EVALUATION RESEARCH IN THE WORKPLACE WITHIN AN ACTION RESEARCH FRAMEWORK

by

DEBBIE BROWN

A thesis submitted

to the Faculty of Graduate Studies

in partial fulfillment of the

requirements for the degree of

MASTERS OF EDUCATION

in

Faculty of Education

University of Manitoba

Winnipeg, Manitoba

THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES

*****

COPYRIGHT PERMISSION PAGE

EVALUATION RESEARCH IN THE WORKPLACE WITHIN AN ACTION RESEARCH FRAMEWORK

BY

DEBBIE BROWN

A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University of Manitoba in partial fulfillment of the requirements of the degree of

MASTER OF EDUCATION

Abstract

The Emergency Cardiac Care Committee (ECCC) of the Heart and Stroke Foundation of Manitoba (HSFM) was established in 1976 to teach Cardio Pulmonary Resuscitation (CPR) to the general public in Manitoba. An action research framework designed study was conducted to evaluate the activities of the ECCC of the HSFM. An evaluation committee which included members from various areas of the HSFM was formed to be a representative action research group responsible for the evaluation process. The study evaluated six areas of the Emergency Cardiac Care Program (ECCP): goals and objectives, resources, staff support, structure of the ECCC, importance of the ECCC to the HSFM, and inter-agency relationships. Qualitative and quantitative data were collected by questionnaire administration. The study group of 40 respondents comprised of the ECCC members and instructor trainers in Manitoba. The majority of respondents indicated the activities of the ECCP still reflected the program objectives and did not require revisions despite respondents identifying different mechanisms or activities for achieving the objectives. Over one-half of the respondents reported they were receiving all the required materials for the maintenance of the ECCP and had no difficulties in obtaining resources. The type and amount of staff support from the HSFM to the ECCC was identified as adequate by the respondents. The structure of the ECCC with the network system was identified as an efficient way to accomplish the ECCP objectives by the majority of respondents. Almost one-half of respondents reported there was

inadequate rural participation within the ECCC. The majority of respondents identified that the ECCC did provide an important service to the HSFM. Inter-agency relationships with all of the member agencies associated with CPR training was reported as satisfactory by over one-half of the respondents. The evaluation study was conducted to gain insight into the ECCP, its objectives, and how they were being met from the respondent's perspective. A personal reflection section at the end provides the researcher's insights on the action research process.

Acknowledgements

I would like to take this opportunity to sincerely thank the following people for their assistance and encouragement.

A grateful acknowledgement is extended to Dr. D. Harvey of the Faculty of Education, University of Manitoba, my thesis chairperson and advisor. Without his assistance, guidance and mentorship, the completion of this thesis work would not have been possible.

Appreciation is also expressed to Dr. Jim Welsh of the Faculty of Education and Dr. L. Scruby of the Faculty of Nursing for their time and effort as members of my thesis committee.

Thanks also to the Emergency Cardiac Care Evaluation Committee (Shelley Tallin, Dr. Barry Garbut, Diana Rassmussen and Dawn Marie Turner) who were the action research group. Their assistance and participation with this study was greatly appreciated.

Gratitude is also expressed to the Heart and Stroke Foundation of Manitoba for providing the opportunity and support for this study.

Special thanks to my colleague and friend Allison Murdoch-Schon for her support, encouragement, and sense of humour to help me make it through the trying times of this project.

Lastly, a special thank you to my husband Lance and my children Sarah, Christine, and Danny, without whose love and support I would not have been able to complete this thesis.

TABLE OF CONTENTS

LIST OF FIGURE

LIST OF TABLES

CHAPTER 1

INTRODUCTION

Evaluation research is "the systematic application of social research procedures for assessing the conceptualization, design, implementation, and utility of social intervention programs" (Rossi & Freeman, 1993, p.5). Program evaluation "is the process of specifying, defining, collecting, analyzing, and interpreting information about designated aspects of a given program and using that information to arrive at value judgments among decision alternatives regarding the installation, continuation, modification, or termination of a program: (Craven, 1980, p. 434).

Program evaluation is crucial for assessing program effectiveness, efficiency, for improving programs, and service delivery, and for guiding resource allocation and policy development (Thompson, 1992). Program evaluation can be thought of as a specific form of action research aimed at providing information to facilitate decision making and to lead to action and change (Midkiff & Burke, 1987).

Over the past decade, political and economic conditions have changed greatly resulting in a strong emphasis on program evaluation. More objective evidence on program effectiveness is now being requested by funding bodies, legislators, and the general public (Rutman, 1987). It is becoming more common to find a formal requirement that programs be routinely evaluated for their effectiveness. Without

evaluations, the relative effectiveness of alternative strategies, resource allocations, organizational designs, and distributions of power cannot be determined (Bryson, 1990).

Program evaluation is part of strategic management where evaluation evidence determines the long run performance of an organization. The monitoring and evaluating of an ongoing program outlines strengths and weaknesses by determining if there is efficient utilization of an organization's assets (Wheeler & Hunger, 1989). Spiraling costs of established programs and restraints on existing resources require organizations to choose what to support and in what magnitude. Policy makers within organizations base their decisions about resource allocations and cut expenditures on evaluation evidence.

Emergency Cardiac Care Committee

The Emergency Cardiac Care Committee (ECCC) was established in 1976 when Manitoba became the first province in Canada to teach Cardio Pulmonary Resuscitation (CPR) to the general public. The ECCC functions as a subcommittee of the Health Promotion committee of the Heart and Stroke Foundation of Manitoba (HSFM) and operates as a non-partisan, non-profit body. The ECCC consists of 33 representatives from organizations involved in the training or delivering of CPR programs in Manitoba.

The ECCC is the policy making and standard setting body for CPR and is responsible for the CPR programs and networks in Manitoba. The ECCC is also responsible for quality control assurance and for maintaining a registry of all registered

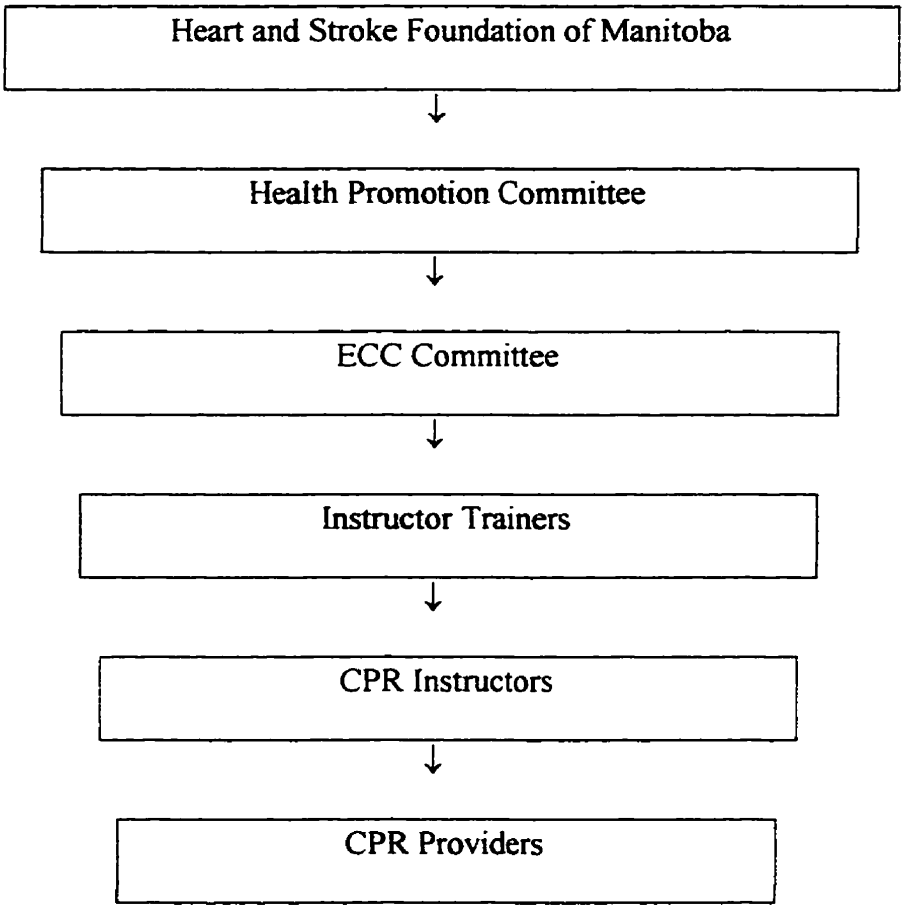
instructors and instructor trainers. The committee provides teaching aids related to Emergency Cardiac Care and develops public education programs relating to emergency care.

The ECCC has three standing committees: Teaching Subcommittee, Infant and Child Subcommittee, and Seminar/Conference Subcommittee. Each of these committees have their own areas of responsibilities.

Organization

The organization of the ECCC is directed toward the formation of a training network. The top of the network begins with the HSFM responsible for coordinating and supporting the efforts of the ECCC. The organization of the training network is demonstrated by the flow chart in Figure 1.

Figure 1 Organizational Flow Chart



Third from the top of the pyramid, the ECCC is responsible for all of the instructor trainers in Manitoba. At the next level, each instructor trainer is responsible for a network of CPR instructors. The sizes of the networks are dependent upon the geographical location of the network, or the population distribution of the area. At the bottom level of the pyramid, the CPR instructors teach classes to the public who are referred to as CPR providers.

The aims of the ECCC are to:

1. Advise, assist, and cooperate with individuals and organizations in preventing death due to heart related dysfunctions
2. Encourage and support CPR networks throughout the province of Manitoba
3. Promote healthier lifestyles in our community (CPR Program Policy and Procedures Manual, 1994).

Purpose of the Study

The purpose of this study was to conduct an evaluation of the activities of the ECCC of the HSFM. Since its formation, the committee had never been evaluated. For the purpose of this study, the program of the ECCC was considered a health education program defined as "a package of services, information, or both that is intended to produce a particular result" (Dignan & Carr, 1987, p.5). The Emergency Cardiac Care Program (ECCP) was evaluated in six areas:

1) goals and objectives
2) resources
3) staff support
4) structure of the ECCC
5) importance of the ECCC to the HSFM, and
6) inter-agency relationships.

Assumptions and Limitations of the Study

The decision between within-organization or outside-organization evaluation raises the issue of accountability and conflict of interest (Rossi & Freeman, 1993). Since this study utilized action research, the composition of the action research group included members involved with the HSFM and the ECCC at different levels. This provided a healthy overall perspective of the ECCP, ensured accountability, and prevented conflict of interest from occurring.

Group members participating in the action research evaluation process gain new awareness of the ECCP and their responsibility for the evaluation process. Evaluations performed in this manner may yield better results, both because those involved understand their organization better and because they provide a check on the outside researcher's interpretations (Cunningham, 1976).

Care must be taken to ensure that objectivity occurs throughout the evaluation process. There may be a certain level of concern by the members of the ECCC toward the evaluation process as the study was commissioned by the HSFM. It may appear there was a hidden agenda and these concerns may influence responses and affect the evaluation process.

The study results will be specific to the ECCP and will not be generalizable to other programs. The questionnaires were sent out to all ECCP Instructor Trainers.

Incidental limitations of this study will be similar to other studies which utilize a self-administered questionnaire for data collection. All questionnaires used were designed with a fixed number of responses providing participants a variety of choices.

Bias may have occurred in that there may not have been adequate response selection available for each individual participant. The category of other has been included when necessary for additional comments.

Data analysis was dependent on which respondents returned their questionnaires. For example, if responses were received only from participants who value the program, participants may not be willing to point out problems and data analysis will be skewed (House, 1993), leading to a bias in the overall results and evaluation recommendations.

The social situation surrounding the administration of the questionnaire along with behavioral self-reports may lead to response bias. Self-reports of true behavior were usually retrospective and dependent on the participant's memory. The fear of program cuts may have affected true responses. The researcher has no option but to assume that most responses will be the truth (House 1993).

CHAPTER 2

LITERATURE REVIEW

Evaluation Research in Health Education Programs

Evaluation research originated in the field of educational research and was tested in the United States in the 1930s (Stufflebeam & Shinkfield, 1985). The development of evaluation research as a special field of practice has occurred over the past two to three decades (Cook & Shadish, 1987; Patton, 1987a; Stufflebeam & Shinkfield, 1985).

During its development, there have been a number of shifts of emphasis in the field of evaluation research. Dehar, Casswell, and Duignan (1993) describe two significant trends: (a) reduced emphasis on quantitative measurement and experimental design; and (b) increased emphasis on program implementation and development.

In the first trend, the need for "hard" data and statistical proof were examined (McLaughlin, 1987). The quantitative experimental model, with its underlying assumptions, was questioned by evaluators on its relevance and applicability to real social settings (Cook & Shadish, 1987). An alternative paradigm, naturalistic evaluation, was developed in response to the perceived limitations of the quantitative experimental paradigm. The naturalistic approach emphasizes description and understanding of social phenomena using qualitative research methods (Elliot, 1991; Patton, 1987b).

With the second trend, evaluators shifted from a sole concern with measuring program effects and comparing these to the goals and objectives of the programs to more attention to the processes by which the program achieved the results it did. Process

evaluation documents and analyzes the way a program operates, and assists in interpreting program outcomes for future program planning (Dehar, Casswell, & Duignan, 1993).

Judd (1987) promotes both outcome and process evaluation combined for program evaluations. He suggests evaluation research should go beyond simple demonstrations of treatment effects to research that permits understanding why a treatment has the effects it does and how the treatment might be improved. Health education programs are aimed at being responsive to the needs of the clients. Program evaluations should enable health professionals to be responsive and demonstrate their responsiveness to the needs of target populations (Dignan & Carr, 1987).

Patton (1987a, p. 15) outlines the practice of evaluation research as "the systematic collection of information about the activities, characteristics, and outcomes of programs for use by specific people to reduce uncertainties, improve effectiveness, and make decisions with regard to what those programs are doing and affecting." Objective and systematic methods are used to assess the extent to which goals are achieved. It is assumed that by providing "the facts", evaluation research assists decision makers to make prudent choices for future courses of action (Weiss, 1987). Social research methods are used to judge and improve the ways in which health education programs are conducted, from the earliest stages of defining and designing programs through their development and implementation (Rossi & Freeman, 1993).

Evaluation Purposes

Evaluations serve different purposes and are executed for a variety of reasons. Anderson and Ball (1987) outline the main purposes of evaluation as:

1. To contribute to decisions about program installations. The evaluation identifies the need for a particular policy or program, provides cost estimates, and explores anticipated operational difficulties.
2. To contribute to decisions about program continuation, expansion or contraction, or certification such as licensing or accreditation. The evaluation examines actual program operations, costs, and impacts.
3. To contribute to decisions about program modification. The evaluation serves to improve the program by examining program content, methodology, context, and practices.
4. To obtain evidence favoring a program to rally support, or to obtain evidence against a program to rally opposition. An evaluation's advocacy purpose in this instance is declared.
5. To contribute to the understanding of basic social or economic processes, thus serving a pure research agenda.

Rossi and Freeman (1993) summarize three reasons why evaluations are performed:

1. To judge merit of programs to appraise the usefulness of attempts to improve them;
2. To assess the adequacy of new programs and to improve program management and administration; and
3. To fulfill the accountability requirements of program sponsors

House (1993) maintains evaluation may be tied to budget cutbacks and new managerialism. Evaluations legitimize, guide, and inform simultaneously. In attempts to improve economic productivity and the management of programs, evaluation has become a tool for informing and legitimizing unpopular steps that organizations must take, including budget cutting. Evaluations of programs may be based on productivity and efficiency, rather than on the needs of the clients.

Evaluations assess accomplishments and identify limitations of a program. Periodic evaluations assist a program to maintain a good public image and ensure continued funding (Dignan & Carr, 1987). Evaluation is often a required feature of all public or private grants. Often program evaluations may be used as a staff development activity. The staff may increase their understanding of the program and be willing to resolve program problems.

Political Nature of Evaluation Research

Evaluation research is a political and managerial activity which may be seen as an integral part of the social policy and public administration movements (Rossi & Freeman, 1993). Weiss (1987) suggests political considerations intrude in three major ways in evaluation:

1. The program with which the evaluation deals was defined, debated, and funded through political processes and in implementation it remains part of political pressures;
2. Evaluations feed into decision making and its reports with evidence of program outcomes have to compete for attention with other factors in the political process; and

3. Evaluation itself makes political statements about the legitimacy of program goals and program strategies.

House (1993) sees evaluation influenced by political forces and in turn, has political effects. He suggests it is important to know whose interests are served and how interests are represented. Different groups have special interests and will be affected differently by the program evaluation. Representing stakeholder views in evaluation is part of the evaluation practice as decision making depends on the values held by relevant policy makers and stakeholders.

Evaluation research results, positive and negative, are considered as inputs to a political process (Caudle, 1989). Evaluation research determines political accountability and effectiveness. Programs are judged on how well they are run within policy parameters. Often, evaluators do not take into consideration the political context of an evaluation.

Smith and Glass (1987) describe program evaluation as a politics paradigm. They emphasize that evaluation and politics are inextricably mixed. Evaluation research studies should consider all major stakeholders who may play a role in maintaining, modifying, or elimination the program. All should be informed of the results of the evaluation.

Rossi and Freeman (1993) recognize two tensions from the political nature of evaluation: "(1) the different requirements of political time and evaluation time; and (2) the need for evaluations to have policymaking relevance and significance" (p. 454). It is essential for evaluators to look outside the technical aspect and be aware of the larger context in which they are working and the purposes being served by the evaluation.

Evaluation Research Methods

House (1993) observed that between 1965 and 1990, the methodology of evaluation has changed considerably. Two different research perspectives are impressive within the social sciences: (1) analytic tradition of quantitative research methods; and (2) sociological tradition of qualitative research methods (Singleton, Jr., Straits, & Straits, 1993). A primary emphasis on quantitative methods has moved to a more flexible atmosphere in which qualitative research methods are acceptable (De Vries, Weijts, Dijkstra, & Kok, 1992; Steckler, 1989).

Patton (1987b) reported that evolvement in evaluation research has led to an increased use of multiple methods including combinations of qualitative and quantitative data. He suggests creating a design and collecting information that is fitting for a specific situation and particular policy making context. What research methods are used depends on whether the program under evaluation is a new intervention, a modification or expansion of an existing program, or a well-established program (Rossi & Freeman, 1993).

Williams (1989) contrasted fourteen evaluation theorists. He found that the major theoretical issue on which they differentiated was "Qualitative versus Quantitative Methodology". The second issue was whether evaluation should be used to judge programs and personnel for accountability or should be used to inform stakeholders. The third issue relates to how and whether clients should participate in the evaluation.

Mullen and Iverson (1980) list six applications that combine both qualitative and quantitative methods for comprehensive program evaluations:

1. Qualitative methods as a tool to boost the development and outlining of program elements;
2. Qualitative methods as a tool to boost quasi-experimental designs - enhances internal validity of quantitative designs;
3. Qualitative methods to increase the observational field and assess program outcomes;
4. Qualitative methods to provide process and in-depth analysis of a program;
5. Qualitative methods to generate both theory and hypotheses; and
6. Qualitative methods used as an alternative to quantitative designs.

According to De Vries et al. (1992), both qualitative and quantitative methods can be considered as separate methodologies contributing to health education research. They advocate combining the two methods for evaluation research. The outcome and the results of both approaches used together is greater than the effects of either used separately and will enhance program evaluation.

Health education programs are complex phenomena which require various methodologies to evaluate (Steckler, McLeroy, Goodman, Bird, & McCormick, 1992). The important point is not whether to use quantitative or qualitative methods, but rather how they can be used to produce the most effective evaluation strategies. The use of multiple methods, and triangulation, can strengthen the validity of findings (Rossi & Freeman, 1993).

Action Research

The origins of action research can be seen in the work of Kurt Lewin, especially in social psychology and education (Anderson, Herr, & Nihlen, 1994). Lewin (1948) believed that knowledge should be built from problem solving in real-life situations. Over the past four decades, there have been different waves from different groups reviving, revitalizing, and refurbishing action research to meet changing needs and circumstances (Kemmis, 1993).

Action research is defined as "a form of collective self-reflective inquiry undertaken by participants in social situations in order to improve the rationality and justice of their own social or educational practices, as well as their understanding of these practices and the situations in which these practices are carried out"(Kemmis & McTaggart, 1988, p. 5). Contrasting traditional research, the distance between researcher and subject is minimized.

Action research is seen as being democratic, forming a collaborative relationship and encouraging development and change while concurrently strengthening the capacity to discriminate and make judgments (Elliot, 1991; Kemmis & McTaggart, 1988; Pope & Denicolo, 1991). Theory and practice form mutual partners in a dynamic relationship, increasing the likelihood that theory can actually direct practice (Carr, 1989). Wallace (1987) considered action research a "bottom up" approach to the generation of knowledge.

Action research aims at producing collaborative learning by doing - participants set out to learn from change in a process of making changes, studying the process and

consequences of these changes, and trying again. Action research is able to increase involvement and participation in the research process (Kemmis, 1993).

Action research was designed precisely for bridging the gap between theory, research and practice. It incorporates both humanistic and naturalistic scientific methods (Holter & Schwartz-Barcott, 1993). A dominant strength of action research is the ability to employ different methodologies to obtain different sources of information in an effort to develop converging lines of inquiry (triangulation) (Hugentobler, Israel, & Schurman, 1992). As a process, action research develops through "a spiral of cycles of planning, acting (implementing plans), observing (systematically reflecting), and then re-planning, further implementation, observing and reflecting" (Kemmis & McTaggart, 1988, p. 22).

Midkiff and Burke (1987) consider program evaluation to be a specific form of action research. Program evaluation research seeks 'real answers' from real life questions by providing practical information for decision making about a specific program. Both program evaluation research and action research require that: (a) data are collected, analyzed, and disseminated back to the participants; (b) results be interpreted to participants; (c) corrective actions based on the data collected be designed and implemented; and (d) these actions be monitored and subjected to further investigation and evaluation (Hugentobler, Israel, & Schurman, 1992; Midkiff Jr. & Burke, 1987).

Action research is similar to many approaches to program evaluation (Herrick, 1992). By concentrating on action and program improvement, action research can be compared to the Content, Input, Process, Product (CIPP) model of evaluation (Stufflebeam et al., 1971). The goal is program improvement and accountability through the acquisition of information that serves decision making.

Kemmis (1993) identifies three versions of action research: (a) "technical" action research which is similar to amateur research conducted under the eye of university researchers; (b) "practical" action research which is advocated by John Elliot (1991); and (c) "emancipatory" or "critical" action research. The latter version, advocated by Kemmis (Carr & Kemmis, 1986), perceives that critical action research is always connected to social action and social movement. There is an "aspiration to change the social (or educational) world for the better through improving shared social practices. . . . and the shared situations in which these practices are carried out" (Kemmis, 1993, p. 1070).

Holter and Schwartz-Barcott (1993) identify four characteristics of action research that remain central to all forms of action research. First, the focus of collaboration entails interaction between a researcher and a group of practitioners. Secondly, the problem is defined in relation to a specific situation and setting. The amount of participation in the problem identification is significant for the results of the change process. Third, the change in practice that occurs depends on the nature of the problem identified. Finally, development of theory is the final goal of action research. Additional knowledge or new knowledge may be generated on the problem under study, or a new theory may be developed based on knowledge developed during the process of solving a practical problem (Elden & Lewin, 1991).

Evaluation research investigates the magnitude to which health education programs achieve their goals (Singleton, Straits, & Straits, 1993). The process of Action Research is intended to support the researcher and the evaluation committee in coping with the challenges and problems of evaluation and carrying through the evaluation in a reflective way (Altrichter, Posch, & Somekh, 1993). It is a powerful strategy to sustain researchers and participants through periods of social change and evaluation.

Participants classification of and arrangement for provision of the sort of feedback they view as important neutralizes or minimizes the negative effects of the feedback they anticipate receiving from other participants (Greenwood, 1994). Social realities of a health education program are realized through the involvement of program administration and program participants. The practical evaluation skills of practitioners are enhanced through the Action Research process.

CHAPTER 3

PROCEDURES

Methodology

The purpose of this study was to perform an evaluation of the ECCP activities using an action research framework based upon "The Action Research Planner" (Kemmis & McTaggart, 1988). Action Research (AR) is one method that allows for the integration of data collection techniques (qualitative and quantitative) which strengthen the process and outcomes of an evaluation (Hugentobler, Israel, & Schurman, 1992). Working together, the researcher and organization collaborate in conducting the evaluation in which the organization and its members initiate, conduct, and implement the results of the evaluation.

Members of the ECCP are professionals who volunteer their services and represent agencies and organizations involved with CPR training. The HSFM staff person acts as a liaison between the agency and the volunteers by providing guidance and clerical support.

AR begins with a social or practical problem rather than a theoretical question. Kemmis and McTaggart (1988) characterize AR as a spiral or cycles of planning, acting, observing, and reflecting which allows for those affected by planned changes to have the opportunity and responsibility for deciding on the courses of action for evaluating the program strategies.

The four cycles of AR operate:

1. to develop a **plan** of action to improve what is already happening,
2. to **act** to implement the plan,
3. to **observe** the effects of action in the context in which it occurs, and
4. to **reflect** on these effects as a basis for further planning and subsequent action through a succession of cycles (Kemmis & McTaggart, 1982).

All participants involved in the research process are equal participants and must be involved in every stage of the research (Grundy & Kemmis, 1982). An evaluation committee comprising of members from different areas of the HSFM was formed to provide a representative action research group responsible for the process of the ECCP evaluation. The evaluation committee members included: a chairperson, a HSFM board member, an ECCC chairperson, a HSFM staff person, and the researcher. The researcher served as an outside consultant whose role was to facilitate the group in decision making and to coordinate responsive action.

AR methodology aims at the improvement of the understanding of the ECCP, the improvement of the practice of the ECCP, and the improvement of the situation in which the ECCP practice takes place (Carr & Kemmis, 1986). The evaluation committee was involved in the AR process in all of its phases of planning, acting, observing, and reflecting.

Forming the AR Group

Members of the AR group (evaluation committee) began by defining common goals evolved from the purpose of evaluating the program. The first phase in conducting a program evaluation study is identifying key evaluation questions, which takes

considerable reflection by AR evaluation committee members and is best facilitated by the researcher. The researcher works jointly with the evaluation committee members to develop key questions and to probe into rationale and assumptions behind their key questions.

ECCC Pre-Evaluation Survey

A pre-evaluation survey was developed by the evaluation committee in November 1993 to distribute to the 33 members of the ECCC committee for their opinion on what areas should be evaluated. Based on the results of the survey, the evaluation committee identified six areas of the ECCP for evaluation:

1. goals and objectives
2. resources
3. staff support
4. structure of ECC
5. importance of ECCC to HSFM, and
6. interagency relationships

The pre-evaluation survey was an essential first step for the evaluation. The evaluation committee wanted to extend participation of the evaluation to the ECCC members. Their input from the pre-evaluation survey further incorporated a collaborative approach between the subjects and researchers. The ECCC members were provided the opportunity to identify the areas of their program that should be evaluated.

Study Design

The study design involved the evaluation of the ECCP on two groups of participants: ECCC members, and instructor trainers. The program participants comprised of the 33 ECCC members and 69 instructor trainers.

Instrument Development

The complexity of the ECCC networks and interagency relationships within the ECCP provided a challenge for data collection. An instrument was developed which allowed for the comparison of organizational-level and individual-level data. Comparisons between the two groups of participants would also allow for cross checking of results and would increase confidence in the interpretation of the results (Jackson, Altman, Howard-Pitney, & Farquhar, 1989).

The ECCP utilize diffused methods of implementation; for example, members of the ECCC belong to a network comprising of one instructor trainer who is responsible for a number of CPR instructors. The CPR instructors in turn teach CPR to the community. The actions of the ECCP are filtered down from one group level to another subsequently reaching the community.

The questionnaire was developed by taking into account the identified areas of evaluation (Appendix A). The questionnaire consisted of closed and open-ended questions that would collect both qualitative and quantitative information. The ECCP is a complex program with multiple networks and levels which require multiple methodologies in order to properly understand and evaluate it (Steckler, McLeroy,

Goodman, Bird, & McCormick, 1992). The evaluation committee and the researcher worked together in an action research format to develop the questionnaire.

The process of questionnaire development was a spiraling cycle of planning, acting, observing and reflecting in order to modify and produce a final instrument for the evaluation. Since this program had never been evaluated, there were no previous guidelines or questionnaires available for comparison.

The evaluation committee worked together to develop questions that would address the areas for evaluation. Once key questions were established through group consensus, an evaluation design was built (Herrick, 1992). The researcher facilitated the development of the questionnaire by drafting questions for the survey based on the areas for evaluation. A draft of the questionnaire was presented to the evaluation committee for their input. Committee members had the opportunity to edit, clarify, and format the questionnaire.

Within the area of goals and objectives, various ECCP activities would be evaluated. The ECCP had six objectives:

1. Monitor and maintain an active network of instructors and instructor trainers for basic life support in Manitoba.
2. Be responsible for the training of instructors within a members network.
3. Direct active and continuing programs of public education to achieve the aims of the ECCC.
4. Stimulate community involvement to achieve effective pre-hospital emergency medical services.
5. Maintain a data base for research purposes, rosters.
6. To develop, implement and maintain a manual of policies and procedures.

The questionnaire was developed to evaluate program activities following the framework of the program's objectives. For example, information on funding could be addressed under objective one - **Monitor and maintain an active network of instructors and instructor trainers for basic life support in Manitoba** and under the resource section of the survey.

Under the five other identified areas for evaluation, further questions were developed with the evaluation committee to include the information from the pre-evaluation survey. In this manner, through an AR format, a comprehensive questionnaire was created that incorporated all six areas for evaluation.

The questionnaire for the ECCC members and the instructor trainers generated program information from their perspective and on how they felt the ECCC network was performing from their level down to the CPR instructors. The questionnaire consisted of 91 questions with subparts under the six evaluation areas and a general information section for program participant demographics (Appendix A).

Survey Procedures

The questionnaire was sent out to all 33 ECCC members and 69 instructor trainers in Manitoba. Prior to distribution to participants, all questionnaires were coded with a participant number. Each participant received a cover letter (see Appendix B) explaining the reason for the study, who was collecting the data, assured anonymity and confidentiality, and information that surveys were being coded only for the purpose of sending reminder notes. Two weeks after the initial mailout of questionnaires, a reminder slip (Appendix C) was mailed out to non-respondents.

Validation of the Instrument

For instruments used for evaluation, validity depends on whether a measure is accepted as valid by the appropriate stakeholders (Rossi & Freeman, 1993). Argyris and Schon (1991) report that the validity of action research depends on the definition of appropriate standards of rigor against which the success of the intervention can be assessed. They suggest instruments and interpretations should be checked with insiders, and a range of tools be used to capture the change process and its results.

The evaluation committee was involved by reviewing the questionnaire for face validity, clarity, completeness, and usefulness. The questionnaire was pilot tested prior to administration. An instructor trainer instructor not on the evaluation committee reviewed and completed the survey. The questionnaire was returned to the investigator with recommendations incorporated into the final draft. The final survey was presented to both the thesis committee and the ethics committee of the Faculty of Education before being sent out to participants.

Response Rate

The response rate for the ECCC members and instructor trainer questionnaire was 39% (40 surveys out of 102 were returned). All surveys returned were eligible for inclusion in the study. Questionnaires represented all 8 health regions in Manitoba and 1 health region in Ontario. Respondent's replies were categorized according to the area that they reside in. The breakdown of the return rate according to the health regions are reported in Table 1.

Table 1

Response rate according to health regions

Health region	N	Percent of Total Number
Interlake	1	2.5%
Central	3	7.5%
Westman	8	20%
Norman	2	5%
Parkland	5	12.5%
Eastman	3	7.5%
Thompson	0	0
Southern	17	42.5%
Ontario	1	2.5%
Total	40	100%

Table 1 indicates low frequencies in five health regions (Interlake, Central, Norman, Eastman, and Ontario), and no response in the Thompson health region. These regions will be under represented in the study results and it will make it difficult to evaluate these areas from the ECCP perspective.

The low return rates may be characteristic of the real-world setting of evaluations with multiple and frequently conflicting interests. If the respondents were concerned with the evaluation of the ECCP, they may have decided not to participate in the study. The context of evaluation must be recognized in two areas: the presence of multiple stakeholders and the reality that evaluation is usually a part of a political process (Rossi

& Freeman, 1993). Many of the respondents may have not understood the importance of program evaluation and may have felt there was a hidden agenda in doing the evaluation.

The question of what constitutes an adequate response rate has no definite answers. In surveys for the general public, response rates of approximately 60% for mailed questionnaires are frequently considered acceptable (Singleton, Straits, & Straits, 1993; Dillman 1978).

Analysis of Data

The data were analyzed for the each group of respondents in its entirety and for a number of subgroups (program objectives, resources, staff support, structure of the ECCC, importance of the ECCC, interagency relationships, and health regions). Descriptive procedures were used to analyze the data. Frequency distributions of categorical variables and mean scores were used to profile respondents.

CHAPTER 4

RESULTS

Findings

This chapter reports on the results of the ECCP evaluation. The ECCC consists of representatives from each organization involved in the training or delivering of CPR programs in Manitoba. The ECCP is responsible for maintaining 6 objectives. There were survey questions asked on each objective in order to capture the activities for which the ECCP is responsible.

Data results and the findings from the survey sent out to the ECCC members and instructor trainers will be presented under the 6 identified areas for evaluation (goals and objectives, resources, staff support, structure of ECCC, importance of ECCC to HSFM, and interagency relationships).

Forty questionnaires were returned (response rate of 39%). There were no questionnaires returned from respondents in the Thompson region. When any of the other eight regions are not represented in the data, it reflects that there were no responses from that region for that particular question.

Description of the ECCC Membership

Table 2 reports the length of time respondents have been a member of the ECCC and the instructor trainers who are not members of the ECCC.

TABLE 2

Length of time on ECCC (N = 18)

Time on Committee	Frequency	Percentage
1 to 5 years	8	44%
6 to 10 years	5	28%
More than 10 years	5	28%

Table 2 indicates 18 out of 40 respondents (58%) were ECCC members. Fifty-four percent of the ECCC members (18 surveys out of 33 ECCC members) returned questionnaires.

Table 3 identifies how long respondents have been instructor trainers.

TABLE 3

Length of time as an instructor trainer (N = 35)

Time as Instructor Trainer	Frequency	Percentage
1 to 5 years	12	34%
5 to 10 years	11	32%
More than 10 years	12	34%

Table 3 indicates that 88% of survey respondents were instructor trainers compared with 18% (5) who were ECCC members. The breakdown on length of time as an instructor trainer reveals an even distribution of time as an instructor trainer. The study results will be provided from instructor trainers who have had a long term association with the ECCC and from those who have been instructor trainers for less than five years.

Tables 2 and 3 show that some respondents did not answer the questions to identify whether they were ECCC members or instructor trainers. One reason may be that respondents did not want themselves identified as ECCC members or instructor trainers. Although the return rate for the study was 40 questionnaires, the number of responses (N) for each analysis will vary as certain respondents often chose not to complete various questions.

A) PROGRAM OBJECTIVES

OBJECTIVE 1

Monitor and maintain an active network of instructors and instructor trainers for basic life support in Manitoba.

Respondents were asked what was the main purpose of maintaining a network. Table 4 indicates 18 (50%) respondents reported the main purpose of maintaining a

network was for quality control. This was the most frequent answer identified by all health regions.

TABLE 4

Main purpose for maintaining a network of instructors and instructor trainers

Health Region	Quality Control Percentage	Educational Support	Public Awareness	Network Communication
Interlake	1 (3%)	-	-	-
Central	1 (3%)	-	-	-
Westman	3(8%)	2(5%)	2(5%)	-
Norman	1(3%)	-	-	-
Parkland	4(11%)	1(3%)	1(3)%	-
Eastman	1(3%)	-	-	1(3%)
Southern	7(19%)	3(8%)	5(13%)	4(11%)
Total N = 37	18(50%)	6(16%)	8(21%)	5(14%)

Since the number of respondents is small in some regions, the real picture on what instructor trainers reported as the main purpose of maintaining a network may be affected. For example, the Southern Region results reported on all four purposes. A concern may be that respondents saw purposes other than quality control as the main purpose.

When asked who was responsible for maintaining and monitoring the network of instructors and instructor trainers, 44% of respondents reported the ECCC is responsible (Table 5). However 35% responded the HSFM was responsible for maintaining and monitoring the network. Ultimately the HSFM is responsible but that has to be delegated to the Health Promotion Committee and in turn to the ECCC.

TABLE 5

Responsibility for maintaining and monitoring the network

Health Region	ECCC	HSFM	HSFM staff	Health Promotion Committee
Interlake	1(3%)	-	-	-
Central	1(3%)	-	-	-
Westman	3(10%)	4(13%)	-	-
Norman	-	1(3%)	-	-
Ontario	1(3%)	-	-	-
Parkland	2(6%)	1(3%)	-	1(3%)
Eastman	1(3%)	-	-	-
Southern	5(16%)	5(16%)	2(6%)	3(10%)
Total N = 31	14(44%)	11(35%)	2(6%)	4(13%)

Instructor Training

Forty-six percent of instructor trainers trained between 1 and 6 CPR instructors in one year as indicated in Table 6. Only the Southern region has instructor trainers who trained 21 to 60 CPR instructors in a 1 year period. Twenty percent of respondents did not train anyone in a 1 year period.

This information is significant as instructor trainer registration is given for a three year period provided that the HSFM policies and procedures are followed. One of the requirements includes teaching two courses per year, one of which is to be at the instructor or instructor trainer level and can be either a registration or reregistration course.

TABLE 6

Amount of new instructors trained in 1 year.

Health Region	None	1 to 6	7 to 20	21 to 60
Interlake	-	-	1(3%)	-
Central	-	3(9%)	-	-
Westman	-	3(9%)	4(11%)	-
Norman	-	1(3%)	1(3%)	-
Ontario	1(3%)	-	-	-
Parkland	2(6%)	2(6%)	-	-
Eastman	-	3(9%)	-	-
Southern	4(11%)	4(11%)	4(11%)	2(6%)
Total N = 35	7(20%)	16(46%)	10(29%)	2(6%)

Table 7 indicates most instructor trainers re-registered between 1 to 6 or 7 to 20 CPR instructors in 1 year. Many instructor trainers (37%) did not re-register any CPR instructors in a 1 year period.

TABLE 7

Number of instructors re-registered in 1 year

Health Region	None	1 to 6	7 to 20	21 to 60
Interlake	-	1(3%)	-	-
Central	2(6%)	-	1(3%)	-
Westman	3(9%)	3(9%)	1(3%)	-
Norman	1(3%)	-	1(3%)	-
Ontario	-	-	1(3%)	-
Parkland	2(6%)	1(3%)	1(3%)	-
Eastman	-	1(3%)	2(6%)	-
Southern	5(13%)	5(13%)	1(3%)	3(9%)
Total N = 35	13(37%)	11(31%)	8(24%)	3(9%)

Personal Costs

Thirty-three instructor trainers reported on personal costs incurred when re-registering CPR instructors. Twenty (70%) instructor trainers stated they did incur personal costs. Of these instructors, 5 (16%) identified monetary costs, 17 (53%) identified volunteer hours, 11 (34%) identified traveling expenses and 4 (13%) identified other costs.

Twenty-nine (83%) instructor trainers stated they did incur personal costs when re-registering themselves as an instructor trainer. Of these instructors, 20 (57%) identified monetary costs, 20 (57%) identified volunteer hours, 20 (57%) identified traveling expenses and 5 (14%) identified other costs. Other costs are identified as: photocopying expenses, telephone costs, postage, costs of topic presentations, and food expenses.

Training Fees

Instructor trainers reported on whether they charged CPR instructors a fee for their training (N = 35). Twenty-two (63%) responded "yes" compared to 13 (37%) who responded "no". No differences were noted across the health regions.

Network Size

Instructor trainers were asked how many CPR instructors belonged in their respective networks. Table 8 reports most instructor trainers have between 6 to 20 or 21 to 50 CPR instructors in their own network.

TABLE 8

Number of instructors in a network

Health Region	1 to 5	6 to 20	21 to 50	More than 50
Interlake	-	-	1(3%)	-
Central	-	2(6%)	1(3%)	-
Westman	-	-	1(3%)	5(14%)
Norman	1(3%)	1(3%)	-	-
Ontario	-	-	1(3%)	-
Parkland	-	4(11%)	-	-
Eastman	-	1(3%)	2(6%)	-
Southern	-	6(16%)	6(16%)	4(11%)
Total N = 36	1(3%)	14(39%)	12(34%)	9(25%)

Status Report for Instructor Trainers

A status report from the HSFM is sent out every six months to the instructor trainers. Twenty-three (70%) respondents identified the quality of the status report is "good to excellent:, 7 (21%) had no opinion, and 3 (6%) reported the report is "fair to poor". No differences were noted across the health regions.

When asked "What additional information should be included in the status report?", 11 (69%) of the of respondents (N = 16 for this question) reported never receiving one. Table 9 provides information on their responses according to health regions. Only five respondents suggested the status report should have additional information included: instructor trainer and CPR instructor information, report of courses taught, question and answer section, recertification location, and price increases.

TABLE 9

Information that should be included in HSFM status report

Health Region	Never received one	No additional information
Westman	3(19%)	2(13%)
Norman	2(13%)	-
Parkland	1(6%)	1(6%)
Southern	5(31%)	2(13%)
Total N = 16	11(69%)	5(32%)

Respondents were asked: "What information in the report, do you feel is not useful to you?" Two respondents stated all of the information is not useful, while one stated some of the information in the status report is inaccurate. Respondents also reported on preferred frequency of the status report: 27 (77%) identified every six months

(as it is now), three (9%) suggested more often, and five (14%) identified less frequently (N = 35).

CPR Newsletter

A CPR newsletter from the HSFM is sent out 3 to 4 times a year. Eighteen (47%) respondents stated the newsletter was excellent, 20 (51%) stated it was good, and one (3%) stated poor. All respondents identified the information was useful to the instructor trainers.

Twenty-six (77%) of the respondents reported a need to have additional information included in the newsletter. Comments on additional information for the newsletter include: more information is needed on new products and resources for CPR (4), information on teaching ideas and CPR standards clarification (3), information on cases where CPR has been used (2), a section devoted to Advanced Life Support, and reports from instructor trainers and instructors.

Network Communication

Respondents reported on the method they used to pass on information to the instructors in their own network (N =37). It is interesting to note that Table 3 reported there were 35 instructor trainers completing the survey while for this question, 37

respondents reported on network communication. This information may be interpreted in two ways: respondents may have not wanted to identify themselves as instructor trainers in Table 4, or there are respondents who are responsible for networks who are not instructor trainers.

Four categories were used: telephone, mail, in person, and other. Instructor trainers were asked to check all methods that applied to them. There were 76 responses which indicated that respondents used more than one method of communication to pass on information in their network. Table 10 presents information on communication methods used according to the health regions. No large differences were noted across the health regions. The most frequent method of communication is the "in person" method (40%) while telephone (28%) was next.

TABLE 10

Method of communication of instructor trainers to their network

Health Region	Telephone	Mail	In person	Other
Interlake	1(1%)	-	1(1%)	-
Central	2(3%)	1(1%)	3(4%)	-
Westman	3(4%)	2(3%)	5(7%)	3(4%)
Norman	1(1%)	1(1%)	-	-
Ontario	-	1(1%)	1(1%)	1(1%)
Parkland	3(4%)	-	5(7%)	3(4%)
Eastman	2(3%)	-	2(3%)	1(1%)
Southern	9(12%)	9(12%)	13(17%)	3(4%)
Total N = 37	21(28%)	14(18%)	30(40%)	11(14%)

Nine respondents identified specific information on the "other" method of communication within their network. Seven respondents stated information was passed on through meetings with their network and two identified they used memos to pass on information to their network.

On frequency of communication from respondents to CPR instructors, Table 11 provides the results according to the health regions. The majority (19)(57%) of

respondents communicate less often than every 3 months. No large differences were noted across the health regions.

TABLE 11

Frequency of communication to the instructors in the network

Health Region	Once a month	Once every 2 to 3 months	Less often
Interlake	-	1(3%)	-
Central	1(3%)	2(6%)	-
Westman	3(9%)	1(3%)	4(12%)
Ontario	-	1(3%)	-
Parkland	-	1(3%)	4(12%)
Eastman	-	1(3%)	1(3%)
Southern	1(3%)	2(6%)	10(30%)
Total N = 33	5(15%)	9(27%)	19(57%)

Objective 1 Effectiveness

Monitor and maintain an active network of instructors and instructor trainers for basic life support in Manitoba.

When asked if the current activities of the ECCP still reflect Objective 1, 30 (81%) respondents answered "yes" compared to seven (19%) who responded "no". Five respondents provided reasons on why the current activities of the ECCP did not reflect Objective 1. These reasons were:

-do not receive frequent information;

-no contact with ECCC;

-objective performed by instructor trainers and instructors and not by ECCC;

-there is no monitoring that is done; and

-need to increase the activities for instructor trainers and instructors to increase networking.

Seventy -three percent (27) of respondents reported revisions are not required for Objective 1 compared to 27% (10) who did report revisions are required (N =37). Five respondents commented that revisions of objectives and updates on policies should occur regularly.

OBJECTIVE 2

Be responsible for the training of instructors within a member's network.

Guidelines for Quality Management of Instructor Training

Respondents reported on awareness of guidelines for quality management of instructor training. Twenty -five (64%) respondents stated they were aware of guidelines compared to 14 (36 %) who stated they were not aware of any guidelines (N = 39).

Table 12 provides information on what the instructor trainers identified as guidelines for quality management of instructor training. The respondents identified four different areas for guidelines for quality training. Twelve (50%) respondents identified the policy manual as guidelines for quality management compared with 6 (25%) who reported the recertification program.

TABLE 12

Guidelines to ensure quality management of instructor training.

Health Region	Policy manual	HSFC standards	IT manuals	Recertification program
Westman	4(17%)	-	-	1(4%)
Norman	1(4%)	-	-	1(4%)
Ontario	1(4%)	-	-	-
Parkland	1(4%)	-	1(4%)	1(4%)
Eastman	-	2(8%)	-	-
Southern	5(21%)	1(4%)	2(8%)	3(13%)
Total N = 24	12(50%)	3(12%)	3(12%)	6(25%)

Objective 2 Effectiveness

Twenty-eight (76%) respondents indicated the activities of the ECCP still reflect Objective 2, while 9 (24%) did not (Southern, Parkland, Norman, and Westman) (N = 37). Seven respondents provided reasons on why the current activities of ECCC did not reflect Objective 2:

-there is no communication from ECCC (Westman, Southern, and Parkland);

-the responsibility falls only on instructor trainers and not on ECCC (3) (Southern and Central); and

-the guidelines are not followed (Norman).

When asked if Objective 2 required revision, 27 (71%) respondents reported revisions were not necessary, compared with 11 (29%) who reported revisions were necessary (Southern, Westman, Norman, and Parkland).

Reasons of why objective 2 required revisions include: 5 respondents stated the ECCC should take more responsibilities in enforcing HSFM policies (Southern, Parkland, and Norman), objective 2 requires revision on a regular basis (Southern), there is a need for specific expectations of instructors (Southern), and the objective should be dropped if it is not the ECCC's responsibility (Southern).

OBJECTIVE 3

Direct active and continuing programs of public education to achieve the aims of the ECCC.

Aims of ECCC

All respondents in the study answered the question whether the CPR programs were achieving the aims of the ECCP. Thirty-one (77%) respondents reported the aims

were being achieved, compared with 9 (23%) who thought they were not being achieved (Norman, Parkland, and Southern).

Comments on why the aims of the ECCC were not being achieved included:

-the focus is on skills only, not on prevention or lifestyles (3) (Southern and Westman);

-CPR program is not active enough in the community (2) (Westman and Parkland);

-information on stroke should be included (Southern);

-more support is needed for the networks in the province (Eastman);

-the links between networks and ECCC is weak and there is confusion on everyone's roles (Southern); and

-the new changes in CPR suggest that if defibrillation is not possible, then efforts of bystander are futile - should this impression be given (Parkland).

As indicated in Table 13, 12 (42.5%) respondents were unaware of how the aims of the ECCP were achieved. Eight (28.5%) respondents identified monitoring collected data, 3 (11%) identified evaluation, and 5 (18%) stated feedback from instructor trainers and CPR instructors were ways of achieving the aims of the ECCP.

TABLE 13

How the aims of ECCC are being achieved

Health Region	Monitor collected data	Evaluation	Feedback from IT and Inst.	Don't know
Interlake	-	-	-	1(3.5%)
Central	-	-	1(3.5%)	-
Westman	2(7%)	-	1(3.5%)	3(11%)
Norman	1(3.5%)	-	-	-
Ontario	1(3.5%)	-	-	-
Parkland	1(3.5%)	1(3.5%)	-	1(3.5%)
Eastman	-	1(3.5%)	-	1(3.5%)
Southern	3(11%)	1(3.5%)	3(11%)	6(21%)
Total N = 28	8(28.5%)	3(11%)	5(18%)	12(42.5%)

Guidelines for Quality Management of CPR Program Delivery

Twenty -one (60%) respondents were aware of guidelines for quality management of CPR program delivery compared with 14 (40%) who were not aware of any guidelines. Respondents identified four different sources of guidelines for quality management (Table 14).

TABLE 14

Guidelines for quality management of CPR program delivery program in Manitoba.

Health Region	HSFM standards	Policy manual	Skill performance	IT and Instructor manual
Interlake	-	-	-	1(5%)
Central	-	-	-	1(5%)
Westman	-	2(9%)	-	1(5%)
Norman	1(5%)	-	-	-
Ontario	-	1(5%)	-	-
Parkland	-	2(9%)	-	1(5%)
Southern	2(9%)	5(24%)	2(9%)	2(9%)
Total N = 21	3(14%)	10(47%)	2(9%)	6(29%)

Respondents were asked "Who is responsible for ensuring quality management of CPR program delivery in Manitoba?" Four different constituents were identified as being responsible for ensuring quality management of CPR program delivery in Manitoba with many (10) (37%) respondents reporting HSFM as being responsible (Table 15).

TABLE 15

Responsibility for ensuring quality management of CPR program delivery in Manitoba

Health Region	HSFM	ECCC	IT's and Inst.	ECCC staff person
Interlake	-	-	-	1(4%)
Central	-	1(4%)	2(7%)	-
Westman	2(7%)	-	1(4%)	-
Ontario	-	1(4%)	-	1(4%)
Parkland	2(7%)	-	1(4%)	-
Eastman	1(4%)	-	2(7%)	-
Southern	5(19%)	3(12%)	3(12%)	-
Total N = 26	10(37%)	5(20%)	9(34%)	2(8%)

Guidelines for measuring client satisfaction with CPR Programs.

Twelve (32%) respondents stated they were aware of guidelines for measuring client satisfaction with CPR programs compared with 26 (68%) who stated they were not aware of any guidelines in place. Nine respondents named the course evaluations used during CPR courses as the guidelines.

Respondents were asked "Who is responsible for measuring client satisfaction with CPR programs?" The respondents cited the same four areas responsible for both ensuring quality management of CPR program delivery in Manitoba (Table 15) and for measuring client satisfaction with CPR programs (Table 16). The main difference is in the latter instance, the majority (12) (60%) of respondents identified instructor trainers and CPR instructors as being responsible which is different from Table 15.

TABLE 16

Responsibility for measuring client satisfaction with the teaching of CPR programs

Health Region	HSFM	ECCC	IT's and Inst.	ECCC staff person
Westman	1(5%)	1(5%)	1(5%)	-
Norman	1(5%)	-	-	-
Parkland	1(5%)	-	2(10%)	-
Eastman	-	-	2(10%)	1(5%)
Southern	2(10%)	1(5%)	7(35%)	-
Total N = 20	5(25%)	2(10%)	12(60%)	1(5%)

Objective 3 Effectiveness

When asked about Objective 3, 25 (76%) respondents reported the activities of the ECCP do reflect Objective 3, while 8 (24%) did not. There were no responses when asked for explanations for their responses.

Twenty-four (73%) respondents indicated Objective 3 does not require revision, compared with 9 (27%) who do felt the objective required revision (Norman, Ontario, Parkland, and Southern). Explanations on a need for revisions include: three respondents stated more needs to be done locally (Parkland, Westman, and Norman), and three respondents suggested concise directions are required with continual revisions (Southern).

OBJECTIVE 4

Stimulate community involvement to achieve effective pre-hospital emergency medical services.

Community involvement

Respondents named four different activities performed to achieve Objective 4 (Table 17) with the majority (22) (65%) identifying teaching CPR as a main activity.

Another 18% reported public speaking for the HSFM. It would be helpful to know the content of the presentations and the target audience.

TABLE 17

Activities performed to achieve **pre-hospital** emergency services.

Health Region	Teach CPR	Public speaking for HSFM	Lobby for rural pre-hospital care	Nothing
Interlake	1(3%)	-	-	-
Central	1(3%)	-	-	1(3%)
Westman	4(12%)	1(3%)	2(6%)	1(3%)
Norman	1(3%)	-	-	-
Parkland	4(12%)	2(6%)	-	-
Eastman	1(3%)	-	2(6%)	-
Southern	10(29%)	3(9%)	-	-
Total N = 34	22(65%)	6(18%)	4(12%)	2(6%)

Respondents were asked, "to what degree did they feel the ECCC activities led to the achievement of effective pre-hospital emergency services?" Twenty-four respondents (62%) stated "very successful to successful", 10 (26%) stated they had no opinion, and 5 (13%) stated "unsuccessful to very unsuccessful". There appeared to be no differences among the different health regions.

Objective 4 Effectiveness

The majority (27) (77%) of respondents reported the activities of the ECCP still reflect Objective 4, compared with 8 (23%) who reported they did not (Central, Westman, Parkland, and Southern) (N =33). Respondents named three different reasons why current activities of the ECCP did not reflect Objective 4 (Table 18). While the number of respondents is small, 45% (5) called for more involvement from the ECCC.

TABLE 18

Reason the current activities of ECCC do not reflect Objective 4.

Health Regions	Need more involvement from ECCC	More support needed	Not aware of any activities
Central	-	-	1(9%)
Westman	2(18%)	1(9%)	-
Parkland	1(9%)	1(9%)	-
Eastman	-	-	1(9%)
Southern	2(18%)	1(9%)	1(9%)
Total N = 11	5(45%)	3(27%)	3(27%)

Twenty-four (73%) respondents reported Objective 4 does not require revision, compared with 9 (27%) respondents who reported revisions were required. Comments regarding revisions of Objective 4 include: there is a need for better standards and controls (Norman); the ECCC should be more committed and leave work to the networks (Southern); and the Health Promotion committee should become more involved in the activities of the ECCC (Southern).

OBJECTIVE 5

Maintain a data base for research purposes, rosters. - HSFM Data Base

A data base of information on instructor trainers, instructors, and CPR courses is maintained by the HSFM. Respondents provided information on how often they usually access the data base: 1 (3%) used the data base at least once a month, 6 (15%) used the data base once every 2-3 months, 12 (31%) used it less often, and 20 (51%) never used the data base. No differences were noted among the health regions.

Reasons for using the data base were provided by 18 respondents: 10 (26%) used the data base for re-registering instructors; 4 (10%) for communication with CPR instructors; and 4 (10%) for quality management. When asked how helpful the stored information is, 2 (5%) respondents stated it was "very helpful", 16 (41%) said "helpful", compared with 1 (3%) who stated "not helpful". No differences were noted among the health regions.

Most (20) (56%) respondents reported the amount of information stored should be decreased, 4 (11%) stated it should be increased, compared with 12 (33%) who reported it should stay the same. Respondents were asked to identify what additional information should be stored in the data base. Seven (20%) respondents reported more or other

information should be stored compared with 7 (20%) who stated no additional information was required. No differences were noted among the health regions.

Suggestions on what additional information should be stored in the data base include: two respondents requested information from individuals who had used CPR in the community; one respondent identified the current system was not user friendly and it was difficult to keep track of the mandatory two courses a year; one identified the information was not accurate; and one respondent requested to have research information included as stated in Objective 5.

Objective 5 Effectiveness

When asked if the activities of the ECCC reflected Objective 5, 27 (73%) respondents stated "yes", compared to 10 (27%) who stated "no" (Westman, Norman, Parkland, Eastman, and Southern). Comments on how the activities of the ECCC do not reflect the objective include: three respondents stated the data base was not accurate or current (Southern and Eastman); and three stated they were unaware of the data base (Westman, Norman, and Parkland).

Twenty-six (77%) respondents stated Objective 5 did not require revision, compared with 8 (23%) who reported revisions should occur (Central, Norman, Parkland, Eastman, and Southern). Comments on Objective 5 revisions include: three

respondents requested that information should be sent out on a yearly basis (Parkland); three asked to include statistics from Emergency Medical Services participation in the data base (Southern); and one requested improved record keeping (Eastman).

OBJECTIVE 6

To develop, implement and maintain a manual of policies and procedures.

CPR Program Policy and Procedure Manual

Respondents were asked how effective the policies in the manual are in meeting the needs of the ECCP. Six (15%) respondents reported "very effective", 28 (72%) stated "effective", compared with 5 (13%) who did not have an opinion. No one reported the manual was "ineffective" or "very ineffective". No differences were noted among health regions.

In responding to the question about adequacy of the scope of the policies, 5 (13%) respondents stated "excellent", 29 (74%) stated "good", while 5 (13%) had no opinion. No one reported the scope of the policies as "fair" or "poor". No differences were noted among the health regions.

Thirty-five subjects responded to the question asking if there should be additional policies included in the manual. The majority (27) (77%) of respondents indicated no additional policies should be included in the manual compared with 8 (23%) who reported a need to include more polices in the manual. Respondents provided six suggestions on additional information to include in the manual: continual updates; instructor standards; sexual and racial harassment information; health care directives; identification of training mannequins; and living wills information. Two respondents reported they have never seen the manual.

Objective 6 Effectiveness

Thirty-five (97%) respondents reported the activities of the ECCP still reflect Objective 6, compared with only 1 (3%) who identified they did not. Comments on the activities of this objective include:

-there is a problem with achieving this objective due to lack of support from the HSFM board;

-there are two versions of the policy and procedure manual. The network head has one that contains the objectives while the instructor manual does not. Everyone should have the manual with the objectives;

-the Health Promotion committee has not provided us with their objectives to refer to, nor allowed us adequate input into their strategic planning; and

-an instructor's manual should be developed.

Only 2 (6%) respondents stated Objective 6 required revision (N = 35). Comments on objective revision include: revisions should occur on a continual basis and revisions should occur in the area of quality control. When asked if there were any unstated objectives being achieved by the ECCC, 21 (78%) respondents reported there were none, compared with 6 (22 %) who identified there were unstated objectives. Three respondents stated "promoting the HSFM" was an unstated objective.

B) RESOURCES

This section refers to the resources provided by the HSFM to the ECCC.

Volunteer time

Respondents provided varied responses to the question on how much time do you usually spend in a month doing ECCC or network activities. Twenty -one (62%) respondents reported spending 1 to 5 hours, 5 (15%) reported spending 6 to 10 hours, 7 (21%) reported spending 11 to 15 hours, while 1 (3%) reported spending 16 or more hours. No differences were noted among the health regions.

Staff time

With regard to staff time, 16 (44%) respondents identified the amount of HSFM staff time provided for the ECCP was "very adequate to adequate", 10 (28%) had no opinion, while 10 (28%) reported the amount of staff time was "inadequate to very inadequate". No differences were noted among the health regions.

Resources

When asked about the amount of resources provided to the ECCP from HSFM, 18 (50%) respondents stated the amount of resources was "very adequate to adequate", 7 (19%) had no opinion, compared with 11 (31%) who stated the resources were "inadequate to very inadequate". Comments on inadequate resources include:

-six respondents reported a need for more support and for more resources;

only contact is through the newsletter and the HSFM staff person;

-know very little about the ECCC and have been teaching for five years;

-work load for two staff people is too much and there is little support from the board of directors;

-the instructor course packages are frequently incomplete; and

-there is not enough emphasis on the northern and remote areas.

Resource Utilization

Most respondents (18) (58%) stated changes were not needed in resource utilization compared to 13 (42%) who reported they would like to see changes in resource utilization. Comments on changes in resource utilization include: a need for more staff and more personal contact from the HSFM (4); there should be an increase in funds (3); the Health Promotion Director has too many responsibilities and does not adequately support all of the programs (3); and there should be easier access to personnel through a toll free number for rural groups.

Types of Materials

Five categories were used to describe the types of materials the HSFM provides to respondents: pamphlets, course materials, videos, administrative paperwork, and other. Since respondents were asked to identify all the types of materials that were provided to them, 118 responses were provided (N = 36). Tables 19 and 20 report on the types of materials provided according to the health regions. Respondents did not comment on the "other" type of materials provided by the HSFM.

TABLE 19

Types of materials provided by the HSFM.

Health Region	Pamphlets	Course materials	Videos	Admini. paperwork	Other
Interlake	1(3%)	1(3%)	1(3%)	1(3%)	1(3%)
Central	3(8%)	3(8%)	3(8%)	1(3%)	-
Westman	5(14%)	6(17%)	6(17%)	5(14%)	1(3%)
Ontario	1(3%)	1(3%)	-	1(3%)	-
Parkland	4(11%)	3(8%)	3(8%)	2(6%)	-
Eastman	3(8%)	3(8%)	3(8%)	3(8%)	-
Southern	13(36%)	14(39%)	13(36%)	13(36%)	-
Total N = 36	30(83%)	31(81%)	29(72%)	26(70%)	2(6%)

Table 19 demonstrates that four different types of materials were consistently provided by the HSFM to the respondents with pamphlets (83%) and course materials (81%) being used most often.

TABLE 20

Perceived adequacy of materials received for the maintenance of ECCC

Health Region	Yes	No
Interlake	1(3%)	-
Central	3(8%)	-
Westman	6(17%)	1(3%)
Norman	-	1(3%)
Ontario	-	1(3%)
Parkland	4(11%)	1(3%)
Eastman	1(3%)	2(6%)
Southern	11(31%)	4(11%)
Total N = 36	26(73%)	10(29%)

The majority (26) (73%) of respondents reported adequate materials were received from the HSFM for the maintenance of the ECCP (Table 20). Although the numbers are small, 10 respondents from six different health regions stated they received inadequate materials for the maintenance of the ECCP.

Six comments were given by respondents regarding inadequate materials received for the maintenance of the ECCC: did not receive any material (2); a need for more

frequent updates (2); remote areas are not informed of new materials; and videos appear to be in short supply with mannequins not easily loaned.

Difficulties in Obtaining Materials

Twenty-eight (78%) respondents reported no difficulty in obtaining materials for the maintenance of the ECCP compared with 8 (22%) who reported having difficulty. Comments on difficulty in obtaining materials include: supplies are frequently not in stock (2); there are often missing pages in the materials; and HSFM should pay for delivery and postage of materials.

Additional comments on resources

Four respondents took the opportunity to provide additional comments on resources. They reported: there is a need for the ECCC coordinator to access more areas for research and quality monitoring; more modern resources are needed; one respondent disliked not being able to drop in and pick up materials; and a list of new materials would be helpful.

C) STAFF SUPPORT

Respondents were asked if the type of staff support provided to the ECCP by the HSFM was adequate (Table 21). There were no responses from the Norman health region.

TABLE 21

Adequacy on the type of staff support provided to ECCP by the HSFM

Health Region	Yes	No
Interlake	1(3%)	-
Central	2(5%)	1(3%)
Westman	7(18%)	1(3%)
Ontario	1(3%)	-
Parkland	4(11%)	1(3%)
Eastman	3(8%)	-
Southern	12(32%)	5(13%)
Total N = 38	30(80%)	8(21%)

Thirty (80%) respondents reported the type of staff support provided to the ECCP by the HSFM was adequate. Six respondents commented on why the type of staff support was not adequate: more staff are required to distribute the materials (4); Health

Promotion chairperson wants to abolish the ECCC; and there is no support from the Health Promotion chairperson.

Table 22 provides information on the amount of staff support provided to the ECCP. There were no responses from the Norman or the Ontario region.

TABLE 22

Adequacy on the amount of staff support provided to ECCP by the HSFM

Health Region	Yes	No
Interlake	1(3%)	-
Central	3(9%)	-
Westman	5(16%)	1(3%)
Parkland	3(9%)	2(6%)
Eastman	2(6%0	-
Southern	8(24%)	8(24%)
Total N = 33	22(67%)	11(33%)

A lower majority (67%) of respondents reported the amount of staff support provided to the ECCP by the HSFM was adequate in comparison with 80% percent of respondents who reported the type of support was adequate. Only two comments on

inadequacy of amount of staff support were included: there is inadequate clerical support; and the ECCC staff person is overworked.

The majority (29) (76%) of respondents identified no difficulty with making contact with the HSFM staff compared with 9 (24%) who stated there was difficulty (Parkland and Southern regions) (N = 38). Comments on contact with the HSFM staff include: three respondents identified it was difficult to contact staff by phone (Southern and Parkland), while another two identified it has become more difficult to make contact with staff over the past few years (Southern and Parkland).

Hours of operation

Thirty (86%) respondents reported the HSFM hours of operation were flexible enough to meet their needs compared to 5 (14%) who reported the hours were not flexible enough (Eastman and Southern). Comments on hours of operation identified the HSFM was not open early enough or late enough to accommodate work schedules. There were no responses from the Norman region.

Staff communication

Twenty-eight (90%) respondents stated the communication between the HSFM staff and the ECCC was effective, while 3 (9%) stated communication was not effective

(Westman and Southern). Two respondents commented that communication with the Director of Health Promotion was difficult. There were no responses from Norman and Ontario health regions.

Twenty-one (75%) respondents reported the amount of communication between the ECCC and the Health Promotion committee was effective compared with 7 (25%) who identified the amount of communication was not effective (Central, Westman, and Southern). Comments provided on the communication between the two areas include: two respondents said there was a need for increased program sharing and support; two respondents said the Health Promotion committee treats the ECCC unfairly; and the HSFM staff person was the only one from the Health Promotion committee to attend the ECCC meetings.

Six respondents provided comments on changes they would like to see in communication patterns between the ECCC and the HSFM. Four respondents suggested there should be more contact initiated by the HSFM staff, one identified more input is needed from the HSFM Board of Directors and not from the Director of Health Promotion, and another respondent identified a need for more visits from the ECCC staff person for updates and support.

Additional comments regarding staff support include: three respondents reported the Brandon HSFM staff support was superb; a need for more staff as present staff

members are spread too thin; more support from the Health Promotion director and the HSFM board is required; to provide support for one additional support person that should be independent of the Health Promotion Director; and the ECCC staff person provides a lot of support.

D) STRUCTURE OF ECCC COMMITTEE

When asked if the structure of the ECCC committee with the network system is an efficient way to fulfill the objectives of the ECCP, 28 (88%) stated "yes", and 4 (12%) stated "no" (N =32). Comments on changes required to the structure of the ECCC include: more rural support is needed; the networks should have two representatives or a back up person; ECCC is too large; and hospitals could be represented by only one person.

Table 23 provides information on communication of the network system.

TABLE 23

Effectiveness of communication between the ECCC members and \or instructor trainers and their network of instructors

Health Region	Yes	No
Interlake	1(3%)	-
Central	3(9%)	-
Westman	3(9%)	5(15%)
Norman	-	1(3%)
Parkland	3(9%)	2(6%)
Eastman	2(6%0	1(3%)
Southern	8(24%)	5(15%)
Total N = 34	20(60%)	14(41%)

Fourteen (41%) respondents from five different health regions reported the communication between the ECCC members and /or instructor trainers and their network of instructors was ineffective compared with 20 (60%) who stated the communication was effective. Thirteen respondents provided explanations on why the network communication was not effective: eleven stated network communication was inadequate (Westman, Norman, Parkland, Eastman, and Southern); and two stated they do not belong to any network (Southern).

Table 24 presents information on the ECCC representation in Manitoba.

TABLE 24

Adequacy of representation on the ECCC that includes all areas of Manitoba

Health Region	Yes	No
Interlake	1(3%)	-
Central	2(6%)	1(3%)
Westman	2(6%)	4(13%)
Norman	-	1(3%)
Parkland	3(10%)	2(6%)
Eastman	1(3%)	2(6%)
Southern	8(26%)	4(13%)
Total N = 31	17(54%)	14(44%)

Seventeen respondents indicated that representation on the ECCC is adequate for all areas of Manitoba. The 14 respondents who reported representation for Manitoba was not adequate represented six different health regions. Twelve respondents explained why the representation in Manitoba was not adequate: eight stated more representation is needed outside of Winnipeg (Parkland, Southern, and Westman); two stated their area has no representation on the ECCC (Eastman); one stated the ECCC is over represented (Westman); and one reported that not enough members attend meetings (Southern).

When asked if any areas of representation should be excluded, 27 (93%) respondents identified there were no areas that should be excluded compared with 2 (7%) who stated there were areas that should be excluded (N = 29). Comments include: private business should be excluded; someone could belong to Red Cross, RCSSC, Ski Patrol, and Westman; and there were concerns with the logic of representation of the ECCC members.

When asked about the size of the ECCC (the number of members), 25 (78%) respondents reported it was adequate, 4 (12%) stated it was too large, and 3 (10%) stated it was too small. No differences were noted across the health regions.

ECCC standing sub-committees

The three standing sub-committees of the ECCC are:

1. Teaching
2. Infant & Child
3. Seminar\conference

The majority of respondents (30) (97%) stated the activities of the **Teaching Committee** do reflect the current objectives of the ECCP compared with 1 (3%) respondent who stated "no" (N = 31). No differences were noted across the health regions.

The same question was asked on the activities of the **Infant and Child Committee**. Thirty (94%) respondents reported the activities reflected the objectives of the ECCP, while 2 (6%) reported they did not. Comments from the Southern region include: they just keep changing slides; and they include information that is not reflective of the objectives of the ECCP.

With the **Seminar\Conference Committee**, 28 (93%) respondents reported the committee's activities reflected the objectives of the ECCP, while 2 (7%) did not. One respondent identified more inservices were required (Southern).

Seven respondents took the opportunity to provide comments on the structure of the ECCC or the three standing committees:

-there is a need to thank people who sit on the committees (Interlake);

-more advance notice of upcoming seminars & conferences are needed to enable rural people to plan to attend (Parkland);

-some of the areas could be covered conjointly between the committees (Southern);

-the structure is good compared to other provinces (Southern);

-more staff time should be spent on the maintenance of programs (Southern);

-would like to see more instructor trainer's and CPR instructors outside the perimeter of Winnipeg (Westman); and

-1 person identified he/she had volunteered to participate on a specific committee but was not included and he/she felt his/her their input would be relevant due to pediatric background (Southern).

E) IMPORTANCE OF ECCC TO THE HSFM

When asked how valuable is the service that the ECCC provides to the HSFM, 25 (75%) respondents responded "very valuable", 7 (20%) responded "of some value", and 2 (5%) had "no opinion".

Table 25 reports on the most important activities the ECCC conducts for the HSFM.

TABLE 25

Most important activity the ECCC conducts for the HSFM

Health Region	Deliver message to public	Maintain high standards	Contact with network	Identify public educational needs
Interlake	-	-	-	1(4%)
Central	1(4%)	-	1(4%)	-
Westman	4(15%)	1(4%)	-	-
Norman	1(4%)	-	-	-
Parkland	-	1(4%)	-	1(4%)
Eastman	1(4%)	1(4%)	-	-
Southern	8(31%)	2(8%)	2(8%)	1(4%)
Total N = 26	15(55%)	5(20%)	3(12%)	3(12%)

Respondents identified four different activities which the ECCC conducts for the HSFM. Fifteen respondents stated that delivering message to the public was the most important activity the ECCC conducts for the HSFM while five respondents stated maintaining high standards.

Twenty-three (70%) respondents stated the HSFM was aware of the ECCC's activities and achievements, while 10 (30%) reported the HSFM was not aware

(Southern, Westman, Central, and Parkland). Several comments were provided on why the HSFM was not aware of the activities and achievements of the ECCC: four identified there was no evidence that the HSFM was aware of the activities of the ECCC (Southern and Parkland); two reported there appears to be no interest from the top level of the HSFM (Southern); and another stated the Director of Health Promotion is unsupportive (Southern).

When asked for suggestions on how the HSFM could adequately recognize the work of the ECCC volunteers, 12 (44%) respondents reported they had suggestions compared with 15 (56%) who had no suggestions. Suggestions include:

-HSFM could show more interest in the work of the ECCC volunteers (Norman and Central); -information could be passed on in the newsletter "FYI" (Southern);

-a "Volunteer of the Year" award (Eastman);

-HSFM could recognize an individual by writing a synopsis about their achievements in newsletter (Southern and Eastman);

-the Winnipeg ECCC thinks that intelligent life ends at the perimeter and should be less condescending. They also added that they did not need anymore certificates (Westman);

-an award banquet hosted by the board would demonstrate how the HSFM value the ECCC volunteers (Southern);

-there is a need for better allocation of staff resources. The coordination of advertising should not conflict with other programs. They also added that training staff in CPR should be mandatory (Southern);

-a member of the ECCC should sit on the board of the HSFM (Southern); and

-a plaque should be used with names engraved on it of the ECCC volunteers (Parkland).

Six respondents took the opportunity to express their views or concerns on the importance of the ECCC to the HSFM. Comments include:

-have concerns for the way volunteers are treated by the HSFM and this reflects comments received from instructors who volunteer for community events (Southern);

-HSFM has a wealth of volunteers through CPR which could also be effective fund-raisers and also be effective public relations for other programs (Southern);

-there has been a constant failure of the HSFM to recognize the ECCC volunteers (Southern);

-ECCC volunteers should keep up the good work (Interlake);

-there is a concern on the length of time some members of the ECCC have served with some on the ECCC for 20 years. Anyone who has been on a committee for "a fixed" number of years, should be encouraged to do a self-evaluation of their contribution (Westman); and

-if the ECCC were to disband the HSFM will lose a large network of people who present HSFM directly to the public (Central).

F) INTER-AGENCY RELATIONSHIPS

When asked how they felt about the working relationship with all of the agencies that the ECCC is involved with, 21 (64%) respondents identified "very satisfactory" to "satisfactory", 9 (27%) had "no opinion", while 3 (9%) reported the working relationship was "unsatisfactory" (Westman and Southern). Two respondents stated there should be better communication and defined lines as to who is in each network (Westman).

Table 26 describes the benefits of working with other agencies. Respondents identified three benefits of having good relationships with other agencies. Fifteen respondents reporting that improved public relations and information was the benefit to having a good relationship with other agencies, while 10 respondents reported the benefit was agencies teaching the HSFM standards.

TABLE 26

Benefits of the ECCC having good relationships with other agencies

Health Region	Improved public relations and information	Achieving common goal	Agencies teaching HSFM standards
Interlake	1(3%)	-	-
Central	-	-	1(3%)
Westman	3(9%)	2(6%)	3(9%)
Norman	-	-	1(3%)
Parkland	1(3%)	1(3%)	1(3%)
Eastman	1(3%)	1(3%)	1(3%)
Southern	9(27%)	4(12%)	3(9%)
Total N = 33	15(45%)	8(24%)	10(30%)

When asked if there are any disadvantages with the ECCC having good relationships with other agencies, 26 (81%) respondents reported there were no disadvantages, while 6 (19%) identified there were disadvantages. Explanations on the disadvantages include: it takes longer to implement change (Southern); from a national perspective too much control is given to national training agencies (Southern); the more hands it flows through, the more diluted it becomes; and are we interested in numbers or quality of training? (Norman).

When asked if there are agencies that should not be included in the ECCC, 19 (58%) respondents identified they did not know, 13 (40%) responded "no", and 1 (3%) responded "yes".

When asked if there were any agencies who should be invited to join the ECCC, 14 (78%) respondents responded "no", compared with 4 (22%) who responded "yes". Comments included: industry should be invited to join the ECCC (Norman); the city police, RCMP, and Winnipeg. ambulance should join the ECCC (Southern); and there is a need for better regional representation (Southern).

Respondents provided a variety of responses to the question asking which agency(ies) provide the most support to the ECCC (N = 10). Four respondents (40%) stated the HSFM provides the most support to the ECCC (Southern, Parkland, and Westman), 2 (20%) identified the hospitals as providing the most support (Southern and Westman), 3 (30%) identified all agencies provide support to the ECCC (Southern and Interlake), and 1 (10%) reported St. John's and the Red Cross provide the most support to the ECCC (Westman)

Respondents were asked to rate the effectiveness of the communication between the ECCC and the various agencies. Table 27 describes the level of perceived effectiveness of the communication between the ECCC and the various agencies.

TABLE 27

Effectiveness of the communication between the various agencies and the ECCC

Health region	Very satisfactory	Satisfactory	No opinion	Unsatisfactory	Very unsatisfactory
Interlake	-	1(3%)	-	-	-
Central	1(3%)	1(3%)	-	-	-
Westman	-	2(7%)	3(10%)	-	2(7%)
Norman	-	-	1(3%)	-	-
Parkland	-	1(3%)	2(7%)	-	-
Eastman	-	1(3%)	1(3%)	-	-
Southern	1(3%)	6(20%)	4(13%)	3(10%)	-
Total N = 30	2(6%)	12(39%)	11(36%)	3(10%)	2(7%)

Twelve (39%) respondents stated the communication between the various agencies and the ECCC was satisfactory compared with 11 (36%) respondents who had no opinion.

Four suggestions were provided for improving the communication patterns between the agencies and the ECCC: there is a need for guidelines for supporting each agency (Westman); often information is one way from the HSFM to the agency but not

from the agency back to the HSFM (Southern); there is a need to let people know what the upcoming events or activities are before they occur (Westman); and telephone networking should be included and improved (Southern).

Agency members were asked what the important benefits to their agency were in being a member of the ECCC. Thirteen respondents identified the benefit of receiving information and updates on activities (Southern, Westman, Interlake, Parkland, and Eastman). Two respondents reported that networking between agencies was the benefit to an agency being a member of ECCC (Southern).

Agency members were asked if they had any concerns with belonging to the ECCC. Fourteen (93%) agency members did not have any concerns compared with 1 (7%) who identified concerns (Southern). No explanation was provided regarding the concerns of belonging to the ECCC.

Four respondents provided additional comments on inter-agency relationships: outside of Winnipeg agencies are unclear or not as involved as urban agencies (Parkland); survival of CPR provincially depends on inter-agency cooperation (Southern); belonging to the ECCC is an important aspect of developing inter-agency relationships (Southern); and in our province there has been a great deal of cooperation among agencies but everyone will agree that it is very difficult when agencies have conflicting mandates (Southern).

The analyses of this study were based on 40 respondents which were instructor trainers and ECCC members. The findings from the six identified areas for evaluation have been presented. The next chapter will present the results of the evaluation of the ECCP.

CHAPTER 5
DISCUSSION

Introduction

This chapter will discuss the results of the evaluation of the ECCP. This study evaluated the ECCC members and instructor trainers' perception and ability to meet each objective in addition to maintaining the network. The implications of the study will be discussed under the following headings: 1) discussion of findings, 2) program recommendations, and 3) conclusions.

Discussion of findings

The purpose of this study was to conduct an evaluation of the activities of the ECCC of the HSFM. The study was organized to evaluate six areas of the ECCC program: a) program objectives, b) resources, c) staff support, d) structure of the ECCC, e) importance of the ECCC, and f) inter-agency relationships. A discussion of the findings will be provided in each area.

A) Program Objectives

Objective 1 - Monitor and maintain an active network of instructors and instructor trainers for basic life support in Manitoba.

Four different purposes were identified by respondents for maintaining a network of instructors and instructor trainers. Additionally, four different areas were also reported as being responsible for maintaining and monitoring the network. These

findings indicate: perhaps more communication efforts are required in this area, the respondents have difficulty in knowing the purpose and who is responsible for maintaining and monitoring the network or there may not be clear guidelines for these areas.

The policy and procedures manual does not clarify the purpose of maintaining a network of instructors and instructor trainers. The duties and responsibilities of the ECCC member job description does include to monitor and maintain an active network of instructors and instructor trainers for basic cardiac life support (CPR Program Policy and Procedures Manual, 1994). No clear direction is provided on how to achieve this objective.

With instructor training, the majority (81%) of respondents trained different numbers of CPR instructors in one year compared with 19% who did not train CPR instructors in a one year period. Instructor trainers have guidelines to follow on how many courses they need to teach to ensure their registration remains current. The findings highlight that the ECCC does not have procedures or structure in place to ensure instructor trainers are teaching their required number of courses per year and to determine if the number of current CPR instructors is effectively meeting the needs for basic life support training in Manitoba.

Many respondents did incur personal costs as a result of performing their duties as instructor trainers for the HSFM (re-registering themselves and CPR instructors). In the area of training fees, 22 respondents reported they charged CPR instructors a fee for their training. This study did not provide information on the amount and the purpose of the fee. This may be an area for further exploration to ensure a consistent or standard practice for CPR instructor training fees across Manitoba.

The size of the networks varies greatly among respondents and regions. However, the health regions with larger populations (Southern, and Westman) had network sizes of more than 50 CPR instructors. The result draws to attention there are no guidelines or recommendations for respondents on network size with consideration given to population of the different health regions. These results raise the issue of an instructor trainer to effectively communicate with and provide adequate support to all of the members in a large network.

Although the majority of respondents were satisfied with quality of the status report, there were eleven respondents who reported not receiving the status report. The accuracy of mailing lists for the respondents requires scrutiny to ensure that all respondents do receive the status report on a regular basis.

For network communication, respondents employed more than one method of communication to pass on information in their network with the "in person" method being used most often by respondents. Fifty-seven percent of respondents pass on information at intervals of three months or longer. There are no guidelines on network communication frequency for the respondents. The findings indicate infrequent network communication is occurring throughout Manitoba. Developing guidelines on frequency of communication with CPR instructors may be helpful to promote effective communication within the networks.

An interesting finding of this study is the respondents' viewpoint on Objective 1. Eighty-one percent of respondents reported the current activities of the ECCP still reflect Objective 1. However, the findings indicate that respondents are not consistent in

identifying activities of ECCC that monitor and maintain the network of instructors and instructor trainers.

Objective 2 - Be responsible for the training of instructors within a members network. Guidelines for Quality of Management of Instructor Training

More than one-third of respondents were not aware of any guidelines for quality management of instructor training. Respondents who were aware of guidelines, identified four different types of guidelines. These findings indicate a need for the ECCC to clarify and communicate the guidelines for quality management to the instructor trainers.

Over three-quarters of the respondents indicated the activities of the ECCP still reflect Objective 2. The explanations on the ineffectiveness of this objective included: a lack of communication from the ECCC, responsibility falling only on the instructor trainers, and guidelines not being followed. A possible issue related to the study results of this objective is to consider whether the ECCP has the structure and capability to monitor the training of CPR instructors in a network system including the quality management of the training.

Objective 3 - Direct active and continuing programs of public education to achieve the aims of the ECCC.

Most (77%) respondents reported CPR programs were achieving the aims of the ECCC. Less than half (42.5%) of respondents were unaware how the ECCC determines CPR programs are achieving the aims of the ECCP. The remainder of respondents

identified three different methods on how the aims of the ECCP were being achieved. These conflicting results illustrate or draw attention to the confusion and inconsistency on respondents' perceptions and activities with the ECCP. It may be helpful to obtain more information on the aims and their related activities.

Although 61% of the respondents stated they were aware of guidelines for quality management of CPR programs, they identified four different guidelines. Consequently, it is not surprising to find that they also have four different opinions on who is responsible for ensuring quality management of CPR program delivery. A possible explanation for this finding may be lack of clear direction and communication from the ECCC to respondents.

Most respondents (68%) were not aware of guidelines for measuring client satisfaction with CPR programs. The course evaluations used during CPR courses were identified as the mechanism for measuring client satisfaction by only nine respondents. It is interesting to note that the course evaluation is the mechanism for measuring client satisfaction. Consistently, the respondents reported four different constituents responsible for measuring client satisfaction. The literature on evaluation indicates a need for information on the extent and ways program elements are delivered. Otherwise there is no way to determine which activities were effective in implementing the program (Rossi & Freeman, 1993). In order for a program to be effective and meet the needs of the participant, the people responsible of implementing a program need to be aware of the mechanism for measuring client satisfaction.

Most respondents (76%) indicated the activities of the ECCP reflected Objective 3 and the majority (73%) indicated it did not require revision. Contrary to these results, major areas of objective 3 do require further inquiry and clarification by the ECCC.

Many respondents were unsure how the aims of the ECCP were being achieved, and identified four different guidelines for quality management of CPR programs.

Objective 4 - Stimulate community involvement to achieve effective pre-hospital emergency medical services

Sixty-five percent of respondents reported teaching CPR was the activity they performed to achieve Objective 4. Most (62%) respondents reported the ECCP activities were successful in leading to the achievement of effective pre-hospital emergency services. There was no clear definition for pre-hospital emergency services or information on what the activities were that will achieve pre-hospital emergency services. The study findings illustrate there are many activities which respondents are performing for pre-hospital emergency services with no mechanism to measure their effectiveness.

The majority of respondents indicated the activities of the ECCP still reflect Objective 4 and it did not require revision. The findings from this objective verify a necessity for the ECCC to clarify their role in pre-hospital emergency care.

Objective 5 - Maintain a data base for research purposes, rosters - HSFM data base.

Over half (51%) the respondents did not use the data base and the ones that did, usually access it only once every 2-3 months. The most often reported reason for using the data base was for re-registering instructors.

The majority (73%) of respondents indicated the activities of the ECCP reflect Objective 5 and 77% reported that no revision was required to this objective. Three

respondents reported the data base was not accurate or current and three respondents suggested the information should be sent out on a yearly basis. Interestingly, the wording of objective 5 does require revision for two reasons: 1) there is no data bases kept on research, and 2) the ECCC does not maintain the data base; HSFM staff maintains the data base and responds to queries from respondents. These findings may suggest respondents are not aware of the role the HSFM plays in supporting their network information. Accuracy and content of data base information should be reviewed to determine the most efficient method to maintain the data base.

Objective 6 - To develop, implement, and maintain a manual of policies and procedures.

The majority (87%) of respondents identified the CPR Program Policy and Procedure Manual to be effective in meeting the needs of the ECCP and the scope of the policies were also considered to be complete. Only 23% of the respondents reported additional policies should be included in the manual. This information contradicts some of the earlier findings whereby respondents have different perceptions on guidelines and policies for CPR in Manitoba. The manual requires revision to include specific information on CPR in Manitoba with clear direction on how the ECCP objectives are to be achieved.

The majority of respondents indicated the activities of the ECCP reflect Objective 6 and it did not require revision. Overall findings of all the objectives indicates a need for the ECCC to review all the objectives to ensure they are clearly stated and measurable for respondents and their networks. The need to redefine objectives often becomes evident after a program is evaluated. The primary purpose of formative evaluation is to create more successful programs by providing evaluation feedback on

program design, implementation and outcomes, depending on the situation (Dehar, Casswell, & Duignan, 1993). These study findings may be considered as an opportune and positive time to refine the program model, objectives, and activities.

B) Resources

Volunteer time and staff time

Over one-half (62%) of respondents reported spending 1 to 5 hours a month doing ECCP or network activities. Only 28% of respondents reported the amount of HSFM staff time provided to the ECCP was inadequate. These findings demonstrate most respondents volunteer a significant amount of time for the ECCP or for network activities.

Resources and resource utilization

Over one-half of the respondents reported the amount of resources provided to the ECCP by the HSFM was adequate. Comments on inadequate resources included: need more support and resources, need more contact with the HSFM, need increased staff time, and resources were often incomplete. Less than one-half of instructor trainers (42%) stated changes were needed for resource utilization in the area of funding, staff support, and access for rural members. The findings appear to indicate a need to explore how resources may be utilized in a more efficient manner for both the HSFM and the respondents.

Types of materials

The respondents identified four types of materials which HSFM provided to them More than one-quarter (28%) of respondents reported they were not receiving all the required materials for the maintenance of the ECCP. Comments on inadequate materials included: no materials received, require more updates on new materials, videos in short supply, and difficulty with accessing mannequins. The results may indicate material accessibility and availability are issues for further exploration by both the HSFM and the ECCC.

C) Staff support

The type of staff support, the amount of staff support, and making contact with staff have been identified by the respondents as adequate. It is important to continue to provide good staff support to the ECCC in a cost-effective manner.

Hours of operation

The hours of operation are flexible to meet the demands of the instructor trainer as identified by over three quarters of respondents. Five respondents commented that the HSFM was not open early or late enough to accommodate their work schedule. Possible alternatives to accommodate respondents who reported difficulties with the hours of operation may require consideration. For example, the HSFM could stay open late one designated day a month to allow easier access or one evening a week.

Staff communication

The findings indicate the communications between the HSFM staff and the ECCC, and the ECCC and the Health Promotion Committee were effective. The concerns identified centre around the perception that the HSFM board and Health Promotion Committee do not take an active interest in the ECCC. Both areas are not communicating effectively to the respondents. The results appear to reflect an ongoing communication problem throughout the network.

D) Structure of ECCC

The majority of respondents indicated the structure of the ECCP with the network system was an efficient way to fulfill the objectives of the ECCP. Only 60% of respondents reported communication between the ECCC members and their network of instructors was effective. Eleven respondents stated the network communication was inadequate. Repeatedly, the study findings indicate the ECCC members and respondents were not communicating adequately with their networks of instructors.

Almost one-half (45%) of respondents indicated there was not adequate representation on the ECCC which includes all areas of Manitoba. More rural representation was identified as a key need for adequate representation. Again, the findings emulate a recurrent theme for a need to improve and enhance rural participation with the ECCC.

ECCC standing committees

Overall for each ECCC standing committee, the majority (over 92%) of respondents reported the activities of each committee reflect the current objectives of the ECCC. Rural respondents requested more advance notice of events and opportunity to participate on committees.

E) Importance of ECCC

Most (95%) respondents reported the ECCC was providing a valuable service to the HSFM and identified four different areas as the single most important thing which the ECCC does for the HSFM. Only 30% of respondents responded the HSFM was not aware of the ECCC's activities and achievements.

The respondents have four different opinions on how they are providing a valuable service to the HSFM. These findings may be interpreted as lack of information or communication provided from the ECCC to respondents on their roles within the CPR network. From another perspective, the HSFM, does not appear to have sufficient visibility within the ECCC and its network members.

F) Inter-agency relationships

Over one-half (64%) of respondents indicated the working relationship with all of the agencies associated with the ECCC was satisfactory. The communication between the agencies and the ECCC was reported as satisfactory. Agency members reported receiving information and networking as benefits to being a member of the ECCC. A

key to the program success is the commitment to the program by many ECCC members, instructor trainers, CPR instructors and agencies at different levels of the network.

The ECCC evaluation was conducted to provide insight into the ECCP, its goals and objectives, and how they were being met from the ECCC members and instructor trainer's perspective. The study findings were based upon six areas of evaluation.

Program Recommendations

The findings of this study bring into focus three key issues to be addressed in order to strengthen CPR training in Manitoba. These issues are:

1. Communication - there appears to be a communication breakdown at two levels.:

a) HSFM to instructor trainer, and ECCC

b) ECCC to instructor trainer and HSFM

2. Role clarification/relationship - it appears that is unclear who or which group is responsible for different activities and this role clarification requires clarification at two levels:

a) HSFM to ECCC

b) ECCC to instructor trainers and other agencies

3. Role of HSFM in CPR programming - it appears from the evaluation that the role for what the Foundation would like to accomplish with CPR has changed over the years. This role has not been not clearly stated and thus not clearly communicated. The results has been the feeling by respondents (volunteers) of not being valued and not accomplishing/understanding the goals.

The program recommendations that follow are based on the above issues and on the findings of this study.

1. HSFM clearly identify and state its goals and objectives with regard to CPR training in Manitoba and its role in Emergency Cardiac Care. The goals should reflect the overall mandate of the Health Promotion Committee which is awareness, skill, and environment.

2. The ECCC evaluation committee identify the action steps needed to meet HSFM goals and objectives.

3. The ECCC evaluation committee identify a Foundation role and responsibility for relationships with other organizations and people involved with CPR training in Manitoba.

4. The ECC evaluation committee identify the Foundation' s roles and responsibilities in relation to the ECCC.

5. A more effective mechanism of communication be established between instructors, instructor trainers, HSFM, and ECCC. This may include newsletters, bulletins, and/or conferences.

6. A process for ongoing evaluation needs to be developed and utilized. Evaluation should include: level of training being done, qualifications of instructors and instructor trainers, role of the ECCC, review of ECCP goals and objectives, review of the HSFM goals and objectives, and need for new resources.

7. The data base should be re-examined, including its costs, information obtained, and its use.

8. Special emphasis be placed on rural vs urban delivery of programs and materials as the rural areas have identified a gap in communication and services.

9. A recognition mechanism be identified so that volunteers do feel valued and not isolated.

Personal Reflections

This evaluation, using an action research framework, identified several areas for consideration and reflection from a personal experience. The researcher had the opportunity to learn to work with an action research group that had diverse vested interests in the program. Each group member had his/her own perceptions of the evaluation process but worked together to form a cohesive action research group.

One researcher role was to educate the group on the process of action research and demonstrate how evaluation theory and action research can guide a real situation of a program evaluation. Another role of the researcher was to define or frame the issues of the program for better understanding of the Emergency Cardiac Care Program. The roles were accomplished through frequent meetings explaining the action research process and promoting equal partnerships for the evaluation process.

Committee representation was crucial and everyone had the opportunity to contribute to the action research process. Upon reflection, complete representation of the target population was lacking in this project. More rural representation and more Emergency Cardiac Care Committee members or instructor trainers should have been involved in the action research group.

It was important to facilitate the group to work together for the evaluation process and to ensure the research was done with and for the representative group. Implementation, recommendations, and directives for the improvement of the program had to be planned and organized to complete the program evaluation. With this project, the action research group developed the evaluation tool, analyzed the data and made program recommendations.

The action research group did not participate in moving the program recommendations forward and were not involved with the dissemination of the study results to the target population. They did not assist with the process of making changes to the ECCC. There was no input into program changes that occurred as a result of the evaluation. In retrospect, the researcher did not ensure that there was a process in place to move change forward and to have this process included as part of the action research procedure. This would have been a valuable learning experience for both the researcher and the action research to complete the action research spiral to the end of the project.

Another important consideration was to be aware of the political processes involved with the evaluation and to work together to overcome any concerns or obstacles of the action research group or the target population. It was important to recognize the political tensions of the social situation - to be fully aware of the political milieu of the evaluation process and how it may affect the action research process. The political situation should be included as part of the action research process and collectively the action research group has to determine ways collectively to address the specific issues.

For the researcher, this was the greatest area of personal growth and if another action research project was to be done, more attention would be paid in this area in working with the action research group and the target population. The researcher, upon reflection, did not have a full appreciation on how important it was to be aware of the political tensions in an action research process.

The action research format provided a wonderful learning opportunity for the researcher to work with groups and to gain expertise in facilitating the process of action research. The researcher promoted collaboration and consultation within the group and

the group members taught the researcher the art of compromise and democratic input. The researcher recommends the action research format for further evaluation studies as it can be promoted as a non intrusive approach to ongoing program assessment and evaluation.

REFERENCES

Altrichter, H., Posch, P., & Somekh, B. (1993). Teachers Investigate Their Work: An Introduction to the Methods of Action Research. London: Rutledge.

Anderson, G., Herr, K., & Nihlen, A. (1994). Studying Your Own School. California: Corwin Press Inc.

Anderson, S. B. & Ball, S. (1987) Evaluation Purposes. In L. Bickman (ed.) Using Program Theory in Evaluation. New Directions for Program Evaluation, no. 33 San Francisco: Jossey-Bass.

Argyris, C., & Schon, D. (1991) Participatory action research and action science compared: a commentary. In W. F. Whyte (ed.) Participatory Action Research, (p. 85-97) California: Sage, Newbury Park.

Bryson, J. (1990). Strategic Planning for Public and Nonprofit Organizations. San Francisco: Jossey-Bass Publishers.

CPR Program Policy and Procedures Manual. (1994) Heart and Stroke Foundation of Manitoba.

Carr, W. (1989). Action research: ten years on. Curriculum Studies, 21(1), 85-90.

Carr, W., & Kemmis, S. (1986). Becoming Critical: Education, Knowledge and Action Research. London: Palmer Press

Caudle, S. (1989) Evaluating program results and success. In R. E. Cleary, N. Henry & associates. Managing Public Programs. San Francisco: Jossey Bass Publishers

Cook, T. D., & Shadish, W. R. (1987). Program evaluation: The worldly science. Evaluation Studies Review Annual, 12, 31-70.

Craven, F. (1980) Evaluating program performance. In J. Jedames, & M. W. Peterson (eds.) Improving Academic Management. (432-457) San Francisco: Jossey-Bass Publishers.

Cunningham, B. (1976). Action research: Toward a procedural model. Human Relations, 29(3), 215-238.

Dehar, M., Casswell, S., & Duignan, P. (1993). Formative and Process Evaluation of Health Promotion and Disease Prevention Programs. Evaluation Review, 17(2), 204-220.

De Vries, H., Weijts, W., Dijkstra, M., & Kok, G. (1992). The utilization of qualitative and quantitative data for health education program planning, implementation, and evaluation: A spiral approach. Health Education Quarterly, 19(1), 101-115.

Dignan, M. & Carr, P. (1987). Program Planning for Health Education and Health Promotion. Philadelphia: Lea & Febiger.

Dillman, D. A., (1978) Mail and Telephone Surveys: The Total Design Method. New York: Wiley.

Greenwood, J. (1994). Action Research: A Few Details, a Caution, and Something New. Journal of Advanced Nursing, 20, 13-18

Grundy, S. & Kemmis, S. (1982) The Action Research Planner. Victoria, Australia: Deakon University

Herrick, M. (1992). Research by the teacher and for the teacher: An action research model linking schools and universities. Action in Teacher Education, 14(3), 47-54.

Holter, I. & Schwartz-Barcott, D. (1993). Action research: what is it? How has it been used and how can it be used in nursing? Journal of Advanced Nursing, 18, 298-304

Hugentobler, M., Israel, B., & Schurman, S. (1992). An action research approach to workplace health: Integrating methods. Health Education Quarterly, 19(1), 55-76.

Elden, M., & Lewin, M. (1991) Cognitive learning. In W. F. Whyte (ed.) Participatory Action Research. London: Sage.

Elliot, J. (1991) Changing contexts for educational evaluation: The challenge for methodology. Studies in Educational Evaluation, 17, 215-238

Jackson, C., Altman, D., Howard-Pitney, B., & Farquhar, J. (1989) Evaluating community- level health promotion and disease prevention interventions. In M. T. Braverman (ed.) Evaluation Health Promotion Programs, 43, (p. 19-32) San Francisco: Jossey-Bass Inc. Publishers

Judd, C. M. (1987) Combining process and outcome evaluation. In M. Mark & R. Shotland (eds.). Multiple Methods in Program Evaluations. San Francisco: Jossey-Bass Inc. (23-41)

Kemmis, S. (1993). Action research and social movement: A challenge for policy research. Education Policy Analysis Archives, 1(1), 1068-2341

Kemmis, S., & McTaggart, R. (1981). The Action Research Planner Victoria, Australia: Deakin University

Kemmis, S., & McTaggart, R. (1988). The Action Reader Planner (3rd. ed.) Deakon University, Victoria: Deakin University Press

Lewin, K. Action research and minority problems. In G. W. Lewin (ed.) Resolving Social Conflicts. New York: Harper.

McLaughlin, M. W. (1987). Implementation realities and evaluation design. Evaluation Studies Review Annual, 12, 73-97.

Midkiff, R. & Burke, J. (1987). An action research strategy for selecting and conducting program evaluations. Psychology in the Schools, 24(2), 135-144.

Mullen, P., & Iverson, D. I. (1980). Qualitative methods for evaluative research in health education programs. Health Education Quarterly, 7(2), 1-8.

Patton, M. Q. (1987a) Creative Evaluation. Beverley Hills: Sage.

Patton, M. Q. (1987b) How to Use Qualitative Methods in Evaluation Beverley Hills: Sage

Pope, M., & Denicolo, P. (1991). Developing constructive action: personal construct psychology, action research and professional development. In O. Zuber-Skerritt (ed.) Action Research for Change and Development. Great Britain: Avebury Gower Publishing Company Limited.

Rossi, P. & Freeman, H. (1993) Evaluation: A Systematic Approach. (5th ed.) Newbury Park, California: Sage Publications, Inc.

Rutman L. (1987). Planning Useful Evaluations: Volume 96, Beverly Hills: Sage Publications.

Singleton, Jr. , R., Straits, B., & Straits, M. (1993). Approaches to Social Research (2nd. ed.) New York: Oxford University Press

Smith, M. L. & Glass G. V. (1987) Research and Evaluation in Education and the Social Sciences. Englewood Cliffs: Prentice-Hall Inc.

Steckler, A., McLeroy, K., Goodman, R., Bird, S., & McCormick, L. (1992). Toward integrating qualitative and quantitative methods: An introduction. Health Education Quarterly, 19(1), 1-8.

Stufflebeam, D. L., Foley, W. J., Gebhart, W. J., Guba, E. G., Hammand, R. L., Merriman, H. O., & Provus, M. M. (1971). Educational Evaluation and Decision Making. Itasca, ILL: F. E. Peacock.

Stufflebeam, D. L. & Shinkfield, A. J. (1985) Systematic evaluation: A self-instructional guide to theory and practice. Boston: Kluwer-Nijhoff

Thompson, J. (1992). Program evaluation within a health promotion framework. Canadian Journal of Public Health, 83, Supplement 1. 67-71.

Wallace, M. (1987). A historical review of action research: some implications for the education of teachers in their managerial role. Journal of Education for Teaching, 13(2), 97-110.

Weiss, C. H. (1987) Where Politics and Evaluation Research Meet. in D. J.

Palumbo (ed.) The Politics of Program Evaluation (47-70) Newbury Park: Sage Publications.

Wheeler, T. L. & Hunger D. (1989) Strategic Management and Business Policy (3rd. ed.) New York: Addison-Wesley Publishing Company

Williams, J. E. (1989) A Numerical Taxonomy of Evaluation Theory and Practice (Mimeo) Los Angeles: University of California at Los Angeles, Graduate School of Education.

APPENDIX A

RESPONDENT QUESTIONNAIRE

ECCC QUESTIONNAIRE FOR ECCC MEMBERS AND ITS

THE HEART AND STROKE FOUNDATION OF MANITOBA (HSFM) IS CONDUCTING THIS SURVEY TO ASSIST IN THE EVALUATION OF THE ROLES AND RESPONSIBILITIES OF THE EMERGENCY CARDIAC CARE COMMITTEE (ECCC) OF THE HSFM. YOUR COOPERATION IN COMPLETING THIS SURVEY WILL GREATLY ASSIST US IN PERFORMING AN EVALUATION THAT REFLECTS THE TRUE NATURE OF THE ACTIVITIES OF THE ECCC.

ECCC OBJECTIVES

OBJECTIVE 1

Monitor and maintain an active network of instructors and instructor trainers for basic life support in Manitoba.

1. What do you feel is the main purpose of maintaining this network?

   _____

2. Who is responsible for maintaining and monitoring this network?

   _____

   If you are not an instructor trainer, go to question 7.

3. As an instructor trainer, approximately how many new instructors did you train last year?

   _____ None
   _____ 1 to 6
   _____ 7 to 20
   _____ 21 to 60
   _____ More than 60

4. About how many instructors did you re-register (recertify) last year?

_____ None
_____ 1 to 6
_____ 7 to 20
_____ 21 to 60
_____ More than 60

5. As an instructor trainer, do you incur any personal costs when you re-register (recertify) instructors?

_____ Yes, is "Yes", check all that apply.

_____ Monetary
_____ Volunteer hours
_____ Traveling expenses
_____ Other (please specify _____

_____ No

6. Do you charge instructors a fee for their training?

_____ Yes
_____ No

7. About how many instructors are there in your network?

_____ 1 to 5
_____ 6 to 20
_____ 21 to 50
_____ More than 50

8. A status report for instructors is usually sent out every six months by the HSFM staff. Do you feel the information is:

_____ Excellent
_____ Good
_____ No opinion
_____ Fair
_____ Poor

9. What additional information would you like to have included in the report?

_____

10. What information in the report, do you feel is not useful to you?

_____

11. Do you feel the report should be sent out:

_____ Every six months (as it is now)
_____ More often
_____ Less frequently

12. A newsletter called "CPR Newsletter" is sent out by the HSFM usually 3 to 4 times a year. Do you feel the information is:

_____ Excellent
_____ Good
_____ No opinion
_____ Fair
_____ Poor

13. Is there any additional information that you would like to have included in the newsletter?
_____ Yes if "Yes", explain _____
_____ No

14. What information in the newsletter do you feel is not useful to you?
_____

15. How do you pass on information to the instructors in your network?

_____ Telephone
_____ Mail
_____ In person
_____ Other (please specify) _____

16. How often do you pass on information to the instructors in your network?

_____ Once a month
_____ Once every 2-3 months
_____ Less often

17. Do the current activities of ECCC still reflect Objective 1?

_____ Yes
_____ No, if "No", explain _____

18. Does Objective 1 need to be revised?

_____ Yes if "Yes", explain _____
_____ No

OBJECTIVE 2

Be responsible for the training of instructors within a members network.

19. Are you aware of any official guidelines to ensure quality management of instructor training?

_____ Yes, if "Yes", what are these guidelines?

_____

_____ No

If you are not an instructor trainer, go to question 21.

20. As an instructor trainer, do you incur any personal costs when re-registering (recertifying) for an instructor trainer?

_____ Yes, if "Yes", Check all that apply.
- _____ Monetary
- _____ Volunteer hours
- _____ Traveling expenses
- _____ Other (please specify _____

_____ No

21. Do the current activities of ECCC still reflect Objective 2?

_____ Yes
_____ No, if "No", explain _____

22. Does Objective 2 need to be revised?

_____ Yes if "Yes", explain _____
_____ No

OBJECTIVE 3

Direct active and continuing programs of public education to achieve the aims of the ECCC.

For the purposes of Objective 3, the programs of public education will be referring to CPR programs only.
The aims of the Emergency Cardiac Committee (ECCC) are:

1) Advise, assist and cooperate with individuals and organizations in preventing death due to heart related dysfunction's,
2) Encourage and support CPR networks throughout the Province,
3) Promote healthier lifestyles in our community

23. Do you feel that CPR programs are achieving the aims of ECCC?

_____ Yes
_____ No, if "No", explain ----------

24. Are you aware of any guidelines for quality management of CPR program delivery in Manitoba?

_____ Yes, if "Yes", what are these guidelines?

_____ No, if "No", go to question 26.

25. Who is responsible for ensuring quality management of CPR program delivery in Manitoba?

---

26. Are you aware of guidelines in place for measuring client satisfaction with the teaching of CPR programs?
_____ Yes, if "Yes", what are these guidelines?

_____ No, if "No", go to question 28

27. Who is responsible for measuring client satisfaction with the teaching of CPR programs?

---

28. How does ECCC determine that CPR programs are achieving the aims of ECCC?

---

29. Do the current activities of ECCC still reflect Objective 3?

_____ Yes
_____ No, if "No", explain ----------

30. Does Objective 3 need to be revised?

_____ Yes if "Yes", explain _____
_____ No

OBJECTIVE 4

Stimulate community involvement to achieve effective pre-hospital emergency medical systems (services).

31. As a member of ECCC or an instructor trainer, what activities do you perform to achieve Objective 4?

_____

32. To what degree, do you feel the ECCC activities lead to the achievement of effective pre-hospital emergency medical services?

_____ Very successful
_____ Successful
_____ No opinion
_____ Unsuccessfully
_____ Very unsuccessfully

33. Do the current activities of ECCC still reflect Objective 4?

_____ Yes
_____ No, if "No", explain _____

34. Does Objective 4 need to be revised?

_____ Yes if "Yes", explain _____
_____ No

OBJECTIVE 5

Maintain a data base for research purposes, rosters.

The HSFM keeps a data base of information on instructor trainers, instructors, and different CPR courses (e.g. Adult CPR, Infant and Child CPR). Research information does not exist.

35. How often do you usually access this data base of information that is kept by the HSFM?

_____ At least once a week
_____ At least once a month
_____ Once every 2-3 months
_____ Less often
_____ Never, **if "Never", go to question 40**

36. What is your main reason for using this data base of information at the HSFM?

_____ Re-registering instructors
_____ Communicate with instructor
_____ Quality management (quality of instructor teaching)
_____ Other (please specify)

37. Do you find that the type of information stored in the data base is:

_____ Very helpful
_____ Helpful
_____ Not helpful

38. The amount of information currently stored should be:

_____ Increased
_____ Stay the same
_____ Decreased

39. Is there other information that should be stored in the data base?

_____ Yes if "Yes", explain _____
_____ No

40. Do the current activities of ECCC still reflect Objective 5?

_____ Yes
_____ No, if "No", explain ----------

41. Does Objective 5 need to be revised?

_____ Yes if "Yes", explain _____
_____ No

OBJECTIVE 6

To develop, implement and maintain a manual of policies and procedures.

The manual of Objective 6 is the "CPR Program Policy and Procedures Manual". The manual is reviewed yearly.

42. How effective are the policies in the manual in meeting the needs of ECCC?

_____ Very effective
_____ Effective
_____ No opinion
_____ Ineffective
_____ Very ineffective

43. How adequate is the scope of the policies in the manual?

_____ Excellent
_____ Good
_____ No opinion
_____ Fair
_____ Poor

44. Do you believe that there should be additional policies included in the manual?

_____ Yes if "Yes", please identify them _____
_____ No

45. Do the current activities of ECCC still reflect Objective 6?

_____ Yes
_____ No, if "No", explain ----------

46. Does Objective 6 need to be revised?

_____ Yes if "Yes", explain _____
_____ No

GENERAL OBJECTIVE QUESTIONS

47. Are there any unstated objectives being achieved by the activities of the ECCC?

_____ Yes if "Yes", explain _____
_____ No

48. Is there anything else about the six objectives that you would like to mention? Please explain

_____

RESOURCES

This section refers to the resources provided by the HSFM to the ECCC.

For the purpose of this study, the term "resources" will include:

1) **financial resources**
2) **HSFM staff time to carry out activities for ECCC, and**
3) **materials (pamphlets, letters, supplies, printing, postage, photocopying, etc.)**

49. How much time do you usually spend in a month doing ECCC or network activities?

_____ 1 to 5 hours
_____ 6 to 10 hours
_____ 11 to 15 hours
_____ 16 or more hours

50. The amount of staff time provided for ECCC by the HSFM is:

_____ Very adequate
_____ Adequate
_____ No opinion
_____ Inadequate
_____ Very inadequate

51. Do you feel that the amount of resources provided to the ECCC by the HSFM is:

_____ Very adequate
_____ Adequate
_____ No opinion
_____ Inadequate
_____ Very inadequate

If "inadequate" or " very inadequate", please explain.

_____

52. Are there any changes in resource utilization that you would like to see?

_____ Yes if "Yes", explain _____
_____ No

53. What types of materials are provided to you by the HSFM? (Check all that apply).

_____ Pamphlets
_____ Course materials
_____ Videos
_____ Administrative paperwork
_____ Other, (please specify) _____

54. Do you feel that you are receiving all the required materials for the maintenance of ECCC?

_____ Yes
_____ No, if "No", explain ----------

55. Have you experienced any difficulties in obtaining these materials?

_____ Yes if "Yes", explain _____
_____ No

56. Additional comments regarding resources are welcomed.

_____

STAFF SUPPORT

57. Do you feel that the **type** of staff support provided to ECCC by the HSFM is adequate?

_____ Yes
_____ No, if "No", explain ----------

58. Do you feel that the **amount** of staff support provided to ECCC by the HSFM is adequate?

_____ Yes
_____ No, if "No", explain ----------

59. Do you have difficulty making contact with staff members of the HSFM?

_____ Yes
_____ No, if "No", explain ----------

60. Are the hours of operation of the HSFM flexible enough to meet the needs of the ECCC members and/or instructor trainers?

_____ Yes
_____ No, if "No", explain ----------

61. Do you feel that the communication between the staff of HSFM and the ECCC is effective?

_____ Yes
_____ No, if "No", explain ----------

62. Do you feel there is enough communication between the ECCC and the Health Promotion Committee of the HSFM?

_____ Yes
_____ No, if "No", explain ----------

63. Are there any changes in communication patterns between ECCC and the HSFM that you would like to see?

---

64. Additional comments regarding staff support are welcomed.

STRUCTURE OF ECC COMMITTEE

65. Do you feel that the present structure of the ECC committee with the system of networks is an efficient way to fulfill the objectives of ECCC?

_____ Yes
_____ No, if "No", what changes are needed? _____

---

66. Do you feel that communication between ECCC network members and/or instructor trainers and their network of instructors is effective?

_____ Yes
_____ No, if "No", explain ----------

67. Do you feel that there is adequate representation on ECCC that includes all areas of Manitoba?

_____ Yes
_____ No, if "No", explain ----------

68. In your opinion, are there any areas of representation that should be excluded?

_____ Yes if "Yes", please identify them _____
_____ No

69. Do you feel that the size of ECCC (the number of members) is:

_____ Adequate
_____ Too large
_____ Too small

ECCC STANDING SUB-COMMITTEES

The three standing sub-committees of ECCC are:

1. Teaching
2. Infant and Child, and
3. Seminar/conference

70. Do the activities of the Teaching Committee reflect the current objectives of ECCC?

_____ Yes
_____ No, if "No", explain ----------

71. Do the activities of the Infant and Child Committee reflect the current objectives of ECCC?

_____ Yes
_____ No, if "No", explain ----------

72. Do the activities of the Seminar/Conference Committee reflect the current objectives of ECCC?

_____ Yes
_____ No, if "No", explain ----------

73. Additional comments on the structure of the ECCC or the three standing sub-committees are welcomed.

_____

IMPORTANCE OF ECCC TO THE HEART AND STROKE FOUNDATION

74. How valuable is the service that ECCC provides to the HSFM?

_____ Very valuable
_____ Of some value
_____ No opinion
_____ Of little value
_____ Not valuable

75. What do you feel is the single most important thing that ECCC does for the HSFM?

_____

76. Do you feel that the HSFM is aware of ECCC activities and achievements?

_____ Yes
_____ No, if "No", explain _____

77. Do you have suggestions on how the HSFM could adequately recognize the work of the ECCC volunteers?

_____ Yes if "Yes", explain _____
_____ No

78. Please feel free to comment on any other concerns you may have regarding the importance of ECCC to the HSFM.

_____

INTER-AGENCY RELATIONSHIPS

79. The degree of the working relationship among all of the agencies that ECCC is involved with is:

_____ Very satisfactory
_____ Satisfactory
_____ No opinion
_____ Unsatisfactory
_____ Very unsatisfactory

If you answered "unsatisfactory" or "very unsatisfactory", then how can the existing inter-agency relationships with ECCC be improved? Please explain.

_____

80. What are the benefits for ECCC in having good relationships with other agencies? Please explain.

_____

81. Are there disadvantages with ECCC working with other agencies?

_____ Yes if "Yes", explain _____
_____ No

82. Are there current member agencies that should not be included in ECCC?

_____ Yes
_____ No
_____ Don't know

83. Are there agencies who should be invited to join ECCC?

_____ Yes if "Yes", please identify _____
_____ No

84. Which agency(ies) provide the most support to ECCC?

_____

85. How effective is the communication between the various agencies and ECCC?

_____ Very satisfactory
_____ Satisfactory
_____ No opinion
_____ Unsatisfactory
_____ Very unsatisfactory

If you do not represent an agency, go to question 88.

86. What are the important benefits to your agency in being a member of ECCC?

_____

87. As an agency representative, do you have any concerns with belonging to ECCC?

_____ Yes if "Yes", explain _____
_____ No

88. Additional comments regarding inter-agency relationships are welcomed.

_____

GENERAL INFORMATION

89. Which health region are you from?

_____ Interlake
_____ Central
_____ Westman
_____ Norman
_____ Ontario
_____ Parkland
_____ Eastman
_____ Thompson
_____ Southern

You may answer both or only one of the following two questions depending upon your situation. There are some people who are both ECCC members and an instructor trainer. While other people may either be a member of ECCC or an instructor trainer.

If you are not an ECCC member, go to question 91

90. How long have you been a member of the ECCC?

_____ 1 to 5 years
_____ 6 to 10 years
_____ More than 10 years

91. How long have you been an instructor trainer?

_____ 1 to 5 years
_____ 6 to 10 years
_____ More than 10 years
_____ Not an instructor trainer

THANK YOU FOR YOUR TIME. PLEASE RETURN THE SURVEY BY JANUARY 18TH, 1995 TO:

Debbie Brown
636 Oakland Ave.
Wpg. MB
R2G 0B8

APPENDIX B

STUDY INTRODUCTORY LETTER

EMERGENCY CARDIAC COMMITTEE QUESTIONS

January 4th, 1995

Dear ECCC member/ Instructor Trainer:

The Heart and Stroke Foundation of Manitoba (HSFM) is conducting an evaluation of the activities and programs of their Emergency Cardiac Care Committee (ECCC). The evaluation will be used by the Foundation and ECCC in planning for the future.

I have been asked by the Foundation to coordinate and conduct this evaluation. I am a graduate student at the Faculty of Education, University of Manitoba. I will also be using the results of this evaluation as partial fulfillment of the requirements for a Master' of Education Degree.

I invite you to voluntarily, to participate in this evaluation by taking the time to complete the enclosed questionnaire titled "ECCC Questionnaire for ECCC Members and IT's".

All questionnaire information is confidential and will be mailed to my personal address. Grouped data will be seen only by the evaluation committee of the HSFM. Questionnaires are coded only for mailing purposes, so I may check your name off of the mailing list when it is returned. Your name will never be placed on the questionnaire. Anonymity is guaranteed.

A copy of the results of the evaluation will be sent to you if you call or write to the Manitoba Heart and Stroke Foundation, 301 - 352 Donald Street, Winnipeg Manitoba, R3B 2H8, phone number (204) 949-2000.

Please direct any questions about the study to me by calling (204) 663-6330 or my thesis advisor, Dr. Dexter Harvey, by calling (204) 474-9223.

Thank you in advance for your participation in this study. I realize that it is your right to refuse to participate in this study without penalty or prejudice. Please enclose your completed questionnaire in the self-addressed stamped envelope and return it by January 18th, 1995.

Sincerely,

Debbie Brown B.N.
Graduate Student in Health Education

APPENDIX C

REMINDER LETTER TO NON-RESPONDENTS

ECC Survey Reminders

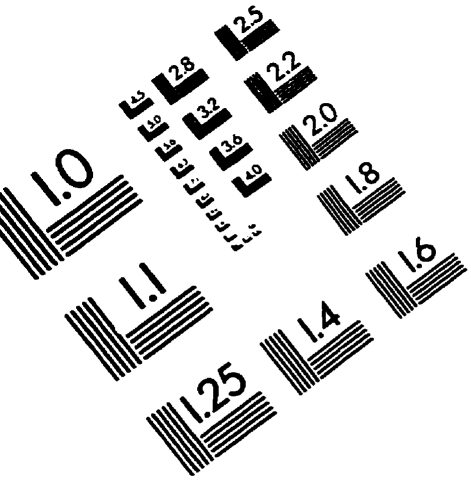
About 2 weeks ago, a survey seeking your knowledge on the activities of the Emergency Cardiac Care Committee (ECCC) of the Heart and Stroke Foundation of Manitoba (HSFM), was mailed to you. It is extremely important that your input also be included in the study so the results will accurately represent the activities of the ECCC.

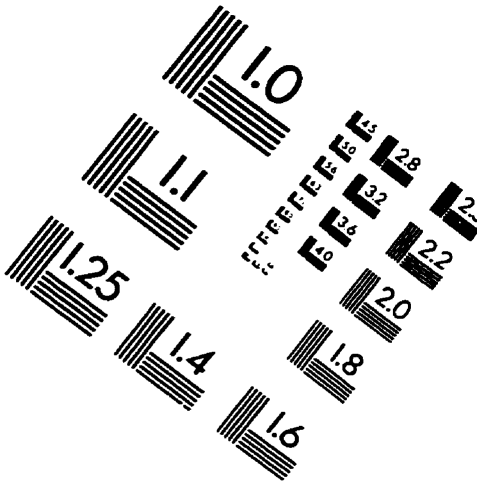
If your have already returned the survey, please accept my sincere thanks. If not, please do so today. If you did not receive the survey or it was misplaced, please call me at (204) 663-6330 and one will be sent to you.

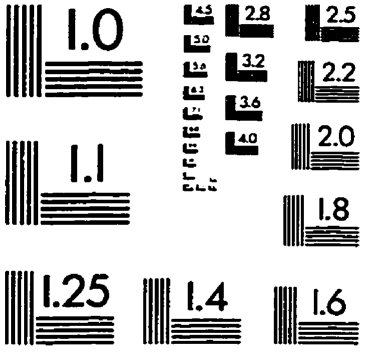
Sincerely,

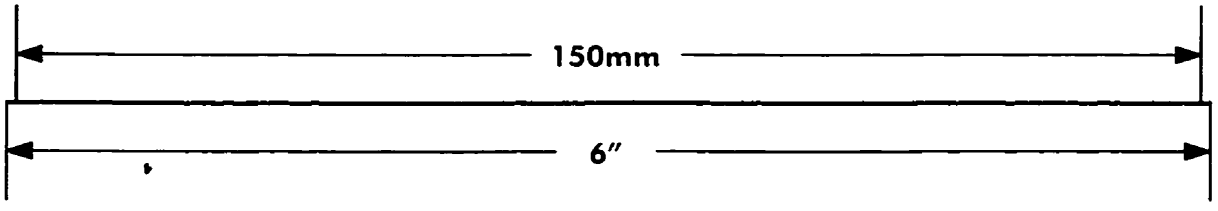
Debbie Brown B.N.

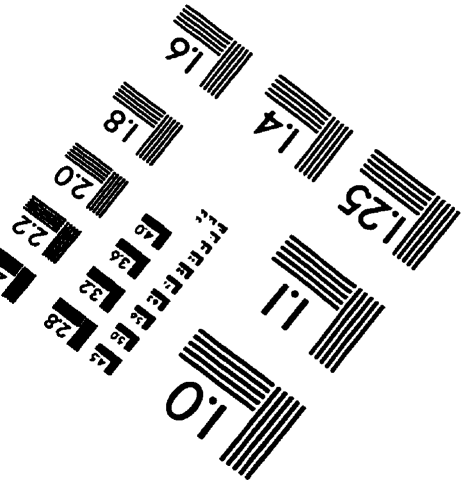
IMAGE EVALUATION TEST TARGET (QA-3)

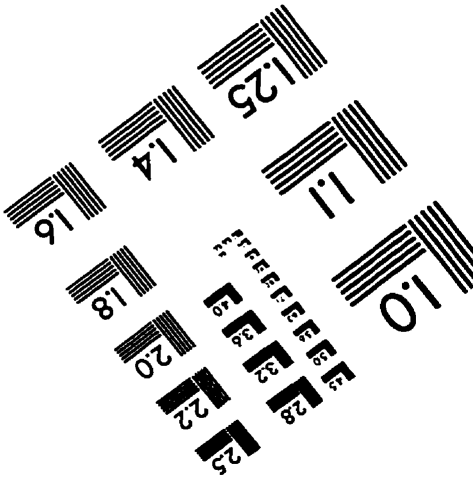












APPLIED IMAGE, Inc
1653 East Main Street
Rochester, NY 14609 USA
Phone: 716/482-0300
Fax: 716/288-5989