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Evaluation of In-Service Skill Enhancement Training for Nurse Educators in India using Kirkpatrick's Model

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ABSTRACT

Background: Structured competency-based training programmes addressing managerial and non-technical skills for nurses remain limited. This study assessed the effectiveness of a Skill Enhancement Programme for nursing educators in India.
Methodology: A five-day residential training programme was designed using Kern's six-step framework. The curriculum covered management principles, nursing administration, leadership, communication, and stress management skills. Training was implemented employing adult-learning methodologies and training outcomes were assessed using Kirkpatrick's model.
Results: Thirty-two nursing educators participated. Participants' feedback was overwhelmingly positive: nearly 91% rated overall facilitation of sessions as "excellent." Knowledge improved significantly from a median score of pre-training 14 to post-training score of 18 out of 20 ($p < 0.001$). Moreover, the study recorded a 75% increase in the median score of participants who received lowest scores, indicating equitable learning gains.
Conclusion: A structured in-service training programme significantly improved nursing educator's managerial and non-technical skills. Institutionalizing such programmes can enhance the quality of healthcare services.
Keywords: nurses, skills enhancement training, soft-skills, managerial skills, non-technical skills, Kirkpatrick model, Kern's curriculum framework

INTRODUCTION

Strengthening the capacity of nursing professionals is crucial for enhancing healthcare service delivery [1,2]. In India, although nurses constitute the largest segment of the health workforce, they have historically lacked opportunities to develop leadership and management skills and

competencies. This deficit is compounded by a nurse-to-population ratio of approximately 1.7 per 1,000—well below the World Health Organization (WHO) recommendation of 2.5—and significant brain drain as trained professionals seek opportunities abroad [3,4,5].

Until recently, the enactment of the National Nursing and Midwifery Commission (NNMC) Act, 2023 represents a landmark policy shift in India's nursing education and regulation. The Act mandates competency-based education, uniform standards of practice, and explicit emphasis on communication, leadership, and other non-technical skills [6]. This is aligned with global trends; the WHO's State of the World's Nursing 2020 report [7] identifies leadership capacity as essential for achieving Universal Health Coverage (UHC) and health system resilience. However, because most management models originate in high-income settings, there is an urgent need for context-specific, competency-based programmes tailored to the Indian landscape [8].

Historically, India's nursing curriculum has remained clinically oriented, with limited emphasis on leadership, team-building and healthcare communication. While Indian Nursing Council (INC) guidelines mandate Continuing Nursing Education (CNE), the focus has remained technical, often neglecting soft skills and managerial competencies [9,10]. Consequently, public sector nurses often face restricted career advancement and limited opportunities to update non-clinical skill sets[4]. While institutions like the National Institute of Health and Family Welfare (NIHFW) and various state-level entities have initiated leadership programs, these efforts remain largely ad hoc, unevenly distributed, and insufficiently evaluated [11,12].

Empirical evidence from India highlights critical gaps in leadership and communication preparedness [12,13]. A qualitative study among nurses in North India [14] found that many felt inadequately prepared for patient communication and counselling, attributing this to limited coverage of these competencies in both pre-service education and in-service training. Another study [15] documented communication training's impact on nurse's empathy, patient satisfaction, and therapeutic relationships. Yet manager and non-technical training remain inconsistently integrated into nurse's professional development programmes.

The NNMC Act recognizes the need for unified standards; however, disparities in skill levels persist due to inconsistent training quality and lack of standard training evaluation mechanism. In addition, a paucity of research examining which training approaches are most effective for adult learners (andragogy) in the Indian nursing context is concerning.

Many training programmes rely on didactic, lecture-based methods rather than interactive, simulation-based, or mentorship-oriented models that have demonstrated superior outcomes [8,16,17,18]. Structured training programmes grounded in established educational and evaluation frameworks offer a potential solution. By integrating experiential learning methods and multi-level evaluation approaches, healthcare organizations can enhance knowledge retention and behavioural transfer. Specifically, Kern's six-step framework [19] provides a systematic approach to curriculum development, ensuring training is both relevant and evidence-based. In addition, Kirkpatrick's Model of Training Evaluation [20] remains one of the most widely used frameworks, assessing training effectiveness across four levels: reaction, learning, behaviour, and results. The present study aimed to assess the effectiveness of a structured, skill-based training among nursing educators.

MATERIALS & METHODS

Study design: A quasi-experimental pre–post design was applied to evaluate a five-day residential Skill Enhancement Programme for nursing educators, using

Kern's six-step curriculum framework and Kirkpatrick's model for evaluation.

Participants: Participants were thirty-two female nursing educators of Government Nursing Colleges from Western India. They represented mid-career professionals, aged 28–59 years, with responsibilities in teaching, supervision, and administration. Eligibility included active faculty status and engagement in academic or administrative functions requiring enhanced managerial competencies.

Study setting: The five-day residential programme was designed and executed by the Centre for Quality Improvement and Patient Safety (QUALIPS) at the Indian Institute of Public Health, Gandhinagar (IIPHG).

Training programme development: Programme development was guided by Kern's six-step curriculum design framework [19]. The first step was problem identification and targeted needs assessment. During the planning period, training needs were assessed by telephonic interaction with the State team to identify priority areas for skills enhancement in management & nursing administration. Subsequently, the team also interacted with stakeholders from intended participants (senior nursing officers, and nurse educators) to understand challenges for the day-to-day work. The needs assessment informed the training programme curriculum focusing on intervention areas such as nursing administration, general management principles, quality improvement tools, leadership, team building, communication, and stress management skills. The second step was determining training goals and objectives. Based on the identified needs, a skill-enhancement programme goal was defined. The programme goals were to equip nursing educators with essential management, leadership, and communication skills for improved patient care and team performance. From this, specific four learning objectives were derived, namely, (1) Understand and apply key management principles; (2) Strengthen nursing administration proficiency; (3) Demonstrate advanced managerial skills; and (4) Promote sustainable patient-centred practices for quality improvement. Based on stakeholder input, stress management and motivational challenges in nursing were integrated throughout the modules as a cross-cutting theme. The third step was the development of educational content strategies. A participatory pedagogy incorporating group work, games, case studies, structured discussions, role-plays, and field exposure was employed. The fourth step included implementation of the curriculum. The training was delivered using adult learning principles to ensure high engagement. Training activities were participatory and experiential. For example, the first day began with an "*ice-breaker"* session to build rapport and setting expectations from the training programme.

Teaching strategies included facilitated group discussions, case-based learning, role plays, gamified exercises, and reflective activities. For example, participants were divided into five small groups for daily activities; each day, "energizers" were used to keep participants energetic. Each day, one group was tasked with summarizing the previous day's lessons – a peer-teaching technique reinforcing recall and active listening.

The curriculum also incorporated *field exposure*. On Day 4, a site visit to a hospital and a simulation lab was organized, where participants observed best practices in biomedical waste management and infection control, linking classroom concepts to real-world applications. Throughout the training, facilitators used short "energizers" and encouraged sharing of experiences among participants, creating a collaborative learning environment. The resource persons of the programme were drawn from a pool of experienced experts in nursing and healthcare management, including experts from hospital, academia – nursing, medical

and public health educational institutions. To personalize the learning, participants pinned their individual expectations on a board at the start of the course and revisited them later to self-assess if expectations were met.

To foster learning reflection and continuous feedback, participants were provided with a *"Share Your Thoughts (parking lot)"* board to jot down spontaneous thoughts or questions during sessions, which were later discussed. The training was intensive but had adequate breaks, informal interactions and energizers to prevent fatigue. On the last day, each participant was asked to develop an action plan to implement learnings from the training in their own context. Participants presented their action plans in a plenary session for peer and expert feedback. All training materials, including presentations, exercise handouts and workshop photos were provided. In addition, a resource book covering curated technical information with proper references provided to each participant to refer to and share with colleagues, thereby extending the training's impact beyond the workshop. The fifth step was evaluation. The training programme was evaluated using Kirkpatrick's four-level model [20], which assessed training effectiveness from immediate reactions to long-term results. Multiple evaluation tools were employed to assess learning at four levels. Level 1 (Reaction): Participant satisfaction and feedback were collected at the end of each session and at programme conclusion. A structured questionnaire (via Google Forms) was shared with participants to rate various aspects particularly, content relevance, instruction quality, time management, logistics, etc. – on a 3-point Likert scale (1 = "average", 2 = "good", 3 = "excellent"). We also invited open-ended comments on what they found most useful and suggestions for improvement; Level 2 (Learning): Knowledge gain was measured using a pre-test and post-test assessment.

At the start of Day 1, participants were asked to complete a 20-item multiple-choice questionnaire covering key concepts from all modules. The same questionnaire was administered at the end of the training. Each correct answer was scored 1 point, resulting in a maximum score of 20. The difference between pre- and post-test scores for each participant was calculated to assess learning; Level 3 (Behaviour): As the training's behavioural impact could only manifest back in the workplace over time, we assessed intended behaviour change through the action plans. On the last day, participants reviewed the expectations they had set on Day 1 and mapped each to learning outcome/s from the training, essentially checking which expectations were met. They then detailed how they plan to apply the new knowledge and skills in their job. Although no long-term follow-up was conducted within this study, these self-reported plans provided insight into expected behaviour changes; and Level 4 (Results): In Kirkpatrick's model, this level examines the broader results or impact of the training. Given the short time-horizon of the training evaluation, we employed Level 4 as the overall programme effectiveness and potential impact as perceived by participants. The post-training feedback form asked participants to rate the overall training and whether it met its stated objectives. These perspectives, albeit subjective, provided an indication of the training's value to the participants.

Statistical Analysis

The quantitative data were gathered through Google Forms and exported to MS Excel for data cleaning and analysis. We employed descriptive statistics including frequencies, percentages, means, medians, and standard deviations to summarize participant characteristics and training evaluation outcomes. Due to the sample size and non-normal distribution of scores, the Wilcoxon Signed-Rank test (non-parametric) was performed to compare pre- and post-test scores and assess the statistical significance of improvement in scores. A p-value < 0.01 was considered statistically significant. To

complement these findings, qualitative feedback and action plans were reviewed.

Ethical considerations: This study adhered to established ethical principles for research involving human participants, ensuring respect for autonomy, confidentiality, and integrity throughout the research process. Participants consent for publication was obtained. Confidentiality and anonymity were rigorously maintained. Participant responses, including pre- and post-test scores and feedback, were de-identified and coded to prevent disclosure of individual identities. Data were de-coded and de-identified to ensure anonymity. Datasets were stored in password-encrypted files, with access strictly restricted to the primary research team. No personally identifiable information was reported in the findings or publications.

RESULT

Participant Characteristics

All 32 nominated nurse educators successfully participated in and completed the training programme. The participants represented a relatively experienced cohort, with a mean age of 40.9 years (SD ± 8.9). The majority of participants were in the 41–51year age group (46.88%), followed by 24–40 years (43.75%) and 52–62 years (9.37%). Table 1 presents socio-demographic characteristics of the study participants.

Table 1. Socio-Demographic and Professional Characteristics of Participants (N = 32)

Variable	Category	n (%)
Age (years)	24–40	14 (43.75)
	41–51	15 (46.88)
	52–62	3 (9.37)
	Mean Age: 40.9±8.9	
Gender	Female	32 (100)
Years of Experience	8–10 years	12 (37.5)
	11–20 years	14 (43.75)
	20–28 years	6 (18.75)
	Mean (years): 14.7±5.6	
Area of Specialization	Critical Care	9 (28.1)
	Paediatric	8 (25.0)
	Psychiatric	4 (12.5)
	Gynaecological	8 (25.0)
	Surgical	4 (12.5)
Educational Qualification	MSc	30 (93.75)
	PhD	2 (6.25)
Designation	Tutor	8 (25.0)
	Lecturer	10 (31.25)
	Associate Professor	8 (25.0)
	Professor	6 (18.75)
Practice Setting	Urban	18 (56.25)
	Rural	14 (43.75)
Prior Clinical Experience	Yes	32 (100)
	No	0 (0)
Prior Management/ Leadership Training	Yes	2 (6.25)
	No	30 (93.75)

Participants had an average of experience of 15 years with SD ± 5.6, ranging from 8 to 28 years. It indicates that most participants were mid-career professionals, with some variability reflecting inclusion of both relatively early-career and highly experienced individuals. The cohort included individuals across diverse specializations, including critical care (28.1%), paediatrics (25.0%), gynaecology (25.0%), psychiatry (12.5%), and surgical nursing (12.5%), reflecting disciplinary diversity from both rural and urban settings. While all participants had prior clinical

experience, only two underwent any formal management or leadership training before this programme.

Training Effectiveness

Training Satisfaction (Reaction – Level 1)

The training programme yielded a high level of participant satisfaction, with the majority responses (98%) rated as "excellent," and nearly 96% of participants satisfied with experts who facilitated the sessions. The training received encouraging qualitative feedback which are reflected in the thematic feedback illustrated in Table 2. Participants appreciated the interactive format and the practical examples shared.

Table 2. Participants feedback on the training

Theme	Description	Verbatim Quotes
Perceived Excellence of Training	Participants expressed overall high satisfaction and perceived the training as exceptional in quality and delivery.	"Training is the 'BEST...I have undertaken many trainings but this is differently best." "Everything was perfect…facilitators, activities, and arrangements. "
Enhanced Learning Outcomes	Participants reported learning beyond expectations, indicating high perceived knowledge gain and value addition.	"We have learned more than what we expected." "This programme is the best… we learned something very important for profession and life with fun."
Institutional Appreciation	Recognition of the organizing institution for providing valuable exposure and opportunity.	"Thanks a lot to IIPHG for providing such valuable exposure." "Opened our vision for the nursing profession…we needed this training in our early-career phase."
Quality of Training Delivery	Participants appreciated the quality teaching strategies.	"Overall, excellent experience — very nice presentations and engaging activities." "The instructors explained concepts in a very simple way."
Interactive and Engaging Pedagogies	High engagement attributed to interactive pedagogy, participatory methods, and active learning environment.	"The training sessions were highly interactive and kept the audience consistently engaged." "We did not feel bored for a single moment…case-based methods were very interesting."

A couple of participants suggested making certain technical topics, particularly procurement and finance management more "simpler with examples from nursing administration" to aid skill application, indicating areas for improvement in future iterations.

Knowledge Gain (Learning – Level 2)

The training achieved a significant improvement in participants' knowledge of the topics covered. Table 3 showcases comparison of Pre- and Post-Training scores with statistical inference. Before the training, scores demonstrated moderate baseline knowledge with a median score of 14 (out of 20), with a mean of 13.7 (SD ± 3.2). The lowest score obtained was 8, indicating few participants had substantial knowledge gaps. After the training, test performance markedly improved – the median post-test score rose to 18, and the mean to 17.5 (SD ±1.8). This gain was statistically significant (Wilcoxon Signed-Rank $p = 1.86 \times 10^{-9}$, $p < 0.0001$).

Table 3. Comparison of Pre- and Post-Training Scores with Statistical Significance

Metric	Pre-Training	Post-Training	p-value	Effect Size (r)
Median Score (IQR)	14.3 (12–16)	18.4 (17–19)	<0.0001	0.78
Mean Score ± SD	13.7 ± 3.2	17.5 ± 1.8	—	
Wilcoxon Signed-Rank Test	—	—	1.86×10^{-9}	

All participants showed improvement in their scores, with those having lower baseline knowledge benefiting the most. For example, the two participants who initially scored 8 improved to 14 following the training; notably, 14 became the new minimum score in the post-test. This 75% increase in the lowest score indicates that the programme effectively supported lower-performing participants, thereby narrowing the knowledge gap within the group. Such gains among the lowest quartile suggest a potential equity-enhancing effect, with less experienced participants catching up to their peers. Overall, 90% of participants scored ≥15 (out of 20) in the post-test, compared to approximately 50% at baseline, reflecting a broad-based improvement. Participants also acknowledged their learning, frequently highlighting the effectiveness of the teaching methods, as illustrated by the following responses:

The instructors explained concepts in a very simple way – this programme is the best. This was my first such training where we learned something very important for our profession and life with fun.

When we hear training, we think of boring sessions. But here we did not feel bored for a single moment and at the same time learn something valuable. We were encouraged to share our experiences and we were not only learning from experts but from our colleagues that was great.

A few suggested adding even more case discussions for complex topics such as finance and nursing administration, underscoring that the appetite for applied learning was high.

Planned Practice Change (Behaviour – Level 3)

At the end of the workshop, participants demonstrated a strong intention to apply what they learned. In a collaborative exercise, they revisited the "expectations tree" created on Day 1 – where each had posted their personal learning goals – and linked each expectation to an outcome or insight from the training (creating a matching "outcome tree"). This activity revealed that most initial expectations (such as *"learn how to handle team conflicts"* or *"better time management in administration"*) were reported as met through acquiring skills from sessions. Participants expressed that the training had given them new perspectives on leadership styles, communication strategies, stress management techniques, and quality improvement tools which they could take back to their institutions.

Each participant then presented their action plan, detailing how they would implement changes at three levels: individual, team, and organizational. Examples of individual-level actions included practicing active listening with students and junior staff, or using stress-relief techniques from the training for personal well-being. At the team level, many participants planned to initiate regular team meetings or feedback sessions in their departments, applying the communication strategies learned. At the organizational level, some participants committed to conduct cascade trainings or workshops for other nursing staff, effectively passing on the knowledge (a direct outcome of the train-the-trainer approach). Others aimed to develop new protocols (e.g., for infection control or patient communication) and present them to their college or hospital management for adoption.

While Level 3 outcomes are based on self-reported plans rather than observed behaviour change (as no follow-up was done in this study), the enthusiastic participation in action planning was a positive sign. All participants identified concrete steps.

Overall Programme Impact (Results – Level 4)

Figure 1 represents participants' rating of the overall training effectiveness. When participants asked to rate the overall training experience, 91% of them gave it an

"excellent" rating and the remaining rated it "good," with none rating it average or poor.

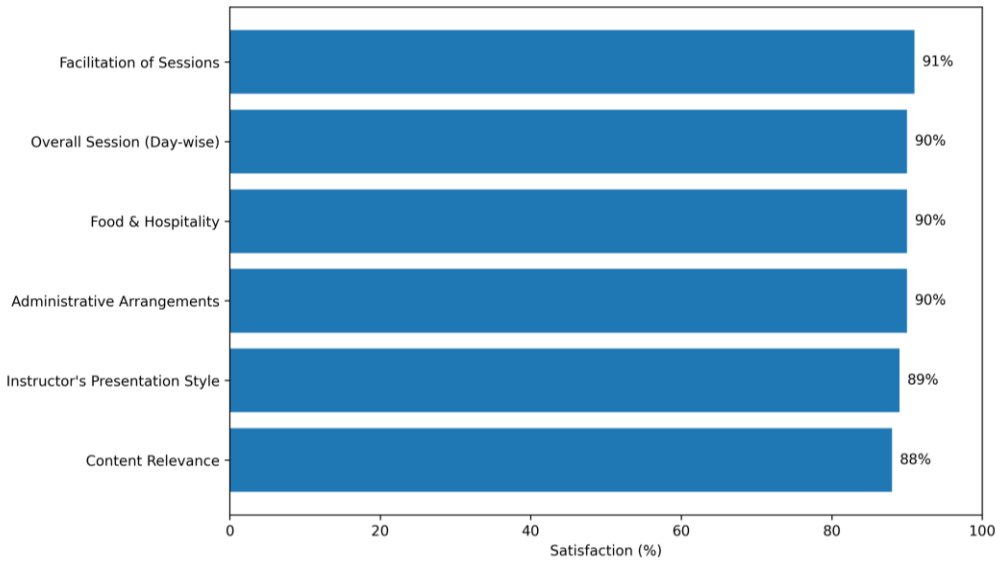

Figure 1. Domain-wise participant satisfaction with training

Furthermore, all participants agreed that the programme's objectives were achieved. In their feedback, many noted gaining "new skills and perspectives" in areas like leadership styles, effective communication, team motivation, and quality management. Several participants mentioned increased confidence in handling administrative responsibilities. These ratings are echoed very well in their verbatim: One participant mentioned, *"I feel more prepared now to take on higher responsibilities at my college."* Another highlighted the value of networking with peers from other institutions, which the residential nature of the programme facilitated, stating it, *"Opened our vision for the nursing profession."*

DISCUSSION

The skill-enhancement programme demonstrated a strong positive impact on participants' knowledge and attitudes. High levels of satisfaction, significant learning gains, and the development of actionable plans for applying newly acquired skills collectively indicate that the training programme achieved its intended short-term outcomes. The findings suggest that a structured, needs-based training programme can substantially enhance the management competencies of nursing educators in the Indian context. Furthermore, the programme enabled participants to identify and plan changes in their professional practice, indicating a favourable trajectory towards behaviour change.

These findings are consistent with emerging evidence that targeted capacity-building interventions for health professionals can enhance both confidence and capability. For example, a recent multi-country programme for public health managers reported significant knowledge gains and over half the participants implementing learned strategies back in their jobs [8]. Another study [20] demonstrated how leadership programmes yielded positive change. The present study contributes to the body of evidence by focusing on nursing educators and showing that even a short, intensive course can yield measurable improvements.

A key strength of the programme was the integration of established educational frameworks in both curriculum design and evaluation. Kern's six-step approach [19] ensured that the training content was aligned with identified needs and clearly defined learning objectives, thereby enhancing its relevance to participants' roles. In parallel,

Kirkpatrick's evaluation model [21] facilitated a comprehensive assessment of outcomes beyond knowledge acquisition, encompassing participant reactions, learning, and intended behavioural changes. The combined application of these frameworks—one guiding instructional design and the other informing evaluation—provides a robust and replicable model for similar training initiatives.

Another notable strength was the application of adult learning principles throughout the training programme. Rather than relying on traditional didactic methods, the programme emphasized interactive pedagogies, including case-based learning, real-world problem solving, and peer-to-peer learning. According to principles of andragogy, adult learners benefit most from learning experiences that are practical, self-directed, and grounded in their prior experiences [22–24]. Evidence from previous studies also supports the effectiveness of interactive and experiential learning approaches in improving training outcomes among healthcare professionals [25–28]. By incorporating group activities, case discussions, and field-based exposure, the programme likely enhanced both knowledge retention and the translation of learning into practice, as reflected in participants' action plans.

The programme's content was both comprehensive and contextually tailored. It covered a breadth of soft skills – leadership, communication, teamwork, stress management – which are often neglected in conventional nurse education. Participants valued this, especially the inclusion of topics like stress management that addressed personal development in addition to administrative skills. Moreover, involving expert facilitators from diverse backgrounds (academia, nursing administration & healthcare) enriched the learning. This multi-faceted design is in line with recommendations from management training reviews that highlight the importance of varied expertise and teaching methods [6,7, 29]. Internationally, capacity-building programmes for health managers in other LMICs (e.g., in Africa and the Middle East) have reported positive outcomes when they adapt to local needs and use interactive learning [30].

The present initiative also aligns with national and global efforts to strengthen nursing leadership. In India, institutions such as the National Institute of Health and Family Welfare have conducted leadership workshops aimed at enhancing managerial competencies among nurse leaders, although such initiatives have often been sporadic. Empirical evaluations of such programmes remain limited. However, midwives in India reported improvements in leadership capacity and were positively received by stakeholders [29]. The findings of the current study are also consistent with global calls to strengthen nursing leadership as a critical component for achieving universal health coverage and improving health system performance [7].

Implications for Practice and Policy

The positive outcomes from this study suggest that similar in-service training programmes can be a viable strategy to enhance the capacity of nurse educators and, by extension, the nursing workforce. For practice, healthcare institutions (particularly, hospitals, and nursing colleges) should consider incorporating regular management and leadership workshops for their nursing staff. Even short courses, if well-designed, can boost confidence and skills. Institutional support, such as allowing time off for training and opportunities to apply new skills (for example, assigning leadership roles in quality improvement initiatives), will be important to sustain the benefits. For policy, state and national nursing bodies could formalize such capacity-building into continuing nursing education requirements. The NNMC Act of 2023 [6] already paves the way by recognizing soft skills; implementing its vision could involve funding and scaling programmes like this across different regions. Partnership with

public health institutes and leveraging technology (for blended or online modules) can help cover larger numbers of nurses. Additionally, establishing structured follow-up mechanisms—such as mentorship programmes or communities of practice—could enhance long-term impact. Notably, participants in the present study expressed a clear interest in ongoing mentorship, highlighting an important gap in current training models.

Implications for Research

This study contributes to the scant literature on management and leadership training for nurses in LMICs, particularly in the Indian context. Future research should prioritize longitudinal outcomes. Moreover, qualitative research could delve into how such training influences nurses' sense of professional identity and motivation – aspects hinted at by some of our participants' comments about feeling more empowered and having a "revised vision" for the profession. Understanding these soft outcomes is key to fostering nurse leadership. Future research should prioritize longitudinal assessments to evaluate sustained outcomes. Key questions include whether trained participants are more likely to assume leadership roles and whether their institutions demonstrate measurable improvements in indicators such as staff retention, team performance, and patient satisfaction. Comparative studies could further examine the relative effectiveness of different training modalities, such as field-based learning, simulation, and classroom-based instruction, in developing specific competencies. In addition, qualitative research could provide deeper insights into how such training influences nurses' professional identity, motivation, and sense of empowerment. Participants' reflections in the current study suggest shifts in perspective and increased confidence, indicating that these "soft outcomes" warrant further exploration to better understand their role in fostering effective nursing leadership.

Limitations of the study

Authors acknowledge limitations of the study. First, the sample size was small (32 participants) and all were women nursing educators, which may limit the generalizability of findings. Second, the evaluation primarily captured short-term outcomes. While knowledge gains were measured immediately post-training and participants' intended actions were documented, but the study did not assess long-term behavioural changes or organizational impact (e.g., whether patient care improved or institutional policies changed as a result of the training). Follow-up studies are needed to examine if the participants implemented their action plans and what barriers or successes they encountered – factors critical for judging sustained impact. Third, the use of a pre and post-test without a control group means improvements could partly reflect a test-retest effect. However, the magnitude of the knowledge gain and the statistical significance make it likely that the training itself was the key driver. Still, future evaluations could strengthen design by including a comparison group or delayed post-tests to assess knowledge retention over time. Lastly, self-reported feedback may carry some positivity bias, especially since participants knew the organizers. Authors attempted to mitigate this by anonymizing the feedback process. It is worth noting that even the suggestion for improvement (more practical cases in finance topics) indicates participants provided constructive critique, not just praise.

CONCLUSION

The structured skill-building programme for nursing educators significantly improved participants' knowledge in management and leadership skills and was received well with high satisfaction. Using adult pedagogy techniques and a needs-based curriculum, the training bridged critical competency gaps in communication, administration, and team leadership. Participants left with

greater confidence and concrete plans to implement improvements in their workplaces.

Although the study was limited to short-term outcomes, it provides a successful example of integrating soft skills development into nursing continuing education in the Indian context. Sustained efforts, including follow-up mentorship and periodic refresher training, are recommended to maintain momentum. Overall, such programmes should be scaled up as part of health workforce development initiatives.

Declaration by Authors

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