Evaluating the purpose and benefits of continuing education in nursing and the implications for the provision of continuing education for cancer nurses

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Accepted for publication 27 August 1993

INTRODUCTION

Over the last 20–30 years, increasing emphasis has been placed upon the importance of updated knowledge in nursing (United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) 1992) and a strategy of mandatory continuing education seems imminent (UKCC 1990). The arguments put forward in the literature for increased emphasis upon continuing education are numerous. Among these, professional accountability, social changes such as shifts in age composition, patterns of illness and the knowledge explosion (Thurston 1992), are said to have dictated the need for increased emphasis upon this issue (Ferrell 1988). Broader
Continuing education in cancer care

thinking and openness to change and to alternatives have also been added to the list of expected outcomes (Jarvis 1987). Authors like Popiel (1977) have gone so far as to state that continuing education must be accepted as a 'human right' and 'social need', and it seems that the more that can be provided of this commodity the better.

Yet Barnball et al (1992) warn that there is a lack of empirically based work analysing nurses' perceptions of their continuing professional education needs, or the perceived outcomes in terms of changes in knowledge, attitudes, skills, job satisfaction, staff retention and career development. Given the reluctance of managers to invest in continuing education (Chiarella 1990), it is even more imperative that educationalists can demonstrate the value of their craft for staff morale, recruitment and retention and, above all, patient care.

For the present author, as a nurse educationalist in cancer nursing with responsibility for the professional development of the staff within a cancer centre, it has been important to search the literature for evidence of the purpose and benefits of continuing education, and to consider the implications for providing continuing education for cancer nurses. Is 'more' continuing education necessarily 'better'? Does it make a difference and if so in what way? These questions are among those addressed in this paper.

**Definition of continuing education**

What is meant by 'continuing education'? While some limit the definition to the provision of study days and courses (Hughes 1990), others argue that it involves the active involvement and motivation of the learner (Stanford 1989) through self-directed learning methods. Echoing these descriptions of a 'top down' or 'bottom up' approach, Jarvis (1987) makes a clear distinction between continuing education and continuing learning, and summarizes as follows:

> continuing learning assumes that the professional will endeavour to keep abreast of all new developments through self-direction, by reading and attending conferences. Continuing education suggests that education courses have to be supplied for the practitioner to attend.

While a focus on continuing learning (Jarvis 1987) may be helpful later in this discussion, continuing education is understood as an all-embracing term relating to:

- planned educational activities intended to build upon the educational and experiential bases of the professional nurse for the enhancement of practice, education, administration, research, or theory development to the end of improving the health of the public.

(American Nurses’ Association 1984)

**Evaluating continuing education**

**The benefits**

The above definition, which is most commonly adopted in the literature (Kershaw 1985, Lathlean 1986, Crotty & Bignell 1987, Hughes 1990), reiterates the common assumptions upon which the purposes and benefits of continuing education are claimed. The benefits, i.e. those goods which accrue to a person, institution or society as a result of investment in a particular project (Rizzuto 1982), may be divided into four main categories (Mitsunaga & Shores 1977):

1. learner satisfaction
2. knowledge, skills and attitude change
3. change in practice
4. ultimate quality of service

**Learner satisfaction and knowledge**

While the overall purpose of continuing education in nursing may be increased quality of service through change in practice, it is learner satisfaction or knowledge acquisition that are most usually evaluated. It is assumed that as knowledge, communication and assertiveness skills are increased, there is professional and educational development and the nurse's ability to improve patient care is enhanced (Mitsunaga & Shores, 1977; Dodwell 1983, Crotty & Bignell 1987). A sound professional education is indeed a prerequisite for safe and competent nursing practice (Akinsanya 1986), and Wilkinson (1992) suggests that keener knowledge improves communication skills in cancer nurses. Yet Warmuth (1987) warns:

> While it is impossible to utilise knowledge that is not possessed, it is quite possible to possess knowledge that is not utilised.

Thus while evaluations of continuing education programmes which are based upon knowledge acquisition almost always show statistically significant cognitive gains (Warmuth 1987), this does not necessarily mean that new knowledge is translated into practice.

Similarly there may be value in evaluating learner satisfaction, if it is agreed that learner satisfaction is directly related to a tendency to seek additional learning experiences and to actual learning, and if the self-perception of having learned is related to actual learning.
(Mitsunaga & Shores 1977, Ferrell 1988) However research is needed to support or reject these assumptions and high learner satisfaction does not allow conclusions to be drawn about the higher level outcomes of continuing education.

Change in practice
The UKCC Working Group 3 (1982) states that the primary objective of nurse education is to ensure that the individual nurse is properly equipped to provide a nursing service of a type that every citizen has a right to expect.

While Barnball et al (1992) argue that evidence of a direct relationship between continuing education and 'good care' is scarce, Cervero (1985), citing studies from the United States (among them Heick 1981, Cox & Baker 1981), claims that objective global evidence does exist that continuing education is effective in changing practice (see also Meservy & Monson 1987) However he admits that it is not likely that published work reflects the true ratio of programme successes to failures and 'success' depends on the programme having measurable outcomes.

Although Hutton (1987), in her review, regards studies as inconclusive in showing any relationship between continuing professional education and enhanced clinical practice, three UK studies have indicated that continuing education programmes with specific measurable objectives may improve clinical practice (Crotty & Bignell 1988, Hughes 1990, Faulkner 1992) Further lack of consensus is illustrated by Hughes' (1990) finding of increased reference and orientation towards research-based practice, while Stanton & Crotty (1991) found that attendance on the ENB 830 course did not necessarily enable the participants to implement research findings in their practice. Thus although the evidence is inconsistent, a programme evaluation based on change in practice is less likely to reveal an effect, and nursing is not alone in this dilemma as Hughes (1990) summarizes.

In profession after profession, the answers to these questions have been so far discouraging efforts at teaching and learning seem to have had little effect on practice.

Difficulty of evaluating outcomes
One of the impediments to assessing the impact of education has been the paucity of reliable and valid evaluation tools for measuring outcomes (Mitsunaga & Shores 1977, Greaves & Loquist 1983) For instance, Ferrell (1988) found that while nurses and their supervisors claimed changes in observation of patients, patient teaching and increased knowledge, their behaviours were not significantly different from those who had not undertaken the course. It is for this reason that Farley (1987) advocates four evaluation programmes, including self-reports and audits, that she has found to demonstrate change of behaviour. In addition to the weakness of the tools, various intervening factors, such as the learner's ability and motivation (O'Connor 1979), the quality of supervision, and working conditions, may affect the assessment of expected benefits in terms of patient care.

Heick (1981), measuring impact after a 12-week mother and baby course, highlights the influence of intervening variables or 'system effects', confirmed by Cervero (1985), that may affect the ability to apply learned concepts to practice, and thus underlines the need for programme reinforcement in the clinical setting (Del Bueno & Kelly 1980, Kiener & Hentschel 1989) Furthermore Carllay (1980, cited in Kiener & Hentschel 1989) suggests that nurses and their managers need to communicate more prior to nurses' participation in continuing education, so that the foundations for a positive approach to future changes are laid. Thus certain conditions must be present for full potential benefits to be realized.

The need to recognize multiple worthwhile outcomes of continuing education is evidenced by Warmuth (1987) who argued that nurses undertaking a 'back to nursing' course who subsequently decided not to return to nursing were not examples of failure of the educational effort (Caplan 1973) Rather than promoting a change in practice the course had contributed to nurses' perceptions of their roles, encouraging them to reflect on their practice and change their rationale for practising or not practising. Nevertheless career development and retention, increased morale and job satisfaction clearly figure more highly as desirable benefits for nurses and their managers (Dodwell 1983).

Crotty (1987) points to the potential relationship between continuing professional education and the prevention of burnout since she argues, burnout-relieving factors, such as self-management, organizational improvements and the use of support systems, may be promoted through the educational process. At the same time possible effects on recruitment and retention are indicated (Mackereth 1989) Yet the claims of these studies are anecdotal and do not conclusively show that such outcomes result from undertaking continuing education, thus failing to evaluate benefit to nurses themselves.

THE CONCEPT OF LIFELONG LEARNING
Attention has been drawn to the problems of reducing nursing to competencies (Jarvis 1987) and attempts to...
subdivide the purpose and benefits of continuing education in nursing may be similarly misguided. Perhaps consideration of continuing learning and lifelong learning is a more appropriate approach to adopt. For this, Jarvis (1983) argues, will produce in the learner the ability to recognize good practice and the determination to ensure that his/her own future practice will not fall below such a standard. That is, not only will it raise quality in patient care but 'produce practitioners mindful of that quality'.

The proposition is that learning to learn and learning to practice are essential characteristics of good practice, in the same way that listening, oral communication, problem solving, creative thinking, goal setting and teamwork are important basic skills of the expert practitioner (Benner 1984, Cheren 1990). Thus it may be learning to learn that is of paramount importance, and where educators have their biggest role, through development of learning partnerships and learning contracts, and thus engendering awareness and commitment to lifelong learning. 'Good care' after all, is where the nursing practice situation constitutes experimental and creative performance (Jarvis 1992). Where motivation to learn is high, and therefore nurses' receptiveness to teaching is high (Alexander 1984).

The environment of learning

The increased emphasis upon the environment of learning (Orton 1981, Fretwell 1982) and on the integrated outcomes advocated by Jarvis (1992), point towards the adoption of a slightly different perspective where more attention is paid to the kind of conditions required, the types of individuals involved, and the characteristics of effective continuing education. It is consideration of these issues that may give most guidance in planning, implementing and evaluating continuing education in cancer nursing.

ASSOCIATED ISSUES

There is certainly evidence in the literature that there is far more to providing continuing education than simply needs assessment and fulfilment. For instance while nurses can sometimes identify their own continuing education needs, they are not always able to do this (Orme & Trickett 1983). Chiarella (1990) argues that it is not surprising that after '3 years exercise in plausibility', nurses need to be helped to state their needs and lack of knowledge. There is a great deal of evidence that some nurses make no attempt to use present resources, for example reading professional journals, or to undertake presently available additional professional education (Myco 1980, Kershaw 1985, Barnett 1987, Hibbs 1989, Frend 1991).

In addition, there is much variation in the accessibility of continuing education courses for nurses of different grades and shifts and from varying health authorities (Barriball et al. 1992). Thus while Lindsey (1990) found a generally positive attitude to education, other factors appeared to influence uptake, such as perceived relevance of content, time and day of presentation, lack of literature about the importance of the content and, not least, the views of managers, low staffing levels and lack of funds (Corner 1990, Larcombe & Maggs 1991).

These issues must all be kept in mind when considering the provision of continuing education for cancer nurses.

IMPACT OF CONTINUING EDUCATION IN CANCER CARE

Relevance of content is particularly notable in cancer care since the knowledge which nurses have about cancer nursing, as a result of their basic education, varies widely (Oncology Nursing Society 1980), and there is much evidence of a deficit in cancer nursing knowledge, among both generalist and specialist nurses (Corner 1990, Pope 1992). Since knowledge is considered a necessary prerequisite to good care and professional development (Corner 1990), there is a requirement to make good this deficit, thus enabling and supporting those giving care.

Two studies that have attempted to evaluate impact in cancer nursing are briefly reviewed here, they demonstrate the need for the benefits of continuing education and the difficulties in evaluating whether these have been achieved.

Welch-McCaffrey (1985)

As has been stated above competency on one occasion does not guarantee competency at any other time (Adelson et al. 1985) yet nurses involved, for instance, in the giving of chemotherapy must have current knowledge of the rationale for treatment and the incidence and severity of potential toxicities. To this end Welch-McCaffrey (1985) developed a 3-day chemotherapy certification course where she used tests before and after the course to assess knowledge. While the test 6 months after the course measured lasting knowledge, the tests compiled for the study had no external validity.

Valencius (1980a,b)

In briefly reporting the first attempt in the USA to evaluate the impact of cancer nursing education, Valencius (1980a,b) describes a sample of 250 nurses,
representing a 57% response rate from all those undertaking cancer nursing courses at one institution over a period of 3 years.

The study demonstrates, in the context of cancer nursing, much of what has been discussed generally, plus the difficulty of following-up past learners. It indicates a lack of perceived need for further information, regarding legal issues in chemotherapy administration, for instance, or concerning radical surgical procedures. This perhaps suggest the lack of recognition among cancer nurses of these deficits.

More information in the areas of nutrition, pain control, prevention and detection, and rehabilitation was not seen as an objective by many nurses. These aspects of care are regarded as having greatest generalizability to other areas of nursing and thus are particularly important since many nurses care for cancer patients within general medical/surgical wards.

Only 28.6% of learners developed educational materials after their programme, underlining the need for more objective means to follow up actual changes in nursing practice, and the need to enlist employer interest in utilization of newly acquired skills. In addition Valencius found greater personal confidence among participants and therefore the possibility of enhanced patient care.

**Evaluation at four levels**

While it has been shown that there are limitations in the present methods of evaluation of continuing education, it is important to encourage enhancement or change in nursing behaviour in cancer care by continuing to evaluate programmes at all four levels: learner satisfaction, knowledge, practice change and quality in practice.

**Optimal benefit**

Heick (1981) and Cox & Baker (1981) make the following recommendations for optimal benefit from continuing education:

1. the continuing education offered is based on demonstrated need,
2. the needs are translated into specific measurable objectives,
3. the length of the continuing education offered is appropriate to the objectives to be achieved,
4. the continuing education participants are a homogeneous group with similar practice goals and learning readiness,
5. learning activities and teaching methods should be varied,
6. objectives should be planned jointly with sponsors and evaluated in practice afterwards,
7. potential variables of limitations, identified as potential reinforcements or hindrances to the clinical application of goals, should be a planned aspect of discussion sessions during the continuing education activity.

Because of their emphasis on self-directed learning and personal motivation, these recommendations may not take into account those who do not have any inclination to take up continuing education, and therefore sit uneasily with prospective plans for mandatory continuing education. Moreover, the guidelines above are appropriate for measurable and demonstrable 'product'-orientated objectives (Popiel 1977). They do not integrate the need to provide a broader view of self and others, encompassing a 'process' orientation where participants are encouraged to risk, explore, to support and defend their ideas.

Jarvis suggests that if lifelong learning was actually fostered in nursing then continuing education might be less necessary (Jarvis 1987). Lathlean (1986) points back to the ward sister and the need to support and educate her/him since it is she/he who is the linchpin for development of staff nurses' skills and who makes or breaks the environment for learning on the ward. Again, the emphasis from authors such as these is upon the importance of learning within the specific clinical area from clinical experts.

**CONCLUSION**

This paper has discussed the major claims for the purpose and benefits of continuing education, and has outlined some of the implications of providing continuing education for cancer nurses. Many hopes and expectations for improved patient care and well prepared staff are vested in the vast numbers of continuing education programmes set up for cancer nurses. Yet it seems that these are largely anecdotal claims and much work has yet to be done in refining and applying the evaluative tools that will help to justify the increasing expense of continuing education in cancer care. The development of research-based studies and preliminary work into cost versus benefit (Rizzuto 1982, Turner 1991) need to be expanded. Further study of the factors that influence incorporation of learning into practice is indicated. It has been argued that evaluation at several levels of programme development and outcome should be made.
since this will help to give an overview of the diverse outcomes and benefits of continuing education (Heick 1981, Cox & Baker 1981, Meservy & Monson 1987)
The discussion of evaluation of behavioural outcomes has been supplemented by a more global view of the issue, from the perspective of lifelong learning as proposed by Jarvis (1987) This viewpoint suggests the development of clinical learning environments, rather than emphasis on ‘interludes of learning’ among spans of repetitive work In turn this has implications for adequate preparation and supervision of ward-based staff (Orme & Trickett 1983, Lathlean 1986), perhaps suggesting the return of the clinical teacher or development of the lecturer practitioner role (Lathlean 1992) Perhaps the expertise of the hospital-based Macmillan clinical nurse specialist could be exploited here? At the very least, cancer nurses need someone who can help them to identify their learning needs within their practice (Larcombe & Maggs 1991)

While these more innovative strategies for increasing learning are devised and tested, there is an ongoing and enhanced need to assess their purpose and benefits in terms of their value to the patient, nurse and to the service provided This requires the development of more sophisticated impact evaluation tools (e.g. Robinson & Robinson 1989) that have validity, reliability and are convenient to administer (Sheehan 1979) There is a need to evaluate according to the specific aims of the programme (Mitsunaga & Shores 1977), remembering that accountability is not so much to do with showing change in patient care but demonstration of attaining specified and reasonable goals Lastly, an important point to which Popiel referred in 1977, but which has been seldom raised since, and is of particular relevance to the cancer care team, is the need to achieve a coalition between nursing, medicine, therapy, radiography and other health care fields, establishing interdisciplinary programmes to avoid duplication of effort and thereby to promote pooling of learning resources

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