-on training courses” under the psychomotor domain, and one cognitive item; “online courses”. The third item is concerned with the “journal clubs” and aligned with the “participation in research” factor under the cognitive domain and replaced

“serving on the editorial board of a professional journal”. Finally, the modification of one item was aiming to add more clarification to the meaning. The meanings of the five-point Likert scale rating in the “Important Activities” and “Activities Actually Undertaken” constructs are explained in tables 3.14 and 3.15 respectively.

Table 3.13: “Important Activities” and “Actually Undertaken Activities” Constructs’ Modifications and Alignment with Bloom’s Taxonomy of Learning Domains

Q-PDN Factors	#	Q-PDN Items	Bloom’s Taxonomy of Learning Domains
Construct 3 (important Activities): I take part in CPD activities:			
Construct 4 (Actually undertaken Activities): Respond to the questions below.			
Participation in Research	1	Training courses	Unrecognized
	2	Reviewing medical literature with regard to <i>about</i> best practices	Cognitive
	3	Carrying out research	Cognitive
	4	Writing articles for professional journals	Cognitive
	5	Serving on the editorial board of a professional journal	Cognitive
	-	<i>Participating in Journal Clubs</i>	Cognitive
Clinical Practice Development	6	Attending Following short courses (2-8 h <i>do not lead to a degree), lectures, conferences, and seminars</i>	Cognitive
	-	<i>Attending online (web-based learning) courses and/or lectures (do not lead to a degree)</i>	Cognitive
	-	<i>Attending hands-on training courses including workshops</i>	<i>Psychomotor</i>
	7	Informing my supervisor if I notice any developments at work that could have an adverse effect on professional practice	Affective
	8	Making sure that I keep up to date with professional developments	Cognitive
	9	Reflecting critically on practical situations	Affective
	10	Determining whether I performed well and whether I could perform better next time	Affective
Participation in Organisation Development	11	Participation in policy development	Cognitive
	12	Making sure that I keep up to date with policy developments	Cognitive
	13	Participating in recruitment and selection interviews with new members of staff	Cognitive
	14	Participating in reflection and/or Intercollegial consultation meetings	Affective
	15	Participating in internal projects	Cognitive

Font: Original items

Font: Added item/text

~~Font:~~ Removed Item/text

Table 3.14: Explanation of the Positions' Meaning on the Likert Scale for the "Important Activities" Construct

Likert Scale Rating	Meaning in the Original Q-PDN	Meaning in the Modified Q-PDN
1	Not Important at All	Not Important at All
2	Not Important	Of Little Importance
3	Somewhat Important	Moderately Important
4	Important	Important
5	Very Important	Very Important

Table 3.15: Explanation of the Positions' Meaning on the Likert Scale for the "Actually Undertaken Activities" Construct

Likert Scale Rating	Meaning in the Original Q-PDN	Meaning in the Modified Q-PDN
1	Never	Never
2	Occasionally	Rarely
3	Sometimes	Occasionally
4	Quite Often	Frequently
5	Very Often	Vey Frequently

3.6.3.1.3 Part Three: Additional Open-Ended Questions

A third open-ended questions' part was added to the questionnaire. It included three questions. The first question is concerned with the RNs' opinion about the "three best CPD practices in Abu Dhabi" while the second question is about the "three most required improvement actions for the CPD practices in Abu Dhabi". Both are intended to contribute directly to the third phase of the study to develop effective CPD strategies. Nevertheless, the third question is an "insurance question" where it has a unique purpose to ensure that all critical aspects were covered by asking about any other comments and/or feedback that was not covered in the questionnaire (Krueger et al., 2015).

3.6.3.2 Pilot the Questionnaire

The modified questionnaire was pre-tested in two forms. Firstly, it was reviewed by experts in the nursing research and questionnaire construction field. They evaluated it for readability and content-related validity, including face validity and construct validity.

Based on the review, clarity was added to two demographic elements, one CPD item was removed, and another was re-considered.

Second, it was piloted with a sample from participants with the same inclusion/exclusion criteria but was not included in the sample. The questionnaire was pre-tested on 40 nurses (10% of the study sample size that counts 400) and 18 RNs responded. These 18 RNs were not part of the survey. After the piloting, the questionnaire was not adjusted as no issues were highlighted.

A set of elements were determined on the pre-test of the questionnaire such as the questions' clarity, instructions' effectiveness, completeness of response sets, the required time to complete it, the data-gathering techniques, any offensive or objectionable parts or that could lead to misunderstanding, sensibility of the items' sequence (Botma et al., 2010). The findings of the pilot study were used for validating the questionnaire; not as part of the questionnaire's results interpretation.

3.6.3.3 Data Collection Procedures

The self-reported questionnaire was an online questionnaire. The online method to distribute and collect the questionnaires is very effective in such a sprawling geographical setting. The online version of the questionnaire was designed on "SurveyMonkey" software which is an online survey development cloud-based software.

The questionnaire's link was sent to randomly selected participants via e-mail. Certain facilities did not allow sharing of RNs contact details. They were instructed on how to conduct the randomisation where they sent the link to the randomly selected RNs. Others preferred to send the questionnaire to RNs after running the randomisation process by the researcher. While few asked the researcher to run the randomisation and send the link directly to the selected RNs. The Questionnaire PICD's information were merged with the e-questionnaire (Annexure E – Questionnaire PICD). The data collection started on 1 July and closed on 14 August. Reminders were sent to the facilities with low response

rates on an average of a reminder every two weeks. The average time spent completing the questionnaire was 11 minutes.

3.6.4 Data Analysis

For investigation of the quantitative data collection, the application of statistical software such as the IBM SPSS package was applied. Statistical analysis comprises two types, i.e. descriptive and inferential, which were conducted in this study. The aim of selecting statistical analysis is informed decision-making by using descriptive analysis for data summarisation and inferential analysis for prediction or testing of relationships (Babbie, 2010; Gillham, 2015). The quantitative statistics were carried on under the supervision of a statistician (Annexure F – Statistician Agreement).

Upon collection of the responses, the data was exported using the Microsoft Excel format which allows for easier conversion to SPSS. Validation and exploration of data was performed to check for inconsistencies in captured data. Coding was conducted by assigning a numerical code for each response option per question. It is a mandatory requirement that all responses collected are converted to numerical codes. Coding is conducted only for closed ended questions.

The statistical analysis methods are summarised in table 3.16 (Babbie, 2010; Gillham, 2015; Tavakol and Dennick, 2011):

Table 3.16: List of Statistical Analysis Methods and Justification

Statistical Analysis	Justification
Cronbach Alpha	Used to determine the internal consistency (reliability) within the data collected.
Pearson Coefficient	Used to examine the validity of the variables. Validity is the determination of whether the test is able to measure what it is utilised to measure.
Frequency Analysis and Descriptive statistics	This allows examination of the responses for the questions individually and includes examination of the mean and standard deviation. The limitation is that the findings do not lead to conclusion and hence, should be followed by other statistical tests. These are used only to describing the data.
Cross-tabulation	This test allows tabulation between the key variables in order to examine the trends in inter-relation between the variables. It is highly beneficial to explore variables in detail.
Correlation	The most commonly applied correlation test is Pearson Correlation wherein the coefficient is utilised to study the relationship strength between two variables. The coefficient can be either positive or negative, implying the relationship is positive or negative respectively.
Regression	This test is conducted for hypothesis testing for examination of the relationships proposed.

3.7 PHASE THREE: QUALITATIVE APPRECIATIVE INQUIRY DESIGN AND METHODS

3.7.1 Design

The research question of phase three was “how can an effective CPD programme, that meets the needs of RNs, be developed, based on the needs of the RNs?” and it was answered by obtaining a set of objectives. The objectives are based on the 5D Cycle’s phases of the AI which are “Define”, “Discovery”, “Dream”, “Design”, and “Destiny” phases (Cooperrider et al., 2008). As per the last part of the study’s aim, to develop CPD strategies, the study reached the “Design” phase of the 5-D Cycle where the best possible CPD strategies were developed. The “Destiny” phase, which is the implementation phase, will be carried out at a later stage during the postdoctoral study.

Define Phase:

- Define the affirmative topic, CPD, and clarify the focus of inquiry; based on the findings of phases one and two.

Discovery Phase:

- Explore and describe what is working well and effectively in the existing CPD programmes and strategies.

Dream Phase:

- Identify the areas of improvement in the existing CPD programme and strategies.
- Describe the expected CPD programme activities in terms of content, provision, and outcomes.

Design Phase:

- Develop the best CPD strategies that would contribute to the improvement of the CPD programme.

Cooperirder and Whitney (2005) presented a practice-oriented definition of the AI as:

“The cooperative, co-evolutionary search for the best in people, their organizations, and the world around them. It involves systematic discovery of what gives life to an organization or a community when it is most effective and most capable in economic, ecological, and human terms” (p.8).

The history of AI goes back to the 1980s as an organisational development tool when Cooperrider questioned the wisdom of the problem-solving mentality with its focus on diagnosing what is wrong (Norum, 2012). This was as a restatement of the action research approach (Priest, Kaufman, Brunton and Seibel, 2013). He proposed an approach that is applicable to corporations and other organisations, helping them to improve their organisational structures and their competitiveness, profitability, and sustainability (Michael, 2005).

Cooperirder et al. (2005) added that AI gives a way to inquiry, imagination, and innovation; not negation, criticism, and spiralling diagnosis. Michael (2005) emphasised that the:

“AI process not only looks to help an organisation to create images of its future but in doing so looks to create an energy, a renewed commitment to change and a sense of hope among the groups of people working to achieve that future” (p.222).

The AI has been adopted in phase three of this study due to its nature as a powerful research and change tool (Kristin et al., 2012). The “Nursing Key Players” were selected as participants since their recognition and appreciation, as key stakeholders, contributes to bringing innovative solutions to the problem (Whitney and Trosten-Bloom, 2010). The AI was used to assess the effectiveness of the CPD policies and strategies with the emphasis on identifying the areas for improvement (Connelly, 2015; Kristin et al., 2012). The generated power of AI is attained by using the 5-D Cycle that serves as the foundation on which change is built (Whitney et al., 2010:51).

3.7.1.1 AI Philosophical Perspective

From a philosophical perspective, AI is a social construction philosophy (Norum, 2012). It has been stated that AI is *“more than a method or technique...it is a way of living with, being with, and directly participating in the varieties of social organizations we are compelled to study”* (Cooperrider & Srivasa, 1987, p. 131 in Priest et al., 2013). This philosophy allows the AI approach to be presented as a positive change approach. This can be expressed in three ways; fully affirmative, inquiry-based, and improvisational.

First, being fully affirmative, it builds on the previous successes and inspires positive possibilities without addressing the negative and deficit approaches.

Second, as an inquiry-based approach, the “art of the question” is considered at the core of the AI that considers all questions as important. However, what matters in the AI is the nature of the question as this nature identifies the future direction. The first and essential step in the AI process is the appreciative interview. Otherwise, it is not an inquiry and eventually there will be neither openness nor transformation. The absence of the interview

turns the “Appreciative Inquiry” to an “Appreciative Perspective” which yields to openness and discovery.

Third, the improvisational aspect of the AI comes from its non-singular methodology. Each AI is “a new creation” that starts with a clear purpose but, in many cases, ends unpredictably, due to the unique nature of each setting (Whitney et al., 2010:51).

3.7.1.2 AI Principles

AI has been featured by five core principles; (1) The Constructionist Principle, (2) The Principle of Simultaneity, (3) The Poetic Principle, (4) The Anticipatory Principle, and (5) The Positive Principle (Cooperrider et al., 2008).

First, the constructionist principle comes from the belief that the reality is “subjective rather than objective”. The language plays a critical role in this principle where communication is placed at the core of the change and organisations (Stratton-Berkessel, 2010). Whitney et al. (2010) referred to this and summarised the discussion by stating “*words create worlds*” (p.51). Moreover, Cooperrider et al. (2008) stated that “*the way of knowing is fateful*”. Thus, the way of communication identifies the outcome of the conversation. Finally, it can be concluded that “meaning is made in conversation, reality is created in communication, and knowledge is generated through social interaction” (Whitney et al., 2010:51).

Second, the principle of simultaneity is represented by the belief that “inquiry creates change” where the change process starts from the moment the first question is asked. It is believed that the inquiry is the intervention itself and the key to the transformation process as they are not two separate concepts.

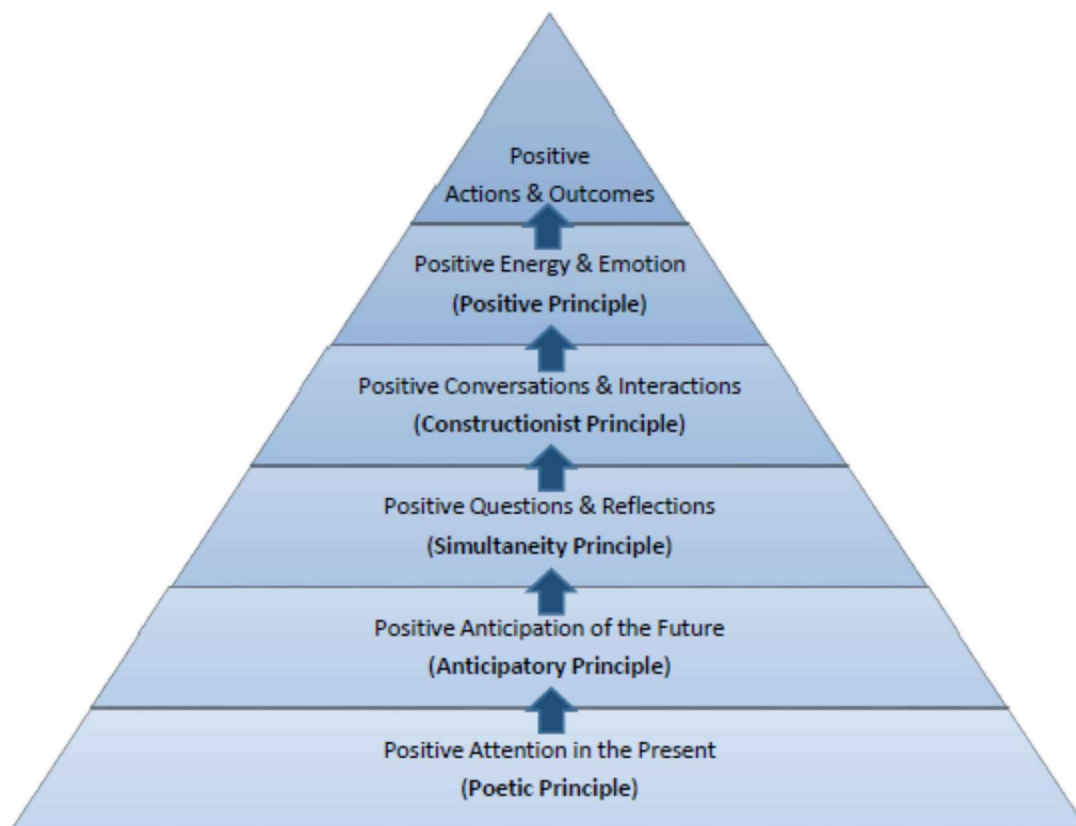
Third, the poetic principle has been explained by Cooperrider et al. (2008) by referring to the human organisations as an “open book” where each person has unique experiences and stories to tell. The choice of these stories crafts the topic that people pay attention to and subsequently make a difference in it; it is the people’s choice.

Fourth, the anticipatory principle emphasises the power of vision where imagination is the most important resource for the future image. Since the “images inspire action”, it is important to envision positive images about the future to act positively in the present.

Fifth, the positive principle is the most concrete principle. It emphasises the type of the questions as “positive questions lead to positive change” (Cooperrider et al., 2008; Stratton-Berkessel, 2010; Whitney et al., 2010).

The pyramid (Figure 3.11) illustrates how these principles are related to each other and work together to generate positive actions and outcomes.

Figure 3.11: AI Principles



Adopted from Moore and Charvat (2007)

3.7.1.3 Deficit-Based Change versus Positive Change

From a change management perspective, the AI presents a different perspective of the change. In contrast to the most common change management deficit approaches that focus on the problems, weaknesses and gaps, the AI focuses on the strengths and uncovers the hopes and dreams to amplify the “positive core”. Thus, the ultimate goal of AI is the transformation within the positive change process. Despite the fact that both approaches work, AI is more effective (Whitney et al., 2010:51).

3.7.1.4 Critique of AI

The AI has been criticised due to its focus on the positive experiences during the discovery phase which would invalidate the negative experiences and subsequently underestimate or suppress the discovery of possible critical negative events and meaningful discussion (Bushe, 2012). However, from the AI advocates’ perspective, Michael (2005) indicated that the dynamic nature of the AI allows participants to speak freely about their experiences rather than defending themselves or justifying their bad experiences, which can often yield a more nuanced understanding of the positive and negative experiences than would a problem-solving approach starting at the level of the negative. Besides, Acosta and Douthwaite (2005) shared their experience with the AI where they found that it can work in different settings, especially when conflict or a lack of progress prevail. However, they identified a critical condition for its success as it requires the key stakeholders’ support and commitment.

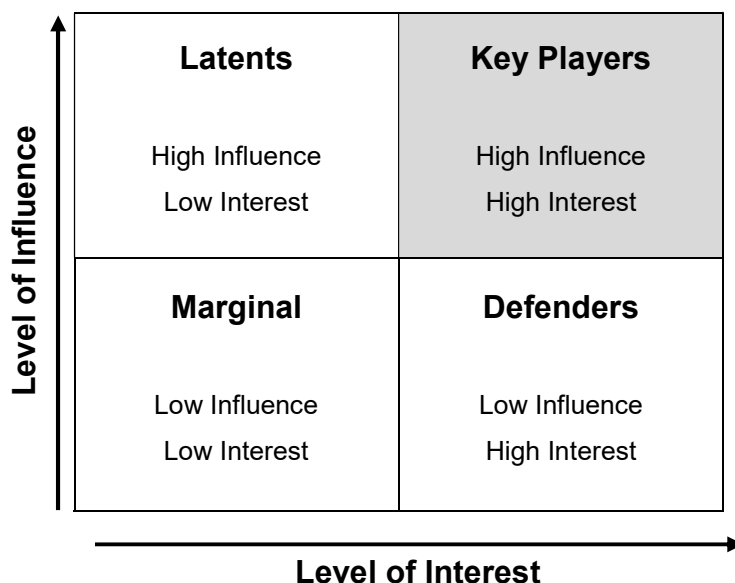
3.7.2 Population, Sampling, and Sample

3.7.2.1 Population

The target population for phase three was the “Nursing Key Players” in Abu Dhabi. The decision on the population for this phase was crucial for the quality of the developed strategy. It was based on the stakeholders’ analysis of the nursing population to identify the most interested and influential stakeholders (Mitchell, Agle and Wood, 1997). The

stakeholder is defined by Cook (2005) as “an individual or organization that is involved in or who will be affected by the project” (p.26). As illustrated in figure 3.12, the levels of influence and interest categorise the stakeholders under four groups. The target population for the AI is the nursing stakeholders with high influence and interest who are defined as “key players”. Both characteristics of the key players identify them as promoters which is considered key for the AI in order to develop CPD strategies (Mitchell et al., 1997). Thus, the key players represent the role of the nursing leaders in Abu Dhabi.

Figure 3.12: Stakeholders Analysis Grid



On the other hand, the participation of key players in AI would be affected by their availability due to other professional and personal commitments. Therefore, their delegates who assume the same characteristics are still considered key players. The delegation is an effective approach in such situations where the delegator delegates the full authority and responsibility to the delegatee whereas the delegator is still accountable for the outcomes (Cipriano, 2010).

3.7.2.2 Sampling

The sampling strategy for the AI is Key Informant (KI) sampling that is based on the stakeholders' analysis. The key informant is identified as purposive sampling (Payne and Payne, 2004). The population is the "key players" due to the impact of their influence, expertise, and knowledge in evaluating the CPD programmes in Abu Dhabi. The AI is viewed as a valuable research tool for interviewing in the field as it has been proven as a methodology for organisational change due to its emphasis on the use of innovative methods to study complex human systems (Nyaupane and Poudel, 2012; Michael, 2005). For this, the KI sampling contributes to selecting the key players as decision makers (De Vos et al., 2011).

In terms of the inclusion criteria, the KIs were directors of nursing, heads of nursing education departments, and heads of nursing tertiary education, or their delegates. The KIs were from a facility within the Emirate of Abu Dhabi; private and government hospitals and centres. Any key player from out of the parameters identified in the inclusion criteria were excluded.

3.7.2.3 Sample

Determining the sample size for the AI was based on the decisions taken about the AI menu of approaches that is discussed in detail in the data collection of the AI. However, in brief, the AI menu of approaches consists of three elements which are the change agenda, form of engagement, and inquiry strategy. According to the menu, the form of engagement was the "AI learning team". On the other hand, the interview process, which is part of the inquiry strategy, was the "Group Interview" which resembles the focus group for one interview. The recommended number of participants in the group interview is five to 15 members (Whitney et al., 2010:51). Hurt and McLaughlin (2012) indicated that it is best conducted with a group of five to seven at a time. A total of 13 invitations were sent while the final number of attendees were eight. The invitations and attendees are summarised in table 3.17. All participants were checked for eligibility according to the inclusion/exclusion criteria. More details about the recruitment process are explained in the next section.

3.7.3 Data Collection

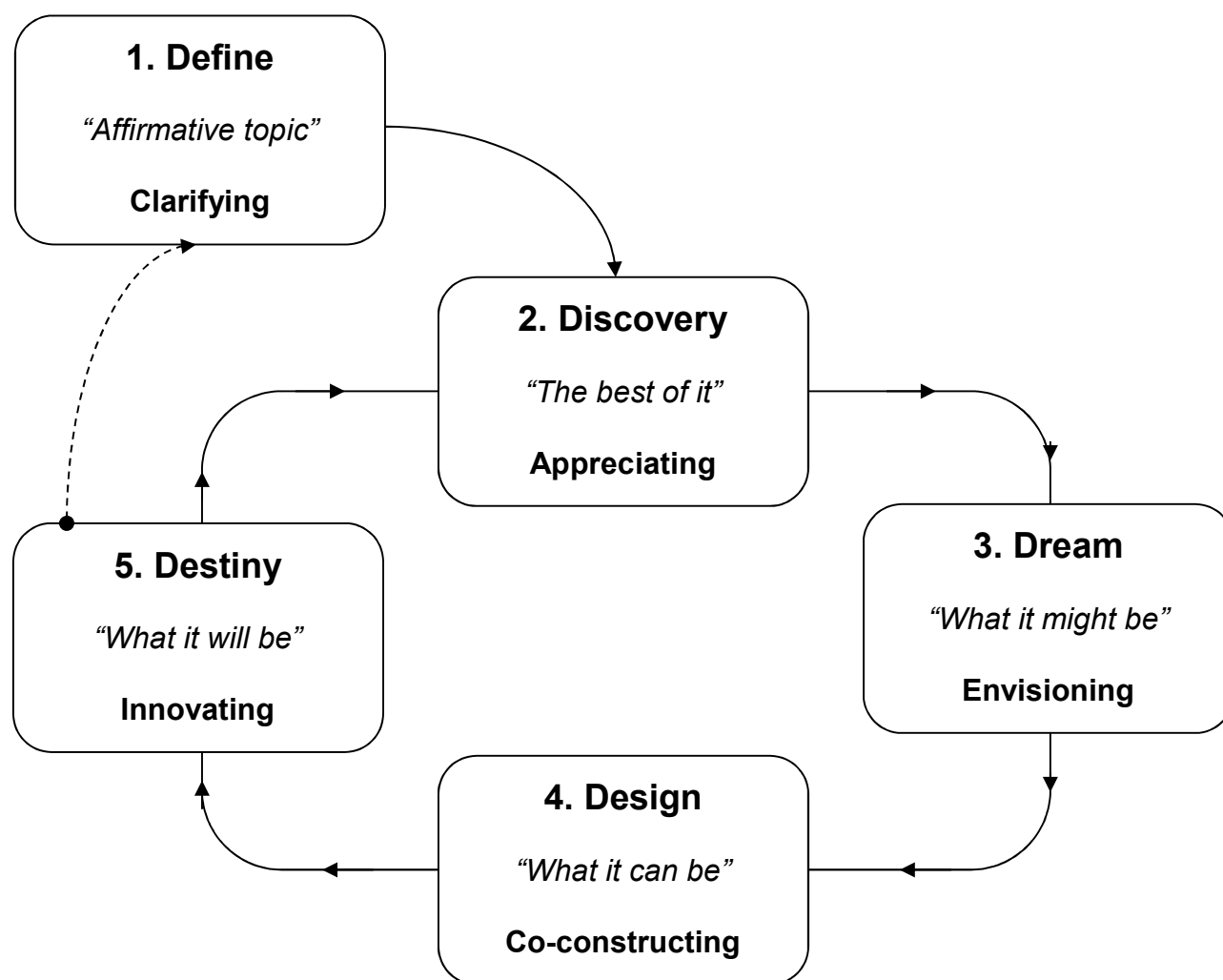
As indicated previously, the data was collected through a focus group; as a form of the “group interviews”. This decision was determined by the fact that AI is “loosely

Table 3.17: Overview of the AI Group Interview Invitations and Attendees

Invitation	Recipient	Attendee	Facility Included in Phases 1 and 2
Invitation 1	Director of Nursing Group of government hospitals and centres in one of the three regions	None Apologised one day before the Interview	Yes
Invitation 2	Director of Nursing Government Hospital	None Apologised two days before the Interview	Yes
Invitation 3	Director of Nursing All government centres in two of the three regions	Two attendees <ul style="list-style-type: none"> • Director of Nursing • Head of Nursing Education 	Yes
Invitation 4	Director of Nursing Government Hospital	None No Response	Yes
Invitation 5	Two Directors of Nursing Group of private hospitals and centers in the three regions	One attendee <ul style="list-style-type: none"> • Delegatee of the Director of Nursing 	Yes
Invitation 6	Director of Nursing Group of private hospitals and centres in the three regions	One attendee <ul style="list-style-type: none"> • Delegatee of the Director of Nursing 	No
Invitation 7	Acting Director of Nursing Private centre	None No Response	Yes
Invitation 8	Assistant Director of Nursing Private hospital	None Apologised one day before the Interview	Yes
Invitation 9	Assistant Director of Nursing Government hospital	One attendee <ul style="list-style-type: none"> • Assistant Director of Nursing 	No
Invitation 10	Assistant Director of Nursing Government hospital	One attendee <ul style="list-style-type: none"> • Delegatee of the Director of Nursing 	No
Invitation 11	Director of Nursing Government Corporate Office	None Apologised one day before the Interview	No
Invitation 12	Manager of Nursing Education Government Corporate Office	One attendee <ul style="list-style-type: none"> • Delegatee of the Manager of Nursing Education 	No
Invitation 13	Nursing Faculty Government School of Nursing	One attendee <ul style="list-style-type: none"> • Nursing Faculty 	No

structured” due to its improvisational feature. It is based on certain principles within the 5D-Cycle (Figure 3.13) that in turn, can be modified to suit the unique culture and situation of the case (Cooperrider et al., 2008; Whitney et al., 2010).

Figure 3.13: AI 5-D Cycle



3.7.3.1 Procedures and Participants’ Recruitment

Before starting the recruitment process, the researcher decided on the venue, date, and time of the AI interview. The venue was arranged in a 20+ seater meeting room in the administration headquarters of one of the government organisations. It was in the Abu

Dhabi region as it is the most convenient region for a central meeting. It is a common practice in the Emirate of Abu Dhabi to conduct meetings, which include participants from different regions, in the Abu Dhabi region. After deciding on the venue and identifying the dates of its availability, the researcher checked for the big healthcare events and meetings in Abu Dhabi to avoid mass decline of the invitation. Then, the day was decided, avoiding the first and last working days of the week as they are usually busy days for most of the key players. The initial time was a half-day morning session, but was then reduced to a three-hour morning session for the key players' convenience.

The recruitment process of the key players started by identifying the potential participants based on the stakeholders' analysis and the inclusion/exclusion criteria. The initial identification included 20 key players who were contacted by the researcher, initially for icebreaking. Icebreaking is an important step with people with high authority and in leadership positions. The first means of communication was a phone call, briefing them about the AI interview and then followed by an invitation e-mail. As a result of the phone call, some of them were available to answer the calls, whereas others appreciated the invitation, but apologised due to their involvement in other official commitments. Delegating a delegatee participant with the same characteristics was negotiated and agreed on with them. Afterwards, 13 official calendar invitations were sent to the confirmed key players or their delegates where many of them either declined the invitation due to urgent commitments or forwarded it to a delegatee in return. As a result, a total of eight participants attended the AI interview (table 3.17).

On the day of the interview, the same process as the focus groups in phase one was followed in terms of greeting the participants and signing the PICD (Annexure G – Appreciative Inquiry PICD). Similarly, during the interview, the role of the researcher as a facilitator and the interview's setting and setup were also similar to the process in phase one. The language of discussion was the official business language in Abu Dhabi, English, and translation was not needed.

Similarly, the interview was recorded by audiotaping for evidence; not analysis purposes. The main material of the AI interview was participants' work and notes on the flipchart papers that reflect the progress through the different phases. The details of the interview's procedures are discussed in the next section; AI 5D-Cycle.

3.7.3.2 AI 5-D Cycle

The 5Ds model was adopted in implementing the AI as it allows nurturing the positive environment and engagement in a systematic manner (Whitney et al., 2010; Cooperrider and Whitney, 2005). At the beginning, there was no agreed-on model until the late 1990s when the "4Ds model appeared and has come to be so strongly associated with AI. However, after few years, the 4Ds model was critiqued by some practitioners as it does not include identification of the inquiry itself where the "Clergy Leadership Institute" in the U.S. suggested 'Define' as the first step to become the 5Ds model (Bushe, 2012).

To achieve the goal of each phase within the 5-D Cycle, the emphasis was on positive affirmative questions aiming to employ the concepts of positive psychology to engage and encourage strengths and overcome weaknesses (Kowalski, 2008). Specifically, the Define cycle is about defining the CPD programme as an affirmative topic and clarifying the inquiry that would facilitate the initiation of the Discovery cycle. For this, the researcher, as a facilitator, presented the study, purpose, processes, and findings of the previous phases. The Discovery cycle is where the identification of what is working well happened where more emphasis on the findings and their discussion was the key topic. Additionally, the nursing directors presented their individual experiences. The Dream cycle is about envisioning of what would work well in the future where the nursing directors presented their ideas as potential strategies. The Design cycle is about planning and prioritising what would work very well in the future where the nursing directors agreed on a set of plans which was formulated as a strategy. Lastly, the Destiny cycle is the implementation of the design (Cooperrider et al., 2005). By closing-up the fourth cycle, Design phase, the study's aim was achieved completely by developing CPD strategies.

3.7.3.2.1 Define

The first step in the AI is identifying the affirmative topic that guides all phases of the 5-D Cycle. In certain situations, the affirmative topics are identified after meeting the people and asking them positive discovery and dream questions. On the other hand, it has been proven that some organisations succeeded with the pre-selected topic(s). The affirmative topic of this AI is pre-selected as it is the core of this study; “CPD Strategies”. This topic is aligned with the study’s aim and the question of phase three. Then, the researcher determined the scope of the project by confirming the “AI menu of approaches”; (1) change agenda, (2) form of engagement, and (3) inquiry strategy (Cooperrider et al., 2008; Stratton-Berkessel, 2010; Whitney et al., 2010).

First, AI can be used for different purposes to achieve change, development, or transformation at the personal, organisational, or community level. Identifying the purpose indicates the change agenda and answers the question “what are we trying to accomplish?” (Cooperrider et al., 2008; Stratton-Berkessel, 2010; Whitney et al., 2010).

This question is posed in the question of phase three:

- How can an effective CPD programme, that meets the needs of registered nurses, be developed, based on the needs of the RNs?

The outcome of answering the question is a “strategy for CPD programme” which falls under the “strategic planning” change agenda. Adopting the AI would contribute to the ultimate goal in helping the stakeholders to discover and realise their highest potential within the process (Cooperrider et al., 2008).

Second, the form of engagement is another critical element in the menu as it should be appropriate to the identified change agenda, timeline, resources, culture, and the participants themselves. There are eight common forms of engagement that have been developed over the years; (1) Whole-System 4-D Dialogue, (2) Appreciative Inquiry Summit, (3) Mass-Mobilised Inquiry, (4) Core Group Inquiry, (5) Positive Change Network, (6) Positive Change Consortium, (7) AI Learning Team, and (8) Progressive AI Meetings. The adopted form of engagement is the “AI Learning Team” as it fits the change

agenda to develop strategy that is considered as a “specific project” with a small group of people. Adopting this form of engagement is to build the work on a reliable framework. The conduct and logistics are unique to this AI, since the proposed forms of engagement aimed to stimulate imagination and creativity to invent an effective positive change approach rather than to copy it (Cooperrider et al., 2008; Stratton-Berkessel, 2010; Whitney et al., 2010).

It is one of the simpler AI Forms of Engagement. It is also known as “Innovation Team”, “Action Group”, “Improvement Team”, “Implementation Team”, or “Project Team”. It uses the 5-D Cycle with a small group of people. From an affirmative perspective, the AI Learning Team of this AI is named the “Innovation Team” as innovative strategies were developed in alignment with the contemporary and complex healthcare market needs. Specifically, the AI Learning Team worked on the strategies, taking into consideration the redesign of the CPD processes and aiming to positively transform the current CPD practices (Cooperrider et al., 2008; Stratton-Berkessel, 2010; Whitney et al., 2010).

Third, the inquiry strategy is about the decisions and steps that should be taken for a successful AI. In its simplest meaning, it is the operational plan that identifies the responsibilities, tasks, timelines, and all other operational elements of the project. These elements represent the choices that were made in each phase of the 5-D Cycle. The main decision of the inquiry strategy was on the interview process as it is a key factor in contributing to the positive core. This decision was affected by participants’ circumstances in terms of their background and availability as leaders. The most common interview types are one-on-one interviews, group interviews, cross-organisational interviews, and electronic interviews, or a combination of any two of them. The adopted type for this AI is the “group interview” that allows for knowing one another, active hearing of one another’s story, and positive interaction among participants. This group interview process is similar to the focus group (Cooperrider et al., 2008; Stratton-Berkessel, 2010; Whitney et al., 2010).

3.7.3.2.2 Discovery

The discovery phase is about discovering what is working very well; “appreciating the best of what is”. This discovery is based on the dialogue within the appreciative interview. This can be attained by focusing on the best moments concerning the CPD affirmative topic which are referred to as the “peak times” and “high-point experiences” in the most alive and effective moments. Specifically, participants share stories about their successful experiences and/or accomplishments, which is known as the “storytelling” phase, to identify the strengths and factors contributing to that state. Thus, the stories and key ideas are expected to identify the “positive core” of the CPD phenomenon (Cooperrider et al., 2008; Stratton-Berkessel, 2010; Whitney et al., 2010). To achieve this, a positive appreciative interview guide was developed for the focus group. The interview guide is discussed in the next section; “development of the instrument”.

3.7.3.2.3 Dream

The dream phase is about seeking “what might be” to “envision results the world is calling for”. Participants engage actively to envision the future of the CPD by identifying their common aspirations. An important outcome of the dream phase is amplifying the positive core to a brighter future by bringing the best dreams to life. This phase is based on discussing the learnt lessons from the discovery phase to imagine a more inspiring positive future. After sharing their dreams, they creatively enacted collective dreams and presented these symbolically. Positively, the dreaming invites participants to expand the context of excellence as their imagination goes beyond the boundaries of the daily operations to find new meanings towards idealism (Cooperrider et al., 2008; Stratton-Berkessel, 2010; Whitney et al., 2010).

Practically, the researcher planned for an effective dream phase in terms of its process and content. Participants were instructed to discuss the learnt lessons, share their dreams, and then enact collective dreams in two forms; graph drawing merged with brief statements. A key element in the dreaming activity is that it should be creative and fun to open the imagination during mapping the positive core. Despite the environment that was conservative due to the leadership nature of participants, the experiential approach was

essential to shift them to a creative atmosphere (Cooperrider et al., 2008; Stratton-Berkessel, 2010; Whitney et al., 2010).

First, at the beginning of the dream phase, participants were asked to reflect on the questions individually.

Second, as a group, they conducted an open-ended conversation for about 25 minutes. Participants were asked to discuss and share what they learned from others and their dreams during the reflections. The researcher started observing the emerged themes at this point.

Third, they clarified their collective dream. Details about the dream were presented in terms of what the dream looks like and how they know that it is coming true. They were asked to be creative in presenting the dream by using any available resources and supplies. In parallel with this, they were asked to identify the common themes and opportunities. The themes are “values-based visionary statements” whereas the opportunities are more specific. Both open the door for the next phase; design. For this purpose, they were asked questions about the most inspiring themes and the boldest innovation opportunities.

Lastly, they were asked to record their common themes and opportunities on an “opportunity map”. It is a very effective tool to visualise the potential innovations and priorities for a smooth transition to the design phase.

3.7.3.2.4 Design

It brings together the “best of what it is” through stories from the discovery phase with the “what might be” through imagination from the dream phase. Together they create “what it can be” where participants “co-construct the future design”. This phase is characterised by the detailed information about what should be done and by the commitment to do so (Cooperrider et al., 2008; Stratton-Berkessel, 2010; Whitney et al., 2010).

Serious choices have been decided on to make the dream true through “social architecture” that shows the relationship between the design and the change agenda. It can be rooted by generating “provocative propositions”. Therefore, the successful design should include a clear identification of the organising elements and creating well-structured “provocative propositions” (Cooperrider et al., 2008; Stratton-Berkessel, 2010; Whitney et al., 2010).

The “provocative propositions” is also known as “possibility statements”, “design statements”, and “design principles”. Regardless of its name, it is a “statement of the ideal organisation”. The statement should be developed while keeping in mind that “words create worlds”. The provocative statement can be judged according to certain elements; (1) narrative nature presenting the hoped for ideal situation, (2) provocative, beyond the known boundaries, (3) affirmative, and (4) statement of intention. The statement should imply tangible actions, processes, structures, and practices but without describing them (Whitney et al., 2010).

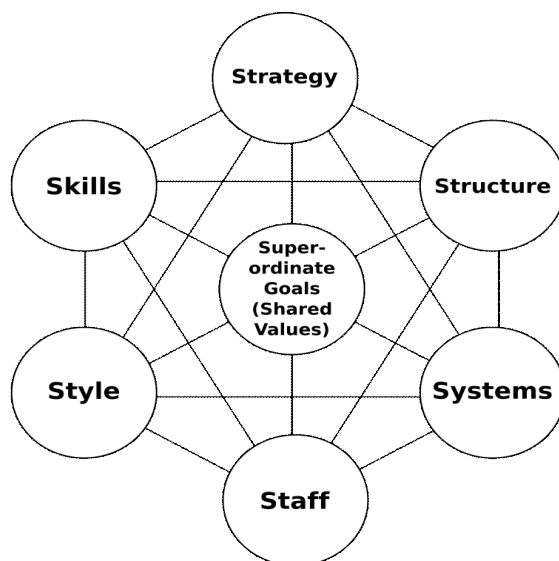
The choices were made also on the design elements, operational and strategic, such as current policies, processes, and practices in order to decide on what should be kept due to its effectiveness, what should be eliminated, and what should be added as a new innovation in response to the current and future needs.

In order to achieve the goal of this phase, affirmative statements describing the ideal situation”, four major steps framed the work of the design phase.

First, the social architecture should be identified before planning the transformation. Whitney et al. (2010) referred to it as “*a model for organizing that implies a set of essential design elements*” (p.206) and identified its potential elements as “*vision, purpose, strategy, structure, leadership, decision-making, communication, systems, relationships, roles, knowledge management, policies, procedures, products, and services*” (p.206). Thus, the identified elements together form the social architecture.

Among the many design models, the McKinsey 7-S Model was adopted for this AI due to its applicability in the strategic planning. It is a business management model that is used for internal organisational analysis purposes. It helps the planners to determine the best approaches to implement a proposed strategy. The model encompasses a total of seven elements that are divided into two types; hard and soft. The hard elements are strategy, structure, and systems whereas the soft elements are shared values, skills, staff, and style (figure 3.14). The core value of the model is that it focuses on the alignment of and co-ordination among these elements and eventually performance improvement would require realignment among them (Waterman Jr, Peters and Phillips, 1980).

Figure 3.14: McKinsey 7-S Model



Second, participants selected the relevant and strategic design elements of the social architecture as it is very difficult to redesign the entire system all at once. However, the transformation happens in one design element that creates the need to change the next one. In essence, the selection of the elements should consider what leads to the dreams' realisation. It is very important to consider elements, such as the authority and decision-making, due to their impact on many other elements (Cooperrider et al., 2008; Stratton-Berkessel, 2010; Whitney et al., 2010).

Third, participants identified the organisational design preferences or ideals in relevance to each selected element. To do so, they “go back to the future” to review the learnt lessons from the discovery and reflect on the dreams. This process helped them to specify their preference of the quality and nature of the design element. Thus, it is the right moment to review the “opportunity map” as it would inspire participants on the specific preferences. The preferences were then listed, preparing them to form the “provocative proposition” (Cooperrider et al., 2008; Stratton-Berkessel, 2010; Whitney et al., 2010).

Fourth, participants crafted the provocative propositions by turning the preferences into “affirmative statements”. The work was focused on the most important elements to them. The provocative proposition usually addresses one or more key design element stating how the preferences of each design element will be evident. The provocative proposition encompasses certain characteristics, such as present tense statement expressing the future as a true present, based on what works according to the successful stories, provocative beyond the norms, and highly desirable by the involved people (Cooperrider et al., 2008; Stratton-Berkessel, 2010; Whitney et al., 2010).

3.7.3.3 Development of the Instrument

The appreciative interview (Annexure H – Appreciative Focus Group Guide) generally starts with the “Lead-in” that introduces the affirmative topic and is then followed by “Sub-questions” to discover different aspects of the topic. Regardless of their type, the AI questions should be clear, simple, subtle, and provocative. What identifies the quality of the AI questions is how much they are inviting to involvement and storytelling (Cooperrider et al., 2008; Stratton-Berkessel, 2010; Whitney et al., 2010).

First, the Lead-in is critical in setting the discussion’s tone during the interview as it clarifies the topic and opens participants’ eyes to its positive aspects. Thus, this views the CPD “at its best” and shows its ultimate benefits. The high-quality lead-in should be personal and affective; not only professionally-oriented as the AI aims to discover this strategic topic from the lived experiences of participants. Thus, the lead-in contributes to

bridging the organisational and human needs and prepares the participants for the sub-questions with full positive thinking and feelings (Whitney et al., 2010).

Second, the sub-questions were crafted in a way to help participants to anchor the affirmative topic to their past experiences and future imaginations. Thus, they can cover the three timeframes; past, present, and future. The natural flow of the sub-questions is an effective approach in the AI; (1) background questions, (2) inward questions, (3) forward questions, and (4) transition questions (Whitney et al., 2010).

First, the background questions open the floor to the “high-point experiences” where the researcher probed the personal, organisational, and environmental factors that lead to the positive experience. These questions were as follows:

- *Tell us what does the CPD mean to you?*
- *Describe a “peak time” or “high-point experience” with the CPD.*
- *What do you value most about the CPD programmes for RNs?*
- *What do you most hope that the CPD programmes contribute to RNs?*
- *What are the factors that made these examples of exceptional performance possible?*

Second, the inward questions usually come after the background questions, within the discovery phase, as they refer back to the told story asking about its meaning and the learnt lessons from the lead causes and conditions. The question was as follows:

- *Reflecting on your stories and the factors, what could be the learnt lessons?*

The forward questions usually come last after identifying the meaning and learnt lessons to unfold the dreams and hopes by imagining the best possible future of the affirmative topic.

Lastly, the transition questions are embedded in the forward questions. They are key in the AI as transitional in terms of the change; not the sequence of questions. They ask

participants to reflect on the imagined future to consider the first step towards transitioning from the current state to the imagined future.

The forward and some transition questions within the dream phase were as follows:

Imagine in the future when RNs look to the CPD programme as exceptional examples of professional development and management commitment towards excellence.

- *What has contributed most to making that exceptional example possible?*
- *How is it making a difference to the future of nursing to have outstanding CPD programmes in UAE?*
- *What bold decisions were made and by whom that set effective CPD strategies?*

While the other transition questions within the design phase were as follows:

- *What are the areas of CPD where you feel nurses could have the most impact on improving the quality of patients' care?*
- *As you reflect on successful ways nurses are currently participating in CPD activities, what initiatives stand out as being exceptionally promising in professional development of nurses and why?*

From a structural interview perspective of the interview, it included background instructions and sequenced questions. The guide was divided into summary sheets and four sequenced parts; introductory text, stage-setting questions, topic questions, and concluding questions.

1. Summary Sheets

The summary sheets were used to collect the summarised data during the interview. The sheets were prepared to be used by participants. The two sheets that were used as templates are the discovery and design sheets (tables 3.18 and 3.19).

Table 3.18: Discovery Sheet Template

Peak Times or High-Point Stories	Root Cause of Success	Learnt Lessons
<i>Pick top stories</i>		

Table 3.19: Design Sheet Template

1. Our Chosen Design Elements	2. What We Learned in Our Discovery	3. What Our Dreams Suggest We Want	4. Our Provocative Proposition
<i>Design Element</i>	<i>Design Preferences (from the discovery)</i>	<i>Design Preferences (from the dream)</i>	<i>Write provocative propositions</i>

2. Introductory Text

The introductory text sets the stage for the AI interview. It was presented at the beginning of the AI, before starting the focus group in the form of a PowerPoint presentation. It included overview information about the AI, significance of AI, importance of storytelling in AI, and how information would be used. In addition to that, the PowerPoint presentation included the major instructions, worksheets, and questions during the interview.

3. Stage-Setting Questions

In this part, the introductory questions were asked, aiming for rapport building with the participants such as:

- Tell us what the CPD means to you.
- Describe a peak experience or high point with the CPD in Abu Dhabi.

4. Topic Questions

In this part, the researcher asked in-depth questions about the affirmative topic. These questions included lead-ins and sub-questions.

5. Concluding Questions

The concluding questions wrap up the interview's phases.

3.7.3.4 Testing the Instrument

The same procedure that was used to test the focus groups interview guide of phase one was used to test the interview guide of phase three. However, the researcher was not able to test it on a group with similar characteristics as key players of the population due to their availability. Therefore, the researcher tested it on a group of senior and expert RNs and nursing faculty as the access to them and their availability were more feasible.

As a result, the interview guide was not modified as it had been found that it is easy to ask, clear, well structured, and with a very clear meaning. However, participants had some inquiries about the AI and 5-D Cycle as it was new to them. Based on these inquiries, the researcher decided to prepare a PowerPoint presentation to be used during the entire actual interview to highlight the main instructions and guide participants through the process. Keeping them informed at all times would ease the process and make it more predictable in order to reduce any sort of discomfort or confusion, especially since the AI concept is new to the population.

3.7.4 Data Analysis

In phase three, as presented previously in the "*AI 5-D Cycle*" section, the decision on the data analysis was based on the unique context of the AI. Moreover, the nature of qualitative data allows for evolving analysis to determine what is meaningful. Thus, it was influenced by four major aspects and resulted in a "Simultaneous Targeted Participatory Thematic Analysis".

First, the AI phases of the 5-D Cycle were conducted with one focus group in one session. This mandated a constrained timeline where the analysis was required immediately in order to proceed to the next phase of the 5-D Cycle. Thus, the qualitative data analysis was completed simultaneously during each phase.

Second, despite the fact that qualitative data analysis usually requires a thorough and systematic process, it was quick and targeted data analysis in this AI. This type of analysis is common in such circumstances where it focuses on the meaningful “high-level” themes with practical implications to inform the next phase. A complete textual analysis is not required where summary sheets were used to guide the narrowly targeted analysis without jeopardising answering the question and achieving the objectives (Guest, MacQueen and Namey, 2011).

Third, expressing the constructionist and simultaneity principles of the AI in the forms of the group discussion and reflection respectively, the analysis was led by participants and observed by the researcher; as a facilitator. This participatory data analysis contributed to the core of the AI, enabling participants to define the affirmative topic, discover the positive core, dream their future, and design it themselves. This meaningful involvement of participants at the level of data analysis is not common (Byrne, Canavan and Millar, 2009). Best, Badham, Corepal, O’Neill, Tully, Kee et al. (2017) have highlighted the increased significant momentum of research co-production recently, and the need for reliable, structured, and accessible participatory methods. However, the involvement of participants in this AI data analysis was limited to organising knowledge learnt from the AI phases and under the supervision of the researcher. This method of “organising knowledge is known as “card-sorting” analysis (Spencer, 2009).

Fourth, the analysis method’s choice was driven by the AI question and objectives. The method of choice was the thematic analysis as the transition from one phase to the next depends on the concluded high-level themes aiming to achieve a collective dream and aspired designed strategy (Braun et al., 2006). The themes are utilised within the outcomes and the AI’s summary sheets of each phase. Besides, the storytelling research approaches, such as the AI, usually require a data analysis method with a narrative approach. However, the storytelling of this AI was influenced by the background of participants as “key players” where their stories about the “peak times” and “high point experiences” were presented as positive views rather than personal lived experiences. Thus, a narrative approach would not contribute to attain each phase’s desired outcome.

3.7.4.1 Appreciative Inquiry SOAR Model

SOAR stands for Strengths, Opportunities, Aspirations, and Results. The SOAR model is the approach of choice in the AI. It has been used due to its features as a dynamic and inviting tool. Additionally, it organises the collected and analysed data to ease the progress from one phase to the next (McKenna, Daykin, Mohr and Silbert, 2007).

In addition to the 5-D Cycle, the SOAR was used to guide the data analysis process and then to summarise and present the key findings in a logical and systematic way. The first part consists of the strengths and opportunities that represent the strategic inquiry. The second part consists of the aspirations and results that form together the appreciative intent. The “results” were not utilised in this study as it includes the action plan and implementation of the strategies which is not within the scope of this study. The questions of each element and structure are summarised in figure 3.15 (McKenna et al., 2007).

Figure 3.15: AI SOAR Model

Strategic Inquiry	Strengths <u>Phase:</u> Discovery <u>Question:</u> what are the greatest assets?	Opportunities <u>Phase:</u> Discovery-Dream <u>Question:</u> What are the best possible opportunities?
Appreciative Intent	Aspirations <u>Phase:</u> Dream-Design <u>Question:</u> What do we want to be and is our preferred future?	Results <u>Phase:</u> Design-Destiny <u>Question:</u> What are the measurable results we want to achieve?

3.8 DATA MIXING AND INTERPRETATION

Analysing the data separately at each phase did not serve the study’s design which was to explore and investigate the effectiveness of the CPD programme in order to develop strategies. As illustrated in figure 3.6, first, the qualitative data of phase one was analysed by identifying qualitative themes. Thereafter, the information was used to modify the Q-PDN questionnaire. Then, the quantitative data of phase two was analysed descriptively and inferentially and this data was used to interpret and validate the qualitative (phase one) data. Afterwards, the results of the interpretation were used to develop the protocol

and agenda for the qualitative appreciative inquiry (AI) in phase three. Finally, the data analysis in the AI happened during the different phases of the AI process.

Thus, the data was integrated at three major points. The first data integration was in using the qualitative data (phase one) to modify the Q-PDN as an instrument for the quantitative phase. The second data integration was in mixing the qualitative and quantitative findings of the core design, basic exploratory sequential design, to obtain different but complementary data. The third data integration was in using this mixed data to develop the AI' protocol, validate its affirmative topic in the "Define Phase", validate the suggested CPD strategy.

3.9 VALIDITY, RELIABILITY, AND TRUSTWORTHINESS

The validity and reliability of the study identify its quality and the generalisability of the findings. Until the moment of writing this dissertation, there was no agreed-on quality language in terms of the validity and reliability of the mixed method studies. Creswell (2009) addressed this issue and stated that new approaches started to arise which is the "legitimation" of the mixed method. However, it is still feasible to address the validity and reliability of the quantitative approach and the trustworthiness of the qualitative approach separately and then consider any validity issues related to the mixed method design.

The multiphase mixed method research design of the study with the exploratory approach of the first two phases provides a strong integration of the qualitative and quantitative approaches. This integration allows solid triangulation and subsequently the bias, which might result from one approach, would be cancelled by the other (Creswell, 2009:14; Zhang et al., 2013).

3.9.1 Trustworthiness of Phases One and Three: Qualitative

In the qualitative phases one and three, the rigour of the study was addressed from the perspective of the trustworthiness model which encompasses five epistemological standards (Lincoln and Guba, 1985, cited in Tashakkori et al., 2010); (1) credibility, (2) transferability, (3) dependability, (4) confirmability, and (5) authenticity. Trustworthiness

has been referred to as the degree of confidence in data, interpretation, and methods used to ensure the quality of a study (Polit and Beck, 2014).

First, to achieve the truth value through the credibility, the researcher collected data using focus group interviews and a questionnaire which represents the triangulation. Additionally, the researcher explained explicitly the different processes and phases of the study to participants which is considered a prolonged engagement. Another important aspect is the researcher's role as a moderator and an interpreter only without being involved in any means to prevent the reflexivity and bias.

Second, to achieve the applicability through the transferability, maximum saturation of data was achieved from the different interviews. Participants were selected purposively while taking into consideration the geographic and administration distribution of the population to achieve higher representation, in addition to the knowledge and experience factors.

Third, to achieve the consistency through the dependability, the researcher concentrated on the triangulation and emphasised the methodology as all other activities require two or more researchers whereas this study was conducted by one researcher. However, all processes and procedures of the study were discussed with the researcher's supervisors. Their advice and directions contributed to the dependability of the study.

Fourth, achieving the neutrality through the confirmability was evident through the triangulation and reflexivity issues. In the same context, the researcher played the role of the moderator only during the focus groups and AI. As a facilitator, the researcher practiced 'bracketing' during and after the focus groups and AI by reflecting on the practices and setting aside the personal views about the CPD issue in Abu Dhabi.

Finally, the authenticity can be achieved through being faithful and committed to the integrity of the participants' voice. This was achieved by selecting the appropriate participants and providing detailed description of the selection criteria.

3.9.2 Validity and Reliability of Phase Two: Quantitative

Validity is defined as whether a research study is truly able to measure what it is aimed to measure. On the other hand, reliability is defined as the extent that describes the consistency of the results over time with accuracy in representing the total population of the study and its ability to reproduce similar results upon application of a similar research methodology. To conduct a quantitative research, the researcher should take into consideration validity and reliability factors. In order to examine the validity between the independent and dependent variables, Pearson correlation coefficient and significance were measured. As seen in Table 3.20, the correlations between the four constructs being examined in this research study were found to be positively correlated and are statistically significant ($p < 0.05$).

Table 3.20: Correlation between the variables

	MOTIVES	CONDITIONS	IA	AAU
MOTIVES	1			
CONDITIONS	.240**	1		
IMPORTANT ACTIVITIES (IA)	.331**	.341**	1	
ACTIVITIES ACTUALLY UNDERTAKEN (AAU)	.175**	.138*	.442**	1

To verify the reliability, i.e. the scale is consistent in reflecting the constructs being measured, Cronbach Alpha was measured. Also noted as internal consistency, a Cronbach Alpha test is applied when the constructs are measured on a scale such as a Likert Scale or similar. The overall score of Cronbach Alpha was identified as 0.890 which indicates a high internal consistency.

Reliability Statistics	
Cronbach's Alpha	N of Items
.890	72

3.10 ETHICAL CONSIDERATIONS

The researcher addressed all matters that would affect humans as the study participants as it is their right to be protected. To achieve this, the researcher dealt with the three main principles that were addressed in the Belmont Report; (1) principle of beneficence, (2) principle of respect, and (3) principle of justice (Miracle, 2016; Polit et al., 2014). Most importantly, the ethical considerations were paid attention to in all process and procedures during the study and within the study's design and instruments.

This study was granted an ethics approval from the Research and Ethics Committee (REC) at the Faculty Health Sciences, University of Pretoria (UP) in RSA. Additional ethical approvals were sought from the concerned RECs or Institutional Review Board (IRB) of each participated facility in Abu Dhabi as per their internal policies and procedures (Creswell, 2009). This presents evidence on the researcher's intention to respect the people (Botma et al., 2010).

As this research required to obtain personal information about participants, they were asked to participate voluntarily in the different phases; RNs in the focus group interviews and the questionnaire while the key players or their representatives in the AI. Participants were protected from any possible harm or revelation of their information and opinions. The nature of the study and its processes was explained to them before their approval to participate. The anonymity and privacy were maintained, and confidentiality was protected at all times. The identity of participants and facilities are not and will not be published. In this regard, participants signed a PICD without any sort of pressure or manipulation with the freedom to withdraw at any time (Babbie, 2010).

All data was securely stored. The self-report questionnaire was conducted through an online software with secured credentials. The electronic documents were stored in a password protected laptop and cloud service and was backed up frequently onto an external hard disk drive. All physical documents, notes, recorders, tapes, and the hard disk drive, were stored in a locked cabinet in the locked researcher's office. The data will

be kept for a period of 15 years after commencing the study and then will be discarded safely (Sieber, 1998; cited in Creswell, 2009).

3.11 SUMMARY OF THE CHAPTER

This chapter presented the theoretical underpinning, paradigm, and overall design of the study. Additionally, design, population, sample and sampling, data collection and analysis methods of each phase of the three phases were discussed in detail. The next three chapters present the findings of the three phases respectively.

CHAPTER 4: QUALITATIVE FOCUS GROUPS FINDINGS

4.1 INTRODUCTION

This chapter presents the findings of the four focus groups that were conducted in phase one. Data was collected from the purposively selected RNs as rich informants. The findings are based on the adopted data analysis style; thematic analysis. While, on the one hand, the findings represent the exploration of the CPD phenomena in Abu Dhabi, they also contribute to the modification of the data collection instrument; Q-PDN questionnaire. The findings are part of the mixed data interpretation that includes the findings of the quantitative phase two. The mixed data inform the last phase of the study; the qualitative appreciative inquiry.

4.2 OVERVIEW OF PARTICIPANTS

The total number of participants in the focus groups was 31 RNs from three regions of Abu Dhabi, representing the government and private sector hospitals and clinics/centres. The majority of participants were female, at staff nurse position, and had Bachelor of Science degrees. The majority of participants were non-Arab RNs (61%); the UAE, was represented by only one RN (3%) (Annexure I – Detailed Profile of the Focus Group Participants). Table 4.1 below summarises the characteristics of participants, whereas Figures 4.1, 4.2, and 4.3 illustrate their major characteristics and distribution.

Table 4.1: Focus Groups Participants' Characteristics

Demographic Element		RNs Count (n)	
Gender	Male	8	
	Female	23	
Nationality	National	1	
	Arab	11	
	Non-Arab	19	
Position	Staff Nurse	19	
	In-charge Nurse	5	
	Clinical Resource Nurse	3	
	Senior Charge Nurse	2	
	Quality Officer	1	
	Midwife	1	
Qualification	Diploma	3	
	Bachelor	26	
	Master	2	
Type of Facility	Government	Hospital	9
		Centre/Clinic	7
	Private	Hospital	3
		Centre/Clinic	12
Region	Abu Dhabi	7	
	Al Ain	12	
	Al Dhafra	12	

Figure 4.1: Gender and Ethnicity Distribution of Participants

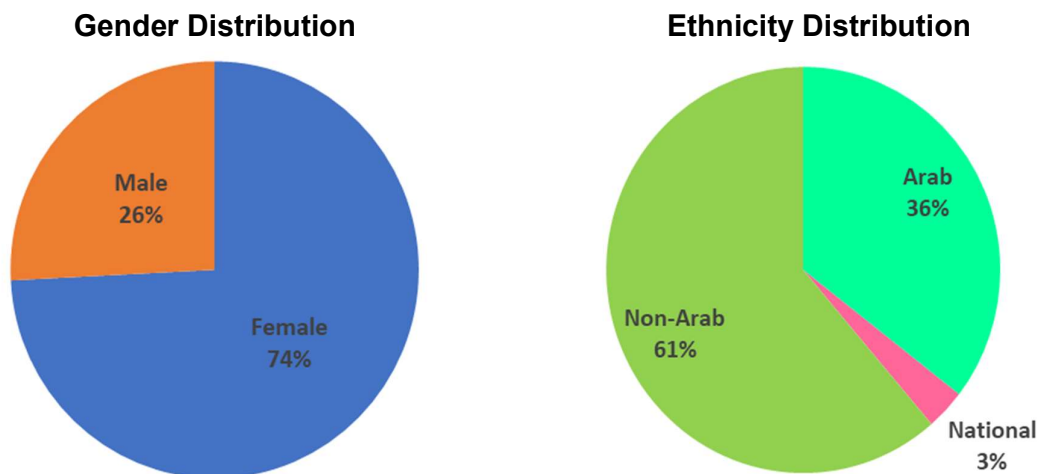


Figure 4.1 illustrates the gender and ethnicity distributions of participants in the focus groups. The gender distribution pie chart shows that female participants represented around three quarters (74%) of the total participants whereas the male participants were only 26%. The ethnicity distribution pie chart shows that national participants were only 3% whereas Arab participants were 36%, adding up to 39% the total number of Arabs. The majority of participants were non-Arab at 61%.

Figure 4.2: Position and Qualification Distribution of Participants

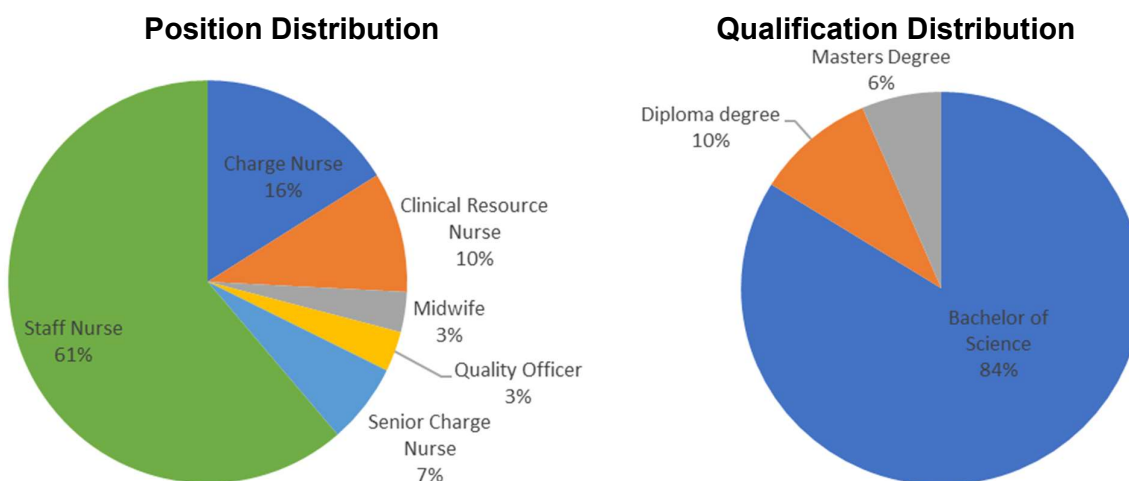


Figure 4.2 illustrates the distribution of the focus groups' participants' position and qualifications. The position distribution pie chart shows that the majority of participants were staff nurses (61%) and the other 39% were nurses (16%), clinical resource nurses (10%), senior charge nurses (7%), quality officers (3%), and midwives (3%). The qualification distribution pie chart shows that the majority of participants held Bachelor of Science degrees, 10% held Diplomas and 6% had "Masters" degrees.

Figure 4.3: Position and Qualification Distribution of Participants

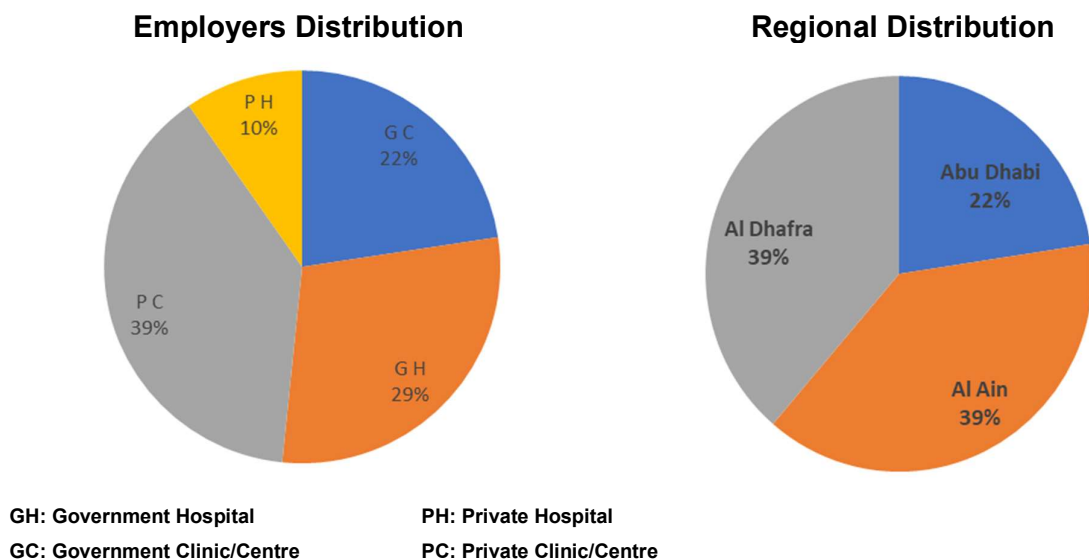


Figure 4.3 illustrates the distribution of the type of facility and region where focus groups' participants are based. The employee distribution pie chart shows that participants working in the government represented 51%, hospitals (29%) and centres (22%), whereas participants from the private sector represented 49%, hospitals (10%) and centres (39%). The regional distribution pie chart shows that 22% of participants work in Abu Dhabi whereas others are distributed equally among Al Ain and Al Dhafra, at 39% each.

4.3 THE FOCUS GROUPS FINDINGS

The analysis of the focus groups resulted in a total of two domains with two themes under each. The domains, themes, sub-themes, and their corresponding categories, where applicable, are listed in table 4.2.

4.3.1 Domain 1: RNs' Perception about the Value of CPD

The first domain was inspired by the first introductory question that was aimed at building a rapport with participants:

- IQ: *“What do you think about the value of the CPD in terms of the development of knowledge, skills, and attitude for nurses?”*

In addition to this question, in response to participants' answers, the following transition and sub-questions were asked:

- TQ: *How do you see the CPD programme in the UAE?*
- TQ: *How do you feel about the CPD as a licensure renewal requirement in the UAE?*
- SQ: *How do you see the content of the CPD activities in terms of the knowledge, skills, and attitude competencies respectively?*
- SQ: *How do you see the impact of the CPD activities on the nurses' knowledge, skills, and attitude competencies?*

Table 4.2: Domains, Themes, and Sub-themes of the Focus Groups' Findings

#	Domain	#	Theme	#	Sub-theme	Categories
1	RNs' Perception about the Value of CPD	1.1	Positive Value of the CPD	1.1.1	Meeting the requirements	
				1.1.2	Updating and gaining new knowledge and skills	
				1.1.3	Better nursing care	
		1.2	Questionable Value of the CPD	1.2.1	Obligation	
				1.2.2	Lack of nurses' needs and interest	
2	Influencing Factors	2.1	Motives	2.1.1	Factors related to personal and professional development	<ul style="list-style-type: none"> • Career development • Update and learn new knowledge and skills
				2.1.2	Factors related to requirements	<ul style="list-style-type: none"> • Licence renewal
				2.1.3	Factors related to career opportunities	<ul style="list-style-type: none"> • Promotion • Career advancement
				2.1.4	Personal factors	<ul style="list-style-type: none"> • Interest (preferred activity and mode of delivery) • Networking and entertainment
		2.2	Barriers	2.2.1	Factors related to intangible conditions	<ul style="list-style-type: none"> • Irrelevant activities to specialty
				2.2.2	Factors related to tangible conditions	<ul style="list-style-type: none"> • Finance (funds and costs) • Time (work schedule, load, social commitments) • Accessibility (geographical distance, late notifications, limited availability)

The RNs' perception about the value of CPD has been viewed as an important influencing factor towards their participation in the CPD activities. The RNs' perception falls in two contrasting themes; positive and questionable values.

4.3.1.1 Theme 1.1: Positive Value of the CPD

The “positive value of the CPD” was the dominant theme among participants, even among those who raised some concerns (this is discussed in theme 1.2). The positive view is justified in three sub-themes. Most of participants indicated that the CPD is “beneficial”, “vital”, “and “important”. The emerged sub-themes are summarised in table 4.3.

Table 4.3: Theme 1.1: Positive Value of the CPD

#	Theme	#	Sub-theme
1.1	Positive Value of the CPD	1.1.1	Meeting the requirements
		1.1.2	Updating and gaining new knowledge and skills
		1.1.3	Better nursing care

4.3.1.1.1 Meeting the requirements

Viewing the CPD as a positive value, from the perspective of meeting the licensure renewal and organisational requirements, was not a common perception. However, it is interesting to highlight this perception as it was mentioned by seven participants although most of them questioned its value in relation to obligation (this is discussed in sub-theme 1.2.1).

This excerpt from a person who is highly reputable due to their expertise and uncountable contributions to the CPD field in Abu Dhabi should be examined and treated carefully. In addition to three other participants, participant 13 stated:

...the CPD helps to maintain the licensure according to the legislation of the Department of Health.

Sharing the same opinion, participant 27 painted a complete picture when stating:

Its rating is very good. Uh, it's one of the mandatory things for relicensing, uh, your nursing license. Uh, and it make sure you get updated. ...I think overall yeah, it's appreciated. It's a good system if it's implemented in the right way. It's a thumb up, yeah, it's a good one.

Participant 30 also expressed a satisfaction when stating that:

Good idea. It's really okay that it is mandatory for licensing, because you will not- we will not do it if it is not mandatory, of course.

On a response to a transition question about the participants' feelings about the CPD as a licensure renewal requirement, many participants expressed total agreement with this obligation due to its positive outcomes. In this context, participant 14 stated:

It is really nice and good you know, to make sure the staff are practicing and get updated. So, I feel it's positive.

Whereas participant 15 responded:

Yes positive. They will-- By themselves, they will go and search because they want to [get] CME hours.

From a different perspective, none of the participants opposed participant 21 when stated:

...to meet the standards of the company.

Viewing the value of CPD positively from the perspective of a requirement for the licence renewal was the experience of many participants. It was the benefits of mandating the CPD, in terms of renewing the licence or meeting the organisation's expectations, behind this positive value.

4.3.1.1.2 Updating and Gaining New Knowledge and Skills

There was no doubt about the value of CPD and its role in terms of updating and gaining new knowledge and skills. The majority of participants, in the interviews, justified their perception by stating this outcome. Some participants indicated that nurses might forget some knowledge, and this was stated by participants 5 and 17 respectively:

...widen up and increase our knowledge in our field, especially if you have lost some knowledge (participant 5).

Normally, we tend to forget, uh, uh, sometimes. So CPD is good for the person to remember (participant 17).

Some participants expressed the same positive perception but under the “relevance” condition, as it is described in the sub-theme 1.2.2 but not from a questionable perception, where participant 28 expressed a comprehensive perception:

It is valuable because, uh, if it is related to your profession, it will refresh, uh, your information about your practice. It might add, uh, new knowledge or information even to your experience.

The same opinion was expressed by participant 13, in an affirmative manner about the skills when stated:

I can say that the CPD programme in Abu Dhabi is effective. I can attest that some of the staff whom I have experienced through the CPD and the clinical practice, their skills have improved significantly.

Thus, all participants, regardless of the conditional agreement of some, have viewed a positive perception about the value of CPD in terms of its benefits towards updating and/or gaining new knowledge and skills.

4.3.1.1.3 Better Nursing Care

From a broader perspective than the personal benefits of the RNs, some participants viewed the positive value about the CPD in terms of its impact on the nursing care and eventually, patient care. Though they were few, it reflects the awareness of the nurses’

community towards the importance of the CPD's benefits and outcomes. This was evident in the excerpt from the statement made by participant 20 after acknowledging the knowledge and skills:

...while they gain and that will benefit the patient care.

On the other hand, participant 3 was concerned about the nursing practice when stating:

...So, we're attending, we are making a new-new knowledge and so that we can put it in our practice.

Similarly, participant 10 was more specific in terms of the decision-making under certain fluid circumstances where the nurses are required to be critical thinkers and proactive and stated:

...it also uh help us um, to deal in decision making with the patient, like, um, in certain, um, circumstances.

Finally, participant 13, who was aware of the atmosphere of the senior management, reflected on the management's positive consideration stated:

It is valued, uh, from the senior levels, uh, because they want to provide that, uh, high quality of care.

Those few responses were not opposed by any participant. On the contrary, most of participants agreed by nodding their heads. This ultimate benefit of the CPD was seen by the participants as both a personal benefit in acquiring new skills and a patient benefit terms of improved patient care.

4.3.1.2 Theme 1.2: Questionable Value of the CPD

Perceiving the value of the CPD positively was not the only perception among the participants. Other participants questioned this value due to their unfavourable experience in terms of its obligation and needs and interest concerns. The emerged sub-themes are summarised in table 4.4 below.

Table 4.4: Theme 1.2: Questionable Value of the CPD

#	Theme	#	Sub-theme
1.2	Questionable Value of the CPD	1.2.1	Obligation
		1.2.2	Lack of Nurses' Needs and Interest

4.3.1.2.1 Obligation

The obligation feeling was a very common perception among RNs in the focus groups. Most of the nurses were emotional in expressing their feelings about mandating the CPD as a licence requirement. The following excerpts highlight this perception which can be described as a frustration for some of them. In this context, participant 13 stated this emotionally in a poetic manner:

*...I mean, not for the sake of learning, it is for the sake of just earning....
...it is just for the sake of the hours.*

The same opinion, indicating that the requirement obligation was the greatest reason for the CPD, was expressed by participants 1, 29, and 31 respectively:

"The very reason why we are attend CME is that because we have to comply with, uh, the requirement from the regulatory board". (Participant 1)
...So, in the meantime, I will not think whether it is beneficial for me or not. But the main issue, I have to renew my licence. (Participant 29)
Actually- yeah, since it's mandatory, since we have no choice, it's for the sake of our licence renewal. (Participant 31)

Similarly, participant 15 reflected on the obligation's effect on the interest and eventually the quality when stated:

...they (the RNs) will not be interested to come, they will be interested only just because for renewing the licence, they will finish the 20 hours whatever it will be.

Expressing the same concerns, participant 28 showed a doubtful perception when stated:

It is not that much in the UAE, because it is connected to the, uh, re-licencing. Uh, in this way, they will push you to bring CMEs regardless of the quality of the CMEs, or even regardless of the, uh, specialty, regardless of the benefits, because he's obliged to be re-licenced.

From a change perspective, participant 21 admitted the perception of RNs when stated:

We have to change the perception of the people on CPD; it is only for licence renewal.

In a response to a transition question about their feelings on mandating the CPD as a requirement for the licence, many RNs expressed how stressful it is and even a burden when participants 2, 8, and 9 stated respectively:

...sometimes we also feel stressed in obtaining CPD points. (Participant 2)

...sometimes, actually, it's becoming stressful for me. (Participant 8)

I think it's-it's a really a burden for all of us. (Participant 9)

Whereas respondents 28 and 29 elaborated more on the consequences of obligation on the human nature by rejecting the idea of obligation by stating:

I don't really, uh, prefer to, uh, make it as a mandatory for me for the re-licencing Because in my opinion, if you are pushing people to do something even if they like or dislike, so what's the difference between those people?

(Participant 28)

If I must do that, I will not accept it. But, okay, if you will tell me, I need 40 hours, I will get you the 40 hours, but you don't know from where I get these 40

hours. (Participant 29)

Thus, the negative perception about the value of the CPD was common among RNs, especially in terms of its obligation. Some participants rejected the idea of obliging the RNs because it is against human nature, others felt very stressed and felt the burden,

whereas many others critiqued the consequences of the obligation in terms of changing the attitude of RNs from an 'earning hours' attitude to a developmental attitude.

4.3.1.2.2 Lack of Nurses' Needs and Interest

RNs' expectations were another determinant of their view of the CPD's value. These expectations are represented by their needs, interest, and the quality of the CPD activities. Several RNs expressed their concerns about the value of the CPD if not appropriately implemented. Some revealed their concerns with regards to the scarce of speciality related CPD activities and participant 27 stated:

if the lecture is relevant to work, uh, I would say, that is, uh, beneficial.

Also, participants 20, 23, and 29 expressed the same opinion:

...we might need to focus it on our scopes ...because most of the CPD, are on general topics. (Participant 20)

... But sometimes we feel, when we are doing CPD, that it's so wide, so—so general. (Participant 23)

It is supposed to be for a target, that means it's related to, uh, uh, it will really benefit the nursing itself. (Participant 29)

However, participant 15 was more specific in identifying the disadvantaged segment when stating:

Like Obstetric, they have obstetric course, CTG courses, there's something in their specific area. But if you look to the general medical-surgical, there is nothing specific for them.

From a futuristic and appreciative perspective, the same perception was expressed by participants 25 and 26 when stating:

...we need a way to improve it. (Participant 25)

It might not be relevant or not related but it's somehow might be needed in the future. (Participant 26)

Whereas participant 20 was very specific in identifying the delivery of the activity as an area of improvement when stating:

...but we might need to improve it and develop it because I think we have different people who are delivering the information, they might not get it the way that it's prepared. ...so, I think that we need one source to deliver the information and a high level that is standardised.

Some RNs reflected on the interest as an unfavourable outcome of providing general and/or irrelevant activities. In this matter, participant 20 stated:

If the topic is not interesting, if it is not what we need, of course we will not be that much interested. It should be related to us, also to be to practice it.

Another quality issue was a concern to some participants where they perceived that some CPD activities were not aimed at developing RNs rather than for commercial and marketing purposes. This experience was shared by participant 23 when expressing that:

Many times, I feel CPD ..., it's a tool for marketing the company. ...it's a tool of marketing and they are selling their product versus what we need to learn. So, you are forced to attend this lecture because of the timing, of the cost, and sometimes the free ones are the-- related to medical companies.

In this context, participant 25 agreed with this concept and elaborated:

Commercial yeah. So, you will attend although you don't need but only because of the points.

Whereas participant 29, from another interview, had the same perception about the commercial purposes which was evident in the excerpt but in a conservative manner:

Here in some, uh, some business are to make CME and sell CMEs to the, uh, candidate....So, if I'm going to get, for example, uh, 40 CME, I don't know how much do I have to pay for that. Yeah. I cannot explain more regarding that issue, because there is a lot of companies in it, because there is profit.

Hence, a significant portion of the RNs question the value of the CPD as a result of their experiences. These experiences are represented in the lack of specialty related activities which lead to losing interest. Another concern was the commercialisation of the CPD activities which affected their quality.

The first domain of the focus groups' findings presented the RNs perception about the CPD's value in the form of two contrasting views; positive and questionable value. These views were introductory to the upcoming discussion, in domain two, about the factors that influence their participation in the CPD activities.

4.3.2 Domain 2: Influencing Factors

The second domain of the findings was the core of the discussion in all aspects; not limited to the two direct key questions about the motives and barriers:

- KQ: *What are your motives to attend CPD activities?*
- KQ: *What are the barriers to attend a CPD activity?*

RNs' response, in many other questions, were finding their path to the motives and barriers; more specifically to the barriers. When they were asked about the perception about the value of the CPD, how they view the CPD, and their needs, their responses were based on the barriers and challenges they experience. Hence, the influencing factors represent the core discussion with RNs.

This script of the findings of the influencing factors are limited to short terms or statements as the discussions were based on an activity using a flip chart. The activity was based on a round robin listing of the factors, motives and barriers, and ranking them according to the most important and most common as per the perception of RNs. Some elaborations were discussed whenever there was a need for clarify of any vague perceptions. Therefore, in addition to the extracted quotes, the findings of this domain are presented in a descriptive manner illustrating the average, distribution, and trends of the responses from the four focus groups. Technically, cross tabulation and bar chart graphs are the tools of choice for such descriptive presentation.

4.3.2.1 Theme 2.1: Motives

The motives towards RNs' participation in the CPD activities were expressed in a variety of ways. Six common motives were analysed from the interviews where they were grouped under four factors as sub-themes. The four factors are (1) personal and professional development, (2) requirement, (3) career opportunities, and (4) personal (table 4.5). The factors were adopted from the motives construct of the Q-PDN questionnaire as a framework for the analysed data. The first three factors were in the original Q-PDN whereas the fourth, personal, was added to the motives construct after modifying its structure, based on the continuum of motivation of the self-determination theory.

Table 4.5: Sub-themes and Categories of the Motives Theme

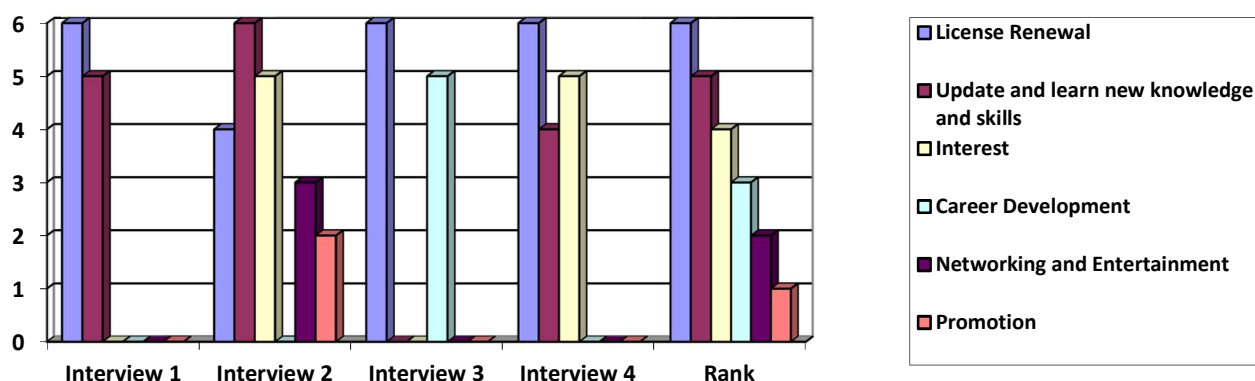
#	Theme	#	Sub-theme	Categories
2.1	Motives	2.1.1	Factors related to personal and professional development	<ul style="list-style-type: none"> • Career Development • Update and learn new knowledge and skills
		2.1.2	Factors related to requirements	<ul style="list-style-type: none"> • Licence renewal
		2.1.3	Factors related to career opportunities	<ul style="list-style-type: none"> • Promotion
		2.1.4	Personal factors	<ul style="list-style-type: none"> • Interest (preferred activity & mode of delivery) • Networking and entertainment

In brief, the six identified motives did not appear equally in the four focus groups. However, their trend was obvious with a simple mathematical calculation (table 4.6). The “licence renewal”, “Update and learn new knowledge and skills”, and “interest” motives were the most trending motives (figure 4.4).

Table 4.6: Overview of the Motives from the Focus Groups

Motive	Interview 1	Interview 2	Interview 3	Interview 4	Total Points	Rank (Points)
License Renewal	1 (6 points)	3 (4 points)	1 (6 points)	1 (6 points)	22	1 (6 points)
Update and learn new knowledge and skills	2 (5 points)	1 (6 points)	0	3 (4 points)	15	2 (5 points)
Interest	0	2 (5 points)	0	2 (5 points)	10	3 (4 points)
Career Development	0	0	2 (5 points)	0	5	4 (3 points)
Networking and Entertainment	0	4 (3 points)	0	0	3	5 (2 points)
Promotion	0	5 (2 points)	0	0	2	6 (1 point)

Figure 4.4: Distribution and Ranking of the Motives



4.3.2.1.1 Factors Related to Personal and Professional Development

The personal and professional development factors represented by “update and learn new knowledge and skills” and “career development” motives were the second most common concluded factors. The “update and learn new knowledge and skills” was very common in all focus groups, except in group 3. Interestingly, the “career development” motive was common in one interview only, interview 3, which is the only one that did not focus on the “update and learn new knowledge and skills” motive (Figure 4.4). In this

context, indicating the “update and learn new knowledge and skills” motive, participants used terms such as “to learn something”, “to enhance skills”, “competence”, “self-development”, “refresh”, “update knowledge”, and “gain new knowledge”. On the other hand, indicating the “career development” motive, they used terms such as “career development” and “to change my specialisation”.

RNs in group 2 have voted on this “update and learn new knowledge and skills” motive as the highest priority for them among a total of five common motives. It has been ranked as the second one in interview 1 among two common motives only and the third in interview 4 among three common motives. However, RNs in interview 3 did not highlight it as a common motive at all where they were more concerned about the “career development” as an ultimate goal rather than “update and learn new knowledge and skills”.

4.3.2.1.2 Factors Related to Requirements

The requirements’ factors were represented by the “licence renewal” only. Unquestionably, this motive was the most common among the focus group where it was ranked as first in three interviews and third in one. In this context, highlighting the “licence renewal” motive, participants used terms such as “renewal of licence”, “obligations”, “to get more hours”, “to gain hours”, and “requirement”. On the other hand, an uncommon concept, “required by the manager”, was mentioned but insufficiently to be a common motive. Interestingly, the same concept, “licence renewal”, has been viewed by most of the participants as a reason to value the CPD either positively or negatively. However, both views agreed on it as a motive, regardless of their likes or dislikes when attaining it.

4.3.2.1.3 Factors Related to Career Opportunities

Career opportunities were viewed from the perspective of the “promotion” motive. It was rated among the common motives during interview 2 and ranked as last among five common motives. Subsequently, it was the least common motive among the common six. The only term used to refer to it is “promotion”. Although highlighted in other interviews, it was not a common motive.

4.3.2.1.4 Personal Factors

'Personal factors' was another concept that required a significant time during the discussion. The analysed experiences were about RNs' interest and, less commonly, about networking and entertainment. The "interest" motive, by itself, was highlighted in two interviews. However, it came in second in both focus groups which placed it as the third most common motive. The only term used to indicate the motive was "interest". This interest has been discussed from three different aspects; interest in the topic, interest in the type of activity, and interest in the mode of delivery. The interest in the topic has been discussed from a barrier perspective (this is discussed in sub-theme 2.2.1) whereas the interest in the type of activity and mode of delivery were discussed from a preference perspective.

In response to a sub-question about the preferred mode of delivery of the content "*which mode of delivery do you prefer in terms of the knowledge, skills, and attitude competencies respectively?*", all participants in the four focus groups have the preference for an interactive activity with an emphasis on the online mode of delivery which was trending in the discussion. The analysis of the responses about the mode of delivery are summarised in table 4.7. It was crystal clear how participants disliked the traditional modes of delivery of the CPD activities. These preferences have a direct connection to the barriers that they face.

Table 4.7: Preferred Mode of Delivery of the CPD Activities

Interview 1	Interview 2	Interview 3	Interview 4
<ul style="list-style-type: none"> • Online Interactive • Physical Interactive 	<ul style="list-style-type: none"> • Physical Attendance • Online Interactive • Video Conference 	<ul style="list-style-type: none"> • Physical Training • Online Video 	<ul style="list-style-type: none"> • Physical Interaction • Recoded Lectures • Video Conference

In a response to key questions about their perception of the important activities "*which CPD activities do you consider important in terms of the knowledge, skills, and attitude competencies respectively?*", the preferred activities were workshops, hands-on training, conferences, lectures, and journal clubs. In comparison to the actually attended activities

(Table 4.8) that were gathered in a response to another key question “what *CPD activities do you usually attend?*”, the analysis does not reveal any significant differences which reflects that RNs attended to what they really prefer. In addition to the “journal clubs” activity that was mentioned in interview 2, the only observed difference is represented by the specification of the training type as hands-on or simulation. This indicates their preference for a hands-on interactive methodology rather than traditional passive learning activities. Moreover, when they mentioned the “lectures” as an activity, they combined it with the term “interactive” as an “interactive lecture”. In other instances, they mentioned “interactive physical attendance” besides the training.

Table 4.8: Attended Activities and Preferred CPD Activities

Interview	Attended Activities	Preferred Activities
Interview 1	<ul style="list-style-type: none"> • Workshops • Lectures • Training 	<ul style="list-style-type: none"> • Lectures • Workshops
Interview 2	<ul style="list-style-type: none"> • Conferences • Workshops 	<ul style="list-style-type: none"> • Workshops • Conferences • Journal clubs - articles review
Interview 3	<ul style="list-style-type: none"> • Training • Workshops 	<ul style="list-style-type: none"> • Simulation Training (hands-on) • Workshops (teamwork)
Interview 4	<ul style="list-style-type: none"> • Workshops • Lectures 	<ul style="list-style-type: none"> • Hands-on training • Workshops • Lectures

From a different perspective, the analysis of group 2 revealed a new factor; networking and entertainment. This was evident in the excerpt from participant 15 when the following comment was made:

Meeting our colleagues outside the work area.

Additionally, participant 18 agreed with what was stated by participants 14 and 16:

Socialising and gathering. (Participant 14)

Social Network. (Participant 16)

In a response to these statements, participant 17 justified this motive by reflecting on the social lives of nurses and stated:

Actually, nurses have difficult social lives.

In fact, the personal factors were not rated the highest among RNs. However, they expressed their perceptions emotionally during this part of the discussions. This implies the impact of such factors on participation in the CPD activities. Their interests were diverse and multidimensional; interest in the topic, interest in the type of activity, and interest in the mode of delivery. Besides their social lives, which might be affected by different factors, RNs have a significant influence on their participation where some of them reflected that entertainment is a motive to participate.

4.3.2.2 Theme 2.2: Barriers

The barriers to participate in the CPD activities, which were analysed from the qualitative data, have been expressed in the different parts of the focus groups. Four main categories of barriers were captured from the data. The barriers were categorised under two different conditions which are considered as sub-themes; intangible conditions and tangible conditions (Table 4.9). Both conditions were adopted from the “conditions” construct of the Q-PDN questionnaire which represents the “barriers”.

Table 4.9: Sub-themes and Categories of the Barriers Theme

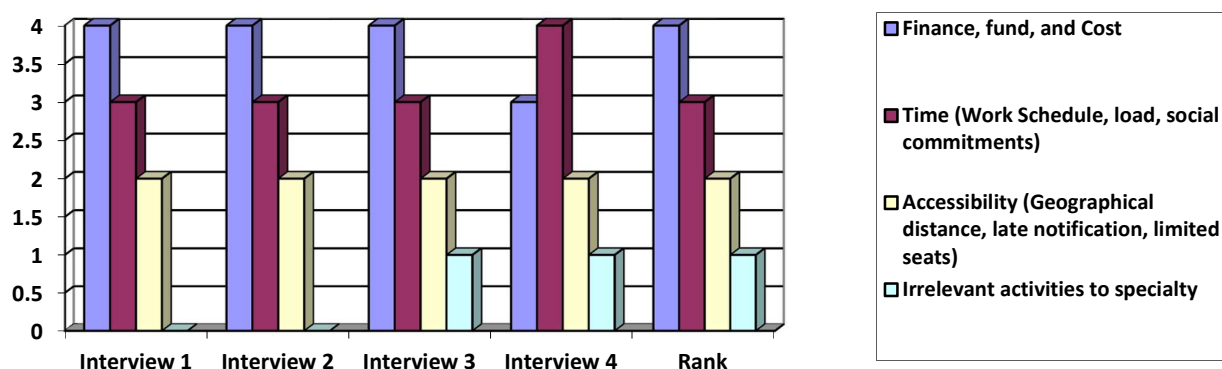
#	Theme	#	Sub-theme	Categories
2.2	Barriers	2.2.1	Factors related to intangible conditions	<ul style="list-style-type: none"> • Irrelevant activities to specialty
		2.2.2	Factors related to tangible conditions	<ul style="list-style-type: none"> • Finance, fund, and cost • Time (work schedule, load, social commitments) • Accessibility (geographical distance, late notification, limited/available seats)

Based on the analysed data (Table 4.10), the trend of the prevailing barriers among the four focus groups can be drawn very clearly showing that the tangible conditions were more common and important to RNs in comparison to the intangible conditions (Figure 4.5). The overall rank of the four categories show that the “finance, fund, and cost” barrier comes first before the “time”, “accessibility”, and “Irrelevant activities”.

Table 4.10: Overview of the Barriers from the Focus Groups

Barrier	Interview 1	Interview 2	Interview 3	Interview 4	Total Points	Rank (Points)
Finance, Fund, and Cost	1 (4 points)	1 (4 points)	1 (4 points)	2 (3 points)	15	1 (4 points)
Time	2 (3 points)	2 (3 points)	2 (3 points)	1 (4 points)	13	2 (3 points)
Accessibility	3 (2 points)	3 (2 points)	3 (2 points)	3 (2 points)	8	3 (2 points)
Irrelevant Activities to Specialty	0	0	4 (1 point)	4 (1 point)	2	4 (1 point)

Figure 4.5: Distribution and Ranking of the Barriers



4.3.2.2.1 Factors Related to Intangible Conditions

The intangible conditions were represented by the “Irrelevant activities to specialty” barrier. It was the least important barrier among the four identified categories. The relevancy issue has been discussed as a direct barrier in two interviews by most of the

RNs. However, it has been discussed from the “needs analysis” perspective in all interviews. In this context, participants 13 and 16 stated:

I prefer to have CPDs related to my, um, role as a nurse. (13)

I need something related to my, uh, position to improve myself. (16)

The same opinion was expressed by participant 19 as the first spontaneous response to the barriers question when responded:

Sometimes the topics.

Looking to the CPD activities, from the perspective of having a clear career perspective, has been an issue for RNs in terms of their development as they suffered with the CPD activities that are irrelevant to their specialty. Despite some nurses highlighting the fact that they attend irrelevant CPD activities aiming to attain the required CPD hours to get their licences renewed, they still see this as a barrier for the kind of participation that aims to develop them professionally.

4.3.2.2 Factors Related to Tangible Conditions

The tangible conditions were represented by three categories: (1) finance, fund, and cost, (2) time (work schedule, load, social commitments), and (3) accessibility (geographical distance, late notification, limited seats).

The financial barrier was the most common and frequent concept in the focus groups. The RNs connected the financial perspective to almost every single aspect under discussion. The financial concern has been discussed from the perspective of “expensive CDP activities”, “affordable CPD activities”, “free CPD activities”, and “funded CPD activities”. It has been evident that the cost of the CPD activities was an intolerable burden. Reflecting on the cost of the CPD activities, participant 13 indicated that:

There are very big expenses really on our shoulders.

Aligned with this, participant 29 presented some details of the cost when stated:

...it's costly for us at least. If you've been asking about our financial status. Who will pay 4,000 AE Dirhams (around 1,100 US Dollars) for 20 hours?

In agreement with participant 29, participant 30 shared the obstacles in the costs by stating a conditional “okay”:

...we need to pay for the CME hours. If it is free, then it's okay for us.

Secondly, the “time” was another challenge for RNs. The time included the offering time of the CPD activities, the workload, the schedule, and the social commitments. Reflecting on the schedule, participant 4 expressed it as a barrier to get free CPDs when stated:

Though there were, um, some free CPDs, we don't usually get them because sometimes they conflict with our work schedules.

Participant 17 added that the length of conferences is a cause for concern by stating:

Not only expensive, 'cause sometimes the conference will be two or three days.

The combination of timing and the social life was expressed by participant 14 by stating:

...they are forced to attend with all real-life constraints, he has to come after night, after off, not to go somewhere for a social activity.

However, participant 31 viewed time as the most concern:

...the problem for us is the time.

Lastly, accessibility was viewed as another major barrier for RNs in Abu Dhabi, especially in the Al Ain and Al Dhafra regions, considering that Al Dhafra is in the rural area. In addition to the late notification and limited seats issues, the most common accessibility concern was the geographical distance. The challenge was highlighted by participant 14 when stating:

...it's a long distance because we have no transport, accommodation, going, coming back, maybe its two-three hours to Dubai where I need to travel six hours to go and come back, so that's a bigger challenge.

Expressing the same opinion, participant 31 stated:

There's no one offering CMEs here, so we have to travel two hours to attend, or even go as far as Dubai. So, four hours.

The notification was another concern for some RNs especially in the governmental facilities which fund such activities. This perception was evident in the excerpt from participant 14:

...there is a symposium going on which covers your area, but maybe it's not within, uh, approach or you are not being addressed or you're not aware.

Whereas participant 16 raised a common accessibility issue among all facilities that is concerned with the limited seats of the free CPD activities:

It would be a limited number, uh, of participants and, uh... you have to wait something to get in.

The limited seats issue was evident also in what mentioned concisely and precisely by participant 3

Limited seats for the free.

Appreciating the efforts of the leadership, participant 16 highlighted the importance of the accessibility issue when stated:

They are trying to make a- a lot of, uh, opportunities for the staff, but I think the access to those programmes, uh, is the-the issue.

Thus, the concerns of the three accessibility aspects added more barriers to RNs' participation in the CPD activities. The geographical distance is a multidimensional barrier as it contributes to the timing and the cost barriers, especially for RNs working in the rural areas. Even with the availability of free convenient courses, RNs face some challenges in terms of the late notification which does not leave them enough room to manage their time. Additionally, the limited seats of these free courses represented another barrier for them.

4.4 CONCLUSION

In conclusion, this chapter presented an overview of participants' perceptions and detailed presentation of the findings under two domains and a total of four major themes. The findings included the framework that shaped the themes. The voices of the RNs were denoted by the excerpts and the transcribed data and the discussion of the findings is presented in the following chapter.

CHAPTER 5: QUANTITATIVE QUESTIONNAIRE FINDINGS

5.1 INTRODUCTION

In this chapter, an examination of the data collected through the survey questionnaire is conducted with the aim of identifying the trends in the data and the existing relationships. The chapter presents the detailed demographic analysis summarising the central tendencies and standard deviations. Furthermore, each of the three primary constructs; motives, conditions, and CPD activities, are examined through frequency analysis to reveal the trends in the collected responses. Correlation analysis through the application of Pearson Correlation test was conducted to determine the strength of the relationships and Regression analysis was conducted to verify the proposed hypotheses.

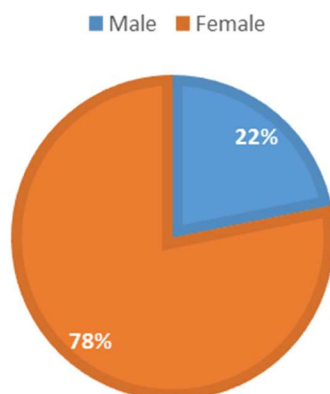
5.2 DEMOGRAPHIC ANALYSIS

5.2.1 Frequency and Descriptive Analysis for Demographics

In this section, the demographic-related questions are examined through the aid of charts and tables as they allow for observation of the trends in the study's population. A total of 261 responses were collected representing a response rate of 69.04% from the originally identified sample ($n = 378$) and 65.25% from the adjusted sample ($n = 400$). Post data screening and cleaning was conducted to eliminate incomplete responses. The demographic questions comprised 11 items: gender, age, nationality, total years of experience as an RN, total years of experience as an RN in Abu Dhabi, facility's region in Abu Dhabi, type of facility, governor of facility, current unit/ward, level of education, and position. Each of these items are examined in detail below.

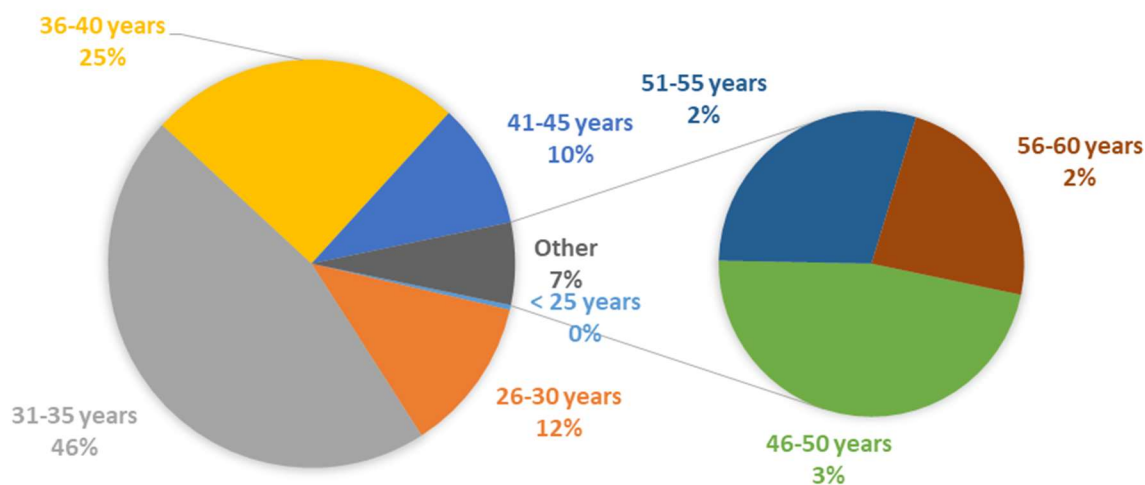
As shown in figure 1, the majority of respondents were females ($N = 204$, 78%) whereas male respondents constituted only 22% ($N = 57$). This reflects that the nursing profession in Abu Dhabi is predominantly female.

Figure 5.1: Responses according to gender



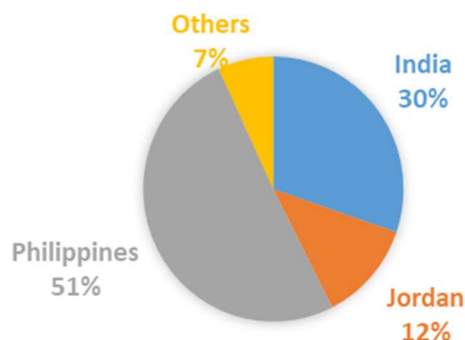
The respondents' distribution based on age group is shared in figure 5.2. As observed, the majority of respondents were between the ages of 31-35 years (N = 120; 46%). Followed by 36-40 years (N = 65; 24.9%), 26-30 years (N = 32; 12.3%), and 41-45 years (N = 26; 10%). The age group with the fewest respondents was < 25 years. This indicates that the majority of nurses in Abu Dhabi fall in the age group of 26 to 45 years.

Figure 5.2: Responses according to age



In terms of nationality, respondents dominating the research study were from the Philippines (N = 132; 50.6%), followed by India (N = 79; 30.3%), and Jordan (N = 32; 12.3%) [See figure 5.3]. This indicates that the higher number of healthcare professionals in the UAE (specifically Abu Dhabi) are Filipinos and Indians.

Figure 5.3: Responses according to nationality



Respondents' classification based on the total years of experience as RNs, is shared in figure 5.4. As observed, N = 91 (34.9%) respondents had 11-15 years of experience as an RN, followed by 6-10 years (N = 79; 30.3%), and 16-20 years (N = 56; 21.5%). In terms of total experience as an RN, the majority of the respondents had 6-10 years of experience (N = 89; 34.1%), followed by 1-5 years (N = 85; 32.6%), and 11-15 years (N = 62; 23.8%) [See figure 5.5].

Figure 5.4: Total Experience of RNs

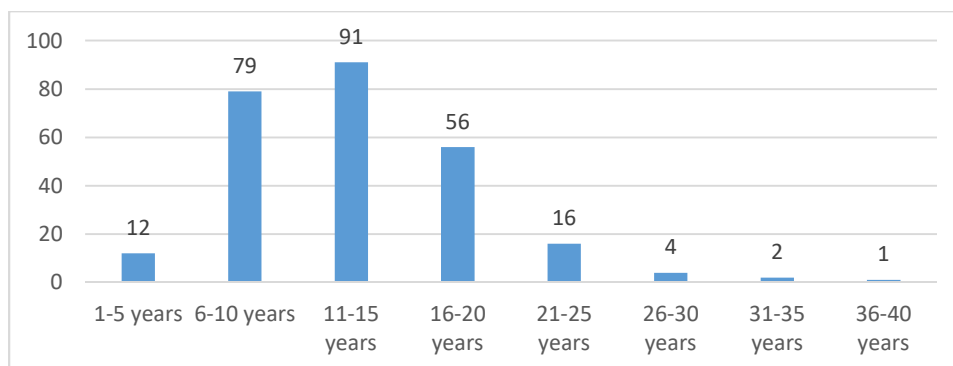
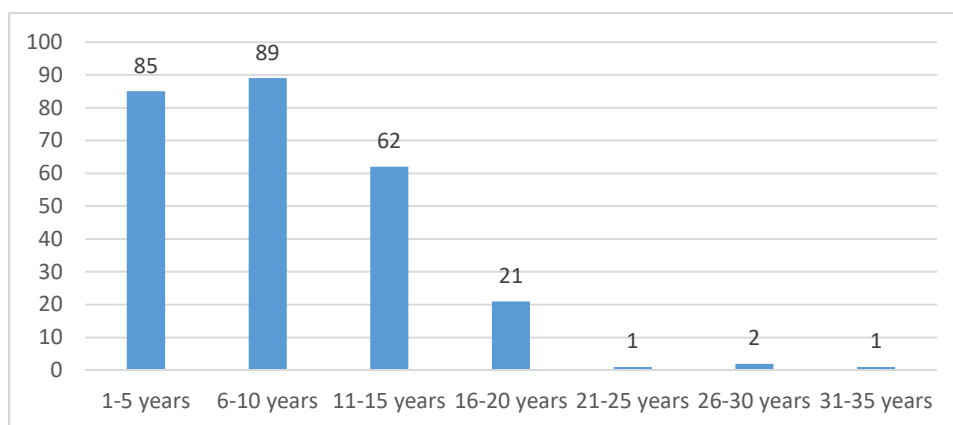


Figure 5.5: Total Experience of RNs in Abu Dhabi

From the 261 respondents, the majority 63.6% (N = 166) were based at facilities located in Abu Dhabi city, while N = 78 (29.9%) indicated their location as Al Ain, and N = 17 (6.5%) as Al Dhafra (See figure 5.6). When asked to indicate the type of facility (figure 5.7), the majority (N = 215; 82.4%) worked in hospitals, while only 17.6% (N = 46) worked at a centre. On the other hand, (figure 5.8) 52.7% (N = 137) indicated the governor of the facility as government with the rest as private (N = 124; 47.5%).

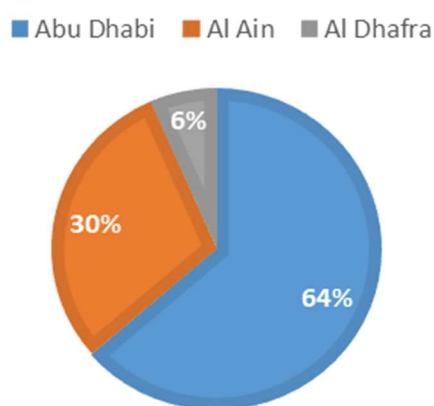
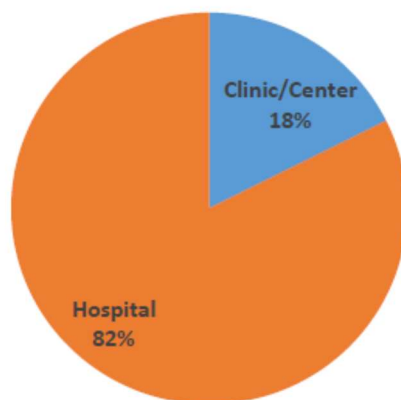
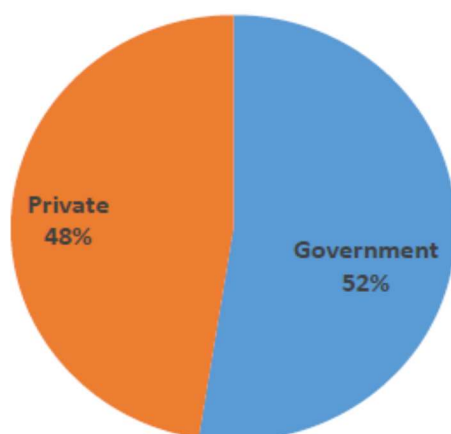
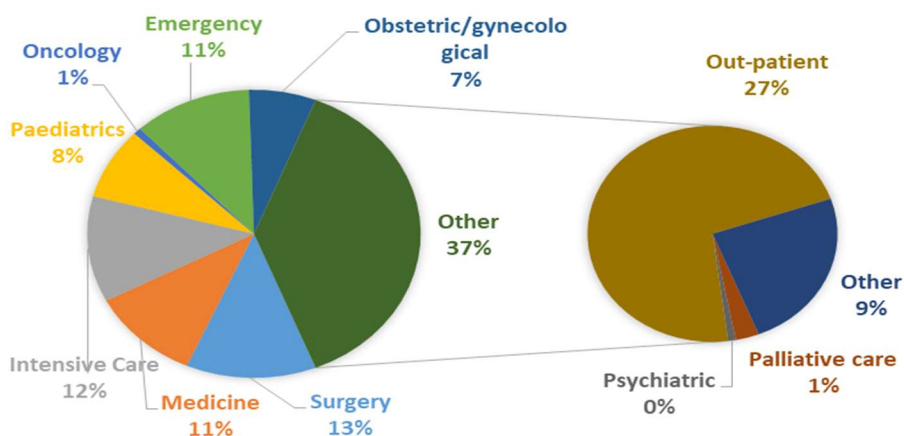
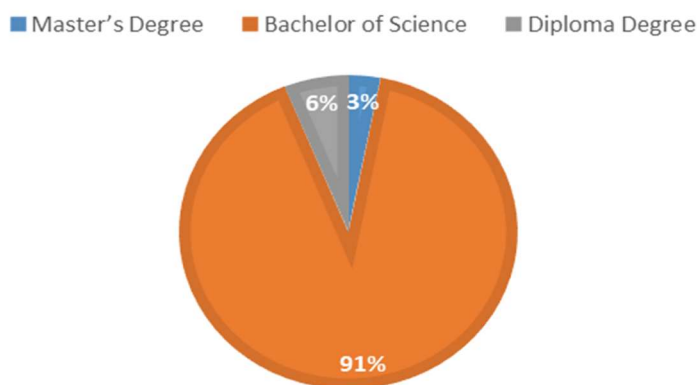
Figure 5.6: Facility's Region in Abu Dhabi

Figure 5.7: Facility's Type in Abu Dhabi**Figure 5.8: Facility's Governor in Abu Dhabi**

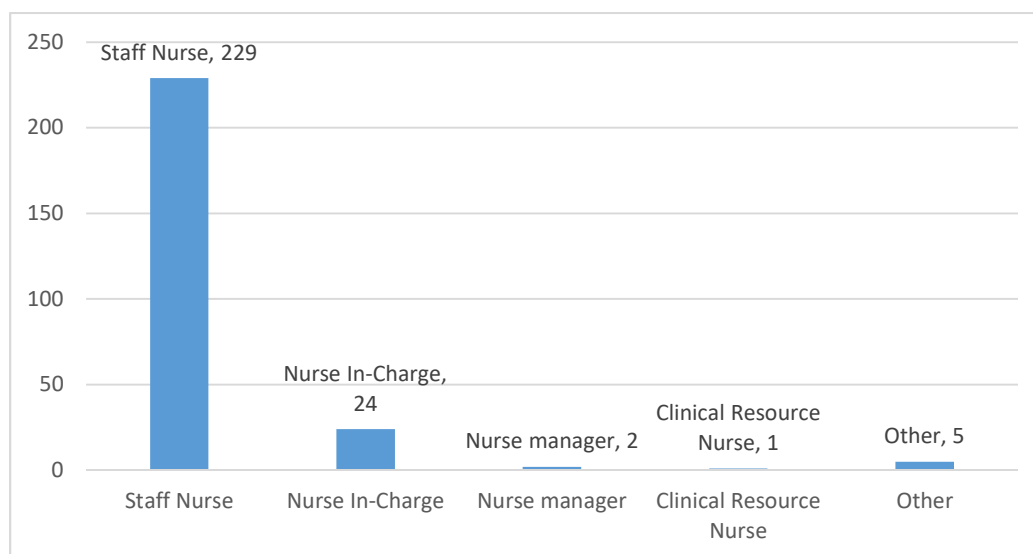
When inquired about the current unit/ward of practice, the majority 27.2% (N = 71) indicated that they work in the out-patient section. A similar distribution was observed between surgery (N = 33; 12.6%), medicine (N = 28; 10.7%), intensive care (N = 31; 11.9%), and emergency (N= 30; 11.5%). A more detailed classification is illustrated in figure 5.9.

Figure 5.9: Current Ward/Unit

In terms of education, as shown in figure 5.10, 237 of 261 respondents had Bachelor of Science degrees (90.8%), followed by Diplomas (N = 16; 6.1%) and Master's Degrees (N = 8; 3.1%) [Figure 8]. This indicates that the nursing profession in Abu Dhabi has a limited outlook towards gaining postgraduate education.

Figure 5.10: Level of Education

The respondents' distribution, based on their current position, is shared in figure 5.11. As observed, the majority of respondents held 'staff nurse' positions (N = 229; 87.7%) followed by 'nurse in-charge' (N = 24; 9.2%). The number of nursing professionals in senior positions is limited.

Figure 5.11: Current Position

The descriptive statistics for the demographic variables are presented in table 5.1. The mean and standard deviation for the variables is also listed in the same table. Standard deviation for nationality and current unit/ward is above the “1” range which indicates that these variables have a higher distribution of data. For other variables, the majority of distribution (68%) fall within the “1” standard deviation from the observed mean.

Table 5.1: Descriptive Statistics for Demographic Variables

Demographic element	Mean	Std. Deviation
Gender	1.78	.414
Age	3.56	1.200
Nationality	3.20	2.306
Total Experience as RN	3.04	1.143
Total Experience as RN in Abu Dhabi	2.13	1.060
Facility's region in Abu Dhabi Emirate	1.43	.614
Type of Facility	1.18	.382
Governor of Facility	1.48	.500
Your Current Unit/Ward	6.06	3.622
Level of Education (Relevant to Nursing)	3.03	.302
Your Current Main Position	1.23	.934

5.2.2 Mapping Demographics with the CPD Constructs

In this section, three demographic variables are mapped against the four CPD constructs to examine the sub-elements within each demographic and its relation to the CPD construct. The three demographic elements are the facility's region in Abu Dhabi, governor, and type of facility. The importance of the three demographic elements come from their position in the sampling procedures. Sub-factors, which are the sub-variables, of each construct are listed in table 5.2.

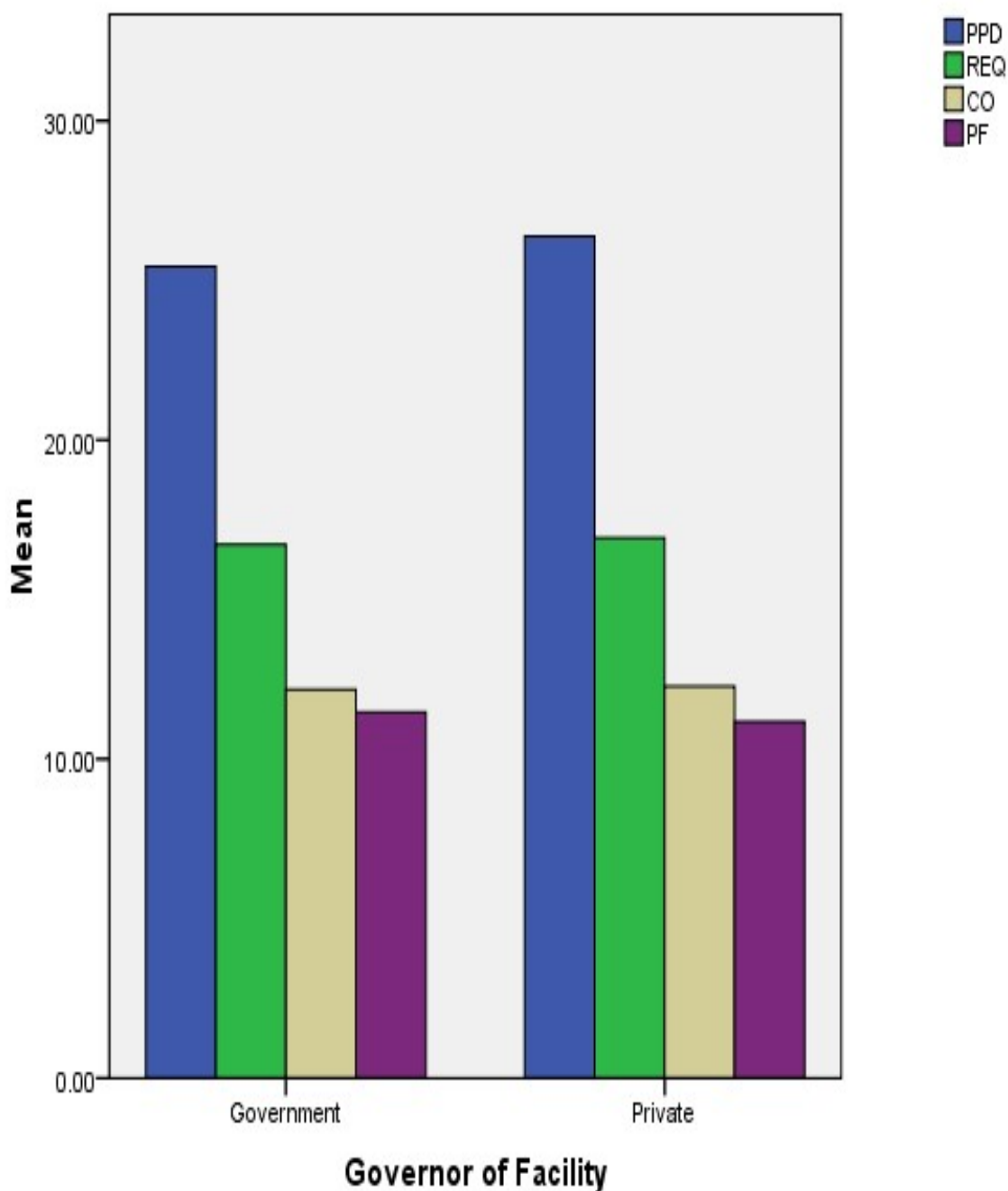
Table 5.2: List of the Constructs and their Corresponding Sub-Factors

Construct	Sub-Factors	Abbreviation of Sub-factors
1. Motives	Personal and Professional Development	PPD
	Requirements	REQ
	Career Opportunities	CO
	Personal Factors	PF
2. Conditions	Intangible conditions	IC
	Material conditions	MC
3. Important Activities (IA)	Participation in Research	IA-PR
	Clinical Practice Development	IA-CPD
	Participation in Organisation Development	IA-POD
4. Activities Actually Undertaken (AAU)	Participation in Research	AAU -PR
	Clinical Practice Development	AAU -CPD
	Participation in Organisation Development	AAU -POD

5.2.2.1 Mapping with the “Motives” Construct

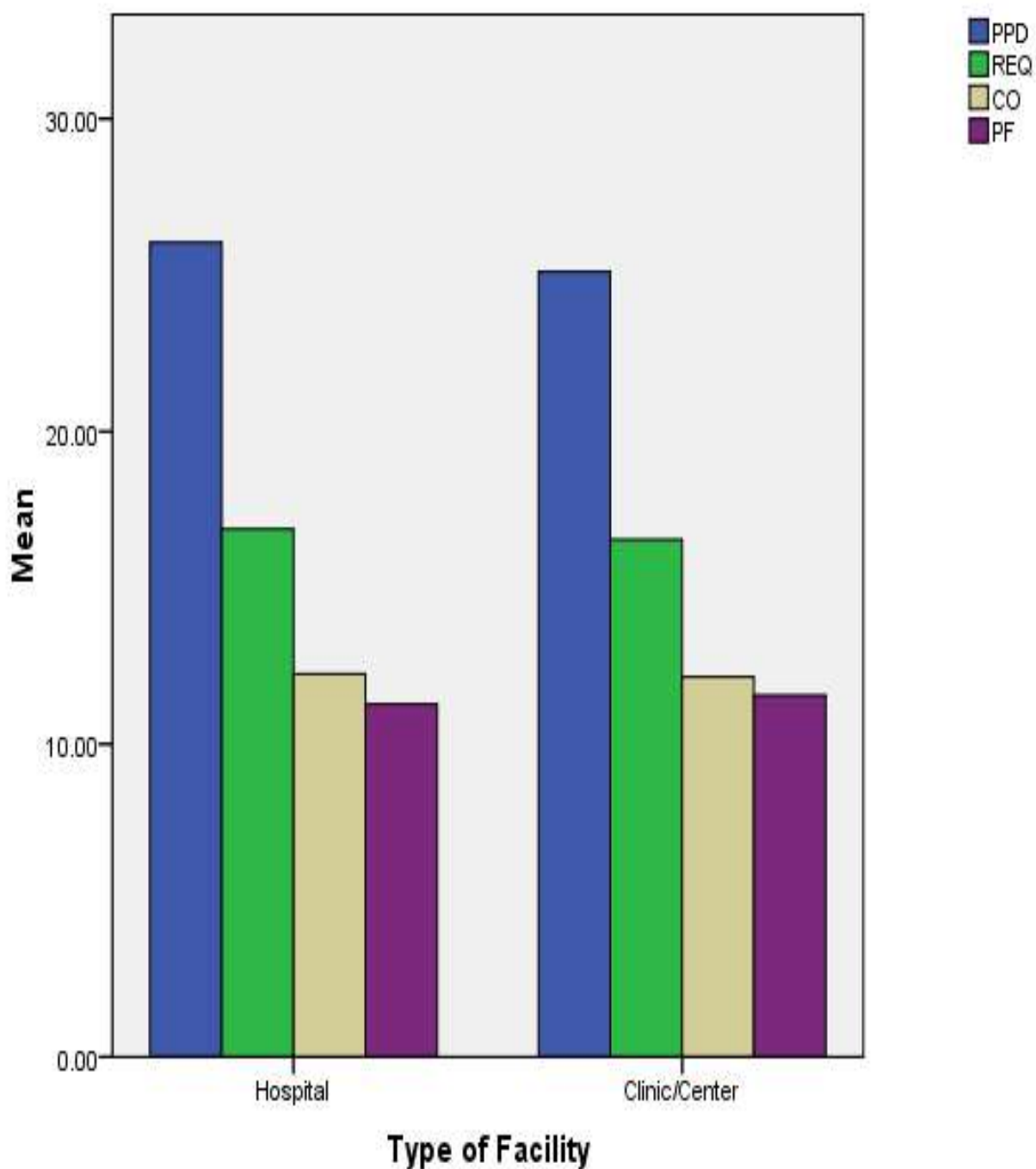
The mean score of the governor of facility for the four sub-variables (sub-factors) in the motives construct reflect an equal distribution of the mean between the government and private sector but with a slightly higher mean for the private sector for the “PPD” sub-factor (Figure 5.12).

Figure 5.12: Mapping Mean between Motives and Governor of Facility



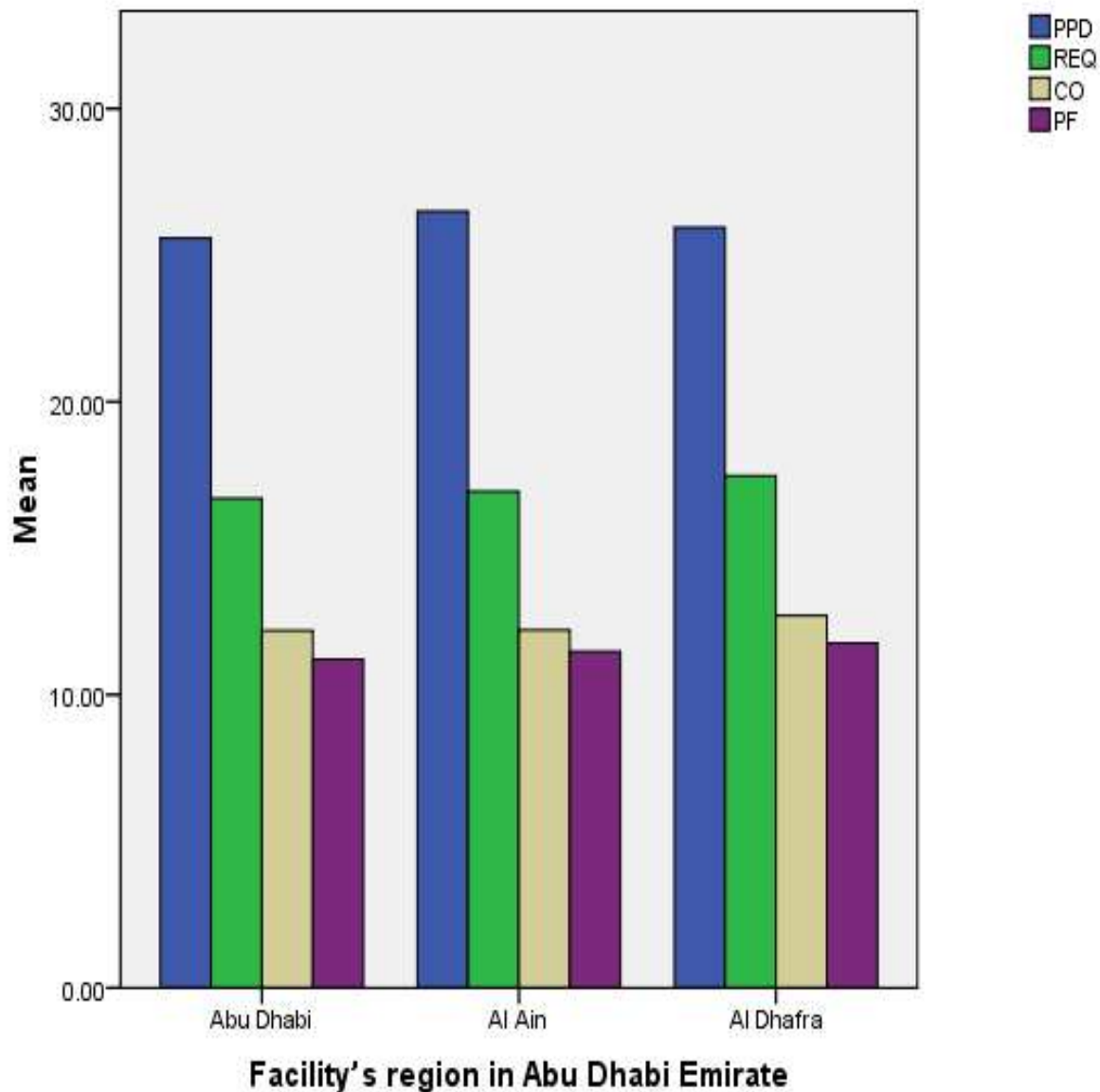
The mean score of the type of facility for the four sub-variables in the motives construct reflect an equal distribution of the mean between the hospitals and centres, except for a slight drop in the mean for the PPD sub-factor for the centres (Figure 5.13).

Figure 5.13: Mapping Mean between Motives and Type of Facility



The mean score of the facility's region in the Abu Dhabi Emirate and the motives sub-factors (figure 5.14) indicates a relatively similar distribution of the mean. However, a slightly higher mean is observed for Al Ain in the case of PPD sub-factor.

Figure 5.14: Mapping Mean between Motives and Facility's Region in Abu Dhabi



5.2.2.2 Mapping with the “Conditions” Construct

The mean score of the governor of facility for the two sub-variables, IC and MC, in the conditions construct reflect an equal distribution of the mean between the government and the private sector (Figure 5.15). However, a higher mean is reported for the IC. A similar distribution of the mean is observed in the case of type of facility as seen in Figure 5.16 with a higher mean reported for the MC.

Figure 5.15: Mapping Mean between Conditions and Governor of Facility

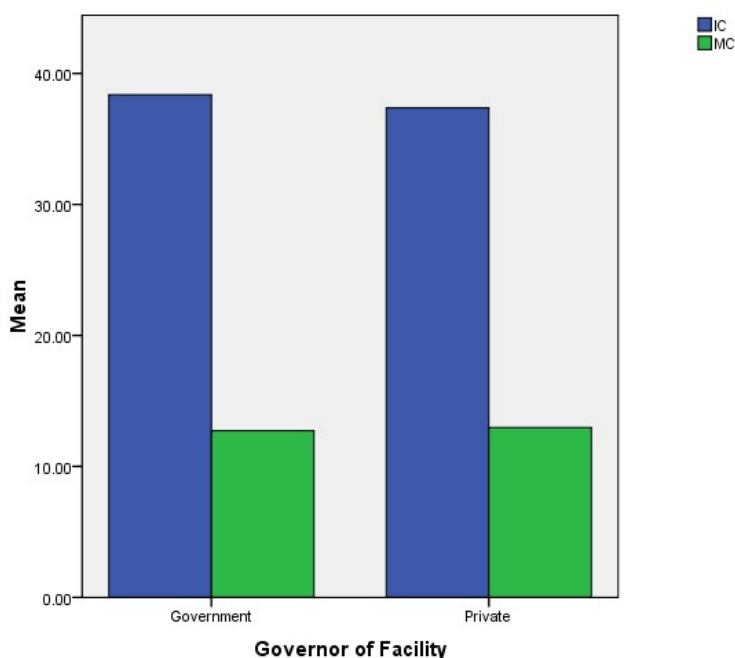
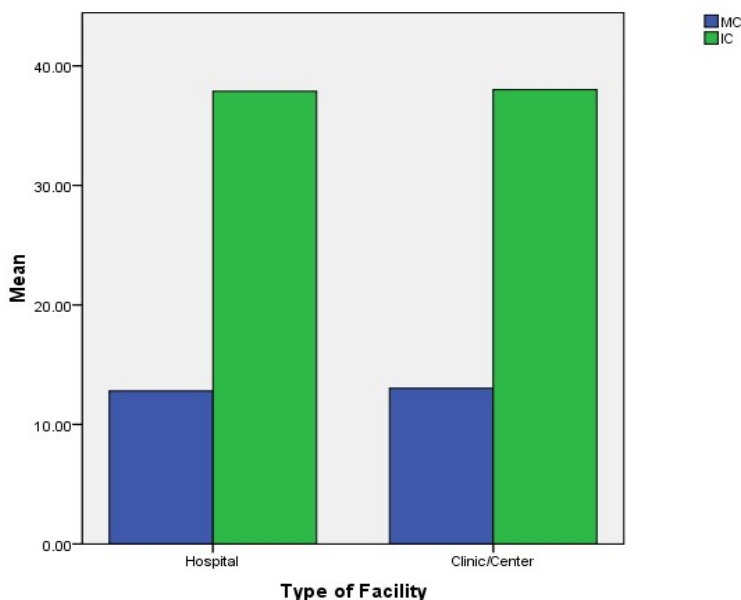
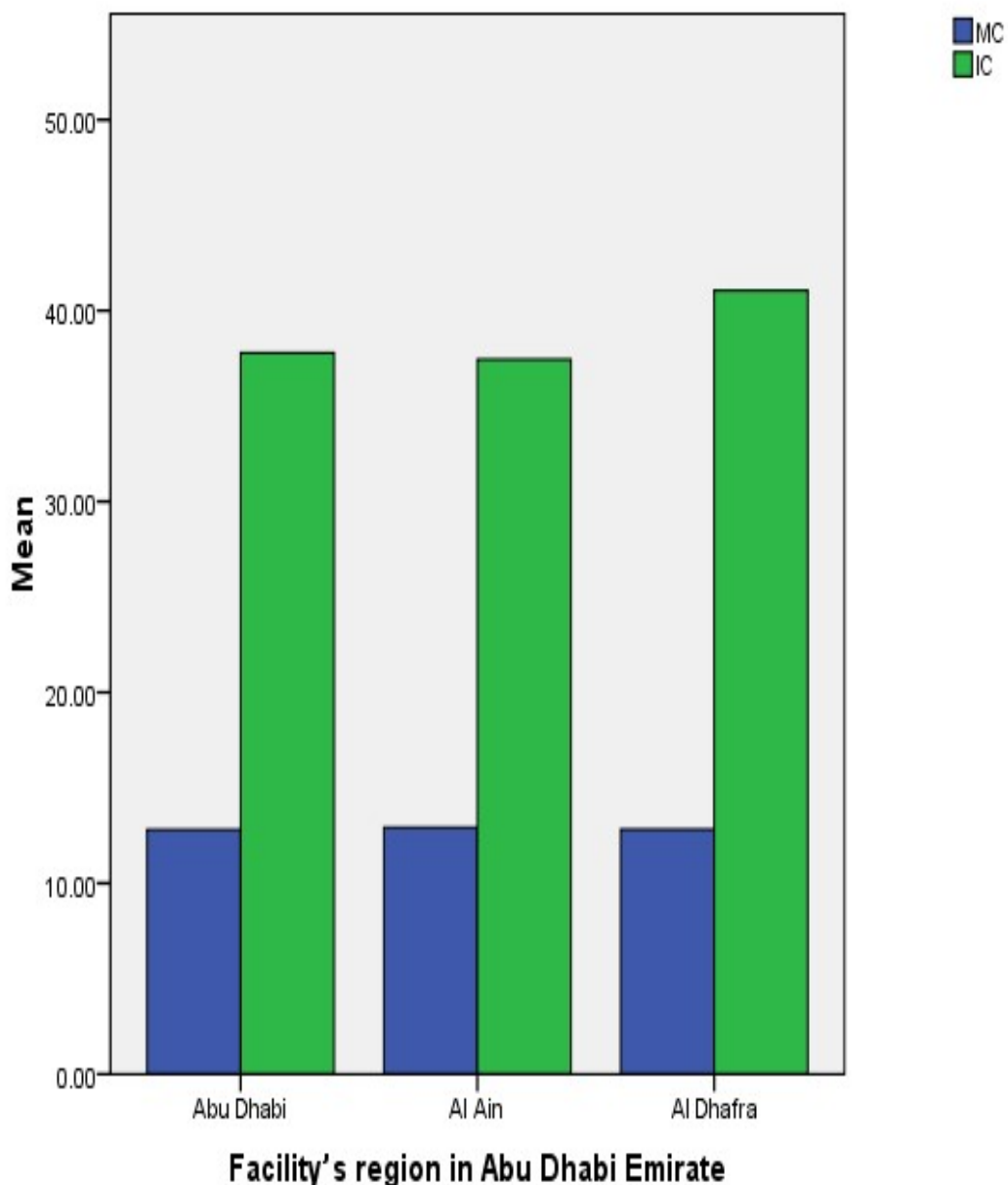


Figure 5.16: Mapping Mean between Conditions and Type of Facility



The mean score of the facility's region in the Abu Dhabi Emirate and the conditions' sub-variables (Figure 5.17) indicates a relatively similar distribution of mean. However, a slightly higher mean is observed for the Al Dhafra region in the case of material conditions (MC).

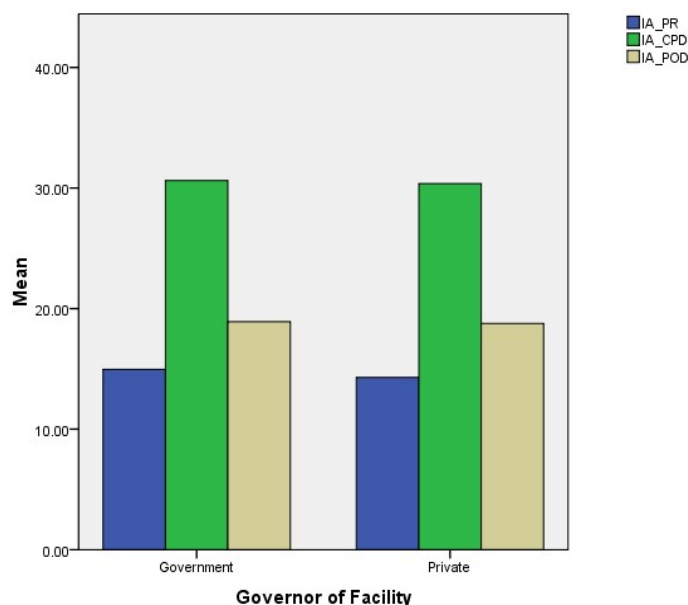
Figure 5.17: Mapping Mean between Conditions and Facility's Region in Abu Dhabi



5.2.2.3 Mapping with the “Important Activities” Construct

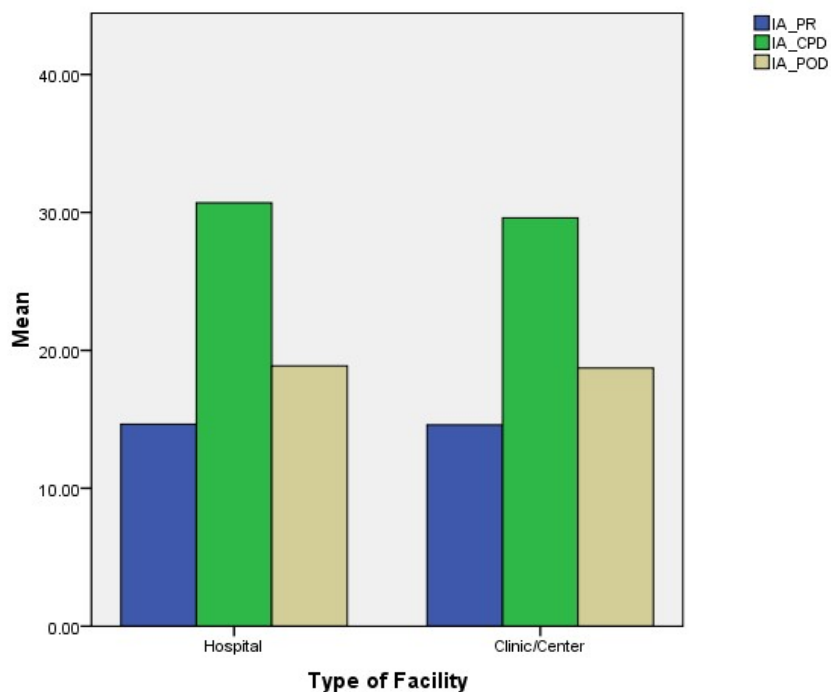
The mean score of the governor of facility for the three sub-variables (IA-PR, IA-CPD, and IA-POD) in the important activities construct reflect an equal distribution of the mean between the government and the private sector (Figure 5.18). However, a higher mean is reported for IA-CPD followed by IA-POD.

Figure 5.18: Mapping Mean between Important Activities and Governor of Facility



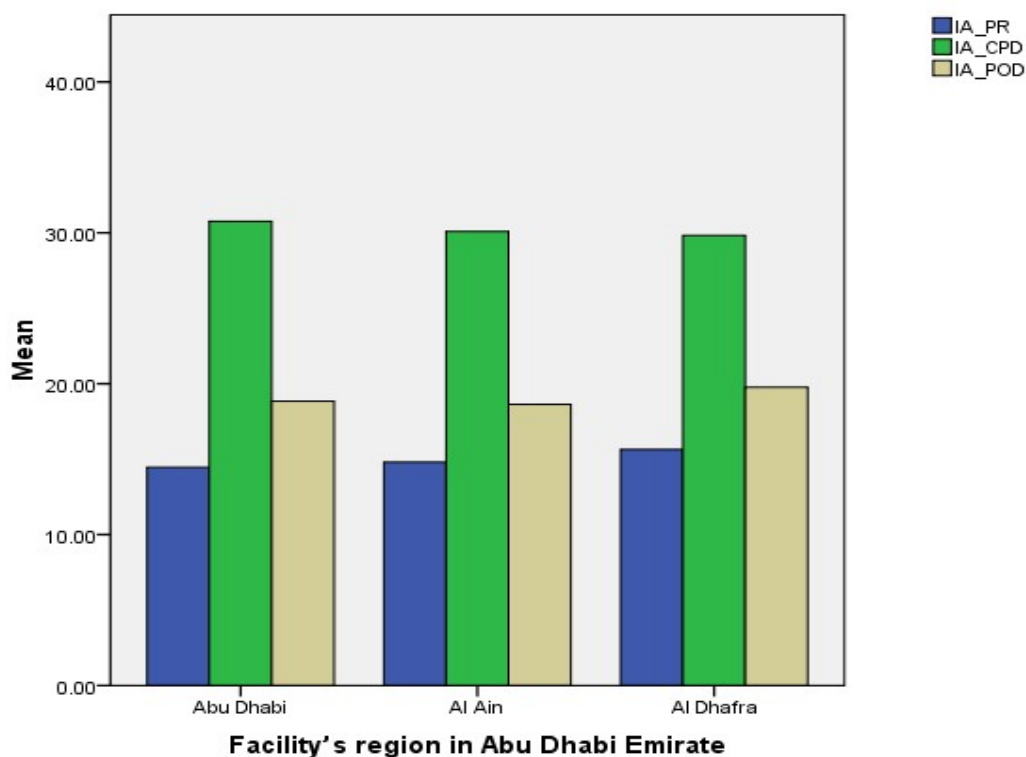
The distribution of mean between the important activities' sub-variables and type of facility, as seen in Figure 5.19, is equal between the hospitals and centres. However, a higher mean is observed for the IA-CPD sub-variable.

Figure 5.19: Mapping Mean between Important Activities and Type of Facility



The mean score of the facility's region in the Abu Dhabi Emirate and the important activities' sub-variables (Figure 5.20) indicates a relatively similar distribution of mean across Abu Dhabi, Al Ain, and Al Dhafra. However, a relatively higher mean is observed for IA-CPD and IA-POD.

Figure 5.20: Mapping Mean between Important Activities and Facility's Region in Abu Dhabi



5.2.2.4 Mapping with the “Actual Activities Undertaken” Construct

The mean score of the governor of facility for the three sub-variables (AAU-PR, AAU-CPD, and AAU-POD) in the “activities actually undertaken” construct reflect an equal distribution of the mean between government and the private sector (Figure 5.21). However, a higher mean is reported for IA-CPD followed by IA-POD. Similarly, the distribution of the mean between the “activities actually undertaken” construct and the type of facility, as seen in figure 5.22, is equal between the hospitals and centres. However, a higher mean is observed for the AAU-CPD sub-variable.

Figure 5.21: Mapping Mean between Actual Activities Undertaken and Governor of Facility

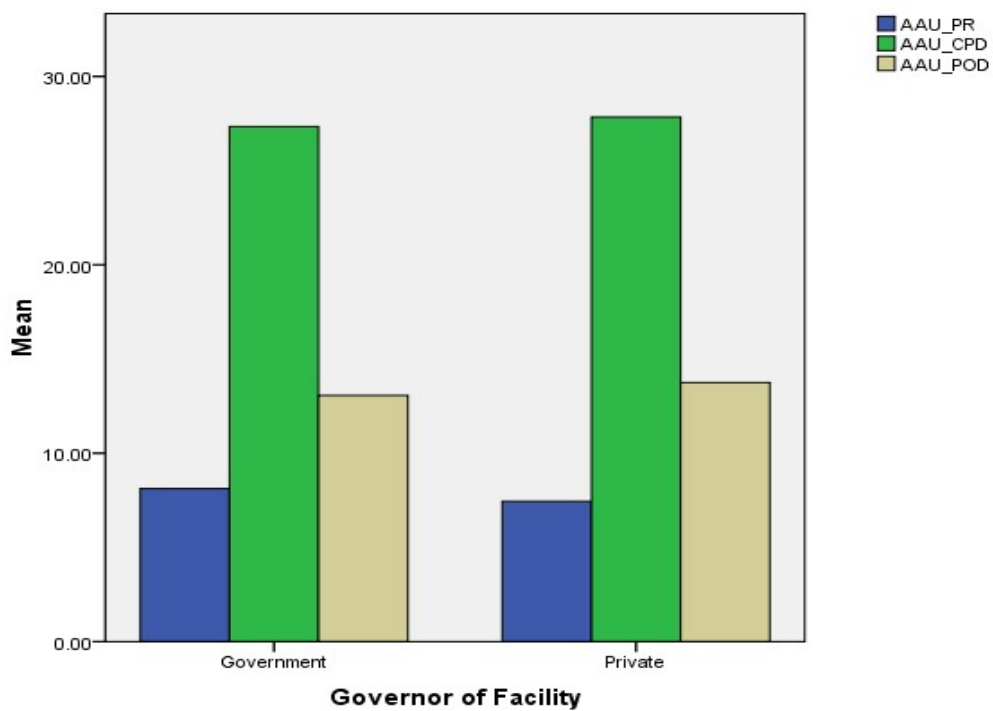
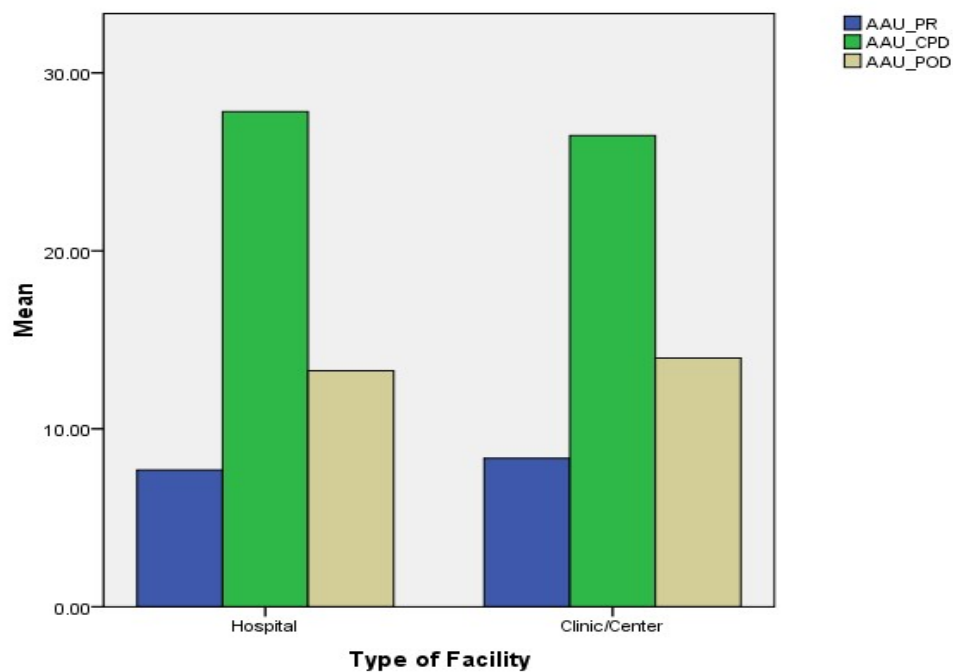
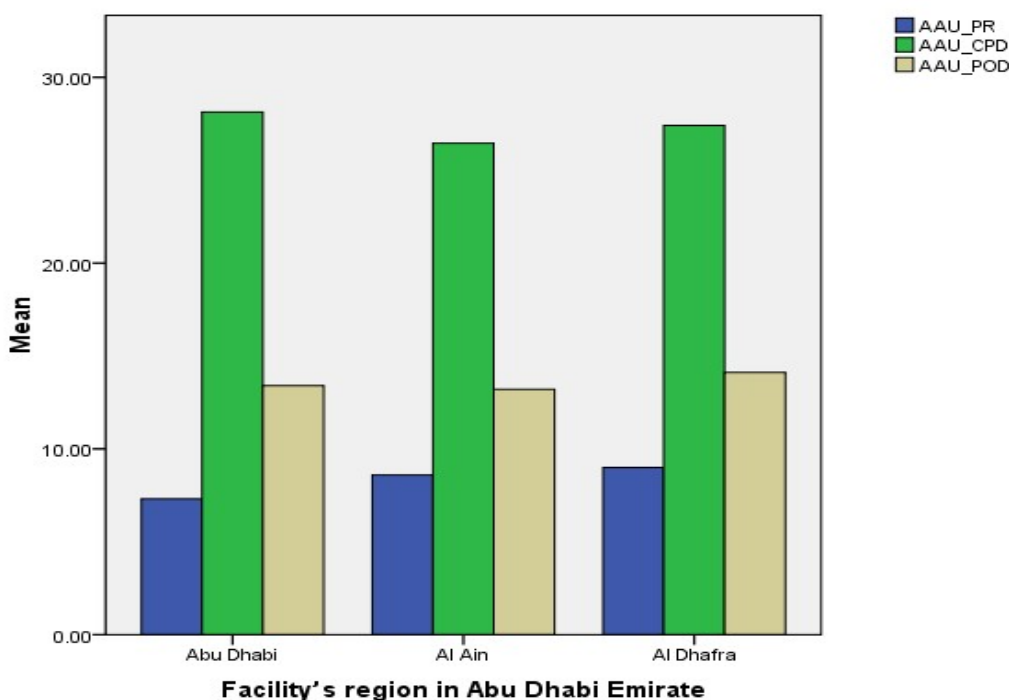


Figure 5.22: Mapping Mean between Actual Activities Undertaken and Type of Facility



The mean score of the facility's region in the Abu Dhabi Emirate and the "actual activities undertaken" sub-variables (Figure 5.23) indicates a relatively similar distribution of the mean across Abu Dhabi, Al Ain, and Al Dhafra. However, a relatively higher mean is observed for Abu Dhabi across AAU-CPD followed by AAU-POD.

Figure 5.23: Mapping Mean between Actual Activities Undertaken and Facility's Region in Abu Dhabi



5.3 CONTINUOUS PROFESSIONAL DEVELOPMENT

In this section, an examination of the four constructs is conducted. These include: motives, conditions, important activities, and actual activities undertaken.

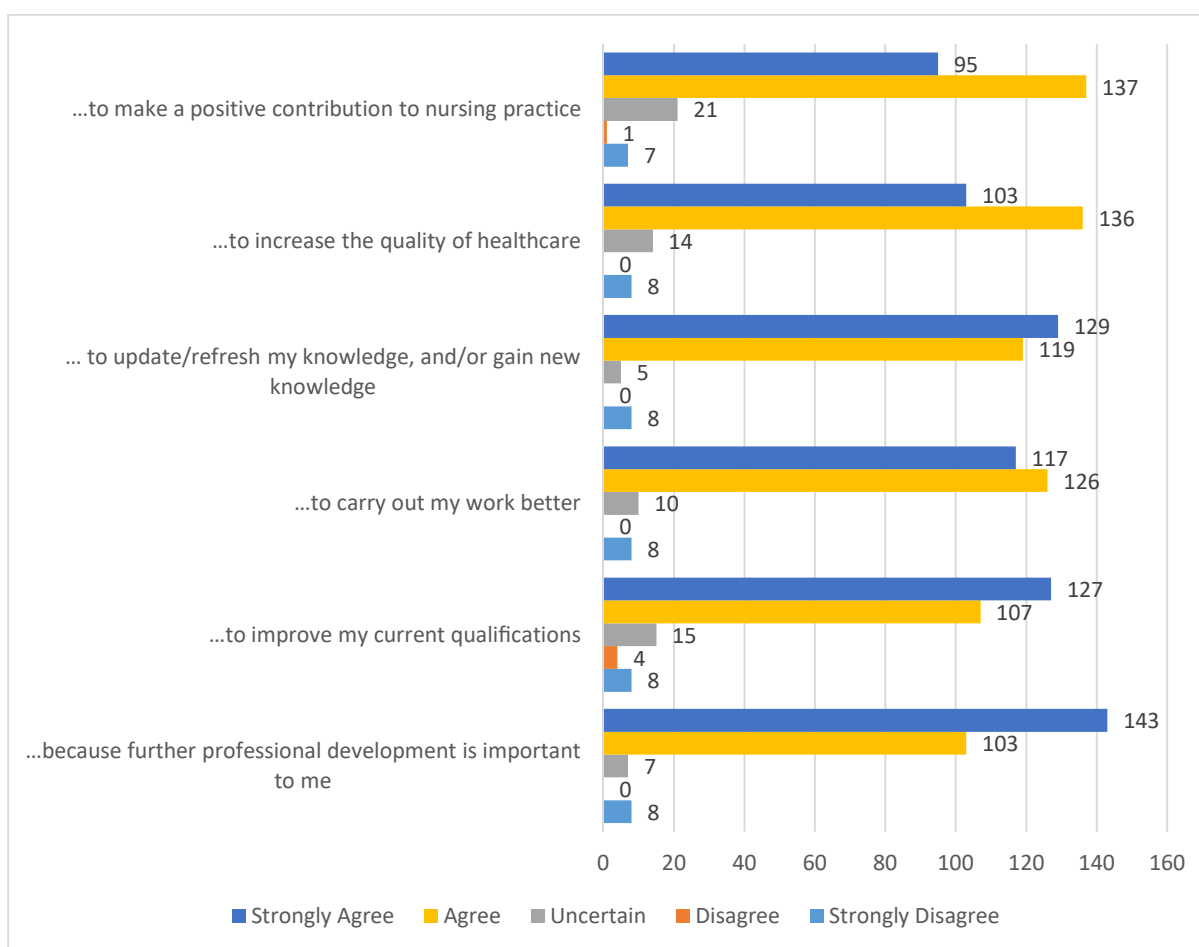
5.3.1 CPD Motives

The motives construct comprises a total of 16 items, which are classified into four sub-variables; personal and professional development (PPD), requirements (REQ), career opportunities (CO), and personal factors (PF).

5.3.1.1 Personal and Professional Development

This sub-variable comprises six items that examine the respondents, based on questions linked with personal and professional development. As observed in figure 5.24, the sum of the “agree” and “strongly agree” responses reveals that 95% of respondents (N = 248) indicated the motive as ‘to update/refresh my knowledge, and/or gain new knowledge’. At the same time, 94.25% (N = 248) indicated the motive ‘further professional development is important’, 93.1% (N = 243) as ‘to carry out my work better’, 91.57% (N = 239) as ‘to increase the quality of healthcare’, 89.65% (N = 234) as ‘to improve my current qualifications’, and 88.88% (N = 232) as ‘to make a positive contribution to nursing practice’. This indicates that the respondents are clear about the importance of CPD in improving their personal and professional development.

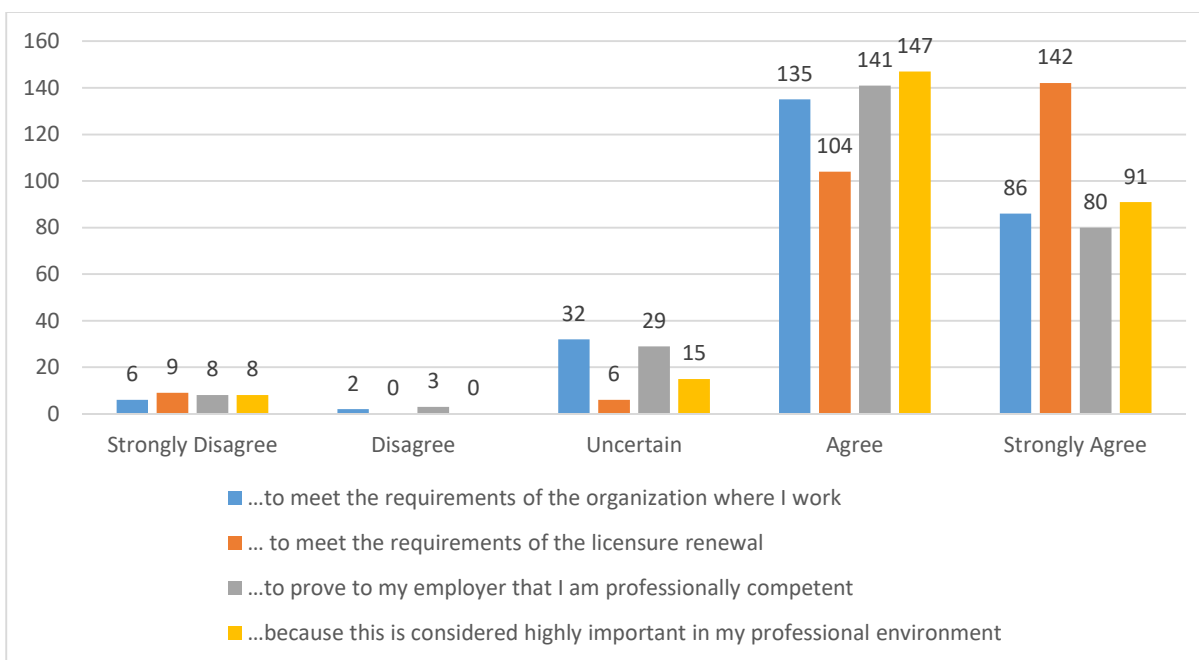
Figure 5.24: Responses for CPD Motives - Personal and Professional Development



5.3.1.2 Requirements

This sub-variable comprises four items which are aimed at capturing the motives of respondents to support their respective organisation. Figure 5.25 presents the responses. Overall, a higher “agreement” and “strong agreement” were observed. The sum of the “agree” and “strongly agree” responses reveals that 94.25% (N = 246) indicated the requirement motive to participate in CPD is ‘to meet the requirements of the licensure renewal’, 91.18 (N = 238) indicated as ‘because this is considered highly important in my profession’, and 84.67% (N = 221) indicated as ‘to meet the requirements of the organisation where I work’ and ‘to prove to my employer that I am professionally competent’. The “agree” responses were higher than the “strongly agree” in all requirement motives except in ‘to meet the requirements of the licensure renewal’. On the other hand, minor “uncertainty” and “disagreement” were observed.

Figure 5.25: Responses for CPD motives – Requirements

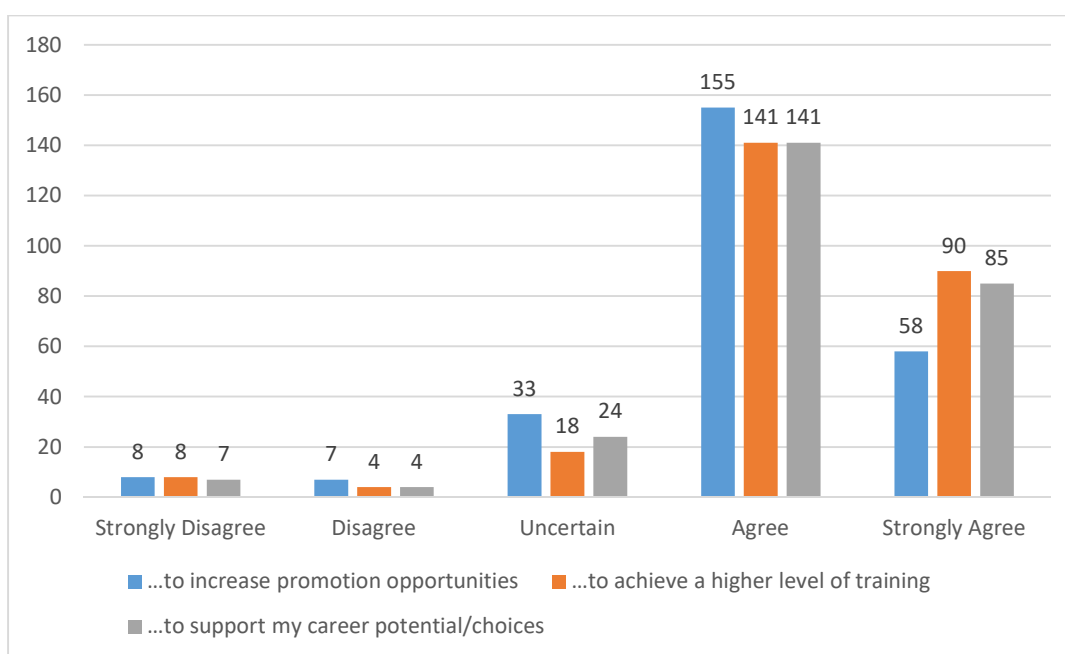


5.3.1.3 Career Opportunities

This sub-variable, under ‘CPD motives’, examines the motive of undertaking CPD and gaining career opportunities. As observed in figure 5.26, there are three items where the majority of respondents agree and strongly agree. The sum of the “agree” and “strongly

agree” responses reveals that 88.5% (N = 231) indicated that the motive behind their participation in CPD is ‘to achieve a higher level of training’, 86.59% (N = 226) indicated ‘to support my career potential/choices’, and 81.6% (N = 213) indicated ‘to increase promotion opportunities’. The “agree” responses were higher than the “strongly agree” in all motives concerning the career opportunities. This indicates the positive orientation of respondents in Abu Dhabi towards CPD in supporting them to gain career development in the form of promotion, specialised training, and better career opportunities.

Figure 5.26: Responses for CPD motives – Career Opportunities

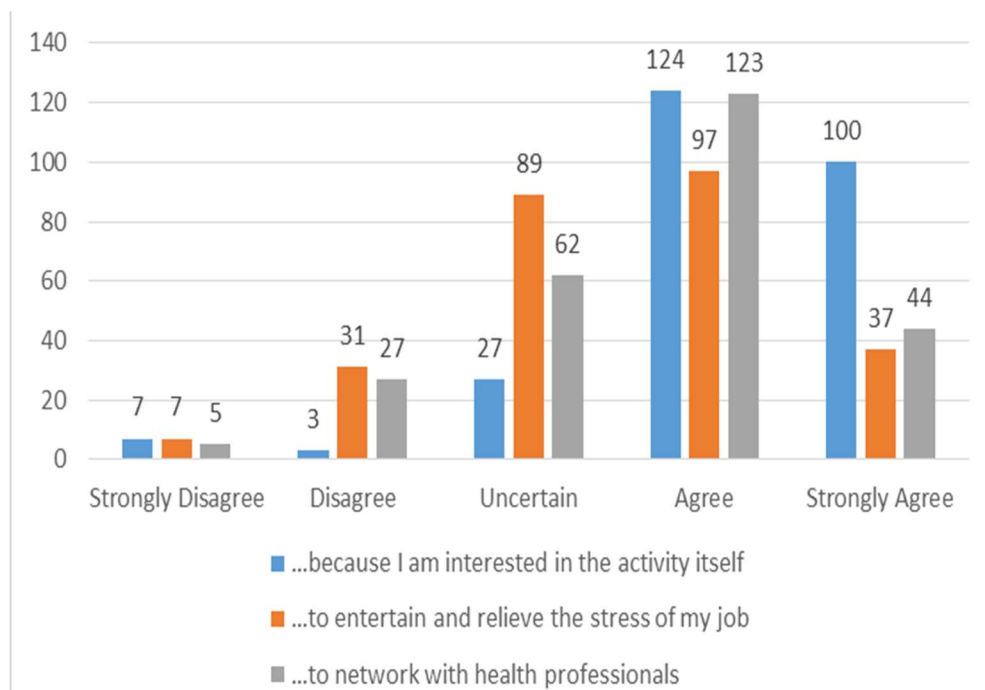


5.3.1.4 Personal Factors

This sub-variable comprises three items; inquiries about the personal motives of the respondents and CPD. As observed in figure 5.27, a higher number of positive responses were reported. The sum of the “agree” and “strongly agree” responses reveals that 85.82% (N = 224) reported that the personal motivation is ‘because I am interested in the activity itself’ whereas 63.98% (N = 167) indicated it as ‘to network with other health professionals’, and 51.34% (N = 134) as ‘to entertain and relieve the stress of the job’. The “agree” responses were higher than the “strongly agree” in all motives concerning the personal factors. A higher degree of uncertainty was also observed in the responses

for CPD supporting personal motives. 34.09% of the respondents indicated that they are uncertain about CPD activities leading to entertainment and/or reducing job related stress. This can be acknowledged as a positive response as well.

Figure 5.27: Responses for CPD motives – Personal Factors



5.3.2 CPD Conditions

This construct corresponds to questions indicating the limiting conditions under which the respondents own CPD can best be realised. There is a total of 13 items which are classified into two sub-variables: intangible conditions (IC) and material conditions (MC).

5.3.2.1 Intangible conditions

This sub-variable comprises 10 items that examine the respondents, based on questions that provide intangibility with CPD activities. As observed in figure 5.28, the overall responses are in agreement and uncertainty. Higher intangibility is recorded for work independence (N = 174; 66.7%), supervisor's support (N = 169; 64.8%), clear career perspective (N = 157; 60.2%), and supervisory coach (N = 153; 58.6%). Similarly, higher uncertainty was observed for intangibility in annual appraisal (N = 93; 35.6%), colleague as a coach (N = 87; 33.3%), and career guidance (N = 81; 31%).

5.3.2.2 Material conditions

This sub-variable comprises three items that examine the respondents based on questions that relate material conditions with CPD activities. As observed in figure 5.29, overall higher responses are reported in agreement and strong agreement. The sum of the “agree” and “strongly agree” responses reveals that 91.95% (N = 240) indicated the condition if ‘provided with the necessary time and/or convenient work schedule’, 91.57% (N = 239) indicated and ‘provided with the necessary time and/or convenient work schedule’, and 83.9% (N = 219) indicated ‘suitable supplementary training courses are offered’. This indicates that the respondents are clear about the material conditions of CPD that influence their participation in CPD activities.

5.3.3 CPD Important Activities and Activities Actually Undertaken

In this section, the constructs 3 and 4 are compared in order to assess the responses about the activities that nurses consider important and those they actually undertake. There are three similar sub-variables in both constructs. These include participation in research, clinical practice development, and participation in organisational development.

Figure 5.28: Responses for CPD Conditions – Intangible Conditions

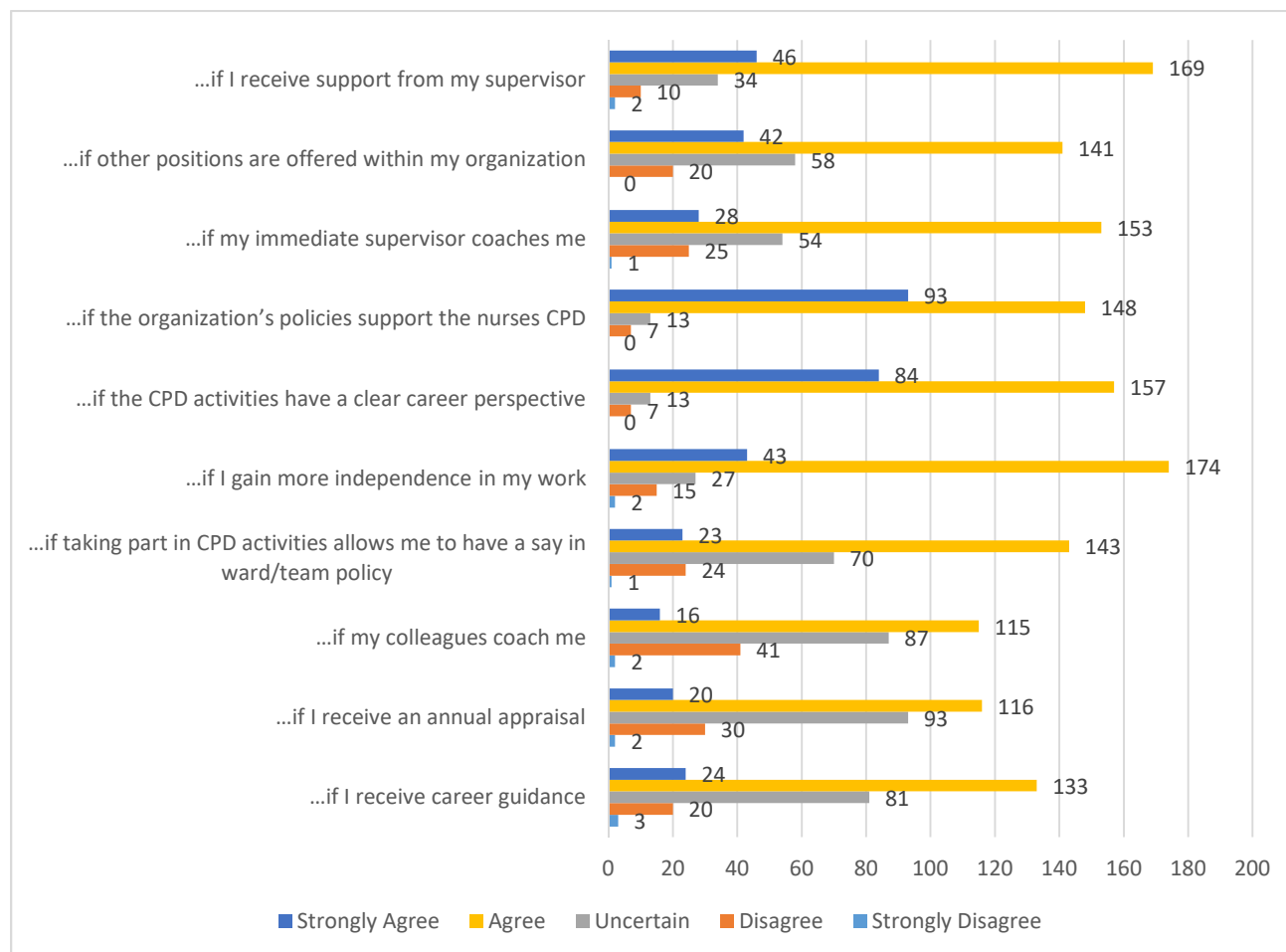
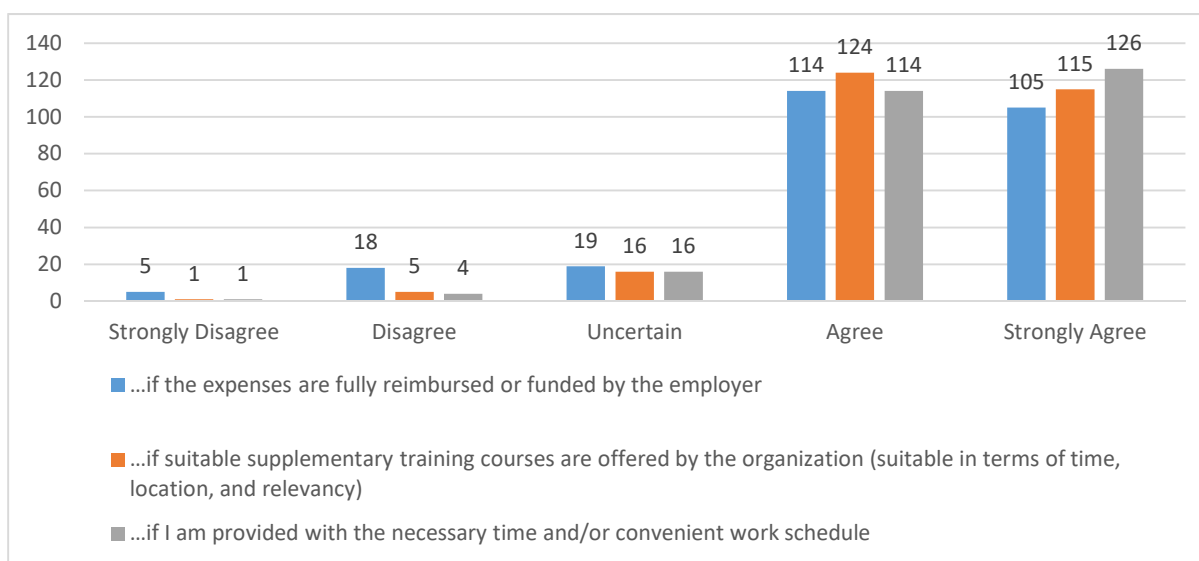


Figure 5.29: Responses for CPD Conditions – Material Conditions



5.3.3.1 Participation in Research

This sub-variable corresponds to questions related to CPD activities that are identified as important and those that are actually undertaken. There are four items.

As observed in figure 5.30, the main activities, as indicated by RNs, based on importance, include medical literature review, journal club preparation, research, and writing journal articles. In contrast, the actual activities undertaken differs. As seen in figure 5.31, writing professional articles is indicated to be the most 'not conducted research activity' (N = 188; 72%), followed by carrying out research (N = 131; 50.2%). The most frequently undertaken CPD activities include reviewing best practice literature (N = 10; 3.8%) and participating in journal clubs (N = 14; 5.4%) which is very low. This indicates that there is wide gap between the CPD activities that are identified as important and actual participation. One reason that can be linked with the above gap is the lack of time that may limit the research related activities for RNs.

Figure 5.30: Responses for CPD Important Activities – Participation in Research

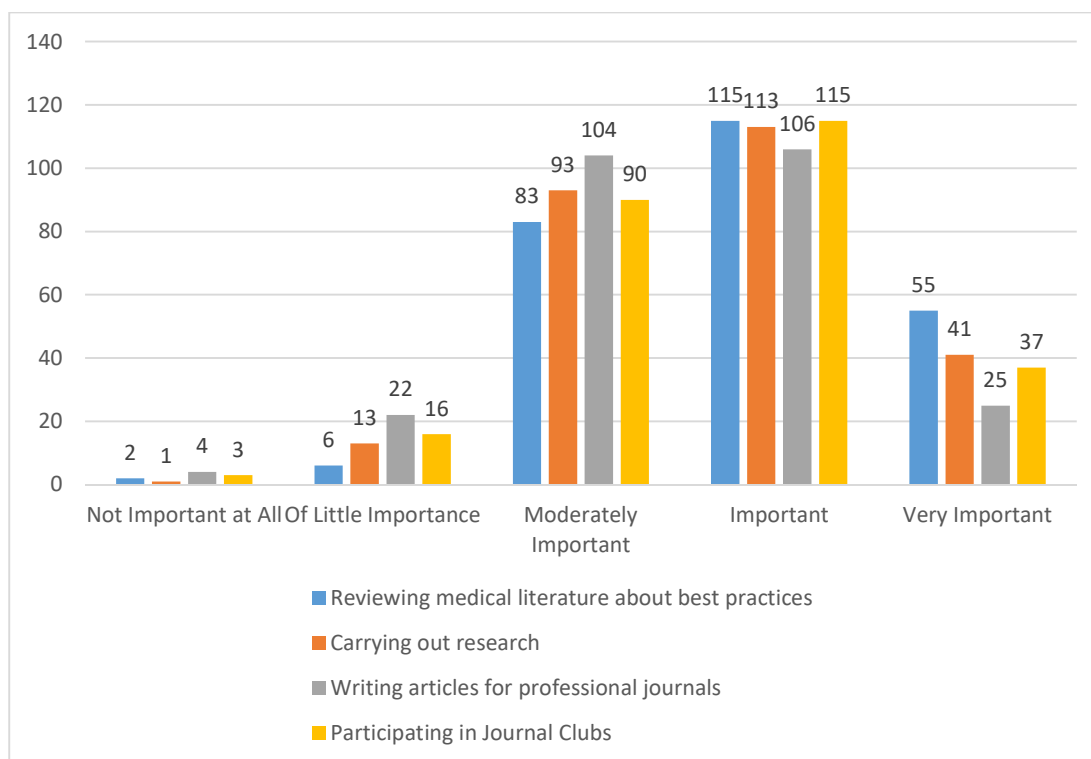
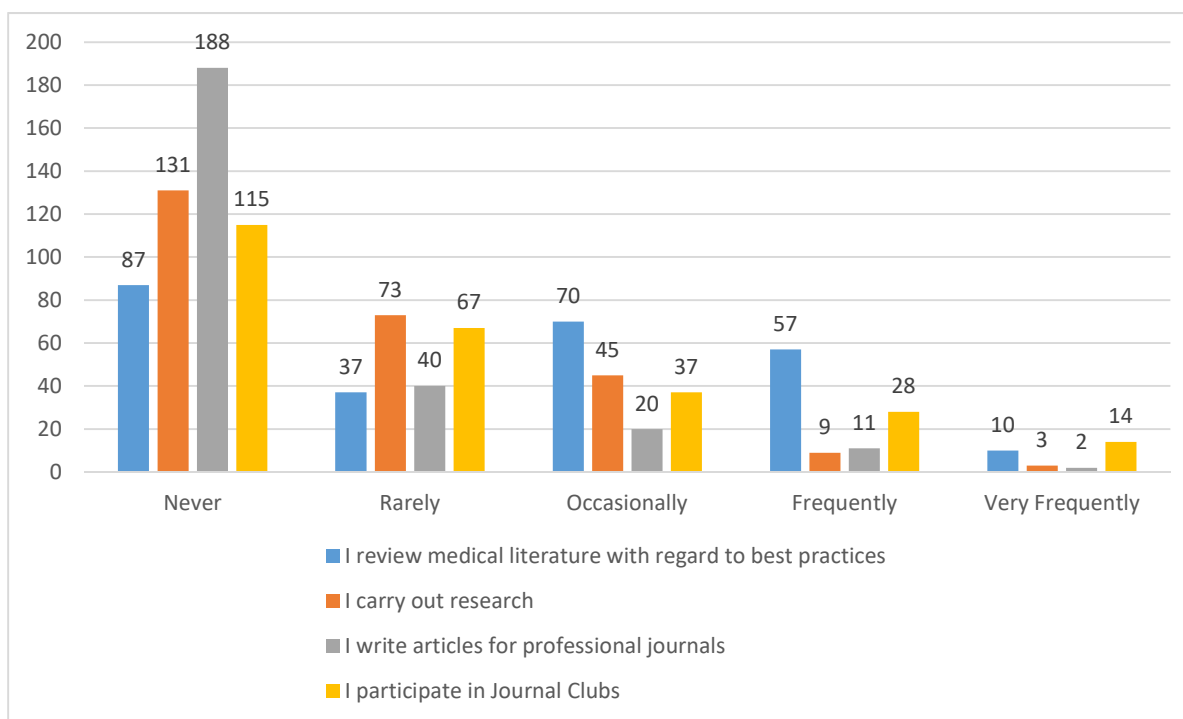


Figure 5.31: Responses for CPD Activities Undertaken – Participation in Research

5.3.3.2 Clinical Practice Development

This sub-variable comprises seven items which measure the CPD activities related to development of clinical practice.

As observed in figure 5.32, the CPD activities selected as of high importance include attending hands-on training courses which includes workshops (N = 143; 54.8%), keeping up to date with professional developments (N = 146; 55.9%), and reflecting critically on practical situations (N = 136; 52.1%). In contrast, the CPD activities that are actually undertaken as part of clinical practice development include (Figure 5.33) ‘hands-on training courses including workshops’ (N = 134; 51.3%), ‘keeping up-to-date with professional developments’ (N = 132; 50.6%), ‘reflect critically on practical situations’ (N = 137; 52.5%), and ‘determine whether I performed well and whether I could perform better next time’ (N = 136; 52.1%). The activities that match, based on importance attributed and actually performed, are “attending hands-on training courses including workshops”, “keeping up-to-date with professional developments”, and “reflecting critically on practical situations”. A smaller gap is observed between the CPD activities

based on importance and actually undertaken in clinical practice development in comparison with participating in research.

Figure 5.32: Responses for CPD Important Activities – Clinical Practice Development

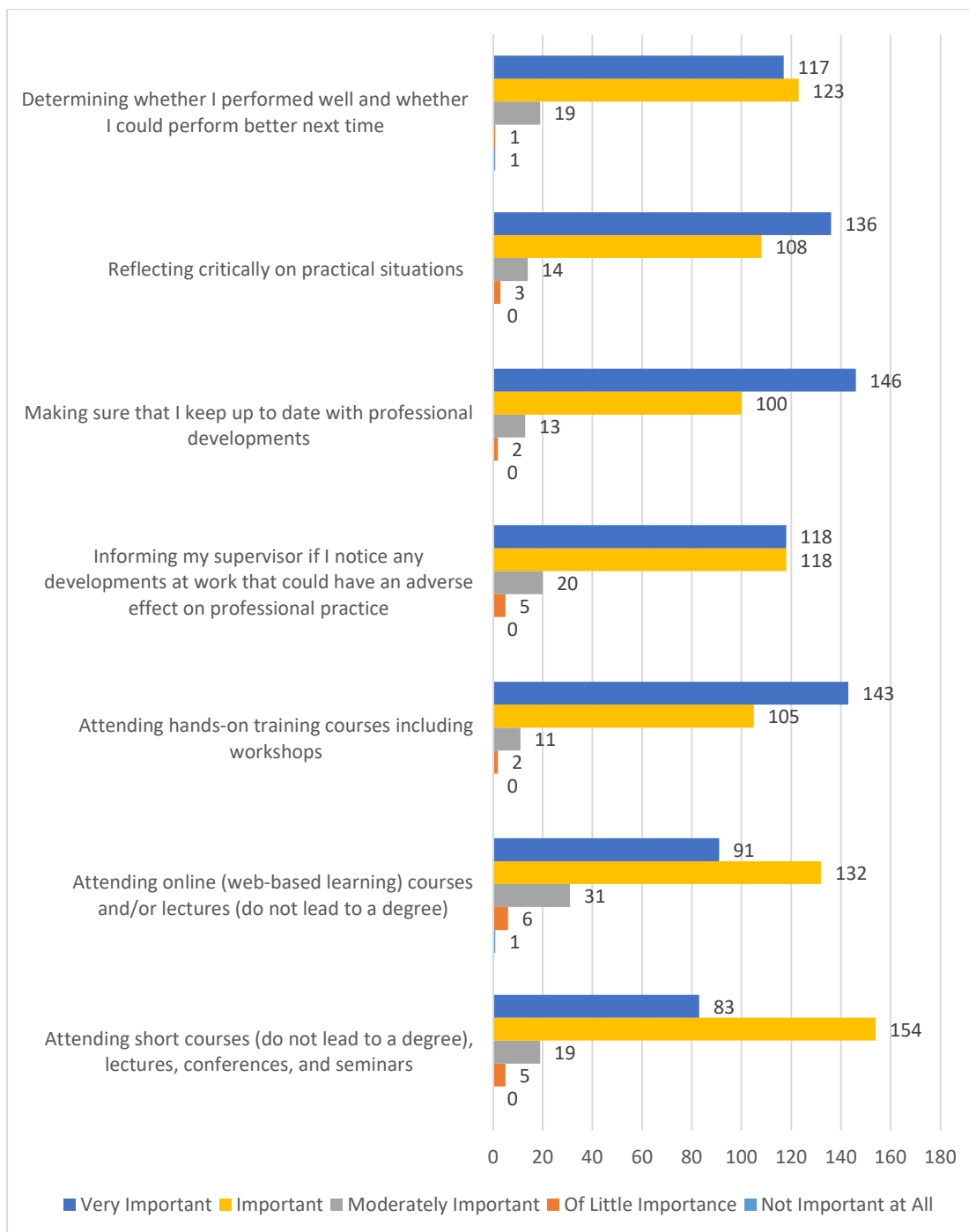
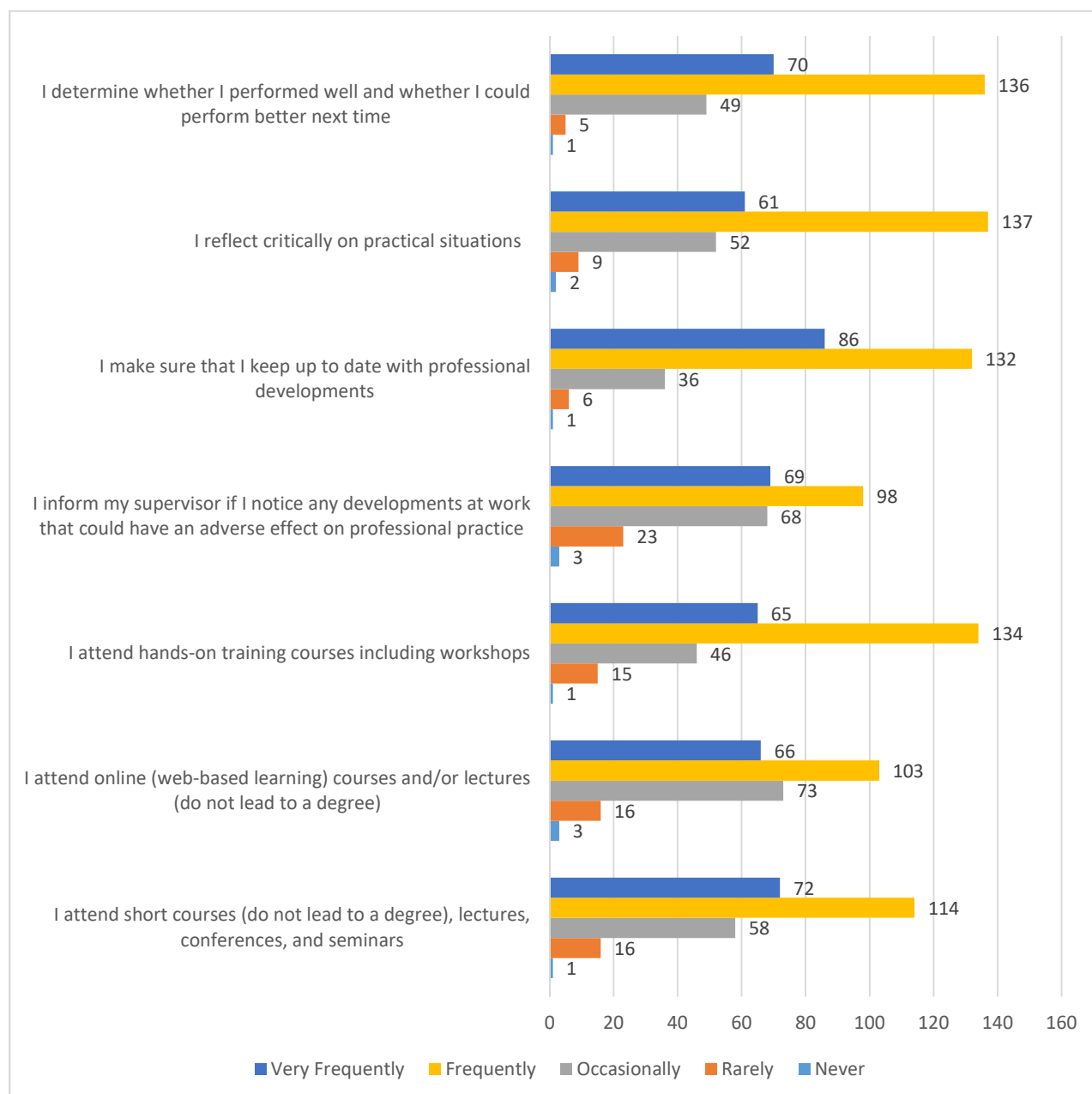


Figure 5.33: Responses for CPD Activities Undertaken – Clinical Practice Development



5.3.3.3 Participation in Organisation Development

This sub-variable comprises five items that measure the CPD activities for participation in organisational development. A comparison of CPD activities for this sub-variable towards importance and actually undertaken, is shown below.

As observed in figure 5.34, the most important CPD activities include 'Participation in policy development' (N = 156; 59.8%), 'Making sure that I keep up to date with policy developments' (N = 137; 52.5%), and 'Participating in internal projects' (N = 131; 50.2%). In contrast, as observed in figure 5.35, a lower response was observed towards these activities being actually performed. 'Participation in policy development' (N = 58; 22.2%), 'Making sure that I keep up to date with policy developments' (N = 86; 33%), and 'Participating in internal projects' (N = 67; 25.7%). Higher negative response was observed for participating in recruitment and selection interviews with new members of staff (N = 136; 52.1%) and participating in reflection and/or intercollegial consultation meetings (N = 97; 37.2%). The results indicate that though there is a slight gap between CPD activities under 'participation in organisational development' as per importance and being undertaken, it is lower in comparison with 'participation in research' and 'clinical practice development' sub-variables.

Figure 5.34: Responses for CPD Important Activities – Participation in Organisation Development

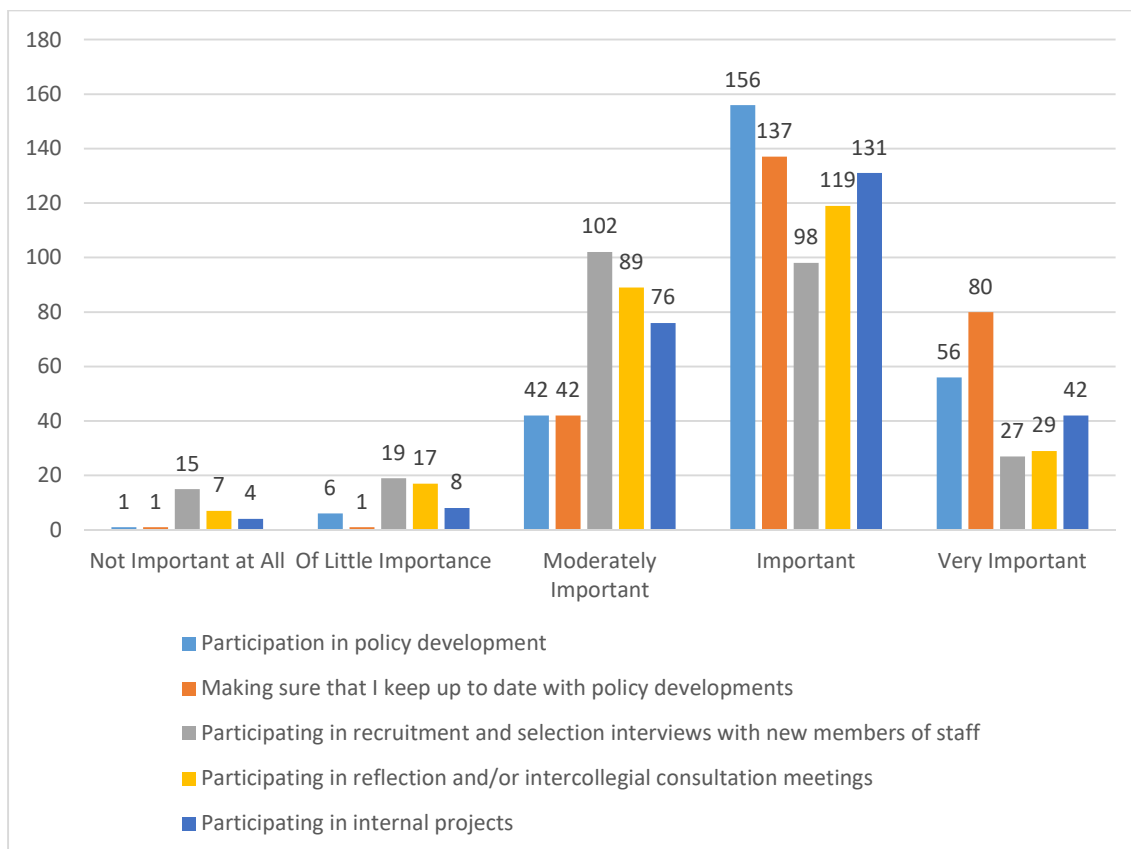
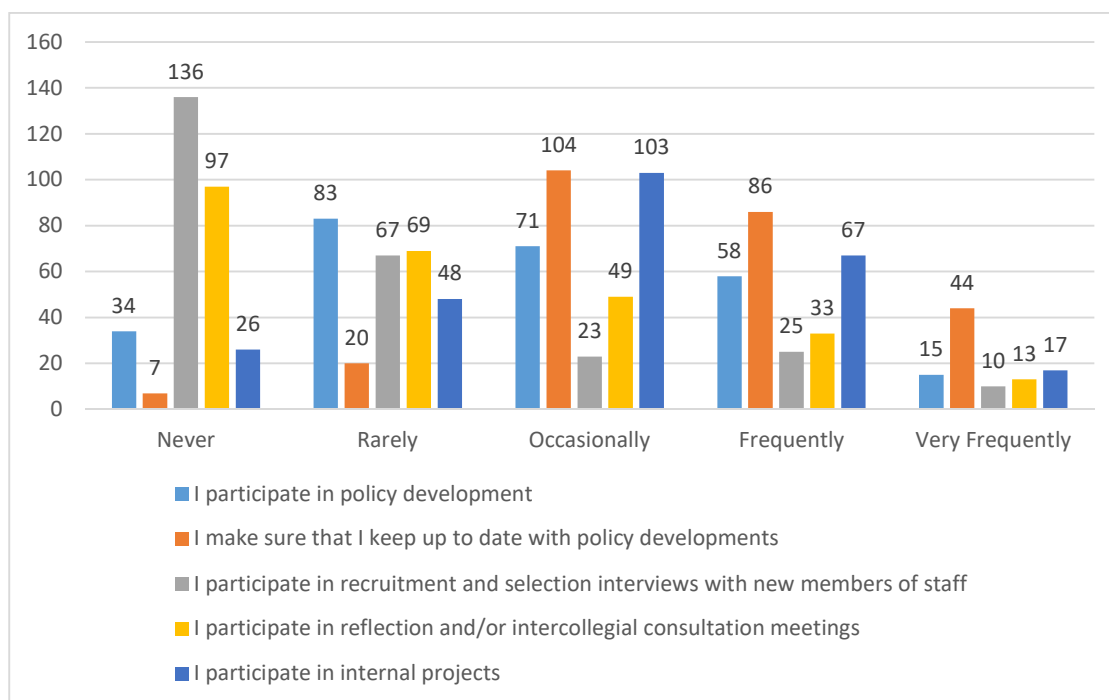


Figure 5.35: Responses for CPD Activities Undertaken – Participation in Organisation Development



5.3.4 Open-ended Analysis

To assess the respondents' opinion on good CPD practices, improvements and comments on CPD issues, the respondents were provided with open-ended questions. In response to the three best CPD practices in Abu Dhabi, the majority indicated that policy and guidelines are the widely applied good practice, followed by strategy, coverage in the CPD, organisational support, team support, guidance through workshops and coaching. Similarly, when asked about the three most required improvement actions for the CPD practices, the majority of respondents indicated that free/affordable CPD activities is recommended. It is followed by Paid Leave/Compensated Time and strategy and guidelines development. When asked to comment and/or provide feedback about CPD issues that are not covered in the questionnaire, competence of CPD trainers and pricing of CPD activities are suggested to be included.

5.4 CORRELATION ANALYSIS

5.4.1 Correlation between Demographics and the CPD Constructs

To examine if a correlation exists between the demographic variables and the four CPD variables [i.e. motives, conditions, important activities, and activities actually undertaken], a Pearson correlation test was applied. Correlation is measured by the application of Pearson correlation strength which ranges from “-1” to “+1”. A stronger negative correlation is associated with the value being closer to “-1” and strong positive correlation is associated with the value being closer to “+1”. The strength of the relationship is classified into three types: strong (+0.7 to 1), moderate (+0.4 to 0.7), and weak (+0 to 0.4). Table 5.3 presents the results.

- Motives of the RNs towards CPD activities were found to have a weak (<0.2) negative correlation with demographic factors excluding nationality, facility region in the Abu Dhabi emirate, governor of facility, and education. The correlations are insignificant.
- Conditions affecting RNs to undertake CPD activities were found to have weak (<0.2) positive and negative correlations with demographic factors, of which a majority were insignificant.
- Important activities considered by RNs were found to have weak (<0.2) positive and negative correlations with the demographic factors with none of them identified as significant. Similar results are observed between CPD actual activities undertaken and demographic factors.

Table 5.3: Correlation between demographics and CPD constructs

Demographic Elements	MOTIVES	CONDITIONS	IMPACT	AAU
Gender	-.070	-.057	-.076	-.041
Age	-.040	.068	.061	-.015
Nationality	.003	-.062	.065	.032
Total Experience as RN	-.069	.140*	.079	.065
Total Experience as RN in Abu Dhabi	-.099	.127*	.091	.042
Facility's region in Abu Dhabi Emirate	.072	.073	.005	.014
Type of Facility	-.038	.019	-.062	.002
Governor of Facility	.044	-.056	-.067	.031
Your Current Unit/Ward	-.041	.030	-.043	-.046
Level of Education (Relevant to Nursing)	.013	-.004	.039	.100

5.4.2 Correlation between CPD Constructs

This analysis is aimed at examining the strength of the relationship between the independent variables (motives, conditions, and important activities) and the dependent variable (CPD activities actually undertaken). The correlation between the independent and dependent variables is presented in table 5.4. As observed, all correlations are identified as positive, with a moderate strength correlation reported between CPD important activities and CPD activities actually undertaken (0.42). There is a weak but positive correlation between CPD activities undertaken and CPD motives (0.175) and CPD conditions (0.138).

Table 5.4: Correlation between the Variables

Variables	MOTIVES	CONDITIONS	IC	AAU
MOTIVES	1			
CONDITIONS	.240**	1		
IMPORTANT ACTIVITIES (IC)	.331**	.341**	1	
ACTIVITIES ACTUALLY UNDERTAKEN (AAU)	.175**	.138*	.442**	1

* Significant relationships marked

At sub-variable level within the three constructs, there is a majority of positive correlations as seen in table 5.5. Amongst the correlations identified, a moderately strong and positive

correlation exists between important activities and actual activities undertaken within the sub-variable 'clinical practice development' (0.572). This indicates that there is a higher chance of clinical practice development related CPD activities to be undertaken if these are considered important by RNs. Similarly, participation in research related CPD activities moderately correlated with participation in research in actual activities undertaken (0.473) and participation in organisational development (0.327).

Table 5.5: Correlation between the Sub-variables and Actual Activities Undertaken

		Actual Activities Undertaken			
		Participation in Research	Clinical Practice development	Participation in organizational development	Total Construct
Motives	Personal & professional development	.127*	.061	.096	.131*
	Requirements	.116	.071	.120	.143*
	Career Opportunities	.179**	.065	.163**	.187**
	Personal factors	.254**	-.022	.211**	.194**
Conditions	Intangible Conditions	.006	.161**	.109	.142*
	Material Conditions	-.169**	.292**	-.035	.071
Important Activities	Participation in research	.473**	.070	.327**	.389**
	Clinical Practice development	-.083	.572**	-.003	.271**
	Participation in organisational development	.388**	.209**	.366**	.448**

5.5 REGRESSION ANALYSIS

In this section, the relationships identified through the framework (discussed in chapter 3) are tested through simple linear regression analysis. The hypotheses are listed below:

- **H-A1:** The motives (construct 1) of RNs in Abu Dhabi have a significant influence on the actually undertaken CPD activities (construct 4).
- **H-A2:** The conditions (construct 2) surrounding RNs in Abu Dhabi have a significant influence on the actually undertaken CPD activities (construct 4).

- **H-A3:** The importance perceived of CPD activities (construct 3) by RNs in Abu Dhabi has a significant influence on the actually undertaken CPD activities (construct 4).
- **Main hypothesis H1:** Motives, conditions, and importance associated with CPD has a significant effect on the CPD activities performed by RNs in Abu Dhabi.

Through the application of univariate regression analysis, the relationship between the independent variables i.e. motives, conditions, and importance and dependent variable i.e. CPD activities actually undertaken is examined.

5.5.1 CPD Motives and Activities Performed

H-A1: The motives of registered nurses in the UAE has a significant influence on the Continuing Professional Development activities performed

Table 5.6 presents the model summary for the four sub-variables in the construct 'CPD motives'. As observed in the model summary, the simple correlation between the four sub-variables of CPD motives is relatively weak as indicated by R. In terms of the variation attributed by the independent variables on CPD activities undertaken, the highest is 3.8% by personal factors. This indicates that for 1% increase in personal factors leads to 3.8% increase in CPD activities actually undertaken. This is followed by 3.5% by career opportunities, 2.1% by CPD requirements, and 1.7% by personal and professional development. Overall, the variation attributed by the motives construct on the CPD activities actually undertaken is 3.1% which is relatively very low.

Table 5.6: Hypothesis H-A1 Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.131 ^a	.017	.013	8.40410	.017	4.542	1	259	.034
2	.143 ^a	.021	.017	8.38978	.021	5.442	1	259	.020
3	.187 ^a	.035	.031	8.32844	.035	9.352	1	259	.002
4	.194 ^a	.038	.034	8.31628	.038	10.137	1	259	.002
MOTIVES	.175 ^a	.031	.027	8.34603	.031	8.222	1	259	.004

1 = personal and professional development (PPD), 2 = requirement (REQ), 3 = career opportunities (CO) and 4 = personal factors (PF)

Table 5.7 presents the significance of the models reviewed. As observed, the main construct 'motives' predicts the CPD activities actually undertaken (dependent variable) well ($p = 0.004 < 0.05$). Upon review of the sub-variables within the motives construct, all four sub-variables are found to predict the dependent variable significantly ($P < 0.05$).

Table 5.7: Hypothesis H-A1 ANOVA

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	320.790	1	320.790	4.542	.034 ^a
	Residual	18292.873	259	70.629		
	Total	18613.663	260			
2	Regression	383.078	1	383.078	5.442	.020 ^a
	Residual	18230.585	259	70.388		
	Total	18613.663	260			
3	Regression	648.678	1	648.678	9.352	.002 ^a
	Residual	17964.985	259	69.363		
	Total	18613.663	260			
4	Regression	701.083	1	701.083	10.137	.002 ^a
	Residual	17912.580	259	69.161		
	Total	18613.663	260			
MOTIVES	Regression	572.721	1	572.721	8.222	.004 ^a
	Residual	18040.942	259	69.656		
	Total	18613.663	260			

1 = personal and professional development (PPD), 2 = requirement (REQ), 3 = career opportunities (CO) and 4 = personal factors (PF)

The coefficients output, as seen in table 5.8, presents the prediction of the dependent variable from the independent variable. As observed, a one point increase in personal

and professional development motives leads to 0.250 points increase in CPD activities actually undertaken. Similarly, 0.414 increase is attributed by requirements, 0.674 by career opportunities, and 0.718 by personal factors. Overall, a one point increase in motives for CPD activities for RNs leads to 0.138 points increase in CPD activities actually undertaken. This leads to the hypothesis H-A1 being accepted.

Table 5.8: Hypothesis H-A1 Coefficients

Model		Unstandardised Coefficients		Standardised Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	42.293	3.085		13.708	.000
	PPD	.250	.118	.131	2.131	.034
2	(Constant)	41.803	3.033		13.784	.000
	REQ	.414	.178	.143	2.333	.020
3	(Constant)	40.533	2.744		14.773	.000
	CO	.674	.220	.187	3.058	.002
4	(Constant)	40.640	2.606		15.595	.000
	PF	.718	.226	.194	3.184	.002
Motives	(Constant)	39.617	3.235		12.247	.000
	MOTIVES	.138	.048	.175	2.867	.004

5.5.2 CPD Conditions and Activities Performed

H-A2: The conditions surrounding registered nurses in UAE have a significant influence on the Continuing Professional Development activities performed

Table 5.9 presents the model summary for the two sub-variables in the construct 'CPD conditions'. As observed in the model summary, the simple correlation between the two sub-variables of the CPD conditions is relatively weak as indicated by R. In terms of the variation attributed by the independent variables on CPD activities actually undertaken, the highest is 2% by intangible conditions. This indicates that for 1% increase in intangible conditions leads to 2% increase in CPD activities actually undertaken. It is followed by 0.5% by material conditions. Overall, the variation attributed by the construct conditions on the CPD activities actually undertaken is 1.9% which is relatively very low.

Table 5.9: Hypothesis H-A2 Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.142 ^a	.020	.016	8.39150	.020	5.334	1	259	.022
2	.071 ^a	.005	.001	8.45607	.005	1.312	1	259	.253
Conditions	.138 ^a	.019	.015	8.39646	.019	5.022	1	259	.026

1 = Intangible conditions (IC), 2 = Material conditions (MC)

Table 5.10 presents the significance of the models reviewed. As observed, the main construct 'conditions' predicts the CPD activities actually undertaken (dependent variable) well ($p = 0.026 < 0.05$). Upon review of the sub-variables within the conditions construct, only one sub-variable i.e. intangible conditions is found to predict the dependent variable significantly ($P < 0.05$).

Table 5.10: Hypothesis H-A2 ANOVA

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	375.590	1	375.590	5.334	.022 ^a
	Residual	18238.072	259	70.417		
	Total	18613.663	260			
2	Regression	93.848	1	93.848	1.312	.253 ^a
	Residual	18519.814	259	71.505		
	Total	18613.663	260			
Conditions	Regression	354.022	1	354.022	5.022	.026 ^a
	Residual	18259.640	259	70.501		
	Total	18613.663	260			

1 = Intangible conditions (IC), 2 = Material conditions (MC)

The coefficients output, as seen in table 5.11, presents the prediction of the dependent variable from the independent variable. As observed, a one point increase in intangible conditions in CPD activities leads to 0.222 points increase in CPD activities actually undertaken. Similarly, 0.288 increase is attributed by material conditions. Overall, a one point increase in conditions for CPD activities in RNs leads to 0.176 points increase in CPD activities actually undertaken. This leads to the hypothesis H-A2 being accepted.

Table 5.11: Hypothesis H-A2 Coefficients

Model		Unstandardied Coefficients		Standardied Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	40.341	3.688		10.939	.000
	IC	.222	.096	.142	2.309	.022
2	(Constant)	45.074	3.272		13.776	.000
	MC	.288	.251	.071	1.146	.253
Conditions	(Constant)	39.854	4.015		9.927	.000
	CONDITIONS	.176	.078	.138	2.241	.026

5.5.3 CPD Activities Importance and Activities Performed

H-A3: The importance given to CPD by registered nurses in UAE has a significant influence on the Continuing Professional Development activities performed

Table 5.12 presents the model summary for the three sub-variables in the construct 'CPD important activities'. As observed in the model summary, the simple correlation between the three sub-variables of CPD important activities individually with the dependent variable "CPD activities actually undertaken" is relatively weak for model 1 and model 2 as indicated by R. However, the correlation is positive and moderate in strength in model 3 i.e. with participation in organisational development ($R = 0.448$). In terms of the variation attributed by the independent variables on CPD activities undertaken, the highest is 2% by participation in organisational development. This indicates that for 1% increase in CPD activities related to participation in organisational development leads to 2% increase in CPD activities actually undertaken. This is followed by 1.51% by participation in research CPD activities and 0.73% by clinical practice development based CPD activities. Overall, the variation attributed by the construct CPD important activities on the CPD activities actually undertaken is 1.96% which is relatively very low.

Table 5.12: Hypothesis H-A3 Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df 1	df2	Sig. F Change
1	.389 ^a	.151	.148	7.81068	.151	46.108	1	259	.000
2	.271 ^a	.073	.070	8.16070	.073	20.497	1	259	.000
3	.448 ^a	.200	.197	7.58050	.200	64.919	1	259	.000
IMPORTANT ACTIVITIES	.442 ^a	.196	.193	7.60254	.196	63.043	1	259	.000

1 = Participation in Research (PR), 2 = Clinical Practice Development (CiPD), 3 = Participation in Organizational Development (POD)

Table 5.13 presents the significance of the models reviewed. As observed, the main construct CPD important activities predicts the CPD activities actually undertaken (dependent variable) well ($p < 0.05$). Upon review of the sub-variables within the motives CPD important activities, all three sub-variables are found to predict the dependent variable significantly ($P < 0.05$).

Table 5.13: Hypothesis H-A3 ANOVA

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	2812.910	1	2812.910	46.108	.000 ^a
	Residual	15800.753	259	61.007		
	Total	18613.663	260			
2	Regression	1365.027	1	1365.027	20.497	.000 ^a
	Residual	17248.636	259	66.597		
	Total	18613.663	260			
3	Regression	3730.499	1	3730.499	64.919	.000 ^a
	Residual	14883.164	259	57.464		
	Total	18613.663	260			
IMPORTANT ACTIVITIES	Regression	3643.821	1	3643.821	63.043	.000 ^a
	Residual	14969.842	259	57.799		
	Total	18613.663	260			

1 = Participation in Research (PR), 2 = Clinical Practice Development (CiPD), 3 = Participation in Organizational Development (POD)

The coefficients output, as seen in Table 5.14, presents the prediction of the dependent variable from the independent variable. As observed, a one point increase in participation in research importance leads to 1.236 points increase in CPD activities actually undertaken. Similarly, 1.165 increase is attributed by participation in organisation development and 0.617 by clinical practice development importance. Overall, a one point increase in CPD activities importance in registered nurses leads to 0.474 points increase in CPD activities actually undertaken. This leads to the hypothesis H-A3 being accepted.

Table 5.14: Hypothesis H-A3 Coefficients

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	30.689	2.707		11.338	.000
	IA_PR	1.236	.182	.389	6.790	.000
2	(Constant)	29.948	4.189		7.149	.000
	IA_CiPD	.617	.136	.271	4.527	.000
3	(Constant)	26.829	2.764		9.707	.000
	IA_POD	1.165	.145	.448	8.057	.000
IMPORTANT ACTIVITIES	(Constant)	18.462	3.847		4.800	.000
	IMPACT	.474	.060	.442	7.940	.000

1 = Participation in Research (PR), 2 = Clinical Practice Development (CiPD), 3 = Participation in Organizational Development (POD)

5.5.4 Effect of Motives, Conditions, and Importance on CPD Activities Performed

Main hypothesis H1: Motives, conditions and importance associated with Continuing Professional Development has a significant effect on the CPD activities performed by registered nurses in UAE

Table 5.15 presents the model summary for the three main constructs i.e. motives, conditions, and CPD important activities. As observed in the model summary, the simple correlation between the three constructs and the dependent variable “CPD activities actually undertaken” is moderate in strength i.e. $R = 0.444$. The variation attributed by the independent variables on CPD activities undertaken is 1.97%. This indicates that for 1%

increase in CPD motives, conditions and CPD important activities leads to 1.97% increase in CPD activities actually undertaken.

Table 5.15: Hypothesis H1 Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.444 ^a	.197	.188	7.62592	.197	21.024	3	257	.000

1 = Motives, Conditions, CPD Important activities

Table 5.16 presents the significance of the model reviewed. As observed, the three constructs together predict CPD activities actually undertaken (dependent variable) well ($p < 0.05$).

Table 5.16: Hypothesis H1 ANOVA

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	3667.910	3	1222.637	21.024	.000 ^a
	Residual	14945.753	257	58.155		
	Total	18613.663	260			

1 = Motives, Conditions, CPD Important activities

The coefficients output as seen in table 5.17 presents the prediction of the dependent variable from the independent variable. As observed, a one point increase in CPD motives leads to 0.028 points increase in CPD activities actually undertaken. Similarly, 0.468 points increase is attributed by participation in organisational development. However, (-) 0.025 points is attributed by CPD conditions. This leads to the hypothesis H1 being accepted.

Table 5.17: Hypothesis H1 ANOVA

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	18.233	4.787		3.809	.000
	MOTIVES	.028	.047	.036	.594	.553
	CONDITIONS	-.025	.077	-.020	-.331	.741
	IMPACT	.468	.066	.437	7.079	.000

5.6 SUMMARY OF THE RESULTS

From the regression analysis conducted, the following hypotheses were found to be significant in nature (Table 5.18), thereby rejecting the null hypothesis.

Table 5.18: Results Summary

Hypotheses	Result
Main hypothesis H1: Motives, conditions and importance associated with Continuing Professional Development has a significant effect on the CPD activities performed by registered nurses in UAE.	Accepted
H-A1: The motives of registered nurses in the UAE have a significant influence on the Continuing Professional Development activities performed.	Accepted
H-A2: The conditions surrounding registered nurses in the UAE have a significant influence on the Continuing Professional Development activities performed.	Accepted
H-A3: The importance given to CPD by registered nurses in UAE has a significant influence on the Continuing Professional Development activities performed.	Accepted

CHAPTER 6: DATA INTEGRATION AND DISCUSSION OF THE CORE DESIGN

6.1 INTRODUCTION

This chapter presents the data integration/mix of the core design and discussion of results and findings derived from primary data collection methods. The chapter begins with a discussion on the use of focus groups in the qualitative phase. Then, it presents a mix of the data of phases one and two that represent the exploratory sequential mixed method; core design. Lastly, the discussion section discusses the qualitative and quantitative findings.

6.2 DISCUSSION ON FOCUS GROUP IN CPD

The researcher decided to use focus groups to identify factors for the quantitative research in the second phase of the data collection. Other researchers have used focus groups as a data collection tool in nursing and CPD research, as well. Price and Reichert (2017) conducted a study aiming to explore the role of on-going training and education on CPD and its impact on career satisfaction of nurses. The study conducted 18 focus groups with 185 participants. The focus groups were conducted over a period of five months in the eight provinces of Canada. The average length of the focus groups was 90 minutes and each focus group had 8 to 15 participants.

In addition, Weglicki et al. (2015) conducted a study to explore the importance of CPD from the perspective of nurses and used focus group as a data collection method. The study involved four focus groups with four participants in each session. Within the context of CPD, Joynes, Kerr and Treasure-Jones (2017) also conducted focus groups among general practitioners, practice nurses, managerial and administrative staff in addition to twelve individual interviews. The study specifically focused on informal learning processes as a tool for CPD. Similarly, Price et al. (2017) conducted a mixed methods

study and adopted focus groups as the primary data collection method to examine the motivational factors regarding continuous professional development. The study conducted two focus groups with nine participants and then conducted questionnaires with 74 participants.

6.3 DATA INTEGRATION OF THE CORE DESIGN

The first integration point was modifying the quantitative instrument (Q-PDN), based on the qualitative findings, which was referred to as the “actual integration” by Creswell et al. (2018). This section presents the second integration point where the qualitative and quantitative findings are mixed with the aim of drawing integrated conclusions.

The findings of the focus group interviews, which were analysed using the thematic analysis to understand meaning, are grouped in two domains: “RNs’ Perception about the Value of CPD” and “Influencing Factors”. On the other hand, the findings of the self-reported questionnaire present, first, the trends in the data concerning the “Influencing Factors”, and second, the existing “Relationships between Variables”. The domains from a single type of data are based on summarising the findings, whereas the common domains are based on the typology development which is proposed by Caracelli and Greene (1993). In the typology, the data is grouped in a set of categories which are represented by the motives, conditions, important activities, and activities actually undertaken. The overlapping of these domains is illustrated in table 6.1.

Table 6.1: Structure of Integrated Data

Domain	Qualitative	Quantitative
RNs’ Perception about the Value of CPD	✓	
Influencing Factors: <ul style="list-style-type: none"> • Perceived influencing factors • Relationships between Variables 	✓	<ul style="list-style-type: none"> ✓ ✓

Thus, the overall mixing design is derived from the core design’s name; exploratory design. However, triangulation has been utilised in the case of common themes to

compare and contrast the qualitative and quantitative findings. On the other hand, despite the fact that the importance of both findings is equally high, the weight of the quantitative data is slightly higher in this study, to support its ultimate aim to develop CPD strategies where the decision makers prefer to look to generalisable data in such situations. However, the importance of the qualitative findings is high in terms of modifying a valid and reliable quantitative instrument (Creswell et al., 2018). In this context, the relationship between the dependent and independent variables plays a strong driving force towards viewing the big picture of the influencing factors that affect RNs' participation in CPD activities.

6.3.1 RNs' Perception about the Value of CPD

RNs' perception about the value of CPD was examined in the qualitative phase only as part of the reporting process. The findings were demonstrated in two forms; positive and questionable value. The majority of participants in the focus groups perceived the value of CPD positively due to the following reasons:

1. Its contribution in meeting the licensure renewal and organisational requirements
2. Its benefit in updating and gaining new knowledge and skills
3. Its impact on the nursing care and eventually, patient care.

On the other hand, a group of participants questioned the value of CPD due to their unfavourable experience as follows:

1. The frustration feeling towards the obligation to attain the CPD hours
2. Lack of RNs' needs and interest in relevance and quality of CPD activities.

6.3.2 Influencing Factors

The influencing factors are grouped into motives, conditions, and important activities whereas the activities actually undertaken is added due to their influence.

6.3.2.1 Perceived Influencing Factors

6.3.2.1.1 Motives

The identified motives from the qualitative and quantitative collected data were not different. On the contrary, the questionnaire's findings supported the findings of the focus groups. The motives that were concluded from the focus groups are listed and sequenced below from the highest to the least positively rated:

1. License renewal
2. Update and learn new knowledge and skills
3. Interest in the activity
4. Career development
5. Networking and entertainment
6. Promotion

As illustrated in table 6.2, all 16 motives that were surveyed in the quantitative phase were agreed by 81.6% (sum of agree and strongly agree) or more by participants except for the “to entertain and relieve the stress of my job” and “to network with health professionals” that scored 51.3% and 64% respectively. These two motives were also among the least positively rated motives in the qualitative phase. Despite, the “promotion” motive that was rated as the lowest motive in the focus groups and second lowest in the questionnaire, its score of 81.6% is still considered high and far from the “networking and entertainment”. Moreover, the “licence renewal” and “update and learn new knowledge and skills” motives scored the highest in both qualitative and quantitative.

On the other hand, despite the fact that only one motive from the qualitative phase falls under each of the “personal and professional development” and “requirements” factors and scored the highest, all other motives tend to be more focused on the “career opportunities” and “personal” factors.

This concludes that the six motives identified in the qualitative phase are supported by the quantitative findings that completed the motives' picture in terms of the other 10 motives that were not reported from the focus groups.

Table 6.2: Motives' Findings in Qualitative and Quantitative Phases

Quantitative				Qualitative
Q-PDN Factors	#	Q-PDN Items	Agree	
Personal and professional development	1	further professional development is important to me	94.2%	
	2	improve my current qualifications	89.7%	
	3	carry out my work better	93.1%	
	4	update/refresh my knowledge, and/or gain new knowledge	95%	✓
	5	increase the quality of healthcare	92.5%	
	6	make a positive contribution to nursing practice	88.9%	
Requirements	7	meet the requirements of the organisation where I work	84.6%	
	8	meet the requirements of the licensure renewal	94.3%	✓
	9	prove to my employer that I am professionally competent	84.7%	
	10	this is considered highly important in my professional environment	91.2%	
Career opportunities	11	increase promotion opportunities	81.6%	✓
	12	achieve a higher level of training	88.5%	
	13	support my career potential/choices	86.6%	✓
Personal Factors	14	I am interested in the activity itself	85.9%	✓
	15	entertain and relieve the stress of my job	51.3%	✓
	16	network with health professionals	64%	✓

6.3.2.1.2 Conditions

The identified conditions/barriers from the qualitative and quantitative collected data were not different. On the contrary, the questionnaire's findings supported the findings of the focus groups. The conditions/barriers that were concluded from the focus groups are listed and sequenced below from the highest to the least positively rated:

1. Finance, fund, and cost
2. Time (work schedule, load, social commitments)
3. Accessibility (geographical distance, late notification, limited seats)
4. Irrelevant activities to specialty.

As illustrated in table 6.3, all 13 conditions surveyed in the quantitative phase were agreed by more than 50% (sum of agree and strongly agree) by participants; six of them between

50% and 70% and the other seven, above 80%. The four barriers that were concluded from the focus groups, fall among those scored high (above 80%) in the questionnaire. On the other hand, despite only one barrier from the qualitative phase falling under the “intangible conditions” and scored the highest, all other barriers tend to be more focused on the “material conditions”.

This concludes that the four barriers identified in the qualitative phase are supported by the quantitative findings that completed the barriers’ picture in terms of the other nine barriers that were not reported in the focus groups.

Table 6.3: Conditions’ Findings in Qualitative and Quantitative Phases

Quantitative				Qualitative
Q-PDN Factors	#	Q-PDN Factors	Agree	
Intangible conditions	1	if I receive career guidance	60.2%	
	2	if I receive an annual appraisal	52.1%	
	3	if my colleagues coach me	50.2%	
	4	if taking part in CPD activities allows me to have a say in ward/team policy	63.6%	
	5	if I gain more independence in my work	83.2%	
	6	if the CPD activities have a clear career perspective	92.4%	✓
	7	if the organisation’s policies support the nurses CPD	92.3%	
	8	if my immediate supervisor coaches me	69.3%	
	9	if other positions are offered within my organisation	70.1%	
	10	if I receive support from my supervisor	82.4%	
Material conditions	11	if the expenses are fully reimbursed or funded by the employer	83.9%	✓
	12	if suitable supplementary training courses are offered by the organisation (suitable in terms of time, location, and relevancy)	91.6%	✓
	13	if I am provided with the necessary time and/or convenient work schedule	92%	✓

6.3.2.1.3 Important Activities and Activities Actually Undertaken

The important activities and activities actually undertaken are interpreted together in order to compare between them, as they share the same factors and items. Their qualitative and quantitative findings are summarised in table 6.4.

The four most important activities that were reported from the findings of the qualitative phase are:

1. Short courses (do not lead to a degree), lectures, conferences, and seminars
2. Online (web-based learning) courses and/or lectures (do not lead to a degree)
3. Hands-on training courses including workshops
4. Journal clubs.

All 16 activities that were surveyed in the quantitative phase were indicated as important by more than 50% of participants except for the “participating in recruitment and selection interviews with new members of staff” activity that scored 47.8%. Nine of the 16 activities were indicated as important by more than 80%, whereas the other six activities scored between 50.2% and 69%.

On the other hand, the two most common activities actually undertaken that were reported from the findings of the qualitative phase are:

1. Short courses (do not lead to a degree), lectures, conferences, and seminars
2. Hands-on training courses, including workshops.

Seven of the 16 activities that were surveyed in the quantitative phase were reported as frequently undertaken by more than 50% of participants. Eight activities were reported as frequently undertaken by less than 30% whereas “making sure that I keep up to date with policy developments” scored 49.9%.

The activities are grouped under three factors; “participation in research”, “clinical practice development”, and “participation in organisational development”. The seven activities that fall under the “clinical practice development” factor were the most important and most

undertaken activities by RNs. The least important and least undertaken activity among the seven was higher than the most important and most undertaken activity from the other two factors. Besides, three of the important activities and the two undertaken activities, as reported from the qualitative phase, fall under the “clinical practice development” factor except for the “journal clubs” activity that in turn, scored among the least important and undertaken activities.

Thus, the quantitative findings do not contradict the qualitative findings. On the contrary, they supported the qualitative findings and allowed for viewing a clearer, bigger picture about the important and undertaken activities. However, the activities “participation in research” and “participation in organisation development” were not highly emphasised in the focus groups.

Another trending feature, in the quantitative findings, was observed in the comparison between the important and undertaken activities (Figure 6.1). The scores of all undertaken activities were less than the scores of their corresponding important activities. This difference varied from 10.6% to 65.5%; the higher the difference, the higher the gap between what RNs perceive as important and how frequently they undertake it. The highest gap was in the activity concerning “carrying out research” where 69% of RNs perceived it as important, however, only 4.5% reported that they carry out research. However, the least gap was in the “making sure that I keep up to date with professional developments” where 94.2% of RNs perceived it as important, while 83.6% made sure that they keep up to date with professional developments. In general, all activities that fall under the “participation in research” and “participation in organisation development” factors have big differences while the least differences were in the activities of the “clinical practice development” factor. The differences trend that was observed in the qualitative findings, does not contradict the quantitative trend, especially with the “journal clubs” and “online activities” that were reported as important but were not undertaken.

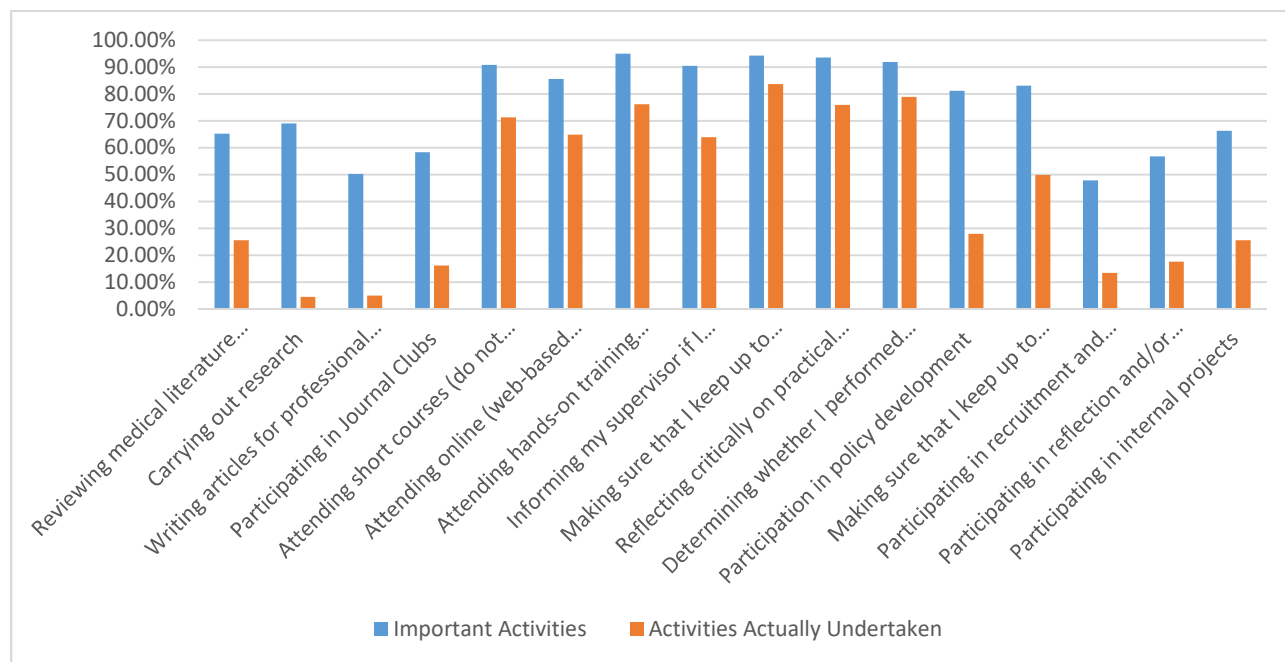
This concludes that the findings of the qualitative phase were supported by the quantitative findings whereas the gap between the importantly perceived and actually

undertaken activities would justify the “lack of interest” concern that was raised in the focus groups.

Table 6.4: Important Activities and Activities Actually Undertaken Findings in Qualitative and Quantitative Phases

Quantitative						Qualitative	
Q-PDN Factors	#	Q-PDN Items	Response				
			Important Activities	Activities Actually Undertaken	Difference	Important Activities	Activities Actually Undertaken
Participation in Research	1	Reviewing medical literature about best practices	65.2%	25.6%	39.6		
	2	Carrying out research	69%	4.5%	65.5		
	3	Writing articles for professional journals	50.2%	5%	45.5		
	4	Participating in Journal Clubs	58.3%	16.1%	42.2	✓	
Clinical Practice Development	5	Attending short courses (do not lead to a degree), lectures, conferences, and seminars	90.8%	71.3%	20.5	✓	✓
	6	Attending online (web-based learning) courses and/or lectures (do not lead to a degree)	85.5%	64.8%	20.7	✓	
	7	Attending hands-on training courses including workshops	95%	76.1%	18.9	✓	✓

	8	Informing my supervisor if I notice any developments at work that could have an adverse effect on professional practice	90.4%	63.9%	26.5		
	9	Making sure that I keep up to date with professional developments	94.2%	83.6%	10.6		
	10	Reflecting critically on practical situations	93.5%	75.9%	14.6		
	11	Determining whether I performed well and whether I could perform better next time	91.9%	78.9%	13		
Participation in Organisation Development	12	Participation in policy development	81.2%	27.9%	53.3		
	13	Making sure that I keep up to date with policy developments	83.1%	49.9%	33.2		
	14	Participating in recruitment and selection interviews with new members of staff	47.8%	13.4%	34.4		
	15	Participating in reflection and/or inter-collegial consultation meetings	56.7%	17.6%	49.1		
	16	Participating in internal projects	66.3%	25.6%	40.7		

Figure 6.1: Difference between Important and Actually Undertaken Activities

6.3.2.2 Relationship between Variables

Examining the relationship between variables concerns the quantitative phase only. It is divided into two sections; correlation and regression analysis.

6.3.2.2.1 Correlation Analysis

First, the correlation analysis examines the relationship between the demographic variables and the four CPD variables. The Pearson correlation strength was between -0.2 and +0.2 for all variables, indicating either weak positive, weak negative, or insignificant correlation, which was the most common.

Second, it examined the strength of the relationship between the independent variables (motives, conditions, important activities) and the dependent variable (CPD activities actually undertaken) that were tested by the Pearson correlation test. It has been found that all correlations are identified as positive, with moderate strength correlation reported between CPD important activities and CPD activities actually undertaken (0.42). There is a weak but positive correlation between CPD activities undertaken and CPD motives (0.175) and CPD conditions (0.138).

6.3.2.2.2 Regression Analysis

The relationships between the independent variables (motives, conditions, important activities) and the dependent variable (CPD activities actually undertaken) were tested through simple linear regression analysis (univariate). All hypotheses listed below were accepted.

- **H-A1:** The motives of RNs in Abu Dhabi have a significant influence on the actually undertaken CPD activities.
- **H-A2:** The conditions surrounding RNs in Abu Dhabi have a significant influence on the actually undertaken CPD activities.
- **H-A3:** The importance perceived of CPD activities by RNs in Abu Dhabi has a significant influence on the actually undertaken CPD activities.
- **Main hypothesis H1:** Motives, conditions and importance associated with CPD has a significant effect on the CPD activities performed by the RNs in Abu Dhabi.

6.4 DISCUSSION OF FINDINGS

The discussion of the findings is presented in the same sequence of presenting the mixed data in the previous section.

6.4.1 RNs' Perception about the Value of CPD

The first domain concerns the RNs' perception about the value of CPD with its two domains; positive and questionable value of the CPD. This domain has a complementary role in the overall findings as it was only concluded from the qualitative findings.

6.4.1.1 Positive value of the CPD

In the focus groups, most of the RNs valued the CPD due to its contribution to meeting the requirements of the employer and licensure body, updating and gaining new knowledge and skills, and yielding a better nursing care (Table 6.5).

Table 6.5: Theme 1.1: Positive Value of the CPD

#	Theme	#	Sub-theme
1.1	Positive Value of the CPD	1.1.1	Meeting the Requirements
		1.1.2	Updating and Gaining New Knowledge and Skills
		1.1.3	Better Nursing Care

In general, in the light of the literature, valuing the CPD positively was not an area of extensive investigation. However, it was embedded in studying the benefits of CPD. Specifically, “meeting the requirements” did not appear in the reviewed literature whereas “better nursing care” appeared once. Thus, the focus was on the “updating and gaining new knowledge and skills”.

Similar to the findings of this study, a quantitative cross-sectional study from China (Ni et al., 2014) reported the RNs’ perception towards CPD as an extremely important measure to further develop their professional competency. The same findings were reported from a qualitative descriptive study that was conducted in Rwanda (Kasine et al., 2018) where the RNs perceived that the CPD increased their theoretical knowledge and psychomotor skills and confidence.

A mixed method study in Nigeria (Nsemo et al., 2013) concluded similar findings. The RNs perceived that CPD helps them to retain their jobs and meet patients’ needs, and allows nurses to maintain professional competence, and develop new skills. Additionally, they perceived that CPD serves as a tool for quality service delivery as it enables nurses to provide quality care.

In a qualitative study (Abebe et al., 2018) describing the in-service training experience, participants experienced improved knowledge, skills, confidence, and job retention after the CPD activity. Similar findings were revealed by a quantitative pre-test/post-test study (Perry et al., 2018), evaluating CPD interventions, when participants demonstrated improved knowledge and perceived competency scores were significantly improved among the nurse participants.

The discussed findings of the “positive value of CPD” have evidently shown that the benefits of CPD concerning “updating and gaining new knowledge and skills” resulted in valuing the CPD positively by RNs. However, the literature did not support findings of this study in terms of “meeting the requirements” and “better nursing care” that inspired RNs who participated in the focus groups of this study to look positively at the CPD value. The reason behind this insufficient support could be the fact that these elements fall under the category of motives rather than CPD value, especially because the literature did not support the opposite.

6.4.1.2 Questionable Value of the CPD

The questionable value of the CPD that was perceived by the RNS resulted from its obligation and the consequences of some CPD activities that lack the nurses’ needs and interest (Table 6.6).

Table 6.6: Theme 1.2: Questionable Value of the CPD

#	Theme	#	Sub-theme
1.2	Questionable Value of the CPD	1.2.1	Obligation
		1.2.2	Lack of Nurses’ Needs and Interest

The questionable value of the CPD was not addressed in the literature that reported about CPD. The past studies that reported findings about the “obligation” and “lack of nurses’ needs and interest”, examined them from an influencing factors’ perspective as either motives or barriers.

By discussing the first domain, it is concluded that examining the importance of CPD and the “RNs’ perception about the value of CPD”, both positive and questionable, was a key factor to understand the meaning of the findings gathered from the RNs about CPD and its influencing factors. Identifying only the influencing factors, motives and barriers, does not imply an inevitable perception about the value of CPD. Thus, investigating the CPD phenomenon, its influencing factors, and outcomes requires initial investigation of its value from the RNs’ perception. The value and importance comes from its vital role in improving patient care and job satisfaction, and in maintaining a competent and motivated

workforce (Nsemo et al., 2013; Skår, 2010). In this context, the weight of the influencing factors should be investigated concerning their impact on the RNs' perception of the value of CPD rather than just rating them.

6.5 INFLUENCING FACTORS

The discussion of the influencing factors starts with the relationships between variables and then the specific perceived influencing factors.

6.5.1 Relationships between Variables

The main hypotheses tested in the results focuses on assessing the impact of motives, conditions, and important activities on the effect of CPD activities of RNs in Abu Dhabi. The results showed that each of these independent variables has a significant positive impact. These results are consistent with previous studies, for example, Pool et al. (2016) conducted a study and interviewed 21 nurses, focusing on the motives of nurses to engage in CPD activities. According to the results, there are four categories and nine motives of learning activities within the context of CPD. The primary motive was to increase competences for both self-directed and formal learning activities. Furthermore, requirements compliance encourages mandatory courses activities.

In addition, Coventry, Maslin-Prothero and Smith (2015) concluded that the reluctance among RNs towards CPD is related to institutional barriers, which include lack of relief cover, paid study leave of absence, time available for mandatory and informal studies, organisational culture (which relates to supervisory support and leadership factors) and the importance of training for the benefit of patients. Overall, it can be inferred that the results obtained in a previous chapter are highly consistent with past studies. Thus, it can be concluded that general theories are applicable in the case of RNs in the UAE, regarding their influencing factors to participate in CPD.

Table 6.7: Hypotheses of the Quantitative Phase

Hypotheses	Result
Main hypothesis H1: Motives, conditions and importance associated with Continuing Professional Development has a significant effect on the CPD activities performed by registered nurses in UAE	Accepted
H-A1: The motives of registered nurses in the UAE has a significant influence on the Continuing Professional Development activities performed	Accepted
H-A2: The conditions surrounding registered nurses in the UAE have a significant influence on the Continuing Professional Development activities performed	Accepted
H-A3: The importance given to CPD by registered nurses in the UAE has a significant influence on the Continuing Professional Development activities performed	Accepted

6.5.2 Perceived Influencing Factors

The hypotheses testing showed that RNs' motives, conditions, and important activities have a significant positive impact on CPD activities actually undertaken. Moreover, the qualitative and quantitative data integration showed that all influencing factors perceived by RNs in the qualitative phase were supported by findings of the quantitative phase.

6.5.2.1 Influence of RN Motives on CPD Activities Actually Undertaken

The findings of the study indicate that there are four types of RN motives. They are personal and professional development, requirements, career opportunities, and personal factors.

From a general perspective, in a study (Priaux et al., 2014), surveying the nurses' perception in Australia, the perceived incentive was the organisational support that positively influenced attitudes to CPD. In the same context, Nsemo et al. (2013) identified the mandatory, professional responsibility, and personal interest and self-development as motivating factors. Broader than both, Ni et al. (2014) reported that nurses perceived five main motivating factors; update knowledge, improve skills, improve the quality of

comprehension, obtain the knowledge necessary to achieve professional status, and raise the level of academic scholarship.

Additionally, in a Delphi study conducted in the Netherlands (Brekelmans et al., 2013), it was found that the two main positively influencing factors are nurses' identification with the nursing profession and the line manager as role model. The opportunity to network and the resulting ability to place a face to a name was a unique valued motive in a mixed-method study conducted in London by (Steven et al., 2018). This human contact was important in enhancing confidence to subsequently contact services and in facilitating communication.

Specifically, the four factors that influence of the motives on the CPD activities actually undertaken, are discussed in detail.

1. Personal and Professional Development

The first factor of the RN motives is the “personal and professional development” that encourages nurses to participate in CPD programmes. Within this context, Viljoen, Coetzee and Heyns (2017) argued that professional development is an organised and formalised effort that focuses on the development of unskilled workers as well as skilled workers to develop more skills. Typically, it has a greater reach and more duration as compared to typical training programmes. Professional development must be a strategic business option if an organisation aims to survive in the global and increasingly competitive environment.

In addition, Bengtsson and Carlson (2015) posited that there are continuous developments and changes in technology render workers' technological skills obsolete if continuous development and training programmes are not available. However, the authors also distinguished CPD agenda from small scale training programmes and argued that the latter are smaller components of the former. Furthermore, the study concluded that it is critical that service organisations, such as healthcare, must focus on

identifying changes and updates in the technological sphere. This is based on the notion that technological updates are related to customer satisfaction and service delivery.

Finally it is important to mention the work of Hariyati, Fujinami and Susilaningsih (2017) who argue that in order to motivate staff to participate in the CPD agenda and maximise their motivation, management must help in identifying a direction for their professional careers. The study recommends that the administration must help nurses to develop a perspective which has three main horizons. The first is the professional endurance or degree to which people are able to cope with the problems that affect their work. The second is the professional insight or degree of knowledge of nurses about their interests, strengths and weaknesses, and how these perceptions affect their professional performance. The third is the professional identity or degree to which workers define their personal values and how they relate to the service delivery.

The findings of two studies from Iran in the Middle East, did not reveal different motives. In the first study, Hamzehgardeshi et al. (2013) surveyed 361 nurses and reported "update knowledge" as the main motive. Shahhosseini et al. (2014), in their mixed method study, reported the same findings; "update knowledge".

2. Requirements

The second factor that was identified in the results was "requirements". The results showed that the requirements of nurses to participate in the CPD programme included requirements from the hospital administration, requirements from authorities, such as licence renewal, to enhance professional competency and increase skills set, and the importance of development in the professional environment. Within this context, Solomon (2018) argues that nursing professionals consider it necessary to adapt continuing education to the job and their professional career. In their opinion, the training of professionals should be seen as a continuum that begins with basic training and must remain constant throughout professional life. In any case, the way to demonstrate the impact of adequate training is in clinical practice and is very difficult to measure in the services provision.

In addition, according to Bindon (2017), patients have the right to expect nurses to maintain their competencies throughout their professional lives. This is because skills and competences have a direct impact on the performance of nurses which in turn, affects the quality of service received by patients. Furthermore, the study argued that regulatory bodies must develop an evaluation and certification framework to ensure that RNs exercise competently. Nurses must ensure that they maintain their competencies throughout their professional careers and must comply with the requirements of the CPD established in the country in which they are practicing.

3. Career Opportunities

The third factor is the “career opportunities” that can be exploited by nurses when getting involved in CPD. A number of benefits has been reported in literature that provides support to the assertions and inferences derived from survey results in case of RNs. Chong, Francis, Cooper, Abdullah, Hmwe and Sohod (2016) posited that CPD helps RNs to increase their individual performance. The increase in performance in turn, helps them to exploit career opportunities emerging during the course of their employment. In addition, based on high performance, nurses may also derive benefits to enjoy incentives and motivational rewards offered by the administration.

Omer, Saeed, Yousif and Elmubarak (2016) drew similar conclusions and explained that by engaging in CPD activities, nurses have the opportunity to increase their knowledge, skills and professional competence. These in turn, enable them to gain better understanding of the situations and improve their relationships with service users and management. The study highlighted a variety of benefits that nurses can derive from CPD activities.

According to Saade, Ghazala, Farhat and Hallit (2018), the positive effect of professional growth plans on nurses' motivation to engage in learning are diverse and multifaceted. The study highlighted greater authenticity (in the formulation of objectives) and greater commitment by faculty to professional development. Having to demonstrate the goals and the progress to the administration encourages nurses to engage in a reflexive process on

their practice. There was also an increase in participation in learning activities, authenticity of objectives from one plan to another, the level of investment in the process, trust, and enthusiasm. The lack of judgement on the part of administrators as well as their encouragement for nurses to determine their own orientations and objectives are not unrelated to these changes.

4. Personal Factors

The fourth set of factors are “personal factors”. In this context, Solomon (2018) concluded that personal empowerment and attention to greater learning are some of the main motives of nurses. CPD plans help them to prioritise and focus on what is really important. In addition, CPD programmes provide greater collaboration between RNs as they are able to share their experiences and opinions about patients and service delivery.

According to Adjorlolo, Aziato and Akorli (2019), the level of needs, beliefs, values, attitudes, and perceptions of the individual are in turn, manifested as motivational reasons or orientations for participation in CPD. The study found that many professionals cannot express reasons why they engage in such a complex activity as continuing education. It was found that participants had different goals which they wanted to achieve but these were varied in the type of motivation. The first motivation type is "goal-oriented", those who use education as a way to achieve clear objectives. The second is "activity-oriented", those who take part in learning first for reasons unrelated to the purposes or contents of the activities in which they enrol, are course takers and people who join groups seeking social contact. The selection of the activity is essentially based on the amount and type of human relationships that can be obtained. The third is the "learning-oriented" those who seek knowledge for their own value. These are not pure types. The best way to represent them would be by three circles that overlap, but the central emphasis is clearly distinctive.

These learning orientations have been explored by other researchers as well. For example, Bindon (2017) carried out an investigation in which the study examined the personal and the professional motivational orientations towards participation in CPD

among RNs. The study used factor analysis to the responses to a self-administered instrument and obtained five factors. The first was professional development and improvement, clearly related to the reasons for participation associated with the performance of nursing practice. Furthermore, the study identified other factors which included knowledge and skills, productivity, maintenance of skills, competence and quality. The second factor was the improvement in professional service, and included phrases related to the implementation of a professional practice focused on patient service. These included reasons related to meeting the patient's expectations, increasing the skills to service the patient and the public. The third factor was learning and interaction with colleagues, which included phrases related to exchanging thoughts with colleagues and that the thoughts of other nurses would stimulate their own. The fourth factor was personal benefits which include phrases that involve personal economic gain, professional advancement, safety and benefits for family and friends. The fifth factor was professional commitment and reflection, which include phrases related to a membership/identity/commitment, with a larger professional group, expanding the image of nursing and reflecting on the value of nursing responsibilities (Bindon, 2017).

Fukada (2018) identified the demographic characteristics, such as age, sex, marital status, previous educational level and income as variables related to participation in CPD. Another variable was the life situation that refers to significant people in personal, family and professional life. In addition to those related to the professional or work environment, that reflected the position they occupy, RNs have a hierarchy of positions (general nurse, clinical specialist, supervisor, head nurse, administrator, teacher in a college, even a university-level teaching member), and every position has unique requirements and responsibilities.

Demographic information such as age, marital status, highest level of education obtained, income, employment category (part time and/or full time), position, area of practice, in addition to the educational opportunity, also strongly influence nurses' decision regarding CPD. Singh (2015) found that motivational orientations, as well as personal and

professional attributes, play an important role in influencing the participation of RNs in CPD.

6.5.2.2 Influence of RN Conditions on CPD Activities Actually Undertaken

Within the context of RN conditions and their impact on the CPD of RNs, this study indicated that there are a wide variety of factors. These can be broadly categorised into two; the intangible and material conditions. In addition, the results also indicated that among the intangible conditions category, the most influencing conditions are work independence, supervisor support, clear career perspective, and supervisory coach.

From a general perspective, a qualitative study (Clark et al., 2015) in England revealed four main themes including organisational supportive culture, partnership working between the educators and managers, a supportive learning environment in the demanding workplace, and changing practice by developing and sharing knowledge and skills.

Another descriptive explorative qualitative study, from Iran, (Eslamian et al., 2015) revealed five main themes concerning the hindering factors. First, learners-related factors, such as lack of participants' preparation for learning, inadequate motivation for learning, and lack of human resources. Second, teachers-related factors, such as inappropriate teachers and defective knowledge transfer methods and teachers' inadequate motivation. Third, educational process related factors, such as imprecise need assessment, improper planning, and inappropriate implementation. Fourth, inadequate facilities that are convenient for the desired education. Finally, defective evaluation where there is a lack of a 'pre-test post-test' in some classes, lack of giving a feedback even in classes with a pre-test or post-test, lack of educational evaluation of educators, and lack of supervision on the educational content.

Specifically, the influence of the conditions on the CPD activities actually undertaken, these two factors are discussed in detail.

1. Intangible Conditions

Comparing the results above with previous studies, the researcher found that, according to Wareing, Buissink, Harper, Olesen, Soto, Braico et al. (2017), institutional factors are critical conditions towards participating in CPD. Professional autonomy and work independence is often cited in literature as motivating factors to increase skills and competences for workers in general, and nurses are no exemption. The autonomy of nurses has also been related to performance level and indicates that higher autonomy increases nurses' performance. In addition, the study also posited that autonomy is a factor of satisfaction and dedication. Higher autonomy encourages nurses to undertake decisions.

In another study by Knox, Cullen et al. (2015), the researchers found that encouragement and support from supervisors or immediate authorities are related to the conditions. According to the results reported in the study, nurses' attitude and behaviour towards the profession and career are significantly affected by the leadership and managerial staff. The study also reported that in cases of career development, supervisors can help nurses to identify their strengths and weaknesses, as well as shortcomings that hinder their career progression. Support and guidance from supervisor nurses can be strong conditions to participate in CPD activities (Knox, Cullen and Dunne, 2015).

Within the same context, Simkhada, Van Teijlingen, Simkhada, Mackay, Khatru, Angell et al. (2017) concluded that in case of career development and progression, nurses must have a clear vision of their profession and how they want to progress in the future. The ambitions of nurses and level of satisfaction from the current career hierarchy determines their level of motivation to increase their skills and put in efforts to promote themselves. Thus, it can be fairly stated that a clear perspective about current and future career levels can be a condition for RNs to participate in CPD activities. This is based on the assumption that these activities provide them with an opportunity to enhance their career and progress.

Smith and Johnson (2019) found that one of the main tools of CPD is coaching and mentoring by supervisors. The study concluded that supervisors have higher levels of skills and competences, as well as knowledge and experience to share with fresh nursing professionals. They are able to provide valuable insights into the health care environment and culture. They affect the professional values, ethics and beliefs of fresh nursing professionals. It can thus be concluded that supervisors/coaches of nurses are a significant condition and subsequently, impact on the desire of RNs to participate in CPD activities.

Other authors also provide conclusions that can be used to support these findings. For example, Mbidi (2018) argued that the increase in the skills of nurses is dependent upon various conditions, such as access to training, clinical and personal supervision and the role of mentors, along with positive attitude and support for learning and personal development throughout life.

It is also worth mentioning Ally, Mogorosi-Pheto and Jacobs (2016), who argued that training and development are most effective when they provide better career opportunities. They are related to the opportunities and advantages obtained through premia for qualifications or other financial advantages. They focus on the satisfaction of certain personal or organisational development needs. Training courses must also be adapted to national circumstances. A training course that provides a personal capacity opposed to another capacity of the organisation can be frustrating and demotivating. For example, health professionals are frustrated when they have received training to use certain equipment to which they do not have access in the workplace. This is also a misuse of training funds. Training designed and prepared to achieve personal and organisational goals must be practical and realistic.

KalaBarathi, Jagadeeswari and Gowri (2018) recommended that training should address issues of high priority or importance, where necessary, to provide services safely and effectively. It was reported that health professionals working in regions of Africa with a high prevalence of HIV/AIDS were concerned about the risks associated with the disease,

and that took away their motivation. Members of the same group of workers reported that this negative effect was greatly reduced when effective training was provided.

2. Material Conditions

The results showed that significant material factors in this category included “expenses are fully reimbursed or funded by the employer”, “suitable supplementary training courses are offered”, and “provided with the necessary time and/or convenient work schedule”.

Considering the broader literature, McMillan, McConnell and O’Sullivan (2016) found that the resource constraints are very important in the motivation of nurses to participate in formal education and professional skill courses. The study highlighted that financial resources available to nurses determine their access to high quality education. If employers do not subsidise and support the expenses incurred in the professional development courses, then the motivation level of nurses to participate is decreased and turned into a barrier. However, the study also stressed that it is critical that performance and the abilities of nurses translates into higher service delivery and high satisfaction of patients. But these constructs are difficult to measure and thus the determination of return on investment in training and development is uncertain. Therefore, the uncertainty about the benefits of a course and its materialisation of its benefits also hinders motivation and attitude of a nurse towards continuous professional development (McMillan et al., 2016).

According to Anderson, Puntillo, Cimino, Noort, Pearson, Boyle et al. (2017), one of the factors for nurses to participate in a training programme is whether the programme meets their immediate needs. In other words, if the training programme is suitable for the nurses, the motivational level is higher and vice versa. The study recommended that hospital administration must have adequate tools and instruments to identify the learning/training needs of current staff. There are a wide variety of instruments developed and used by researchers that have high levels of reliability and internal consistency. The results of the survey conducted by the study demonstrated that the majority of the nurses and managers agreed that training needs analysis and relevant instruments are useful and effective. Finally, the researcher recommends that the training courses must be aligned

with long term strategy of the facility. The leadership must be able to envision the skills and competences of the staff who are required to meet the strategic aims and goals of the healthcare facility. Using this vision, the leadership must identify skill shortages and select relevant training courses.

The result in this study demonstrated that nurses' motivation is also affected by certain conditions, such as the necessary time that is available for them to participate in training. There are various tools, such as convenient and flexible work schedules, that can facilitate nurses to schedule participation in CPD. Within this context, Al-Huneiti, Hunaiti, Al-Masaeed, Balachandran and Mansour (2016) showed that working conditions of nurses have a significant impact on the performance and quality of service delivered by nurses. The study reported that the majority of the literature supported that the work schedule has a significant impact on the personal and professional satisfaction of nurses. It was identified that some factors have significant negative impacts which include excessively long shifts, uncertainty about shift timings, and frequent rotations.

In a study (Haywood et al., 2013) that was guided by the IPA approach, it has been found that the main barriers to participate in CPD are funding and time. In another study, Nsemo et al. (2013) identified several hindering factors, such as busy shift and scheduling, family responsibilities, geographic distance to venues, and high cost of courses. Additionally, they reported that the attitude of nurse managers was a hindering factor, especially when programmes are organised outside the health facility. Ni et al. (2014) reported almost similar hindering factors such as time constraints, work commitments, a lack of opportunity, cost of the courses, and previous negative experiences with CE programmes. In the same context, the findings from a different study supported what has been already identified (Priaux et al., 2014) as understaffing and time were the major barriers.

In a mixed method study (Steven et al., 2018) that was conducted in London, the findings revealed workload pressures as the main barrier. A more specific study with qualitative evaluations was conducted in three African countries, by Feldacker et al. (2017), and

revealed five major structural barriers; lack of financial support, limitations in CPD coordination, staff shortage, lack of needs analysis, and limited facility resources.

Similarly, the Middle East studies showed the same findings. The two Iranian studies reported three barriers; "work commitments" (Hamzehgardeshi et al., 2013; Shahhosseini et al., 2014), lack of support, and time (Shahhosseini et al., 2014). Another study from Saudi Arabia (Aboshaiqah et al., 2018) found three major barriers; lack of financial support, commitment and scheduling problems, and the inability to attend regular classes.

Within this context, it can be inferred that if nurses are provided with flexible work schedules that can facilitate them having time and energy to participate in training programmes, it is likely to have a significant impact on their levels of motivation. Since time is also considered to be a resource, therefore this study concludes that available time for training activities is an important factor for nurses to participate and plan their CPD.

6.5.2.3 CPD Important Activities and CPD Activities Actually Undertaken

The findings of this study emphasised that the importance of CPD activity is an important influencing factor in the degree of RNs participating in CPD courses in the UAE. Within this context, the results indicated that there are three sub-categories of factors.

The first category was the importance of participation in research activities by nurses. The research activities can be defined as writing journal articles based on research.

The second category of factors is clinical practice development. Within this context, the results demonstrated that participation in CPD activities is affected by the importance of the activity, such as attending workshops, involvement and interaction with literature related to professional development, the degree or frequency of nurses to conduct critical self-reflection upon their own skills and competences and to identify strengths and weaknesses, as well as professional limitations.

The third category of factors is participation in organisational development. In this category, the factors that affect the participation of RNs in the UAE in CPD activities are varied. The factors identified in the results are the involvement of nurses in policy development, the inclination of nurse to ensure compliance with organisational policies, participation in organisational projects, and meetings and discussions with colleagues about professional development and changes.

While comparing the results above with past studies, the researcher found no studies that evaluated the impact of importance of CPD activities and RNs' tendency or reluctance towards CPD activities, however, there is indirect evidence to support the assertions above from the interest and learning process perspectives. For example, it was found, according to Sade and Peres (2015), that the motivation of nurses to participate in training courses and particularly in CPD activities, is the level of awareness of nurses regarding their benefits. The author recommended that institutions should focus on raising awareness among nurses about the notion of CPD. The awareness must be focused on its benefits for individuals, the workforce, the institution, service quality, and for the overall healthcare system. The study recommended that awareness campaigns, providing knowledge and promotional materials, should take place.

Dutch experts, in a Delphi study (Brekelmans et al., 2013), highlighted three negatively influencing factors, and among them is the lack of attractive education programmes. From an educational perspective, a descriptive explorative qualitative study, from Iran, (Eslamian et al., 2015) revealed five main themes concerning the hindering factors. First, learners-related factors such as lack of participants' preparation for learning, inadequate motivation for learning, and lack of human resources. Second, teachers-related factors such as inappropriate teachers and defective knowledge transfer methods and teachers' inadequate motivation. Third, educational process related factors such as imprecise need assessment, improper planning, and inappropriate implementation. Fourth, inadequate facilities that are convenient for the desired education. Finally, defective evaluation where there is lack of a pre-test post-test in some classes, lack of giving a feedback even in

classes with a pre-test post-test, lack of educational evaluation of the educators, and lack of supervision on the educational content.

Another study addressed the educator as a role model where their observed attitudes and values influence the participating RNs (Pool et al., 2016). A study conducted by Rizany, Hariyati and Handayani (2018), with clinical nurses, concluded that they consider their dedication to teaching students pleasant in their clinical practices. This study pointed out negative aspects, such as the lack of recognition of this dedication and the scarcity of time to perform this successfully. The most considered values to protect students learning in clinical practices are that the nurse who develops this activity gathers capacity, competence and effectiveness.

Miltner, Jukkala, Dawson and Patrician (2015) reflect on the links between training and the development of professionals in general and stated that a continuous learning orientation develops in a dynamic professional practice. Nursing training has that characteristic, since a good part of its learning is acquired in clinical practice and there are continuous changes occurring in it. Also, in the dynamism of the clinic, which is significant for training, nurses find opportunities to interaction with different professionals and these interactions influence nurses' orientation towards professional development. Interaction with GPs, social workers, specialised nurses, and other healthcare workers have an indirect motivating effect on nurses and trigger self-reflection.

6.5.2.4 Impact of CPD Motives, Conditions and Important CPD activities of RNs

This research identified a number of factors that can be attributed to three main independent constructs, namely, motives, conditions, and important CPD activities. The results and discussion so far indicate that CPD must be a strategic business goal in order for the organisation to survive in the global and increasingly competitive environment. Therefore, CPD should be a part of long-term strategy of the healthcare facilities. The research showed that fast and continuous technological updates in the health care sector render skills and competences of nurses obsolete. Therefore, updating and upgrading of skill sets and increasing nurses' competences is one of the motivations of nurses to

participate in CPD activities. It is critical that service organisations, such as healthcare service organisations, must focus on identifying changes and updates in the technological aspects. Furthermore, nurses must have a long-term vision for their professional career which motivates them to develop CPD plans and to gain skills that will help them progress and succeed as per the long term vision.

Similar conclusions have been drawn by Solomon (2018), who argued that the professional development phenomenon is the learning process and axis of all educational activities. The rise of the industrial era, the great scientific and technological advances, as well as the constant change of methods and systems have created the need to have a skilled and updated workforce. This allows them to cope with the new challenges. This is how entrepreneurs have convinced themselves that training is a factor in raising the level of productivity and quality of care.

In addition, Bindon (2017) concluded that human resources are the most important for organisations, but it is necessary to adapt their characteristics and skills where they perform their current tasks and where they will be using the same for future tasks. Each individual is unique and therefore varies in professional competences, experience and skills. Similarly, motivational factors for the development of skills and professional competences also vary from one person to another and from workers in one profession to another. The healthcare service sector is no exemption to the golden principle identified above. Within this context, it is important to highlight that the motivations found in the results of this study are limited to RNs in the UAE.

Knox et al. (2015) posited that training is an activity to achieve the objectives of the organisation. Through it, management can develop the talents and creative abilities of individuals and increase the skills to use resources and promote teamwork, among others. There are also regulatory requirements and frameworks that stress the role of education and continuous development for the nursing profession. This indicates the responsibility of hospitals and relevant government authorities to include CPD in broad

policy making. This can be related to the motivating factor that many nurses participate in CPD because they are required by the organisation and regulatory requirements.

In the area of health care, Chong et al. (2016) highlighted the importance of continuous development innovations by pointing out that innovation in scientific, technological and sociological environments lead to the obsolescence of current knowledge and skills within a remarkably short period of time. A complete basic professional preparation was no longer enough for a lifetime of practice. In addition, rapid technological changes result in the need for continuous expansion of skills in new areas of knowledge. CPD has become increasingly essential for the guarantee of quality nursing practice.

CPD is a strategy of the nursing administrators to train and develop the staff. The impact of education transcends all the operations of the healthcare facility since it is necessary for the nursing staff to acquire the knowledge and develop the necessary skills to provide quality patient care (Saade et al., 2018). The nursing administrator must provide opportunities for staff to grow, develop, and enhance their service and performance. The administration must plan CPD programmes for the progress of all RNs. It must ensure that there is a positive attitude towards training, providing support to nurses, and identifying education and skill gaps (Fukada, 2018).

A direct relationship between attendance of CPD programmes and the improvement of nursing practice has been demonstrated. CPD also increases productivity by minimising accidents and errors, promoting better organisational culture, and increasing job satisfaction and better nursing care. Therefore, these benefits provided by the CPD also play an important motivating factor of nurses (Wareing et al., 2017). Similar results have been reported in this study which indicates high consistency between current and past research.

Given the importance of CPD, significant research has been conducted to study the phenomenon of RNs' participation to explain the underlying motivating reasons (Ally et al., 2016). It was found that the personal orientations of the nursing staff are the main

force to promote participatory behaviour. In addition, it can be positively and/or negatively influenced by demographic variables, life situation, educational opportunity, and employers' organisational structure (Smith et al., 2019).

If, as current research indicates, CPD contributes to quality practice in nursing care, then the reasons that influence RNs participation acquire greater significance for the nursing profession. There are various factors that constitute the way in which personal and professional motivation shapes the participation of nurses in CPD (McMillan et al., 2016). Sade et al. (2015) conducted a descriptive, comparative and correlated study to examine the nursing staff at two health institutions, one public and one private and categorised the motivational factors into personal factors and professional environment factors.

The degree to which nurses participate in CPD is varied where participation is affected by complex reasons. These include nurses' personal characteristics such as attitudes, values, beliefs, expectations and motivation towards CPD. Knowing these factors is of the utmost importance for nursing administrators since they can make decisions regarding programming, motivational forms and continuous training needs of staff (Pool et al., 2016). The lack of CPD in developed countries results in the loss of the professional licence. Therefore in some countries, CPD is mandatory as a method to combat obsolescence in a rapidly changing profession (Rizany et al., 2018).

The participation of nurses in CPD has been mandated in some countries with the assumption that professionals lack motivation to voluntarily update knowledge and skills without external pressure. Several studies have used motivational guidelines as a conceptual framework to examine the voluntary participation of nurses while others have explored the motivation to participate in mandatory situations (Knox et al., 2015).

Studies that take place in areas where participation is voluntary, found that nurses were highly motivated by the cognitive interest (the desire for continuous learning, to achieve knowledge and to increase skills) necessary to improve competence at work. Harper, Gallagher-Ford, Warren, Troseth, Sinnott and Thomas (2017) examined the relationship

between motivational orientations of nurses to participate and the compulsory category of CPD, with a sample of 843 nurses who completed CPD programmes, in states that have legislation and those which lack it. The study concluded that nurses participated for reasons related to professional value and patient care, rather than the presence or requirement of legislation.

Garneau and Pepin (2015) studied the motivational orientations of RNs who participated in compulsory CPD and concluded that nurses demonstrated the same pattern of motivational orientations compared to those who voluntarily participate in CPD. Both groups are motivated by cognitive interest and a desire for professional advancement. These findings help to dispel the concerns of those who claim that nurses will not participate in CPD unless they are forced to attend by a legislative or mandatory requirement. In the same way, Sachdeva (2016) posited that participation in CPD is mainly influenced by a desire for competence or professional knowledge and not due to mandatory requirements.

CPD is a means for health care institutions to achieve their quality of care objectives and the impact it has on the personal and professional growth of participants. Thus, it is necessary for nursing administrators, educators, or those who plan CPD activities to consider the reasons for participation. The reasons can be used to plan, promote, teach and develop strategies that are adapted to the needs of participants (Finn, 2018).

6.6 SUMMARY

The discussion above clearly indicates that the methodology and instruments for data collection used in the core design are reliable and commonly used in past studies and thus have consistency with past research efforts. In addition, the results also indicated that all factors identified in this study not only have empirical support from current research but also get support from past studies. The discussion implies that there is a variety of motives among nurses to participate in the CPD activities. It can be inferred that increase in knowledge and skills is one of the main motivating factors along with the career benefits of CPD. CPD activities help nurses to progress in their careers which also

bring material and non-material advantages. Furthermore, the discussion shows that the importance of CPD activities and research activities by nurses are also important factors in determining CPD participation and involvement.

CHAPTER 7: QUALITATIVE APPRECIATIVE INQUIRY FINDINGS AND DISCUSSION

7.1 INTRODUCTION

This chapter presents the findings and discussions of the Qualitative Appreciative Inquiry workshop that was conducted in phase three, through the 5-D Cycle. The data was collected from the purposively selected KI Nursing Key Players as nursing stakeholders with high influence and high interest. The data analysis was “Simultaneous Targeted Participatory Thematic” within the 5-D Cycle phases. The findings’ presentation of the data analysis was guided by the SOAR framework throughout the cycle where the outcome of the design phase represents the proposed strategies for an effective CPD programme in the UAE, specifically in the Abu Dhabi Emirate.

The presentation of the findings is guided by the research question of the study’s phase three and the designated objective(s) of each phase of the 5-D Cycle. The research question is “how can an effective CPD programme, that meets the needs of RNs, be developed?” where designated objectives are:

Define Phase:

- Define the affirmative topic CPD and clarify the focus of the inquiry based on the findings of phases one and two.

Discovery Phase:

- Explore and describe what is working well and effectively in the existing CPD programmes and strategies.

Dream Phase:

- Identify the areas of improvement in the existing CPD programmes and strategies.
- Describe the expected CPD programme activities in terms of content, provision, and outcomes.

Design Phase:

- Develop the best CPD strategies that would contribute to the improvement of the CPD programme.

7.2 OVERVIEW OF PARTICIPANTS

The total number of participants in phase three were eight nursing key players representing the government and private sectors in the three regions of the Emirate of Abu Dhabi (Table 7.1). Participants represented the hospitals and centres, including a healthcare group of hospitals and centres, the hospitals or centres, and one person represented the only nursing tertiary education facility, a college in Abu Dhabi.

7.3 THE APPRECIATIVE INQUIRY 5-D CYCLE FINDINGS

The findings of the 5-D Cycle are as follows:

7.3.1 Define Phase

The objective of the define phase is:

- Define the affirmative topic CPD and clarify the focus of the inquiry based on the findings of phases one and two.

The researcher, as a moderator, presented an overview of the main findings of phases one and two of the study. First, clarity was given about CPD as the topic of the inquiry and second, key players were informed about RNs' needs as the strategies should be based on these needs. This clarification was the starting point of defining the already identified affirmative topic.

Participants agreed on the affirmative topic entitled "Sustainable CPD Strategies for Excellence". The discussions started by exploring the key terms concerning effective strategies and included terms such as "sustainability", "effectiveness", "excellence", "strategies", and "CPD". In this context, participant 6 stated:

"Any CPD strategy should be sustainable in order to keep up-to-date with the continuous changes and needs in the market".

Table 7.1: Profile of the AI Participants

Participant	Position	Gender		Region			Governor		Type of Facility		
		M	F	Abu Dhabi	Al Ain	Al Dhafra	G	P	H	C	College
1	Nursing Senior Lecturer	•		•	•	•	•				•
2	Nursing Director	•		•	•		•			•	
3	Nursing Education Manager - Clinical Resource Nurse (CRN)		•	•	•		•			•	
4	Deputy Nursing Director	•			•		•		•		
5	Representative of Deputy Nursing Director	•		•			•		•		
6	Representative of Nursing Education Manager (Corporate)	•		•	•	•	•		•	•	
7	Representative of Deputy Nursing Director	•		•	•	•		•	•	•	
8	Representative of Deputy Nursing Director		•	•	•	•		•	•	•	

M: Male

F: Female

G: Government facility

P: Private facility

H: Hospital

C: Clinic or Centre

And, participant 3 added that:

“The CPD strategies should be aligned with the DOH trending practices towards excellence”.

After a few minutes of the cross talking and discussions among participants, they agreed on a final affirmative topic, and participant 8 stated:

“We believe that the CPD strategies should be sustainable and excellent”.

Then, all participants approved the affirmative topic that was stated by participant 3 as:

“Sustainable CPD strategies for excellence”

Then, from the stated affirmative topic, the purpose was derived formulated and derived as ***“to develop sustainable CPD programs for excellence”***. By this, the objective of the Define phase was achieved and the phase was closed and prompted the move to the next phase; Discovery.

7.3.2 Discovery Phase

The objective of the discovery phase was to:

- Explore and describe what is working well and effectively in the existing CPD programmes and strategies.

To achieve this objective, participants were invited to share their positive stories about “Peak Times” or “High-Point Experiences” with the CPD. Achieving this objective led to the identification of the positive core of the CPD phenomenon in Abu Dhabi. For this purpose, the following questions were used in the “storytelling” phase:

Rapport:

- Tell us what the CPD means to you?
- Describe a “peak time” or “high-point experience” with the CPD.

Probing, especially when the information was insufficient

- What do you value most about the CPD programmes for RNs?
- What do you hope the CPD programmes contribute to RNs?

Root cause of success

- What are the factors that make these examples of exceptional performance possible?

Lessons learnt

- Reflecting on your stories, what could be the learnt lessons?

All participants shared their stories, resulting in a total of eight stories. However, after discussing the stories, it was agreed that five stories should be analysed in order to identify the “root cause of success” and conclude the “learnt lessons” from each story which are summarised in table 7.2. The five great stories were about:

1. All RNs renew their nursing licence
2. Clear CPD system in place
3. Category 2 CPD
4. Approval process
5. Stipulation to share information.

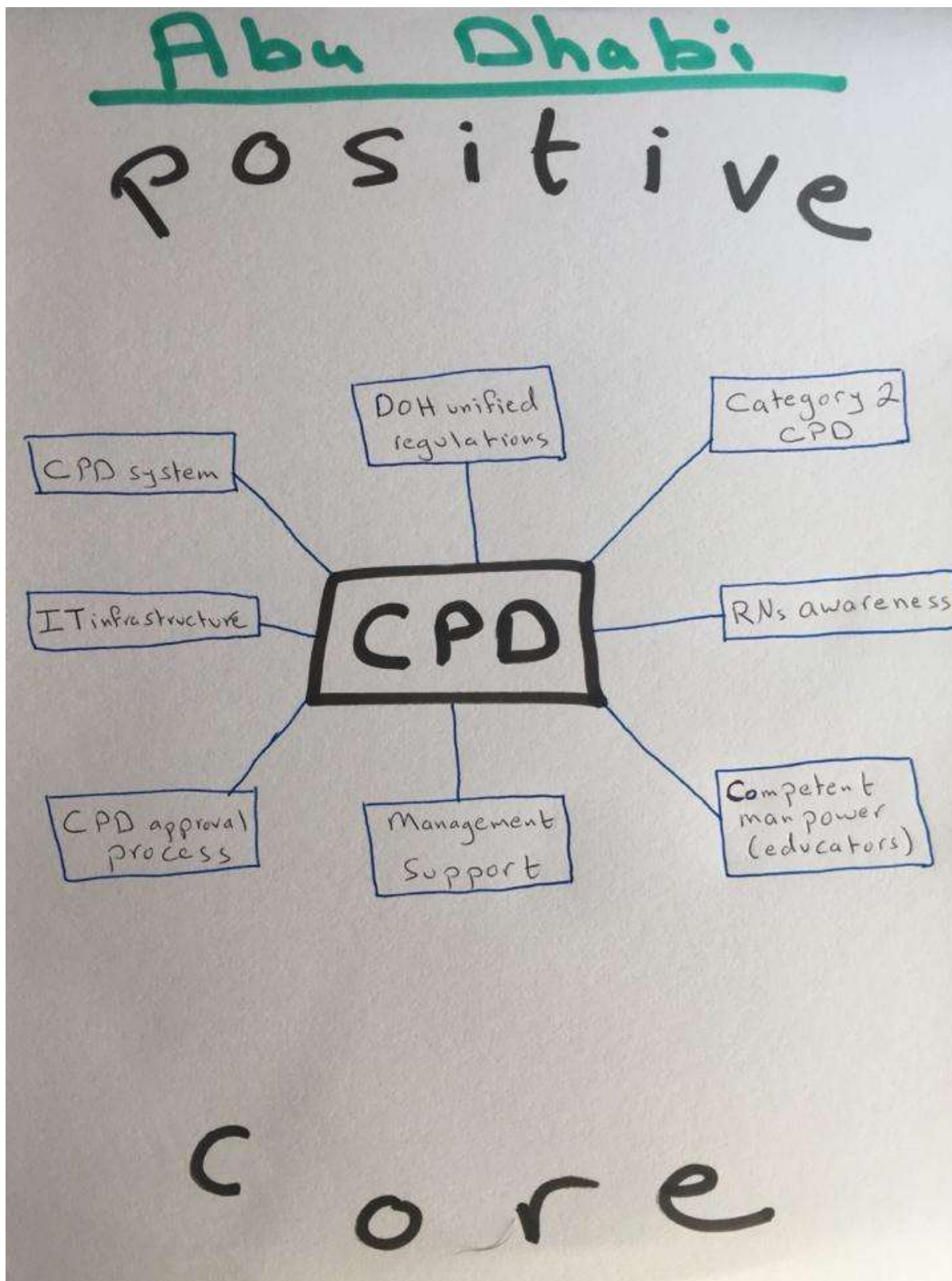
Afterwards, a conclusion was reached on the positive core of the CPD in Abu Dhabi from the learnt lessons (figure 7.1). Seven of the following eight identified elements of “Positive Core” were utilised in the final strategy; except “management support”. They represent the “Strengths” in the SOAR model:

1. Category 2 CPD
2. RNs awareness
3. Competent manpower (educators)
4. Management support
5. CPD approval process
6. IT infrastructure
7. CPD system
8. DOH unified regulations

Table 7.2: Summary of Discover Phase

#	Story	Root cause of Success	Learnt Lessons
1	All RNs renew their nursing licence	<ul style="list-style-type: none"> • Clear requirement (20 category 1 & 20 category 2 hours every two years) • Easy process to obtain hours • Category 2 is planned internally • Management support 	<ul style="list-style-type: none"> • Increased RNs' awareness towards CPD • Management support is a key positive driving force for change • Category 2 CPD activities are very effective
2	Clear CPD system in place	<ul style="list-style-type: none"> • Regulated by the DOH • Strong IT infrastructure • Published guidelines and policy • Online • Allows for repeating the activity in a different setting 	<ul style="list-style-type: none"> • All facilities to abide by the DOH regulations • Build on the existing CPD system and strong IT infrastructure
3	Category 2 CPD	<ul style="list-style-type: none"> • Very beneficial for RNs in terms of knowledge and skills improvement • Based on the RNs needs • Approved, managed, and planned internally • Does not require DOH approval (decentralised) • Easy access by RNs • Builds strong CPD programme within the facilities • Management support more than category 1 • Ability to replicate within a one-year period • Preferred by RNs • Very feasible for facilities facing difficulties with category 1 • Available competent manpower to conduct it 	<ul style="list-style-type: none"> • Any CPD programme should resemble the category 2 CPD • Utilising the efforts of competent nursing educators (manpower) will be great asset for any CPD programme • Management support is a key positive driving force for change
4	Approval process	<p><u>Category 1</u></p> <ul style="list-style-type: none"> • Published guidelines • Does not emphasise the content of the activity • If familiar with the process, easy to get approved. • Online <p><u>Category 2</u></p> <ul style="list-style-type: none"> • Do not require DOH approval 	<ul style="list-style-type: none"> • Build on the existing approval process that has very clear guidelines • Approval process of category 2 CPD is very efficient and effective
5	Stipulation to share information	<ul style="list-style-type: none"> • Staff encouragement • Planned post-activity reflection within the facility • Empowers the attending RNs • Benefiting the other RNs • Good investment value for sponsored and time-relieved participants 	<ul style="list-style-type: none"> • Any CPD strategy should take into consideration staff motivation and empowerment • Sharing knowledge is a key success factor in any CPD programme/strategy

Figure 7.1: Positive Core Map



Note: The researcher inquired about the CPD categories 1 and 2 during the storytelling activity. Participants clarified that the required hours are 40 hours every two years in the form of 20 hours from category 1 and another 20 hours from category 2. Category 1 was defined as any CPD activity that is approved and/or accredited by the DOH, whereas category 2 is any other CPD activity that can be done online or internally within the healthcare facility. The discussions in this section were mainly about the CPD category 2 that is planned and conducted internally within the healthcare facilities which should be based on RNs' needs and specialty.

By this, the objective the Discovery phase was achieved, and the phase was closed and prompted the move to the next phase; Dream.

7.3.3 Dream Phase

The objectives of the dream phase were to:

- Identify the areas of improvement in the existing CPD programme and strategies.
- Describe the expected CPD programme activities in terms of content, provision, and outcomes.

To achieve these objectives, participants were asked to envision the future beyond the known boundaries and “expand the context of excellence” and for this purpose, the following questions were asked to trigger their imagination:

Imagine the future where RNs look to the CPD programme as exceptional examples of professional development and management commitment towards excellence.

- What has contributed most to making that exceptional example possible?
- How does having outstanding CPD programmes in the UAE make a difference to the future of nursing?
- What bold decisions were made and by whom that set effective CPD strategies?

However, to complete the “strategic inquiry” of the SOAR model, its second arm, the “Opportunities” were identified by participants. Thus, an “opportunity map” (figure 7.2) was drafted and refined during the dream phase. The key “opportunities” were as follows:

1. Communication and co-ordination platforms
2. Certified centres as CPD providers
3. Nursing specialty programmes
4. Needs-based CPD activities
5. Blended learning CPD activities
6. PQR for CRNs and nursing faculty
7. Facility-level framework for CPD programmes.

After reviewing the findings of the “strategic inquiry” (“strengths” and “opportunities”), participants shared their dreams individually and then agreed on a collective dream that consists of sub-dreams. These dreams were based on a set of five strategic goals that were inspired by the strengths and opportunities. The individual dreams and their justification (as stated by participants) are summarised in table 7.3. The dreams represent the initial “Aspirations”, the first arm of the “appreciative intent”, of the SOAR model. Participants enacted a total of 10 collective dreams:

- Linking the CPD activities to the annual appraisal of RNs
- Linking the CPD activities to the RNs specialty and/or area of practice
- Reviewing the CPD programme of each facility on an annual basis along with the facility’s re-licence
- Having a designated nursing education department in each facility
- Having all faculty nursing educators and CRNs in the PQR
- Having certified facilities as CPD provider centres
- Having communication and co-ordination platforms under the DOH, including the government and private sectors
- Having an online interactive platform for nursing educators to share and discuss CPD issues and updates
- Having funded nursing specialty programmes for RNs
- Incorporating and promoting the online interactive CPD activities as a blended learning approach.

Figure 7.2: Opportunity Map

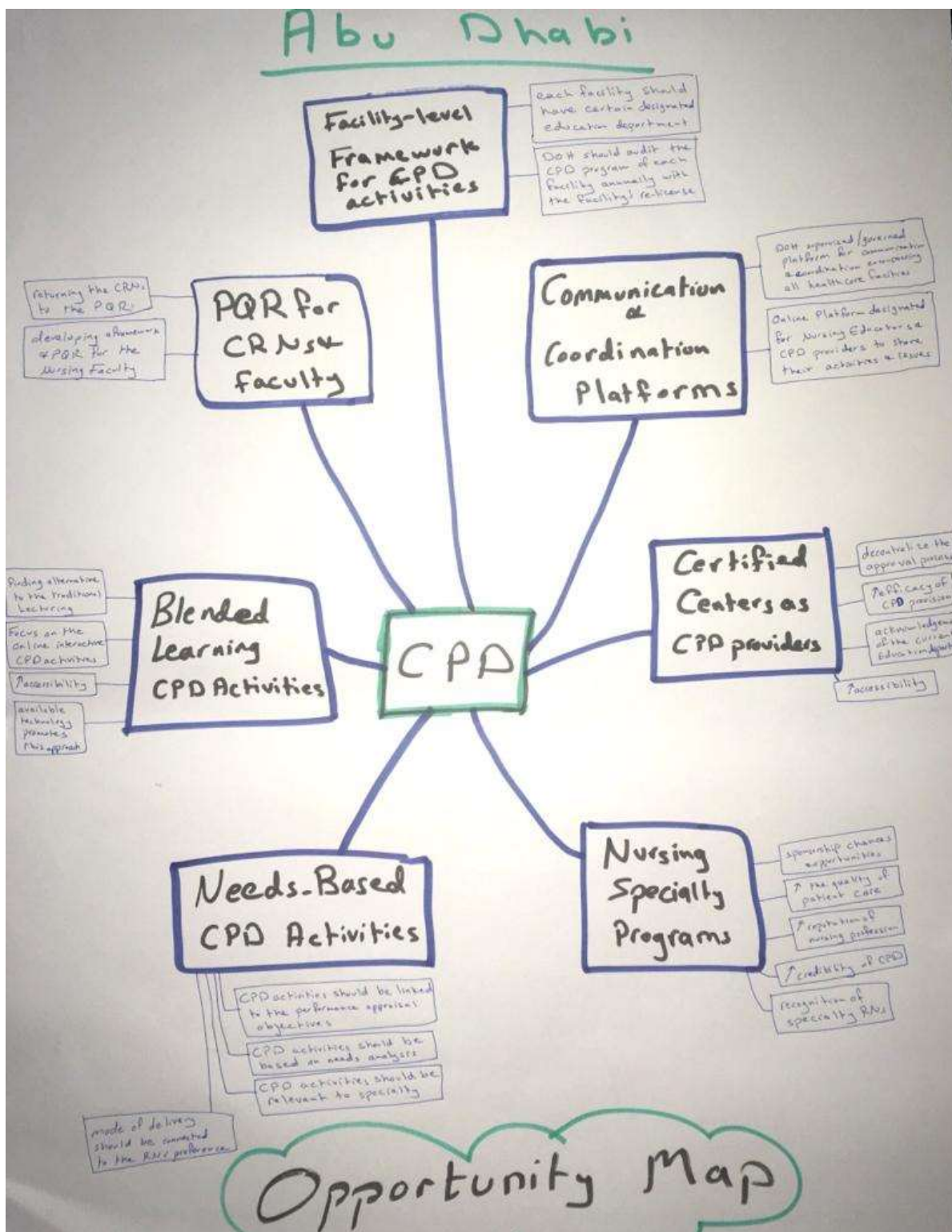


Table 7.3: Summary of the Individual Dreams

Participant	Individual dreams and justification
1	<ul style="list-style-type: none"> • Recognition and acknowledgement of the nursing educators (faculty) as professional nurses <ul style="list-style-type: none"> ○ <i>“They are not licenced as RNs”</i> ○ <i>“They should be a key CPD provider and planner”</i>
2	<ul style="list-style-type: none"> • To link the CPD activities to the annual objectives <ul style="list-style-type: none"> ○ <i>“To reflect actual needs and performance”</i> ○ <i>“This should be audited by the DOH before the re-licence”</i> • To conduct annual review of the education program based on the needs analysis of facilities by the DOH <ul style="list-style-type: none"> ○ <i>“It should be done with the facility’s licence renewal”</i> ○ <i>“It should be done even if there is no education department”</i> ○ <i>“This is an enforcement to have a proper education plan”</i>
3	<ul style="list-style-type: none"> • Returning the CRN to the PQR <ul style="list-style-type: none"> ○ <i>“It was removed around 10 years ago”</i> ○ <i>“Having the CRNs on the PQR adds value to the work and frames their practice”</i> • To have a nursing education department in all healthcare facilities <ul style="list-style-type: none"> ○ <i>“It is critical as long as the licence is linked to the CPD”</i> ○ <i>“This will systematise the nursing education process within the facilities”</i> ○ <i>“This facilitates the process of offering CPD activities relevant to the specialty”</i> • To have more diverse learning methodologies in category 1 <ul style="list-style-type: none"> ○ <i>“The current category 1 focuses on the traditional lecturing education which is not very effective”</i>
4	<ul style="list-style-type: none"> • To have CPD activities relevant to the specialty <ul style="list-style-type: none"> ○ <i>“Category 1 should be similar to category 2”</i> ○ <i>“The approval process of category 2 should be eased and enhanced”</i> • To have a communication and co-ordination platform <ul style="list-style-type: none"> ○ <i>“It should be at all levels; not only operational level”</i> ○ <i>“To share the knowledge and expertise of the different specialties”</i> • To decentralise the DOH approval process <ul style="list-style-type: none"> ○ <i>“To avoid the unnecessary obstacles and delays”</i> • To have facilities certified CPD provider <ul style="list-style-type: none"> ○ <i>“To avoid the DOH long process as the facility will be accredited annually; not to accredit every activity”</i> ○ <i>“To increase the efficiency of the provision CPD activities”</i>

5	<ul style="list-style-type: none"> • To have a culture of CPD among RNs and within the organisation <ul style="list-style-type: none"> ○ <i>“Because this is the core principle of any change”</i> ○ <i>“Anything else will be easy to achieve if we stand in this position”</i>
6	<ul style="list-style-type: none"> • To increase the accessibility to CPD activities through online live activities <ul style="list-style-type: none"> ○ <i>“This is a key element in addressing the accessibility barrier”</i> • To focus on the interactive learning style with the new millennial RNs <ul style="list-style-type: none"> ○ <i>“This adds more engagement and interest”</i> ○ <i>“It improves the impact of CPD”</i> • To have an online interactive platform for the nursing educators <ul style="list-style-type: none"> ○ <i>“This should be structured formally at the level of the DOH”</i> ○ <i>“Any educator, who prepares or designs a CPD activity, can share with the other educators within Abu Dhabi”</i> ○ <i>“This build for a string body of CPD knowledge and bank of activities”</i>
7	<ul style="list-style-type: none"> • To unify the efforts within each specialty across Abu Dhabi <ul style="list-style-type: none"> ○ <i>“This should be structured formally at the level of the DOH”</i> ○ <i>“This includes sharing the resources and accepting RNs from other facilities to attend internal specialty CPD activities and in turn, they transfer the new learnt knowledge to their facilities”</i>
8	<ul style="list-style-type: none"> • To have more accessibility by having a more blended learning approach <ul style="list-style-type: none"> ○ <i>“The mode of delivery and accessibility are major barriers”</i> • To have specialty nursing programmes <ul style="list-style-type: none"> ○ <i>“The programmes should be funded”</i> ○ <i>“The specialised RNs improve the quality of patient care and enhance the reputation of the nursing profession”</i> ○ <i>“The specialty programme is a high level CPD by itself”</i>

In conclusion, by identifying opportunities that were added to the strengths (positive core), the first part of the SOAR model (strategic inquiry) was considered complete. And by identifying the collective dreams (initial aspirations) that were based on the strategic goals, the objective of the Dream phase was achieved, and the phase was closed and prompted a move to the next phase, Design, to identify the final “aspirations”.

7.3.4 Design Phase

The objective of the destiny phase is to:

- Develop the best CPD strategies that would contribute to the improvement of the CPD programme.

To achieve this objective, participants were asked to describe the ideal situation in the form of “provocative propositions” by turning “preferences” into “affirmative statements”. Thus, the researcher asked participants the following futuristic questions to stimulate their “aspirations” as opposed to receiving structured answers:

- What are the areas of CPD where you feel nurses could have the most impact in improving the quality of patients’ care?
- As you reflect on successful ways nurses are currently participating in CPD activities, what initiatives stand out as being exceptionally promising in the professional development of nurses and why?

The core task was identifying preferences which are referred to as “design preferences”. Participants were asked to use the provided “design worksheet” (table 7.4) to fill the “design preferences” from the learnt lessons of the discovery phase and the “design preferences from the dream phase in alignment with the design element as per the “McKinsey 7-S Model”. They had to craft the “provocative propositions” by turning the preferences into affirmative statements.

Although participants found that some design preferences might fall under more than one design element, they decided to focus on the structure, system, and staff as their dreams were about these elements.

By identifying the provocative propositions, the final “aspirations” of the SOAR model were completed. Thus, the objective of the design phase was achieved where the provocative propositions represented the best CPD strategies for RNs in the UAE, specifically in Abu Dhabi.

Table 7.4: Design Worksheet

Our Chosen Design Elements	What We Learned in Our Discovery <i>(design preferences)</i>	What Our Dreams Suggest We Want <i>(design preferences)</i>	Our Provocative Proposition
Strategy	None	None	None
Structure	<ul style="list-style-type: none"> • IT infrastructure 	<ul style="list-style-type: none"> • Communication and co-ordination platforms • Certified centres as CPD providers 	<ul style="list-style-type: none"> • Create communication and co-ordination platforms in the form of committees under the DOH to include both the government and private sector. The committees should include the three levels; strategic, tactical, and operational RNs. • Design and create an online interactive platform for RNs responsible for CPD planning and provision. This is to help RNs to share knowledge on CPD activities and to discuss CPD issues and updates. • Accredit the qualified healthcare facilities as certified CPD provider centres by the DOH, in accordance with certain criteria and regulations set out by the DOH).
System	<ul style="list-style-type: none"> • Category 2 CPD • CPD approval process • DOH unified regulations • CPD systems 	<ul style="list-style-type: none"> • Needs-based CPD activities • Blended learning CPD activities • Facility-level framework for CPD programmes • Nursing specialty programmes 	<ul style="list-style-type: none"> • Link the CPD activities to the annual appraisal objectives and to the specialty and/or area of practice of RNs. This process should be audited by the DOH based on probability sampling procedures. • Create a framework that incorporates the online interactive CPD activities as a blended learning approach and to be approved as category 1 CPD to increase the accessibility of CPD

			<p>activities. Quality assurance should be part of the framework.</p> <ul style="list-style-type: none"> • Create sponsored nursing specialty programmes to graduate specialised RNs. The launch of the programmes should be associated with creating licencing and certification frameworks within the DOH. • Mandating all healthcare facilities to have a designated nursing education department. The CPD plan should be audited annually by the DOH along with the licensure renewal of the facility.
Skills	None	None	None
Staff	<ul style="list-style-type: none"> • RNs awareness • Competent manpower (educators) 	<ul style="list-style-type: none"> • PQR for CRNs and nursing faculty 	<ul style="list-style-type: none"> • Returning the CRNs to the PQR due to the importance of their role in the CPD which is a licensure renewal requirement. • Developing a framework for the nursing faculty personnel to be licensed as RNs due to their potential developmental and transitional role in the CPD programmes.
Style	<ul style="list-style-type: none"> • Management support 	None	None
Shared Value	None	None	None

7.3.5 Destiny Phase

The Destiny/Deliver phase is not part of this research study as it encompasses the development of an action plan for each strategy and its implementation. The action plan and implementation requires the approval of the DOH. In the same context, the “Results” of the SOAR model is not part of the study as they resemble the Destiny phase.

However, the researcher will share the findings and strategy with the DOH, the regulatory body in Abu Dhabi, namely with the director of CPD. The researcher communicated with the director before conducting the AI to make her aware for the study. She revealed an interest in the study and its findings and outcomes. Additionally, the key players who participated in the strategy development showed an interest in supporting the strategy with the DOH as it reflects the actual needs of Abu Dhabi.

At the post-doctoral level, the preliminary developed goals, objectives, and strategic recommendations/initiative might be reviewed after adopting the strategy if amendments are required per the DOH before its implementation. Then, the Results (R) will be evaluated based on the evaluation methodology and Key Performance Indicators (KPIs) that will be developed.

7.3.6 Summary of the 5-D Cycle

In summary, the findings of the AI concluded in a set of nine strategic recommendations or initiatives in the form of provocative propositions that were crafted by the nursing key players in Abu Dhabi. The strategic recommendations are focused on three design elements; structure, system, and staff.

The CPD strategic plan is presented in table 7.5 that illustrates how the strategy was culminated throughout the AI's 5D Cycle and within the SOAR framework. First, in the define phase, the purpose of the strategy was formulated and derived from its affirmative topic. Second, in the discovery phase, the “positive core” was concluded from the stories about the “peak times” representing the Strengths (S). Third, in the dream phase, the Opportunities (O) were concluded first, then the CPD Strategic goals were formulated from the Opportunities (O), and finally the Initial Aspirations (a) were inspired by the Strengths (S)

and Opportunities (O). Fourth, in the design phase, the CPD strategic objectives were formulated from the Initial Aspirations (a) to meet the goals, then the provocative propositions were formulated based on “What was learnt in the Discovery” and “What the Dreams suggest is wanted”. They were represented by the strategic recommendations/initiatives which are referred to as Final Aspirations (A). Fifth, the Destiny/Deliver phase is not part of this research study. However, the strategy that will be supported by the key players who participated in its development, will be shared with the regulatory body, DOH. The strategy’s implementation and evaluation will be pursued at the post-doctoral level.

Table 7.5: CPD Strategic Plan

5D Cycle	SO AR	CPD Strategic Plan				
Define Phase		Affirmative Topic				
		Sustainable CPD Strategies for Excellence				
	Purpose	To Develop Sustainable CPD Programs for Excellence				
Design Elements		1. Structure		2. System		3. Staff
Discovery Phase	S	Positive Core				
		a) IT infrastructure	b) Category 2 CPD c) CPD approval process d) CPD system e) DOH unified regulations		f) RNs awareness g) Competent manpower (educators)	
Dream Phase	O	i. Communication and co-ordination platforms	iii. Nursing specialty programmes iv. Needs-based CPD activities v. Blended learning CPD activities		vi. PQR for CRNs and nursing faculty vii. Facility-level framework for CPD programmes	
		ii. Certified centres as CPD providers				
	Goals	1.1 To facilitate the communication and co-ordination process among the different facilities	1.2 To decentralize the CPD approval process	2.1 To promote nursing specialty programs and activities the reflect the RNs' needs		2.2 To improve the accessibility of the CPD activities

	a	<p>1.1a Having communication and co-ordination platforms under the DOH, including the government and private sectors</p> <p>1.1b Having an online interactive platform for nursing educators to share and discuss CPD issues and updates</p> <p>2.1a Having certified facilities as CPD provider centres</p>		<p>2.1a Linking the CPD activities to the annual appraisal of RNs</p> <p>2.1b Linking the CPD activities to the RNs specialty and/or area of practice</p> <p>2.1d Having funded nursing specialty programmes for RNs</p> <p>2.1e Reviewing the CPD programme of each facility on an annual basis along with the facility's re-licence</p> <p>2.1f Having a designated nursing education department in each facility</p> <p>2.2a Incorporating and promoting the online interactive CPD activities as a blended learning approach.</p>				<p>3.1a Having all faculty nursing educators and CRNs in the PQR</p>
	Objectives	<p>1.1 To create communication and co-ordination platforms</p> <p><i>(SR1 & SR2)</i></p>	<p>1.2 To develop and approve certified centres as CPD providers</p> <p><i>(SR3)</i></p>	<p>2.1. To encourage participation in needs-based CPD activities</p> <p><i>(SR4)</i></p>	<p>2.2 To offer nursing specialty programmes</p> <p><i>(SR6)</i></p>	<p>2.3 To develop facility-level framework for CPD programmes</p> <p><i>(SR7)</i></p>	<p>2.4 To offer blended learning CPD activities</p> <p><i>(SR5)</i></p>	<p>3.1 To recognise and acknowledge the role of the CRNs and nursing faculty</p> <p><i>(SR8 & SR9)</i></p>
Design Phase	A	<p>Provocative Propositions <i>Strategic Recommendations/Initiatives (SR: N = 9)</i></p>						
		<p>1. Create communication and co-ordination platforms in the form of committees under the DOH to include both the government and private sector. The committees should include the three levels; strategic, tactical, and operational RNs.</p> <p>2. Design and create an online interactive platform for RNs responsible for CPD planning and provision. This is to help RNs to</p>	<p>4. Link the CPD activities to the annual appraisal objectives and to the specialty and/or area of practice of RNs. This process should be audited by the DOH based on probability sampling procedures.</p> <p>5. Create a framework that incorporates the online interactive CPD activities as a blended learning approach and to be approved as category 1 CPD to increase the accessibility of CPD activities. Quality assurance should be part of the framework.</p> <p>6. Create sponsored nursing specialty programmes to graduate specialised RNs. The launch of the programmes should be</p>	<p>8. Returning the CRNs to the PQR due to the importance of their role in the CPD which is a licensure renewal requirement.</p> <p>9. Developing a framework for the nursing faculty personnel to be licensed as RNs due</p>				

		<p>share knowledge on CPD activities and to discuss CPD issues and updates.</p> <p>3. Accredit the qualified healthcare facilities as certified CPD provider centres by the DOH, in accordance with certain criteria and regulations set out by the DOH.</p>	<p>associated with creating licensing and certification frameworks within the DOH.</p> <p>7. Mandating all healthcare facilities to have a designated nursing education department. The CPD plan should be audited annually by the DOH along with the licensure renewal of the facility.</p>	<p>to their potential developmental and transitional role in the CPD programmes.</p>
<p>Destiny Phase</p>	<p>R</p>	<p>Results will be evaluated based on the evaluation methodology and KPIs that will be developed at the post-doctoral level</p>		

SOAR: Strengths (S), Opportunities (O), Aspirations (Initial: a; Final: A), Results (R)

7.4 DISCUSSION OF FINDINGS

The discussion of the findings, which are represented by the strategic recommendations, is based on two interpretative aspects. First, the findings are compared to the RNs' needs and perception that were concluded from the data integration of the core design. Second, they are compared to the benchmarking of the international CPD practices that was presented in chapter two. No previous similar studies were found in the literature. Studying the CPD was common in the literature in the form of qualitative, quantitative or mixed methods, however Appreciative Inquiry was not one of them. Thus, after validating the methods and findings of the core design in the previous chapter, validating the data in comparison with the RNs' needs and perception and the benchmarked international CPD practices is the approach of choice in phase three. This is supported by the fact that the strategic recommendations are UAE context-driven rather than aiming at generalisation.

7.4.1 Comparison with the RNs' Needs and Perception

Effective strategic planning should be based on and aligned with the needs of the RNs' requirements and perceptions as they represent the core of the healthcare manpower (Ginter, Duncan and Swayne, 2018). Therefore, the strategic recommendations should reflect and at minimum, do not contradict the RNs' needs and perceptions. As discussed, and presented in table 7.6, three strategic recommendations have direct and strong connection with the RNs' needs and perceptions while the other six do not contradict them but still have a very positive contribution to CPD. Specifically, all five "structural" and "staff" related strategic recommendations do not contradict, however the majority (three out of four) of the "system" related strategic recommendations have a direct and strong connection.

Table 7.6: Strategic Recommendations Alignment with RNs' Needs and Perception

Design Element	Strategic Recommendations	Alignment with the RNs' needs and perception
Structure	1. Create a communication and co-ordination platform in the form of committees under the DOH to include both the government and private sector. The committees should include the three levels; strategic, tactical, and operational RNs.	<ul style="list-style-type: none"> • No contradiction • <i>It would contribute to the solution of the communication issue, "late notification", about the CPD activities</i>
	2. Design and create an online interactive platform for RNs responsible for CPD planning and provision. This is to help RNs to share knowledge on CPD activities and to discuss CPD issues and updates.	<ul style="list-style-type: none"> • No contradiction • <i>It supports the findings in terms of the "online" and "interactive" approaches</i>
	3. Accredit the qualified healthcare facilities as certified CPD provider centres by the DOH, in accordance with certain criteria as set out by the DOH.	<ul style="list-style-type: none"> • No contradiction • <i>It empowers the facilities facing challenges with the central accreditation process of their CPD activities</i>
System	4. Link the CPD activities to the annual appraisal and to the specialty and/or area of practice of RNs. This process should be audited by the DOH based on probability sampling procedures.	<ul style="list-style-type: none"> • Direct and strong connection • <i>It supports the issue of the "relevance" of CPD activities and subsequently the "interest" issue where the CPD activity will be directly connected to the RNs needs and specialty</i>
	5. Create a framework that incorporates the online interactive CPD activities as a blended learning approach and approved as category 1 CPD to increase the accessibility of the CPD activities. Quality assurance should be part of the framework.	<ul style="list-style-type: none"> • Direct and strong connection • <i>It supports the solutions of the "access" issue</i> • <i>It supports the RNs' preference towards the "online" approach</i>
	6. Create sponsored nursing specialty programmes to graduate specialised RNs in the different nursing specialties. The launch of the programmes should be associated with creating licencing and certification frameworks within the DOH.	<ul style="list-style-type: none"> • No contradiction • <i>It supports "specialty" issue</i>

	7. Mandate all healthcare facilities to have a designated nursing education department. The CPD plan should be audited annually by the DOH along with the licensure renewal of the facility.	<ul style="list-style-type: none"> • Direct and strong connection • <i>It supports most of the needs and issues perceived by the RNs</i>
Staff	8. Return the CRNs to the PQR due to the importance of their role in the CPD which is a licensure renewal requirement.	<ul style="list-style-type: none"> • No contradiction • <i>They support most of the needs and issues perceived by the RNs</i>
	9. Develop a framework for the nursing faculty personnel to be licensed as RNs due to their potential developmental and transitional role in the CPD programmes.	

Thus, this examination of the alignment points on two possible indicators. First, the RNs' needs and perceptions are focused on the "system" rather than on the "structure" and "staff" design elements. Second, the RNs and their leaders do not have the same view of the CPD challenges, since only three of the six strategic recommendations are directly connected to the RNs' needs and perceptions. However, this could be viewed as a normal discrepancy as the leaders usually have a more holistic view of the big picture whereas the RNs would be more concerned about their personal work-related issues.

On the other hand, despite the existence of several strengths, RNs are still facing challenges concerning the system. Thus, the regulatory bodies and governors of the CPD should develop programmes that address the RNs' needs and perceptions. Additionally, they should conduct systematic and periodic evaluation of the effectiveness of these programmes in order to update and modify them according to the changes in the needs of the most important manpower in the healthcare industry that is featured by its complex and rapid changes to meet the community needs.

7.4.2 Comparison with the Benchmarked International CPD Practices

The benchmarking that was presented in chapter two examined the CPD requirements and processes in selected international CPD programmes. The benchmarking grouped the data under eight elements; terminology, mandatory versus optional, linkage to licensure, required hours, type of activity, relevance of activity to the specialty, alignment with the profession's scope of practice, and adoption of a model or framework. The strategic recommendations are not addressed in all elements since they addressed the areas of improvement rather than the entire programme. However, this comparison will include all elements with emphasis on the strategic recommendations.

The terminology, mandatory, linkage to requirements, and required hours elements were not a subject of discussion for a change. First, the most common term used internationally is CPD, however the used term in Abu Dhabi is CNE which is also used in Texas in the USA. Second, CPD is a mandatory requirement in most of the benchmarked countries which is the case in Abu Dhabi. Third, except for France, Germany, and Ontario in Canada, CPD is linked to the nursing licence in most countries which is the case in Abu Dhabi. Fourth, despite the variety in the period, most countries require an average of 20 hours per annum which is the case in Abu Dhabi that requires 40 hours every two years.

The type of activity was an area of inconsistency among the reviewed bodies where some specified these and others did not. In Abu Dhabi, the type of activity is not specified and not recommended to be specified. However, the emphasis here is on the nature of the CPD activity which was recommended in the fifth strategic recommendation that emphasises the online and interactive blended learning as this gives more access and offers diversity, consistent with most of the countries. On the other hand, the third strategic recommendation concerning the accredited CPD provider facilities is consistent with the practices adopted in Australia, New Zealand, and the USA who have approved lists of certified organisations to offer learning activities.

The relevance to specialty and alignment with scope of practice are two overlapping elements. All countries, except France, specified the alignment with the scope of practice

which is the case in Abu Dhabi. However, the relevance to specialty was specified in Texas in the USA, RSA, Australia, and New Zealand only, whereas Abu Dhabi's situation is similar to the others that did not specify it. However, six (3, 4, 6, 7, 8, and 9) of the strategic recommendations either indirectly contribute to the provision of CPD activities relevant to the specialty, or directly address it, such as the fourth strategic recommendation that suggests, with a very clear language, connecting the CPD activities to the annual appraisal and to the specialty.

Finally, most countries have a sort of CPD framework or guidelines that has shaped the CPD requirements and processes which is the case in Abu Dhabi. However, these frameworks were neither clearly presented nor framed the practices in a CPD model except in the case of RSA and New Zealand. The fifth strategic recommendation fills this gap where it is suggested to "*create a framework.... Quality assurance should be part of the framework*" that would build an effective and reliable CPD programme in Abu Dhabi. In conclusion, most of the strategic recommendations are consistent with the international best practices and even, if implemented, would prepare for developing a state of the art CPD programme that places the CPD in Abu Dhabi among the top in the world.

7.5 SUMMARY OF CHAPTER

This chapter presented the findings and discussion of the qualitative inquiry phase. The final findings are represented by the strategic recommendations that were retrieved from the provocative propositions. The findings were validated by comparing and aligning them to the RNs' needs and perceptions as per the findings of the core design of this study and by comparing them to the benchmarked international CPD practices. The conclusions, limitations, implications, and recommendations are presented in the next chapter.

CHAPTER 8: CONCLUSIONS, LIMITATIONS, IMPLICATIONS, AND FUTURE RECOMMENDATIONS

8.1 INTRODUCTION

This chapter concludes the thesis by summarising the key findings that were generated from the three phases of the mixed method design. Then, it presents the identified limitations, implications, and future recommendations of the study.

8.2 AIM, QUESTIONS, AND OBJECTIVES OF THE STUDY

The aim of this study was to explore and investigate the perspective of registered nurses regarding the effectiveness of the Continuing Professional Development in the UAE in order to develop inclusive CPD strategies.

The questions, objectives, and hypotheses were as follows:

1. What is the perception of RNs on the effectiveness of the CPD programme?
 - *Objective 1.1*: explore and describe the perception of RNs about the effectiveness of the CPD programme on their performance.
2. What are the intrinsic and extrinsic hindering and facilitating factors that influence RNs' participation in the CPD programme?
 - *Objective 2.1*: identify and determine the intrinsic and extrinsic hindering factors that influence RNs' participation in the CPD programme.
 - *Objective 2.2*: identify and determine the intrinsic and extrinsic factors that facilitate RNs' participation in the CPD programme.
 - *Objective 2.3*: identify the most important CPD activities.

- *Objective 2.4:* identify any perceived differences in the hindering factors, facilitating factors, important activities, and actual activities undertaken in terms of the region, governor, and type of facility.
3. How can an effective CPD programme that meet the needs of RNs be developed?
- *Objective 3.1:* define the affirmative topic of CPD and clarify the focus of inquiry; based on the findings of phases one and two.
 - *Objective 3.2:* explore and describe what is working effectively in the existing CPD programmes and strategies.
 - *Objective 3.3:* identify areas of improvement in the existing CPD programmes and strategies.
 - *Objective 3.4:* describe the expected CPD programme activities in terms of content, provision, and outcomes.
 - *Objective 3.5:* develop the best CPD strategies that would contribute to the improvement of the CPD programme.

8.3 KEY FINDINGS OF THE STUDY

The key findings of the study are concluded from its three phases. In alignment with the three main questions, the findings are grouped under three major domains; RNs' perception about the value of CPD, influencing factors, and strategic recommendations.

8.3.1 RNs' Perception about the Value of CPD

The RNs' perception about the value of CPD was examined to answer the first question. The findings were demonstrated in two forms; positive and questionable value.

The results indicate that the CPD value can be perceived positively by the RNs due to the following reasons:

1. CPD's contribution in meeting the licensure renewal and organisational requirements
2. CPS's benefit in updating and gaining new knowledge and skills

3. CPD's impact on the nursing care and eventually, patient care

On the other hand, the results indicate that CPD value can be questioned by the RNs if they experience the following:

1. Frustration feeling towards the obligation to attain the CPD hours
2. Lack of RNs' needs and interest in terms of the relevance and quality of CPD activities

8.3.2 Influencing Factors

The findings about the influencing factors were generated in two aspects; how they were perceived factors and the relationship between them.

8.3.2.1 Perceived Influencing Factors

The perceived factors were generated from the data integration of the qualitative and quantitative findings of the core design in order to answer the second question.

The findings revealed 16 motives falling under four groups of factors; personal and professional development, requirements, career opportunities, and personal. All factors were very important. The most highlighted motives are:

1. licence renewal
2. update and learn new knowledge and skills
3. interest in the activity
4. career development
5. promotion

Additionally, the findings revealed 13 conditions/barriers falling under two groups of factors; intangible and tangible conditions. The tangible conditions were of highest importance. The most highlighted barriers are:

1. finance, fund, and cost
2. time (work schedule, load, social commitments)
3. accessibility (geographical distance, late notification, limited seats)

4. irrelevant activities to specialty
5. lack of policies that support CPD
6. lack of supervisor's support

The findings revealed nine highly important activities and six moderately important activities for the RNs. On the other hand, the findings revealed that the RNs undertook most frequently, five activities and moderate frequently, two activities. The activities are grouped under three factors; participation in research, clinical practice development, and participation in organisational development. The clinical practice development factor was the most important and frequent type of activities.

All activities that fall under the “participation in research” and “participation in organisation development” factors have a big difference between the important activities and how frequently they were undertaken, while the least differences are in the activities of the “clinical practice development” factor. The four most highlighted important and undertaken activities are:

1. short courses, lectures, conferences, and seminars
2. online courses and/or lectures
3. hands-on training courses, including workshops
4. Making sure to keep up to date with professional developments
5. Reflecting critically on practical situations
6. Determining whether performed well and could perform better next time

8.3.2.2 Relationship between Variables

The relationship between variables was generated from the quantitative findings only. It is divided into two sections; correlation and regression analysis.

The correlation analysis was tested by the Pearson correlation test. It examined the relationship between the demographic variables and the four CPD variables and revealed either weak positive, weak negative, or insignificant correlation which was the most common.

However, the correlation analysis that examined the strength of the relationship between the independent variables (motives, conditions, and important activities) and the dependent variable (CPD activities actually undertaken) revealed positive correlation. In essence, the correlation is moderately positive between CPD important activities and CPD activities actually undertaken, weak positive between CPD activities undertaken and CPD motives and CPD conditions.

On the other hand, the relationships between the independent variables (motives, conditions, important activities) and the dependent variable (CPD activities actually undertaken) were tested through simple linear regression analysis (univariate). All hypotheses listed below were accepted.

- **H-A1:** The motives of RNs in Abu Dhabi have a significant influence on the actually undertaken CPD activities.
- **H-A2:** The conditions surrounding RNs in Abu Dhabi have a significant influence on the actually undertaken CPD activities.
- **H-A3:** The importance perceived of CPD activities by RNs in Abu Dhabi has a significant influence on the actually undertaken CPD activities.
- **Main hypothesis H1:** Motives, conditions and importance associated with CPD has a significant effect on the CPD activities performed by the RNs in Abu Dhabi

8.3.3 Strategic Recommendations

The strategy of an effective CPD programme is represented by the concluded nine strategic recommendations that fall under three design elements; structure, system, and staff. These strategies were generated from the Appreciative Inquiry workshop through the 5-D Cycle in order to answer the third question. The strategic recommendations are listed in table 8.1.

Table 8.1: Strategic Recommendations

Design Element	Strategic Recommendations
Structure	10. Create a communication and co-ordination platform in the form of committees under the DOH to include both the government and private sector. The committees should include the three levels; strategic, tactical, and operational RNs.
	11. Design and create an online interactive platform for RNs responsible for CPD planning and provision. This is to help RNs share knowledge on CPD activities and to discuss CPD issues and updates.
	12. Accredite the qualified healthcare facilities as certified CPD provider centres by the DOH, in accordance with certain criteria as set out by the DOH.
System	13. Link the CPD activities to the annual appraisal and to the specialty and/or area of practice of RNs. This process should be audited by the DOH, based on probability sampling procedures.
	14. Create a framework that incorporates the online interactive CPD activities as a blended learning approach and approved as category 1 CPD to increase the accessibility of the CPD activities. Quality assurance should be part of the framework.
	15. Create sponsored nursing specialty programmes to graduate specialised RNs in the different nursing specialties. The launch of the programmes should be associated with creating licencing and certification frameworks within the DOH.
	16. Mandate all healthcare facilities to have a designated nursing education department. The CPD plan should be audited annually by the DOH along with the licensure renewal of the facility.
Staff	17. Return the CRNs to the PQR due to the importance of their role in the CPD which is a licensure renewal requirement.
	18. Develop a framework for the nursing faculty personnel to be licensed as RNs due to their potential developmental and transitional role in the CPD programmes.

8.4 LIMITATIONS

The intention behind deciding on the mixed method design of this study was due to several reasons and benefits. Among them was the intention to overcome the possible bias of a single method design and to subsequently strengthen the findings. However, despite the enormous strengths, the complexity of the study has encountered a number of limitations and challenges. Most of the limitations were related to the availability of previous similar studies in certain CPD areas, operational aspects, and AI as a change approach.

First, the available literature was a limitation that would affect the validation of the specific portions of the findings. As discussed in chapter three, the third and fourth constructs that share the same items in the Q-PDN were divided into three groups of activities. The researcher did not find published studies about the first group activities that examines the RNs' perception about the importance of "participation in research". Additionally, there were no previous CPD studies that adopted Appreciative Inquiry to develop a CPD strategy. However, the researcher validated the findings by aligning the strategic recommendations and comparing them to the RNs' needs and perceptions from the findings of the study and to the benchmarked international CPD practices.

On the other hand, the recruitment process of participants in the focus groups was based on the nursing directors' judgement to nominate the rich informants from their facilities. Additionally, the strategy was to invite 12 participants, hoping to have 6-8 attending participants. Both factors contributed to an unfavourable situation in the first focus group interview where all 12 participants attended the interview and many of them were actual rich informants. This resulted in a very shallow discussion at certain points and even no response from those non-rich informants on several points. However, the researcher learnt the lesson from the first focus group and co-ordinated for a better arrangement with the nursing directors to have a maximum of eight participants, and then increased the number of focus groups to four instead of the preliminary three.

Second, the access to participants was a major challenge due to the huge geographical area and the confidentiality concerns of some facilities. The geographical distance was an obstacle in recruiting possible participants from some rural areas for the focus groups despite the fact that the interviews did not exclude any region. On the other hand, some facilities refused to share the list of RNs in order to run the participants' selection and randomisation for the survey's sample. The researcher prepared detailed instructions and templates for this purpose in order that this could be conducted by the education or quality departments in these facilities.

In addition, the IRB approval process was a frustrating experience for the researcher, in order to get this from the 12 selected facilities as per their internal regulations. This process included completing different forms and presenting the proposal in most of the facilities which took a long time to be accomplished. Moreover, some facilities granted the approval only after several months from the date of submitting the request. In the same context, one of the population segments, private hospitals in Al Dhafra, was not represented in the survey due to “no approval” issue where the request was denied after six months from the date of submission due to additional unattainable approval requirements. However, this issue did not affect the overall representation of the sample as they count only six out of the 400 potential respondents that was increased from 378 to address such situations.

Third, the AI approach was a new concept introduced to the nursing community in Abu Dhabi. As a result, the researcher introduced the concept in detail at the start of the AI workshop to prepare participants to its positivity principle in change that differs from what is known as deficit-based change. Despite that, the participants’ discussion tended to focus on the weaknesses and gaps in the system rather than on valuing the existing strengths. In general, this did not affect the outcomes of the AI but it was frustrating and embarrassing to the researcher to redirect the discussion at several points to the positive. Additionally, this gave some participants an uncomfortable feeling as they were eager to express their feelings and concerns about the CPD freely without any perceived restrictions. Besides, the frequent redirection of the discussion accounted for wasting extra time which was already limited to three hours. However, by the end of the AI, participants valued and showed interest in knowing more about AI as a change approach.

8.5 IMPLICATIONS

In the light of the discussions presented in chapters six and seven, it is perceived that the findings of this study are of significant contribution to the body of knowledge, theory, practice, and policy.

First, the body of knowledge about nursing CPD is rich in terms of the influencing factors and benefits. Thus, the findings of this study support the existing literature. However, as discussed in the limitations, the major contribution to the body of knowledge is represented by the areas where no previous studies were found, such as the RNs' perception about the importance of "participation in research" CPD activities and the strategic recommendations. Additionally, the findings provide a deep insight into the relationship between the influencing factors and the RNs' participation in CPD activities.

Second, the results of this study fit the three theories/models that were used to guide the development and modification of the data collection instruments of the core design. This conclusion is supported by the examined validity of all items of the Q-PDN questionnaire. The three theories and/or models are Self-Determination Theory (SDT), Kanter's Structural Empowerment Model, and Bloom's Taxonomy of Learning Domains.

Third, the implications to practice can be manifested in addressing the preferences challenges that encounter the RNs' participation in CPD activities. RNs showed their interest in online and interactive activities that are relevant to their area of practice and specialty. Thus, the CPD providers should take these concerns into consideration when planning the CPD programmes. This fact cannot be ignored due to the strong relationship between the influencing factors and the RNs' participation in CPD. Additionally, the RNs' perceived value of CPD and its precipitating factors should be taken into consideration before planning the CPD programmes as the challenges would lead to a generation of RNs that does not appreciate the value of CPD. Thus, this would result in more serious consequences that affect the effective use of CPD even if they participate by obligation.

Fourth, the most critical implication of the findings is concerning the CPD policies and the concerned bodies. The strategic recommendations that are based on the RNs' needs and perceptions when benchmarked against the best international CPD practices would contribute to developing a CPD framework in Abu Dhabi. The decision makers will become more aware to the RNs' needs as it is the first study about nursing CPD in Abu Dhabi. These needs are supported, on one hand, by the positive relationship between the

influencing factors and participation in CPD, on the other hand, by the evidenced differences between the RNs' preferred versus actually undertaken activities.

8.6 RECOMMENDATIONS

The future recommendations are derived from the discussion of the findings and the identified limitations. The recommendations emphasise future research and policy makers.

First, this research studies the nursing CPD in Abu Dhabi which is the largest Emirate in the UAE. It studied the private and government hospitals and centres in all regions; both rural and urban. Despite that, further research is needed at the national level to address the different perceptions of all RNs in UAE, especially that CPD is governed by different authorities in other parts of the country which would constitute to different practices and subsequently, different perceptions.

Second, it is recommended that the future CPD researches include the "participation in research" factor in addition to all other factors related to the RNs' perceived importance of CPD activities. Studying this area was very limited in the nursing CPD. Additionally, future studies should examine the perception about the value of CPD as examining the influencing factors independently from their influence on the RNs' perception about the CPDs value would yield to list of influencing factors.

Third, it is recommended that all future nursing CPD researches incorporate the development of a strategy or strategic recommendations. The strategic recommendations are beneficial in all settings even when a clear CPD strategy exists, as these strategies require frequent evaluation and updating. Moreover, Appreciative Inquiry has proved its effectiveness in this and the previous studies. Thus, it is recommended to adopt the AI approach in developing strategies, due to its core principles as presented in chapter three.

Fourth, it is highly recommended that the IRB approval process is unified under the umbrella of the DOH in Abu Dhabi. This umbrella should include all healthcare facilities

where the researcher could not get access approval from each desired facility that operated according to different criteria. The healthcare facilities can keep the right to grant management approval as per their internal rules and regulations.

8.7 FINAL CONCLUSION

This study was guided by its aim “to explore and investigate the perspective of registered nurses regarding the effectiveness of the Continuing Professional Development in the UAE in order to develop inclusive CPD strategies”. To attain this aim, an advanced multiphase mixed method design, which is also referred to as complex mixed method, was adopted. The study started with the basic exploratory sequential mixed method as a core design, qualitative then quantitative, which was followed by a qualitative Appreciative Inquiry to develop the strategy. The CPD strategic recommendations were developed based on the RNs’ needs and perceptions and compared with the benchmarked international CPD practices. The main consideration was the evidence of an existing relationship between the perceived influencing factors and the RNs’ participation in CPD.

REFERENCES

Abebe, L., Bender, A., Pittini, R. 2018. Building the case for nurses' continuous professional development in ethiopia: A qualitative study of the sick kids-ethiopia paediatrics perioperative nursing training program. *Ethiopian Journal of Health Sciences*. 28(5).

Aboshaiqah, A.E., Qasim, A., Abualwafa, N. 2018. Barriers for continuing professional development among nurses in saudi arabia. *Middle East Journal of Nursing*. 101(344):1-6.

Acosta, A.S., Douthwaite, B. 2005. Appreciative inquiry: An approach for learning and change based on our own best practices.

Adjorlolo, S., Aziato, L., Akorli, V.V. 2019. Promoting maternal mental health in ghana: An examination of the involvement and professional development needs of nurses and midwives. *Nurse Education in Practice*. 39105-10.

Al-Huneiti, R., Hunaiti, Z., Al-Masaeed, S., Balachandran, W., Mansour, E. 2016. Nurses' attitudes towards e-learning for e-health education. *International Journal of Handheld Computing Research (IJHCR)*. 7(1):77-84.

Alam, M., Sumy, S.A., Parh, Y.A. 2015. Selection of the samples with probability proportional to size. *Science Journal of Applied Mathematics and Statistics*. 3(5):230-3.

Ally, H., Mogorosi-Pheto, J., Jacobs, W. 2016. The perceptions of professional nurses regarding the implementation of staff development programmes in a public hospital in gauteng, south africa.

Alqatawneh, J., Siddiqi, J., Akhgar, B., Btoush, M. 2009. E-business security: Methodological considerations. *World Academy of Science and Technology*. 49624-31.

Alsop, A. 2000. Continuing professional development in healthcare : A guide for therapists, Oxford, Blackwell Science.

Alsop, A. 2013. Continuing professional development in health and social care : Strategies for lifelong learning, Chichester, West Sussex, Wiley-Blackwell.

ANA & NNSDO. 2010. Nursing professional development: Scope and standards of practice, Silver Spring, MD, American Nurses Association.

Anderson, L.W., Krathwohl, D. 2001. A taxonomy for learning, teaching, and assessing : A revision of bloom's taxonomy of educational objectives, Longman, New York.

Anderson, W.G., Puntillo, K., Cimino, J., Noort, J., Pearson, D., Boyle, D., et al. 2017. Palliative care professional development for critical care nurses: A multicenter program.

Anderson, W.G., Puntillo, K., Cimino, J., Noort, J., Pearson, D., Boyle, D., Grywalski, M., Meyer, J., O'Neil-Page, E., Cain, J. 2017. Palliative care professional development for critical care nurses: a multicenter program. *AJCC*. 26(5):361-71.

Antaki, C., Billig, M., Edwards, D., Potter, J. 2003. Discourse analysis means doing analysis: A critique of six analytic shortcomings.

Anzul, M., Downing, M., Ely, M., Vinz, R. 2003. On writing qualitative research: Living by words, Routledge.

Aromataris, E., Riitano, D. 2014. Systematic reviews: Constructing a search strategy and searching for evidence. *AJN, American Journal of Nursing*. 114(5):49-56.

Babbie, E.R. 2010. The practice of social research, Australia, Wadsworth Cengage Learning.

Babbie, E.R. 2011. Introduction to social research, Belmont, Calif., Wadsworth Cengage learning.

Baker, R.L. 2003. The social work dictionary, Washington, DC, NASW Press.

Barreiro, P.L., Albandoz, J.P. 2001. Population and sample. Sampling techniques. Management mathematics for European schools. 6.

Baumgartner, T.A., Strong, C.H., Hensley, L.D. 2002. Conducting and reading research in health and human performance, New York, McGraw-Hill.

Bengtsson, M., Carlson, E. 2015. Knowledge and skills needed to improve as preceptor: Development of a continuous professional development course—a qualitative study part i. BMC nursing. 14(1):51.

Bernard, H.R. 1995. Research methods in anthropology, Walnut Creek, AltaMira.

Best, P., Badham, J., Corepal, R., O'neill, R.F., Tully, M.A., Kee, F., et al. 2017. Network methods to support user involvement in qualitative data analyses: An introduction to participatory theme elicitation. Trials. 18(1):559.

Billett, S. 2010. The perils of confusing lifelong learning with lifelong education. International Journal of Lifelong Education. 29(4):401-13.

Bindon, S.L. 2017. Professional development strategies to enhance nurses' knowledge and maintain safe practice. AORN journal. 106(2):99-110.

Botma, Y., Greeff, M., Mulaudzi, F.M., Wright, S.C.D. 2010. Research in health sciences, Johannesburg, Heinemann.

Boyatzis, R.E. 1998. Transforming qualitative information: Thematic analysis and code development, sage.

Braun, V., Clarke, V. 2006. Using thematic analysis in psychology. Qualitative research in psychology. 3(2):77-101.

Braun, V., Clarke, V. 2012. Thematic analysis. In: Cooper, H., Camic, P. M., Long, D. L., Panter, A. T., Rindskopf, D.Sher, K. J. (eds.) *Apa handbook of research methods in psychology. Quantitative, qualitative, neuropsychological, and biological.* Washington, D.C.: American Psychological Association.

Breen, R.L. 2006. A practical guide to focus-group research. *Journal of Geography in Higher Education.* 30(3):463-75.

Brekelmans, G., Poell, R.F., Van Wijk, K. 2013. Factors influencing continuing professional development: A delphi study among nursing experts. *European Journal of Training and Development.* 37(3):313-25.

Brekelmans, G., Maassen, S., Poell, R.F., Van Wijk, K. 2015. The development and empirical validation of the q-pdn: A questionnaire measuring continuing professional development of nurses. *Nurse education today.* 35(1):232-8.

Brekelmans, G., Maassen, S., Poell, R.F., Weststrate, J.D., Geurdes, E. 2016. Factors influencing nurse participation in continuing professional development activities: Survey results from the netherlands. *Nurse education today.* 4013-9.

Brownie, S.M., Hunter, L., H., Aqtash, S., Day, G.E. 2015. Establishing policy foundations and regulatory systems to enhance nursing practice in the united arab emirates. *Policy, Politics, & Nursing Practice (PPNP).* 16(1-2):38–50.

Bryman, A. 2006. Integrating quantitative and qualitative research: How is it done? *Qualitative Research.* 6(1):97-113.

Bryman, A., Bell, E. 2007. *Business research methods*, Oxford, Oxford University Press.

Burns, N., Grove, S.K. 2005. *The practice of nursing research : Conduct, critique, and utilization*, St. Louis, Mo., Elsevier/Saunders.

Burns, N., Grove, S.K. 2009. *The practice of nursing research : Conduct, critique, and utilization*, St. Louis, Mo., Elsevier, Saunders.

Bushe, G. 2012. Foundations of appreciative inquiry: History, criticism and potential. *AI practitioner*, 14 (1), 8-20. Accessed online. 11(18):13.

Bynum, A., Irwin, C., Cohen, B. 2010. Satisfaction with a distance continuing education program for health professionals. *Telemedicine & e-Health*. 16(7):776-86.

Byrne, A., Canavan, J., Millar, M. 2009. Participatory research and the voice-centred relational method of data analysis: Is it worth it? *International Journal of Social Research Methodology*. 12(1):67-77.

Camp, R.C. 2007. *Benchmarking : The search for industry best practices that lead to superior performance*, Portland Or., Productivity Press.

Caracelli, V.J., Greene, J.C. 1993. Data analysis strategies for mixed-method evaluation designs. *Educational Evaluation and Policy Analysis*. 15(2):195-207.

CARNA. 2019. Continuing competence. [20 January 2019]. Available from: <http://www.nurses.ab.ca/content/carna/home/registration-and-renewal/registration-requirements/continuing-competence.html>.

CBRN. 2019. Continuing education for license renewal. [20 January 2019]. Available from: <https://www.rn.ca.gov/licensees/ce-renewal.shtml#content>.

Cherryholmes, C.H. 1992. Notes on pragmatism and scientific realism. *Educational Researcher*. 21(6):13-7.

Chong, M.C., Sellick, K., Francis, K., Abdullah, K.L. 2011. What influences malaysian nurses to participate in continuing professional education activities? *Asian Nursing Research*. 5(1):38-47.

Chong, M.C., Francis, K., Cooper, S., Abdullah, K.L., Hmwe, N.T.T., Sohod, S. 2016. Access to, interest in and attitude toward e-learning for continuous education among malaysian nurses. *Nurse education today*. 36370-4.

Cipriano, P.F. 2010. Overview and summary: Delegation dilemmas: Standards and skills for practice. *Online Journal of Issues in Nursing*. 15(2).

Clark, E., Draper, J., Rogers, J. 2015. Illuminating the process: Enhancing the impact of continuing professional education on practice. *Nurse education today*. 35(2):388-94.

CNO. 2019. Quality assurance program. [20 January 2019]. Available from: <https://www.cno.org/en/myqa/>.

CNO. 2019. Annual membership renewal. [20 January 2019]. Available from: <http://www.cno.org/en/maintain-your-membership1/annual-membership-renewal/>

Connelly, L.M. 2015. Evaluation research. *Medsurg nursing : official journal of the Academy of Medical-Surgical Nurses*. 24(1):60, 34.

Conradson, D. 2005. Focus groups. In: Flowerdew, R.Martin, D. (eds.) *Methods in human geography: A guide for students doing a research project*. Harlow: Pearson Prentice Hall.

Cook, C.R. 2005. *Just enough project management : The indispensable four-step process for managing any project, better, faster, cheaper*, New York, McGraw-Hill.

Cooke, A., Smith, D., Booth, A. 2012. Beyond pico : The spider tool for qualitative evidence synthesis. *Qualitative Health Research*. 22(10):1435-43.

Cooperirder, D.L., Whitney, D. 2005. A positive revolution in change: Appreciative inquiry. In: Cooperirder, D. L., Sorrensen, P. F.Whitney, D. (eds.) *Appreciative inquiry: Rethinking human organization toward a positive theory of change*. Champaign, IL: Stipes.

Cooperrider, D.L., Whitney, D. 2005. *Appreciative inquiry: A positive revolution to change*, San Francisco, CA, Berrett-Koehler.

Cooperrider, D.L., Whitney, D., Stavros, J.M. 2008. *Appreciative inquiry handbook: For leaders of change*, San Francisco, Berrett-Koehler Publishers.

Corbin, J.M., Strauss, A.L. 2015. Basics of qualitative research : Techniques and procedures for developing grounded theory, Los Angeles, SAGE.

COT. 2007. Professional standards for occupational therapy practice. In: Therapists, C. O. O. (ed.).

Coventry, T.H., Maslin-Prothero, S.E., Smith, G. 2015. Organizational impact of nurse supply and workload on nurses continuing professional development opportunities: An integrative review. *Journal of advanced nursing*. 71(12):2715-27.

Creswell, J.W. 2009. Research design : Qualitative, quantitative, and mixed methods approaches, Los Angeles, Sage.

Creswell, J.W., Plano Clark, V.L. 2007. Designing and conducting mixed methods research, Thousand Oaks, California, SAGE Publications.

Creswell, J.W., Plano Clark, V.L. 2018. Designing and conducting mixed methods research, Thousand Oaks, California, SAGE.

Davis, L., Taylor, H., Reyes, H. 2014. Lifelong learning in nursing: A delphi study. *Nurse education today*. 34(3):441-5.

De Vos, A.S., Strydom, H., Fouché, C.B., Delport, C. 2011. Research at grass roots : For the social sciences and human services professions, Pretoria, Van Schaik.

Deci, E.L., Ryan, R.M. 1985. Intrinsic motivation and self-determination in human behavior, New York, Plenum.

Deci, E.L., Ryan, R.M. 2000. The "what" and "why" of goal pursuits: Human needs and the self-determination of behavior. *Psychological Inquiry*. 11(4):227-68.

Depoy, E., Gitlin, L.N. 1994. Introduction to research. Multiple strategies for health and human services. London: Mosby.

DHA. 2014. Continuing professional development guideline. In: Authority, D. H. (ed.).

DOH. 2018. Healthcare capacity master plan. Department of Health - Abu Dhabi.

DOH. 2019. Continuing medical education questions. Available from: <https://www.haad.ae/haad/tabid/1472/Default.aspx>.

Drummond, K.E., Murphy-Reyes, A. 2018. Quantitative research designs: Experimental, quasi-experimental, and descriptive. Nutrition research: Concepts and applications. Burlington, MA: Jones & Bartlett Learning.

Eason, T. 2010. Lifelong learning: Fostering a culture of curiosity. Creative Nursing. 16(4):155-9.

Ebadi, A., Vanaki, Z., Nehrir, B., Hekmatpou, D. 2007. Pathology of continuing educational programs in iran medical society. Strides in Development of Medical Education. 4(2):140-5.

Ebrahimi, H., Mohammadi Hosseini, F., Amirnia, M., Mehraee, A., Jamali, V., Hejazi, S.A. 2012. Factors influencing nurses' participation in continuing education programs in tabriz university of medical sciences. Iranian Journal of Medical Education. 12(7):518-26.

EC. 2013. Study concerning the review and mapping of continuous professional development and lifelong learning for health professionals in the eu.

EC. 2019 [Internet]. Glossary:Lifelong learning - statistics explained. European Commission [cited 2019 19 March]. Available from: https://ec.europa.eu/eurostat/statistics-explained/index.php/Glossary:Lifelong_learning.

Emirates247. 2016a. Uae healthcare market to grow 12.7% to dh71.56bn by 2020: Alpen capital. Emirates247.

Emirates247. 2016b. Dubai's fertility rate drops: Study. Emirates247.

Eslamian, J., Moeini, M., Soleimani, M. 2015. Challenges in nursing continuing education: A qualitative study. *Iranian journal of nursing and midwifery research*. 20(3):378-86.

Feldacker, C., Pintye, J., Jacob, S., Chung, M.H., Middleton, L., Iliffe, J., et al. 2017. Continuing professional development for medical, nursing, and midwifery cadres in malawi, tanzania and south africa: A qualitative evaluation. *PloS one*. 12(10):e0186074.

Finn, J. 2018. The rhetoric and reality of continuing professional development for critical care nurses: A critical ethnographic perspective. Victoria University.

Fukada, M. 2018. Nursing competency: Definition, structure and development. *Yonago acta medica*. 61(1):001-7.

Gagné, M.N., Deci, E.L. 2005. Self-determination theory and work motivation *Journal of Organizational Behavior*. 26(4):331-62.

Garneau, A.B., Pepin, J. 2015. A constructivist theoretical proposition of cultural competence development in nursing. *Nurse education today*. 35(11):1062-8.

Gates, B., Waight, M. 2007. Reflections on conducting focus groups with people with learning disabilities: Theoretical and practical issues. *Journal of Research in Nursing*. 12(2):111-26.

Gill, J., Johnson, P., Clark, M. 2010. *Research methods for managers*, Los Angeles, SAGE.

Gillham, B. 2015. *Developing a questionnaire*, London, Continuum.

Ginter, P.M., Duncan, W.J., Swayne, L.E. 2018. *The strategic management of health care organizations*, John Wiley & Sons.

Giri, K., Frankel, N., Tulenko, K., Puckett, A., Bailey, R., Ross, H. 2012. *Capacity Plus*[Internet]. Keeping up to date: Continuing professional development for health workers

in developing countries. Capacity Plus [updated 12 February 2019]. Available from: <https://www.capacityplus.org/technical-brief-6/>.

Grix, J. 2010. The foundations of research, Houndmills, Basingstoke, Hampshire, Palgrave Macmillan.

Grove, S.K., Burns, N., Gray, J. 2013. The practice of nursing research : Appraisal, synthesis, and generation of evidence, St. Louis, Mo., Elsevier/Saunders.

Guba, E.G., Lincoln, Y.S. 2005. Paradigmatic controversies, contradictions, and emerging confluences. . In: Denzin, N. K.Lincoln, Y. S. (eds.) The sage handbook of qualitative research. third edn. Thousand Oaks, CA: Sage.

Guest, G., Bunce, A., Johnson, L. 2006. How many interviews are enough? An experiment with data saturation and variability. Field Methods. 18(1):59-82.

Guest, G., Macqueen, K.M., Namey, E.E. 2011. Applied thematic analysis, Sage Publications.

Guest, G., Macqueen, K.M., Namey, E.E. 2012. Introduction to applied thematic analysis. Applied thematic analysis. 320.

HAAD. 2017. Abu Dhabi health statistics 2016.

Halcomb, E.J., Gholizadeh, L., Digiacomio, M., Phillips, J., Davidson, P.M. 2007. Literature review: Considerations in undertaking focus group research with culturally and linguistically diverse groups. Journal of Clinical Nursing. 16(6):1000-11.

Hamzehgardeshi, Z., Shahhosseini, Z. 2013. A cross-sectional study of facilitators and barriers of Iranian nurses' participation in continuing education programs. Global Journal of Health Science. 6(2).

Hariyati, R.T.S., Safril, S. 2018. The relationship between nurses' job satisfaction and continuing professional development. *Enfermeria clinica*. 28(Suppl 1):144-8.

Hariyati, R.T.S., Fujinami, Y., Susilaningih, F. 2017. Correlation between career ladder, continuing professional development and nurse satisfaction: A case study in indonesia. *International Journal of Caring Sciences*. 10(3):1490.

Harper, M.G., Gallagher-Ford, L., Warren, J.I., Troseth, M., Sinnott, L.T., Thomas, B.K. 2017. Evidence-based practice and us healthcare outcomes: Findings from a national survey with nursing professional development practitioners. *Journal for nurses in professional development*. 33(4):170-9.

Haywood, H., Pain, H., Ryan, S., Adams, J. 2013. Continuing professional development: Issues raised by nurses and allied health professionals working in musculoskeletal settings. *Musculoskeletal Care*. 11(3):136-44.

HCPC. 2019. Standards of continuing professional development.

Hemmington, N. 2000. Barriers and drivers to continuing professional development; the case of the hospitality industry. *Continuing Professional Development*. 3(1):23-32.

Hennink, M.M., 2007. *International focus group research : A handbook for the health and social sciences*[Internet]. Cambridge: Cambridge University Press. Available from: <http://site.ebrary.com/id/10213851>.

Hesse-Biber, S.N., Leavy, P. 2011. *The practice of qualitative research*, Los Angeles, SAGE.

Hollander, J. 2004. The social contexts of focus groups. *Journal of Contemporary Ethnography*. 33(5):602-37.

Holloway, K., Arcus, K., Orsborn, G. 2018. Training needs analysis - the essential first step for continuing professional development design. *Nurse Education in Practice*. 287-12.

Hopkins, P. 2007. Thinking critically and creatively about focus groups. *Area*. 39(4):528-35.

Hosseini, N. 2015. Qualitative and descriptive research: Data type versus data analysis. *Language Teaching Research*. 19(2):129-32.

Hurt, R.L., McLaughlin, E.J. 2012. An applied introduction to qualitative research methods in academic advising. *NACADA Journal*. 32(1):63-71.

ICN. 2005 [Internet]. Regulation terminology. ICN [cited 2018 27 July]. Available from: http://www.icn.ch/images/stories/documents/networks/Regulation/Regulation_Terminology.pdf.

IOSH. 2019. About cpd. Available from: <https://www.iosh.co.uk/membership/about-membership/professional-development/about-cpd.aspx>.

Jack, J.B., Tony, R., Judith, D.B., Sandra, C. 2014. Developing and evaluating interventions that are applicable and relevant to inpatients and those who care for them; a multiphase, pragmatic action research approach. *BMC Medical Research Methodology*.

Jetmarová, B. 2012. The value position of the role of knowledge management and its benefits for benchmarking application. *Journal of Organizational Knowledge Management*. 20121-9.

Johnson, R., Onwuegbuzie, A., Turner, L. 2007. Toward a definition of mixed methods research. *Journal of Mixed Methods Research*. 1(2):112-33.

Johnson, R.B., Turner, L.A. 2003. Data collection strategies in mixed methods research. In: Tashakkori, A., Teddlie, C. (eds.) *Handbook of mixed methods in social and behavioral research* Thousand Oaks, CA: Sage.

Johnson, R.B., Onwuegbuzie, A.J. 2004. Mixed methods research: A research paradigm whose time has come. *Educational Researcher*. 33(7):14-26.

Jones, B., Michael, R., Butt, J., Hauck, Y. 2016. Tanzanian midwives' perception of their professional role and implications for continuing professional development education. *Nurse Education in Practice*. 17116-22.

Joynes, V., Kerr, M., Treasure-Jones, T. 2017. Exploring informal workplace learning in primary healthcare for continuous professional development. *Education for Primary Care*. 28(4):216-22.

Kalabarathi, S., Jagadeeswari, M.J., Gowri, P.M. 2018. A study to assess the impeding factors for nurses' participation in continuous professional development activities.

Kanter, R.M. 1993. *Men and women of the corporation*, New York, BasicBooks.

Kasine, Y., Babenko-Mould, Y., Regan, S. 2018. Translating continuing professional development education to nursing practice in rwanda: Enhancing maternal and newborn health. *International Journal of Africa Nursing Sciences*. 875-81.

Kitzinger, J. 2005. Focus group research: Using group dynamics to explore perceptions, experiences, and understandings. In: Holloway, I. (eds.) *Qualitative research in health care*. Maidenhead: Open University Press.

Kivunja, C., Kuyini, A.B. 2017. Understanding and applying research paradigms in educational contexts. *International Journal of Higher Education*. 6(5):26-41.

Klopper, H. 2008. The qualitative research proposal. *Curationis*. 31(4):62-72.

Knox, S., Cullen, W., Dunne, C.P. 2015. A national study of continuous professional competence (cpc) amongst pre-hospital practitioners. *BMC health services research*. 15(1):532.

Kowalski, K. 2008. Appreciative inquiry. *The Journal of Continuing Education in Nursing*. 39(3):104.

Kristin, K., Jane, U., Mary, M., Bonnie, S., MéLanie, L.-T., Mary, C.-A., et al. 2012. Appreciative inquiry: A strength-based research approach to building canadian public health nursing capacity. *Journal of Research in Nursing*. 17(5):484-94.

Krueger, R.A. 1994. *Focus groups : A practical guide for applied research*, Thousand Oaks, California :, SAGE.

Krueger, R.A., Casey, M.A. 2015. *Focus groups : A practical guide for applied research*, Thousand Oaks, California, SAGE.

Laal, M., Salamati, P. 2012. Lifelong learning; why do we need it? *Procedia - Social and Behavioral Sciences*. 31399-403.

Laschinger, H.K.S., Finegan, J., Shamian, J., Wilk, P. 2001. Impact of structural and psychological empowerment on job strain in nursing work settings: Expanding kanter's model. *JONA: The Journal of Nursing Administration*. 31(5):260-72.

Levy, P.S., Lemeshow, S. 2013. *Sampling of populations: Methods and applications*, John Wiley & Sons.

Liamputtong, P. 2011. *Focus group methodology: Principles and practices*, LA, SAGE.

Lincoln, Y.S., Guba, E.G. 1985. *Naturalistic inquiry*, Beverly Hills, Calif., Sage Publications.

Mbidi, T.S.N. 2018. *Factors associated with participation in continuous professional development activities leading to professional growth of professional nurses working in a public national referral hospital in namibia*. Stellenbosch: Stellenbosch University.

Mckenna, C., Daykin, J., Mohr, B.J., Silbert, T. 2007. *Strategic planning with appreciative inquiry: Unleashing the positive potential to soar*. Innovation Partners International.

Mckimm, J., Swanwick, T. 2009. Setting learning objectives. *British Journal of Hospital Medicine (2005)*. 70(7):406-9.

Mcmillan, D.J., Mcconnell, B., O'sullivan, H. 2016. Continuing professional development—why bother? Perceptions and motivations of teachers in ireland. *Professional development in education*. 42(1):150-67.

Megginson, D., Whitaker, V. 2007. *Continuing professional development*, London, Chartered Institute of Personnel and Development.

Merton, R.K., Lowenthal, M.F., Kendall, P.L. 1990. *The focused interview : A manual of problems and procedures*, New York London, Free Pree ; Collier Macmillan.

Michael, S. 2005. The promise of appreciative inquiry as an interview tool for field research. *Development in Practice*. 15(2):222-30.

NCPDNM. 2004. *Report on the continuing professional development of staff nurses and staff midwives*.

Miltner, R.S., Jukkala, A., Dawson, M.A., Patrician, P.A. 2015. Professional development needs of nurse managers. *The Journal of Continuing Education in Nursing*. 46(6):252-8.

Miracle, V.A. 2016. The belmont report: The triple crown of research ethics. *Dimensions of Critical Care Nursing*. 35(4):223-8.

Mitchell, R.K., Agle, B.R., Wood, D.J. 1997. Toward a theory of stakeholder identification and salience: Defining the principle of who and what really counts. *The Academy of Management Review*. 22(4):853-86.

Moore, S.M., Charvat, J. 2007. Promoting health behavior change using appreciative inquiry: Moving from deficit models to affirmation models of care. *Family & Community Health*. 30S64-S74.

Morgan, D.L. 1995. Why things (sometimes) go wrong in focus groups. *Qualitative Health Research*. 5(4).

Morgan, D.L. 2007. Paradigms lost and pragmatism regained : Methodological implications of combining qualitative and quantitative methods. *Journal of Mixed Methods Research*. 1(1):48-76.

Morgan, D.L. 2014. *Integrating qualitative and quantitative methods : A pragmatic approach*, Thousand Oaks, California, SAGE Publications, Inc.

Morse, J.M., Niehaus, L. 2009. *Mixed method design : Principles and procedures*, Walnut Creek, Calif., Left Coast Press.

Mouton, J. 1996. *Understanding social research*, Pretoria, Van Schaik Publishers.

Munhall, P.L. 2012. *Nursing research : A qualitative perspective*, Sudbury, MA, Jones & Bartlett Learning.

Murphy, C., Cross, C., Mcguire, D. 2006. The motivation of nurses to participate in continuing professional education in ireland. *Journal of European Industrial Training*. 30(5):365-84.

NCNZ. 2018. Continuing competence. [20 January 2019]. Available from: <http://www.nursingcouncil.org.nz/Nurses/Continuing-competence>.

Ni, C., Hua, Y., Shao, P., Wallen, G.R., Xu, S., Li, L. 2014. Continuing education among chinese nurses: A general hospital-based study. *Nurse education today*. 34(4):592-7.

Nieswiadomy, R.M. 2014. *Foundations in nursing research*, Harlow, Essex, Pearson. Nmba/. Continuing professional development. [20 January 2019]. Available from: <https://www.nursingmidwiferyboard.gov.au/registration-standards/continuing-professional-development.aspx>.

NMC. 2018. Continuing professional development. [20 January 2019]. Available from: <http://revalidation.nmc.org.uk/what-you-need-to-do/continuing-professional-development.html>.

Norum, K.E. 2012. Appreciative inquiry. In: Given, L. M. (eds.) The sage encyclopedia of qualitative research methods. Thousand Oaks: SAGE Publications, Inc.

Nsemo, A.D., John, M.E., Etifit, R.E., Mgbekem, M.A., Oyira, E.J. 2013. Clinical nurses' perception of continuing professional education as a tool for quality service delivery in public hospitals calabar, cross river state, nigeria. *Nurse Education in Practice*. 13(4):328-34.

Nyaupane, G.P., Poudel, S. 2012. Application of appreciative inquiry in tourism research in rural communities. *Tourism Management*. 33(4):978-87.

O'cathain, A., Murphy, E., Nicholl, J. 2010. Three techniques for integrating data in mixed methods studies. *BMJ*. 341(sep17 1):c4587.

OCLC. 2018. Worldcat. [cited 2018 25 December]. Available from: <https://www.oclc.org/en/worldcat.html>.

Omer, S.A., Saeed, O.K., Yousif, M.A., Elmubarak, A.H. 2016. Barriers towards continuing professional development among academic staff of health sectors faculties in university of gezira.

Oppenheim, A.N. 2000. Questionnaire design, interviewing and attitude measurement, Bloomsbury Publishing.

Palinkas, L.A., Horwitz, S.M., Green, C.A., Wisdom, J.P., Duan, N., Hoagwood, K. 2015. Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health and Mental Health Services Research*. 42(5):533-44.

Patterson, M., Williams, D. 1998. Paradigms and problems: The practice of social science in natural resource management. *Society & Natural Resources*. 11(3):279-95.

Patton, M.Q. 2015. Qualitative research & evaluation methods : Integrating theory and practice, Thousand Oaks, California, SAGE Publications, Inc.

Paulo, M.S., Loney, T., Lapão, L.V. 2019. How do we strengthen the health workforce in a rapidly developing high-income country? A case study of abu dhabi's health system in the united arab emirates. *Human resources for health*. 17(1):9.

Payne, G., Payne, J. 2004. Sampling: Types. Key concepts in social research. London: SAGE Publications.

Perry, N.R., Azulay Chertok, I.R. 2018. Continuing education model for nurses regarding substance use disorder. *Journal of Health Education Research & Development*. 06(03).

Polit, D.F., Beck, C.T. 2014. Essentials of nursing research: Appraising evidence for nursing practice, Philadelphia, Lippincott Williams & Wilkins.

Pool, I., Poell, R., Ten Cate, O. 2013. Nurses' and managers' perceptions of continuing professional development for older and younger nurses: A focus group study. *International Journal of Nursing Studies*. 50(1):34-43.

Pool, I.A., Poell, R.F., Berings, M.G.M.C., Ten Cate, O. 2016. Motives and activities for continuing professional development: An exploration of their relationships by integrating literature and interview data. *Nurse education today*. 3822-8.

Pool, I.A., Poell, R.F., Berings, M.G.M.C., Ten Cate, O., Info:Eu, R.D.N. 2015. Strategies for continuing professional development among younger, middle-aged, and older nurses : A biographical approach. *International Journal of Nursing Studies*. 52(5).

Priaulx, M.K., Margaret, M., Rachael, S., Lisa, R., Annette, F.-B., Rae. 2014. Continuing professional development in nursing in australia: Current awareness, practice and future directions. <http://dx.doi.org/10.5172/conu.2013.45.1.33>. 10.5172/conu.2013.45.1.33.

Price, S., Reichert, C. 2017. The importance of continuing professional development to career satisfaction and patient care: Meeting the needs of novice to mid-to late-career nurses throughout their career span. *Administrative Sciences*. 7(2):17.

Priest, K.L., Kaufman, E.K., Brunton, K., Seibel, M. 2013. Appreciative inquiry: A tool for organizational, programmatic, and project-focused change. *Journal of Leadership Education*. 12(1).

PRISMA . 2015. Flow diagram. [cited 2019 20 August]. Available from: <http://prisma-statement.org/PRISMAStatement/FlowDiagram.aspx>.

Purfarzad, Z., Bahrami, M., Keshvari, M., Rafiei, M., Sivertsen, N., Cert, G. 2019. Effective factors for development of gerontological nursing competence: A qualitative study. *Journal of continuing education in nursing*. 50(3):127-33.

QSR. 2019. Nvivo qualitative data analysis software | qsr international. [cited 2019 3 August]. Available from: <https://www.qsrinternational.com/nvivo/home>.

RCN. 2009. A joint statement on continuing professional development for health and social care practitioners : A collaborative statement, London, Royal College of Nursing.

RCS. 2019. Continuing professional development. [12 February 2019]. Available from: <https://www.rcseng.ac.uk/standards-and-research/standards-and-guidance/revalidation/cpd/>.

Richard, J.T. 2016. Writing integrative literature reviews : Using the past and present to explore the future. *Human Resource Development Review*. 15(4):404-28.

Richards, K. 2003. *Qualitative inquiry in tesol*, New York, Palgrave Macmillan.

Rizany, I., Hariyati, R.T.S., Handayani, H. 2018. Factors that affect the development of nurses' competencies: A systematic review. *Enfermeria clinica*. 28154-7.

RNCOS. 2015. Uae healthcare sector outlook 2020.

Ryan, G.W., Bernard, H.R. 2000. Data management and analysis methods. In: Denzin, N. K.Lincoln, Y. S. (eds.) Handbook of qualitative research. second edition edn. Thousand Oaks, CA: Sage.

Saade, S., Ghazala, F., Farhat, A., Hallit, S. 2018. Attitudes towards continuous professional development: A study of pharmacists in lebanon. Pharmacy Practice (Granada). 16(1).

Sachdeva, A.K. 2016. Continuing professional development in the twenty-first century. Journal of Continuing Education in the Health Professions. 36S8-S13.

Sade, P.M.C., Peres, A.M. 2015. Development of nursing management competencies: Guidelines for continuous education services. Revista da Escola de Enfermagem da USP. 49(6):988-94.

SANC. 2018. CPD. [20 January 2019]. Available from:
<http://www.sanc.co.za/archive/archive2018/newsc1803.htm>.

Scales, P., Pickering, J., Senior, L., Headly, K., Garner, P., Boulton, H. 2011. Continuing professional development in the lifelong learning sector, Maidenhead, Open University Press/McGraw-Hill Education.

Schaeffer, N.C., Presser, S. 2003. The science of asking questions. ARC. 29(1):65-88.

Scotland, J. 2012. Exploring the philosophical underpinnings of research: Relating ontology and epistemology to the methodology and methods of the scientific, interpretive, and critical research paradigms. English Language Teaching. 5(9):9-16.

Scott, D., Usher, R. 2010. Researching education, Bloomsbury Publishing.

Shahhosseini, Z., Hamzehgardeshi, Z. 2014. The facilitators and barriers to nurses' participation in continuing education programs: A mixed method explanatory sequential study. Global Journal of Health Science. 7(3):184-93.

Simkhada, B., Van Teijlingen, E., Simkhada, P., Mackay, S., Khatru, R., Angell, C., et al. 2017. Assessing the need and type of CPD for nurses trained and working in nepal.

Simpson, T.A. 1994. The relevance of early educators' ideas for modern teacher educators.

Singh, I. 2015. Training and professional development for nurses and healthcare support workers: Supporting foundation for quality and good practice for care of the acutely ill older person. *Int Arch Nurs Health Care*. 1(007).

Skår, R. 2010. How nurses experience their work as a learning environment | springerlink. *Vocations and Learning*. 3(1):1-18.

Smith, C.M., Johnson, C.S. 2019. Preparing nurse leaders in nursing professional development: Quality improvement in nursing professional development. *Journal for nurses in professional development*. 35(4):222-4.

Solomon, J. 2018. A participatory action research study on continual professional development with nurses in grenada west indies. Cardiff University.

Speet, M., Francke, A.L. 2004. *Individuele professionalisering van verpleegkundigen in de beroepsopleiding en in de praktijk (individual professionalization of nurses in vocational training and practice)*, Utrecht, Neherlands, NIVEL.

Spencer, D. 2009. *Card sorting: Designing usable categories*, Rosenfeld Media.

Stein, A.M. 1998. History of continuing nursing education in the united states. *Journal of continuing education in nursing*. 29(6):245-52.

Steven, A., Larkin, V., Stewart, J., Bateman, B. 2018. The value of continuing professional development: A realistic evaluation of a multi-disciplinary workshop for health visitors dealing with children with complex needs. *Nurse education today*. 6756-63.

Stewart, D.W., Shamdasani, P.N. 1990. *Focus groups : Theory and practice*, Newbury Park, Calif., Sage Publications.

Stewart, D.W., Shamdasani, P.N., Rook, D.W. 2007. Focus groups, Thousand Oaks, California, SAGE Publications, Ltd.

Stratton-Berkessel, R., 2010. Appreciative inquiry for collaborative solutions : 21 strength-based workshops. San Francisco, CA: Pfeiffer.

Sulaiman, N., Elbadawi, S., Hussein, A., Abusnana, S., Madani, A., Mairghani, M., et al. 2017. Prevalence of overweight and obesity in united arab emirates expatriates: The uae national diabetes and lifestyle study. Diabetology & Metabolic Syndrome.

Tashakkori, A., Teddlie, C. 2003. Handbook of mixed methods in social & behavioral research, Thousand Oaks, Calif., SAGE Publications.

Tashakkori, A., Teddlie, C. 2010. Sage handbook of mixed methods in social & behavioral research, Los Angeles, Calif. :, SAGE Publications.

Tavakol, M., Dennick, R. 2011. Making sense of cronbach's alpha. International journal of medical education. 253.

TBON. 2019. Education - continuing nursing education & competency. [20 January 2019]. Available from: https://www.bon.texas.gov/education_continuing_education.asp.

Teddlie, C., Yu, F. 2007. Mixed methods sampling. Journal of Mixed Methods Research. 1(1):77-100.

Teekens, P., Wiechula, R., Cusack, L. 2018. Perceptions and experiences of nurses and midwives in continuing professional development: A systematic review protocol. JBI database of systematic reviews and implementation reports. 16(9):1758-63.

The National. 2016. The unhealthy lifestyle choices that are plaguing our population.

USUAE_Business_Council 2016. The u.A.E. Healthcare sector: An update. USUAE Business Council

Viljoen, M., Coetzee, I., Heyns, T. 2017. Critical care nurses' reasons for poor attendance at a continuous professional development program. *American Journal of Critical Care*. 26(1):70-6.

Wang, Y., Wei, S., Li, Y., Deng, S., Luo, Q. 2013. Challenges and a response strategy for the development of nursing in china: A descriptive and quantitative analysis. *J Evid Based Med*. 6(1):21-33.

Wareing, A., Buissink, C., Harper, D., Olesen, M.G., Soto, M., Braico, S., et al. 2017. CPD in radiography: A collaborative european meta-ethnography literature review. *Radiography*. 23S58-S63.

Waterman Jr, R.H., Peters, T.J., Phillips, J.R. 1980. Structure is not organization. *Business horizons*. 23(3):14-26.

Weglicki, R.S., Reynolds, J., Rivers, P.H. 2015. Continuing professional development needs of nursing and allied health professionals with responsibility for prescribing. *Nurse education today*. 35(1):227-31.

Whitney, D., Trosten-Bloom, A. 2010. *The power of appreciative inquiry: A practical guide to positive change*, San Francisco, Berrett-Koehler Publishers.

Wilkinson, S. 2004. Focus groups: A feminist method. In: Hedde-Biber, S. N.Yaiser, M. L. (eds.) *Feminist perspectives on social research*. New York: Oxford University Press.

Zhang, W., Creswell, J. 2013. The use of "mixing" procedure of mixed methods in health services research. *Medical Care*. 51(8):e51-e7.

ANNEXURE A

Focus Group Interviews PICD

PICD: Focus Groups

PARTICIPANT'S INFORMATION & INFORMED CONSENT DOCUMENT (PICD)

STUDY TITLE

DEVELOPMENT OF STRATEGIES FOR CONTINUING PROFESSIONAL DEVELOPMENT (CPD) PROGRAM FOR REGISTERED NURSES IN UNITED ARAB EMIRATES (UAE): A MIXED METHOD STUDY

Principal Investigator

Mohamad A. El Najm (PhD Student)

Institution

Nursing Science Department, University of Pretoria

DAYTIME AND AFTER-HOURS TELEPHONE NUMBER(S): +971-55-5598332

DATE AND TIME OF FIRST INFORMED CONSENT DISCUSSION:

dd	mmm	year

:
Time

Dear Mr. / Mrs. date of consent procedure
...../...../.....

1) INTRODUCTION

You are invited to volunteer for a research study. This information leaflet is to help you to decide if you would like to participate. Before you agree to take part in this study you should fully understand what is involved. If you have any questions, which are not fully explained in this leaflet, do not hesitate to ask the investigator. You should not agree to take part unless you are completely happy about what we expect of you.

2) THE NATURE AND PURPOSE OF THIS STUDY

You are invited to take part in a research study. The aim of this study is *“to explore and investigate the perspective of the registered nurses (RNs) regarding the effectiveness of the Continuing Professional Development (CPD) in UAE in order to develop CPD strategies”*.

3) EXPLANATION OF PROCEDURES TO BE FOLLOWED

Participation involves being interviewed by the principal investigator in a focus group setting. The interview will last approximately 120 minutes. By signing this form, you allow the researcher to take notes during the interview and recording of the interview and subsequent dialogue by audio tape. In case you do not want the interview and dialogue to be taped, you are fully entitled to withdraw from participation.

4) RISK AND DISCOMFORT INVOLVED

You will not be exposed to any procedures except the interview.

5) POSSIBLE BENEFITS OF THIS STUDY

Understanding the Nurses needs and contributing to the knowledge and strategies of Continuing Professional Development.

6) I may at any time withdraw from this study.

7) HAS THE STUDY RECEIVED ETHICAL APPROVAL?

The Research Ethics Committee of the University of Pretoria, Faculty of Health Sciences, telephone numbers 012 356 3084 / 012 356 3085 granted written approval for this study.

9) CONFIDENTIALITY

All records obtained whilst in this study will be regarded as confidential. Results will be published or presented in such a fashion that participants remain unidentifiable.

10) CONSENT TO PARTICIPATE IN THIS STUDY

I have read and understood the above information before signing this consent form. The content and meaning of this information have been explained to me. I have been given opportunity to ask questions and I am satisfied that they have been answered satisfactorily. I hereby volunteer to take part in this study.

I have received a signed copy of this informed consent agreement.

.....
Participant's name Date

.....
Participant's signature Date

.....
Investigator's name Date

.....
Investigator's signature Date

.....
Witness name Date

.....
Witness signature Date

ANNEXURE B

Focus Group Guide

Focus Group Interview Stages and Questions

Stage 1: Introduction (10 minutes)

- Welcome and introduction of the facilitator/moderator
- Introduction of the topic and purpose
- Explanation how the results will be used
- Explanation of why the participants were selected particularly and appreciate them
- Presentation of the guidelines such as:
 - No right or wrong answers, only differing points of view
 - Alert about the tape recording, one person speaking at a time
 - Calling each other by the first name or any other comfortable basis
 - No need to agree with others, but listening respectfully as others share their views is a must
 - Rules for cellular phones; must be turned off and if must respond to a call, it should be done quietly and rejoin the group as quickly as you possible.
 - Identifying the facilitator's role as to guide the discussion
- OQ: Please share your name and specialty

Stage 2: Rapport Building (10 minutes)

- IQ: What do you think about the value of the CPD in terms of the development of knowledge, skills, and attitude for nurses? (round robin)

Stage 3: In-Depth Discussion (60-90 minutes)

- TQ: How do you see the CPD program in UAE?
- TQ: How do you feel about the CPD as a licensure renewal requirement in UAE?
- KQ: What CPD activities do you usually attend?
- KQ: What are your motives to attend CPD activities?
- KQ: What are the barriers to attend a CPD activity?
- KQ: Which CPD activities do you consider important in terms of the knowledge, skills, and attitude competencies respectively?
 - SQ: Which mode of delivery do you prefer in terms of the knowledge, skills, and attitude competencies respectively?
 - SQ: What is the content of the CPD activities?
 - SQ: How do you see the content of the CPD activities in terms of the knowledge, skills, and attitude competencies respectively?

- SQ: How do you see the impact of the CPD activities on the nurses' knowledge, skills, and attitude competencies?
- KQ: What are your CPD needs and expectations?
 - SQ: How do you identify these needs?
 - SQ: How do you recognize that these needs and expectations are met?
 - SQ: Are the CPD activities connected to your performance appraisal?
 - SQ: Are they mandatory?

Stage 4: Closure (10 minutes)

CQ: Are there any other questions/information/issues you want to ask/share about the CPD in UAE?

OQ: Opening Question

IQ: Introductory Question

TQ: Transition Question

SQ: Sub-Question

KQ: Key Question

CQ: Closing Question

ANNEXURE C

Randomization Technique and Procedure

Randomization Technique and Procedure

A Step-by-Step Instructions

Randomization List Preparation on an Excel Sheet

1. Create a new excel sheet with all RNs' E-mails in Column A. **Label cell A1 (Heading) as "E-mails"** and Start listing the E-mails from cell A2.
2. **Label cell B1 (Heading) as "Random Number"**. In cell B2, underneath your heading row, enter "**= RAND()**" and copy it down the column until the end of the list. A random number will appear in all B cells until the end of the list.
3. **Label C1 (Heading) as "Selection"**. To extract a random value from column A without duplicates, enter the following formula in cell C2 and copy it down to the list until the desired sampling number (piloting and actual)

Formula: **=INDEX(\$A\$2:\$A\$16, RANK(B2,\$B\$2:\$B\$16), 1)**

Important note: change the number **16** according to your list. For example, if there are 200 RNs in your facility, number 16 should be replaced by 201 as the last name will be in row 201 (200 names + 1 heading row)

	A	B	C	D	E
1	Name	Random number	Random names		
2	Aiden Wood	0.835885891	Emma Robinson		
3	Amelia Thomas	0.80546987	Amelia Thomas		
4	Aria Williams	0.403285515	Aubrey Moore		
5	Aubrey Moore	0.867317132	Elijah Smith		
6	Ava Jones	0.559189193	Grayson Martin		
7	Caden Clark	0.939963926			
8	Carter Hall	0.049466174			
9	Charlotte Hill	0.265383438			
10	Chloe Taylor	0.882824503			
11	Elijah Smith	0.045253356			
12	Emma Robinson	0.926567103			
13	Ethan Miller	0.506537311			
14	Grayson Martin	0.168482678			
15	Harper Brown	0.515533809			
16	Pete White	0.788189062			

ANNEXURE D

Modified Questionnaire Q-PDN

MODIFIED QUESTIONNAIRE - PROFESSIONAL DEVELOPMENT OF NURSES
(Modified Q-PDN)

PART 1 – General Characteristics

1	Gender	<ul style="list-style-type: none"> • Male • Female
2	Age	<ul style="list-style-type: none"> • < 25 years • 26-30 years • 31-35 years • 36-40 years • 41-45 years • 46-50 years • 51-55 years • 56-60 years • > 60 years
3	Nationality	<ul style="list-style-type: none"> • List of all nationalities
4	Total Years of Experience as a Registered Nurse	<ul style="list-style-type: none"> • 1-5 years • 6-10 years • 11-15 years • 16-20 years • 21-25 years • 26-30 years • 31-35 years • 36-40 years • > 40 years
5	Years of Experience as a Registered Nurse in Abu Dhabi	<ul style="list-style-type: none"> • 1-5 years • 6-10 years • 11-15 years • 16-20 years • 21-25 years • 26-30 years • 31-35 years • 36-40 years • > 40 years
6	Facility's Region in Abu Dhabi Emirate	<ul style="list-style-type: none"> • Abu Dhabi • Al Ain • Al Dhafra
7	Type of Facility	<ul style="list-style-type: none"> • Hospital

		<ul style="list-style-type: none"> • Clinic/Center
8	Governor of Facility	<ul style="list-style-type: none"> • Government • Private
9	Your Current Unit/Ward	<ul style="list-style-type: none"> • Surgery • Medicine • Intensive Care • Paediatrics • Oncology • Emergency • Obstetric/gynecological • Palliative care • Psychiatric • Out-patient • Other (Specify)
10	Level of Education (Relevant to Nursing)	<ul style="list-style-type: none"> • Doctoral Degree • Master's Degree • Bachelor of Science • Diploma degree • Other (Specify)
11	Your Current Main Position	<ul style="list-style-type: none"> • Staff Nurse • Nurse In-Charge • Nurse manager • Clinical Resource Nurse • Nursing Administration • Other (Specify)

PART 2 - Continuous Professional Development (CPD) Questions

1. The term Continuous Professional Development (CPD) refers to all activities which may contribute to your professional development. Below are a number of reasons and motivations for participating in CPD activities. Please indicate the extent to which you agree with each statement listed below regarding motivations.

1. Strongly Disagree
2. Disagree
3. Uncertain
4. Agree
5. Strongly Agree

#	Items	1	2	3	4	5
I take part in CPD activities to:						
1	...because further professional development is important to me					
2	...to improve my current qualifications					
3	...to carry out my work better					
4	...to update/refresh my knowledge, and/or gain new knowledge					
5	...to increase the quality of healthcare					
6	...to make a positive contribution to nursing practice					
7	...to meet the requirements of the organization where I work					
8	...to meet the requirements of the licensure renewal					
9	...to prove to my employer that I am professionally competent					
10	...because this is considered highly important in my professional environment					
11	...to increase promotion opportunities					
12	...to achieve a higher level of training					
13	...to support my career potential/choices					
14	...because I am interested in the activity itself					
15	...to entertain and relieve the stress of my job					
16	...to network with health professionals					

2. Below are several statements about the limiting conditions under which your own Continuing Professional Development (CPD) can best be realised. Please indicate the degree to which you agree or disagree with the statements in the list.

1. Strongly Disagree
2. Disagree
3. Uncertain
4. Agree
5. Strongly Agree

#	Items	1	2	3	4	5
I take part in CPD activities:						
1	...if I receive career guidance					
2	...if I receive an annual appraisal					
3	...if my colleagues coach me					
4	...if taking part in CPD activities allows me to have a say in ward/team policy					
5	...if I gain more independence in my work					
6	...if the CPD activities have a clear career perspective					
7	...if the organization's policies support the nurses CPD					
8	...if my immediate supervisor coaches me					
9	...if other positions are offered within my organization					
10	...if I receive support from my supervisor					
11	...if the expenses are fully reimbursed or funded by the employer					
12	...if suitable supplementary training courses are offered by the organization (suitable in terms of time, location, and relevancy)					
13	...if I am provided with the necessary time and/or convenient work schedule					

3. Several CPD activities are listed below. Please indicate the degree to which you consider the items listed below to be important to your own professional development.

1. Not Important at All
2. Of Little Importance
3. Moderately Important
4. Important
5. Very Important

#	Items	1	2	3	4	5
1	Reviewing medical literature about best practices					
2	Carrying out research					
3	Writing articles for professional journals					
4	Participating in Journal Clubs					
5	Attending short courses (do not lead to a degree), lectures, conferences, and seminars					
6	Attending online (web-based learning) courses and/or lectures (do not lead to a degree)					
7	Attending hands-on training courses including workshops					
8	Informing my supervisor if I notice any developments at work that could have an adverse effect on professional practice					
9	Making sure that I keep up to date with professional developments					
10	Reflecting critically on practical situations					
11	Determining whether I performed well and whether I could perform better next time					
12	Participation in policy development					
13	Making sure that I keep up to date with policy developments					
14	Participating in recruitment and selection interviews with new members of staff					
15	Participating in reflection and/or intercollegial consultation meetings					
16	Participating in internal projects					

4. **Several CPD activities are listed below. Please indicate how often you actively perform each of these activities.**

1. Never
2. Rarely
3. Occasionally
4. Frequently
5. Very Frequently

#	Items	1	2	3	4	5
1	I review medical literature with regard to best practices					
2	I carry out research					
3	I write articles for professional journals					
4	I participate in Journal Clubs					
5	I attend short courses (do not lead to a degree), lectures, conferences, and seminars					
6	I attend online (web-based learning) courses and/or lectures (do not lead to a degree)					
7	I attend hands-on training courses including workshops					
8	I inform my supervisor if I notice any developments at work that could have an adverse effect on professional practice					
9	I make sure that I keep up to date with professional developments					
10	I reflect critically on practical situations					
11	I determine whether I performed well and whether I could perform better next time					
12	I participate in policy development					
13	I make sure that I keep up to date with policy developments					
14	I participate in recruitment and selection interviews with new members of staff					
15	I participate in reflection and/or intercollegial consultation meetings					
16	I participate in internal projects					

PART 3 - Additional Questions

- 1. In your opinion, what are the three most very good CPD practices (Strategies, Policies, Guidelines, Programs, etc...) in Abu Dhabi?**

- 2. In your opinion, what are the three most required improvement actions for the CPD practices (Strategies, Policies, Guidelines, Programs, etc...) in Abu Dhabi?**

- 3. Do you have any other comments or feedback about CPD issues that are not covered in the questionnaire?**

That's the end of the questionnaire

Thank you for your participation

ANNEXURE E

Questionnaire PICD

PICD: Questionnaire

PARTICIPANT'S INFORMATION & INFORMED CONSENT DOCUMENT (PICD)

Researcher's Name: Mohamad A. El Najm

Student Number: 18262156

Nursing Science Department

University of Pretoria

Dear Participant,

Study Title

DEVELOPMENT OF STRATEGIES FOR CONTINUING PROFESSIONAL DEVELOPMENT (CPD) PROGRAM FOR REGISTERED NURSES IN UNITED ARAB EMIRATES (UAE): A MIXED METHOD STUDY

I am a PhD student in Nursing in the Nursing Science Department, University of Pretoria. You are invited to volunteer to participate in our research project on "The Effectiveness of The Continuing Professional Development (CPD) Program in Upscaling Knowledge, Skills, and Attitudes of Registered Nurses in United Arab Emirates (UAE): A Mixed Method Study".

This letter gives information to help you to decide if you want to take part in this study. Before you agree you should fully understand what is involved. If you do not understand the information or have any other questions, do not hesitate to ask us. You should not agree to take part unless you are completely happy about what we expect of you.

The purpose of the study is "to explore and investigate the perspective of the registered nurses (RNs) regarding the effectiveness of the Continuing Professional Development (CPD) in in order to develop CPD strategies".

We would like you to complete a questionnaire. This may take about 20 minutes. We will collect the questionnaire from you before you leave the ward/clinic. It will be kept in a safe place to ensure confidentiality. Please do not write your name on the

questionnaire. This will ensure confidentiality. We will be available to help you with the questionnaire or to fill it in on your behalf.

The Research Ethics Committee of the University of Pretoria, Faculty of Health Sciences, telephone numbers 012 356 3084 / 012 356 3085 granted written approval for this study.

Your participation in this study is voluntary. You can refuse to participate or stop at any time without giving any reason. As you do not write your name on the questionnaire, you give us the information anonymously. Once you have given the questionnaire back to us, you cannot recall your consent. We will not be able to trace your information. Therefore, you will also not be identified as a participant in any publication that comes from this study.

In the event of questions asked, which will cause emotional distress, then the researcher is able to refer you to a competent counselling.

Note: The implication of completing the questionnaire is that informed consent has been obtained from you. Thus, any information derived from your form (which will be totally anonymous) may be used for e.g. publication, by the researchers.

We sincerely appreciate your help.

Yours truly,

Mohamad A. El Najm

ANNEXURE F

Statistician Agreement

Statistician Agreement

Date: 24 / October /2018

LETTER OF CLEARANCE FROM THE BIOSTATISTICIAN

This letter is to confirm that the student(s),

with the Name(s) Mohamad A. El Najm

Studying at the University of Pretoria

discussed the Project with the title Development of Strategies for Continuing Professional Development (CPD) Program for Registered Nurses in United Arab Emirates (UAE): A Mixed Method Study with me.

I hereby confirm that I am aware of the project and also undertake to assist with the Statistical analysis of the data generated from the project.

The analytical tool that will be used will be SPSS Software for Univariate, Bivariate, ad Multivariate statistical analyses to achieve the objective(s) of the study.

Name Mahmouud Batainah

Date 24/10/2018

Signature _____



Tel: +971-52-702 0972

Department or Unit Fatima College of Health Sciences, UAE

ANNEXURE G

Appreciative Inquiry PICD

PICD: Appreciative Inquiry

PARTICIPANT'S INFORMATION & INFORMED CONSENT DOCUMENT (PICD)

STUDY TITLE

DEVELOPMENT OF STRATEGIES FOR CONTINUING PROFESSIONAL DEVELOPMENT (CPD) PROGRAM FOR REGISTERED NURSES IN UNITED ARAB EMIRATES (UAE): A MIXED METHOD STUDY

Principal Investigator

Mohamad A. El Najm (PhD Student)

Institution

Nursing Science Department, University of Pretoria

DAYTIME AND AFTER-HOURS TELEPHONE NUMBER(S): +971-55-5598332

DATE AND TIME OF FIRST INFORMED CONSENT DISCUSSION:

dd	mmm	year

:
Time

Dear Mr. / Mrs. date of consent procedure/...../.....

1) INTRODUCTION

You are invited to volunteer for a research study. This information leaflet is to help you to decide if you would like to participate. Before you agree to take part in this study you should fully understand what is involved. If you have any questions, which are not fully explained in this leaflet, do not hesitate to ask the investigator. You should not agree to take part unless you are completely happy about what we expect of you.

2) THE NATURE AND PURPOSE OF THIS STUDY

You are invited to take part in a research study. The aim of this study is *“to explore and investigate the perspective of the registered nurses (RNs) regarding the effectiveness of the Continuing Professional Development (CPD) in UAE in order to develop CPD strategies”*.

3) EXPLANATION OF PROCEDURES TO BE FOLLOWED

Participation involves attending meeting in an Appreciative Inquiry setting with a group of for the nursing leaders in UAE. The meeting will last approximately 180 minutes. By signing this form, you allow the researcher to take notes during the interview and recording of the interview and subsequent dialogue by audio tape. In case you do not want the interview and dialogue to be taped, you are fully entitled to withdraw from participation.

4) RISK AND DISCOMFORT INVOLVED.

You will not be exposed to any procedures except the meeting.

5) POSSIBLE BENEFITS OF THIS STUDY.

Understanding the Nurses needs and contributing to the knowledge and strategies of Continuing Professional Development.

6) I may at any time withdraw from this study.

ANNEXURE H

Appreciative Focus Group Guide

Appreciative Focus Group Interview Phases and Questions

A. Define (15 minutes)

- Welcome and introduction of the facilitator/moderator
- Introduction of the topic and purpose
- Explanation how the results will be used
- Explanation of why the participants were selected particularly and appreciate them
- Presentation of the guidelines such as:
 - Alert about the tape recording, one person speaking at a time
 - Agreeing on a comfortable basis for calling the names
 - No need to agree with others, but listening actively as others share their views is highly appreciated
 - Rules for cellular phones; must be silent and if must respond to a call, it should be done quietly and re-join the group as quickly as you possible.
 - Identifying the facilitator's role as to guide the discussion
- Agreeing on the CPD issue's definition

B. Discovery (45-60 minutes)

- Tell us what does the CPD mean to you?
- Describe a "peak time" or "high-point experience" with the CPD.
- What do you value most about the CPD programs for RNs?
- What do you most hope that the CPD programs contribute to the RNs?
- What are the factors that made these examples of exceptional performance possible?
- Reflecting on your stories and the factors, what could be the learnt lessons?

C. Dream (45-60 minutes)

Imagine in the future when RNs look to the CPD program as exceptional examples of professional development and management commitment towards excellence.

- What has contributed most to making that exceptional example possible?
- How is it making a difference to the future of nursing to have outstanding CPD programs in UAE?
- What bold decisions were made and by whom that set effective CPD strategies?

D. Design (45-60 minutes)

- What are the areas of CPD where you feel nurses could have the most impact on improving the quality of patients' care?

- As you reflect on successful ways nurses are currently participating in CPD activities, what initiatives stand out as being exceptionally promising in professional development of nurses and why?

ANNEXURE I

Detailed Profile of the Focus Group Participants

Participant	Focus Group	Gender	Nationality	Position	Degree	Type of Facility	Governor	Region
1	1	Female	Philippines	Midwife	Bachelor	Hospital	Private	Al Ain
2	1	Female	Philippines	Staff Nurse	Bachelor	Hospital	Private	Al Ain
3	1	Female	Philippines	Staff Nurse	Bachelor	Clinic/Center	Private	Al Ain
4	1	Female	Philippines	Staff Nurse	Bachelor	Clinic/Center	Private	Al Ain
5	1	Female	Philippines	Staff Nurse	Bachelor	Clinic/Center	Private	Al Ain
6	1	Female	Philippines	Staff Nurse	Bachelor	Clinic/Center	Private	Al Ain
7	1	Female	India	Staff Nurse	Bachelor	Hospital	Private	Al Ain
8	1	Female	Philippines	Staff Nurse	Bachelor	Clinic/Center	Private	Al Ain
9	1	Female	Philippines	Staff Nurse	Bachelor	Clinic/Center	Private	Al Ain
10	1	Female	Philippines	Staff Nurse	Bachelor	Clinic/Center	Private	Al Ain
11	1	Female	Philippines	Staff Nurse	Bachelor	Clinic/Center	Private	Al Ain
12	1	Female	Philippines	Staff Nurse	Bachelor	Clinic/Center	Private	Al Ain
13	2	Male	Palestine	Clinical Resource Nurse	Masters	Hospital	Government	Al Dhafra
14	2	Male	India	Senior Charge Nurse	Bachelor	Hospital	Government	Al Dhafra
15	2	Female	Lebanon	Charge Nurse	Bachelor	Hospital	Government	Al Dhafra
16	2	Female	Jordan	Senior Charge Nurse	Bachelor	Hospital	Government	Al Dhafra
17	2	Female	Jordan	Charge Nurse	Bachelor	Hospital	Government	Al Dhafra
18	2	Female	Somalia	Clinical Resource Nurse	Bachelor	Hospital	Government	Al Dhafra
19	3	Female	Jordan	Charge Nurse	Diploma	Clinic/Center	Government	Abu Dhabi
20	3	Female	UAE	Clinical Resource Nurse	Diploma	Clinic/Center	Government	Abu Dhabi
21	3	Male	Philippines	Staff Nurse	Bachelor	Clinic/Center	Government	Abu Dhabi
22	3	Female	Egypt	Staff Nurse	Bachelor	Clinic/Center	Government	Abu Dhabi
23	3	Female	Somalia	Charge Nurse	Diploma	Clinic/Center	Government	Abu Dhabi
24	3	Female	Philippines	Staff Nurse	Bachelor	Clinic/Center	Government	Abu Dhabi

25	3	Female	Philippines	Staff Nurse	Bachelor	Clinic/Center	Government	Abu Dhabi
26	4	Male	Philippines	Staff Nurse	Bachelor	Clinic/Center	Private	Al Dhafra
27	4	Male	Jordan	Quality Officer	Masters	Hospital	Government	Al Dhafra
28	4	Male	Jordan	Staff Nurse	Bachelor	Hospital	Government	Al Dhafra
29	4	Male	Jordan	Charge Nurse	Bachelor	Hospital	Government	Al Dhafra
30	4	Male	Philippines	Staff Nurse	Bachelor	Clinic/Center	Private	Al Dhafra
31	4	Female	Philippines	Staff Nurse	Bachelor	Clinic/Center	Private	Al Dhafra