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Ideal and Real Performance Expectations of Baccalaureate Nursing Graduates as Perceived by Graduates, Nurse Educators, and Nurse Administrators

Maureen Martin Fochtman
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IDEAL AND REAL PERFORMANCE EXPECTATIONS OF BACCALAUREATE
NURSING GRADUATES AS PERCEIVED BY GRADUATES, NURSE
EDUCATORS, AND NURSE ADMINISTRATORS

by

Maureen Martin Fochtman

A Dissertation
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
Degree of Doctor of Education
Department of Educational Leadership

Western Michigan University
Kalamazoo, Michigan
April 1987

IDEAL AND REAL PERFORMANCE EXPECTATIONS OF BACCALAUREATE
NURSING GRADUATES AS PERCEIVED BY GRADUATES, NURSE
EDUCATORS, AND NURSE ADMINISTRATORS

Maureen Martin Fochtman, Ed.D.

Western Michigan University, 1987

Nurse educators and nursing service administrators have different expectations for the baccalaureate graduate nurse. The difference in expectations has made the transition from student to practitioner difficult for the new graduate.

The purpose of this study was to identify the ideal and real expectations regarding entry level performance as perceived by nurses who graduated in 1985 from 17 of 31 baccalaureate programs represented in the Consensus on Entry project. The ideal and real expectations of the graduates were compared to the nurse educators' and the nursing service administrators' results from the Consensus on Entry project.

One hundred fifty-four baccalaureate graduates completed the Benner Proficiency Scale and the Six-Dimension Scale of Nurse Performance. The graduates' ideal expectations were compared to the graduates' real expectations. The graduates' ideal and real expectations were compared to the nurse educators' expectations. The graduates'

ideal and real expectations were compared to the nursing service administrators' expectations.

It was found that baccalaureate graduates ideally would like to be more proficient in the performance of technical skills, critical care skills, interpersonal skills/communication, leadership skills, planning and evaluation, and teaching and collaboration skills than they really are at graduation.

On the ideal and real expectations of performance of baccalaureate graduates on the six dimensions of nursing practice tested, there were differences between the responses of graduates, nurse educators, and nursing service administrators. Additional studies are needed on programs that assist the transition of student nurses to practitioners, collaboration among nurses and other health care workers and how their collaboration affects patient outcomes, how nurses plan, make decisions, and evaluate care, and leadership in nursing.

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nursing graduates as perceived by graduates, nurse educators,
and nurse administrators**

Fochtman, Maureen Martin, Ed.D.

Western Michigan University, 1987

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DEDICATION

To the memory of my parents,
James and Geraldine Martin

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Maureen Martin Fochtman

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CHAPTER I

INTRODUCTION

Purpose of the Study

This exploratory study was conducted to identify ideal and real expectations of entry level performance, as perceived by nurses who graduated in 1985 from 17 baccalaureate programs represented in the Consensus on Entry Skills project (Stull, 1985). The perceptions of the graduates were compared with nurse educators and nurse administrators who participated in the Consensus on Entry Skills project. Throughout this paper, the term graduates refers to baccalaureate graduate nurses who have completed a four-year program in nursing education.

The baccalaureate project, "Consensus on Entry Skills" (Stull, 1985), was funded in June 1984 by the Division of Nursing, United States Department of Health and Human Services. Twenty-nine teams from 13 Midwest states representing 31 baccalaureate programs, 28 skilled nursing facilities, 29 community health agencies, and 34 hospital based services were selected. The purpose of the Consensus project, which was headquartered at St. Louis University, was to gain consensus on entry level skills in the Midwest, to compare and contrast the perspective of

the service settings and baccalaureate education, and to develop ongoing collaborative efforts between education and service.

The assumption underlying the Consensus on Entry Skills project was that nurse educators and nursing service administrators were not satisfied with the product of baccalaureate nursing education programs. Several authors (Cicatiello, 1979; Dexter & Laidig, 1980; Ehrat, 1979; Field, Gallman, Nicolson, & Dreher, 1984; Gray, 1979; Halloran, Mishkin, & Hanson, 1980; Keen & Dear, 1983; Peters, 1980) have discussed the gap between the expectations of nursing service administrators and nurse educators, regarding the entry level performance of the baccalaureate graduate. The baccalaureate graduate nurse experiences reality shock because of the gap in expectations between nurse educators and nursing service administrators. Reality shock, the startling discovery and reaction to the realization that school-bred values and expectations conflict with work world values, occurs in nursing as in other occupations. However, it has been found to be a significant factor in the almost one-third exodus rate of nurses from the practice of nursing within a few years of graduation (Kramer, 1971, p. 15).

If one of the reasons that nurses are leaving the nursing profession is because of the divergent values of nurse educators and nursing service administrators, it is

important to note the differences of the two groups.

K. Smith (1965) and Dickerson (1975/1976) both examined nursing service personnel values and nurse educators' values. K. Smith (1965) gathered 52 performance evaluations completed by head nurses and 56 performance evaluations completed by nurse educators, then analyzed them for values content. In 13 of 25 categories, K. Smith was able to find significant differences between head nurses and nurse educators (p. 197). To a significant extent, these two groups evaluated the performance of graduate nurses based on quite different criteria (p. 201). The areas the head nurses (service) and the nurse educators valued are shown in Table 1.

Dickerson (1975/1976) compared the values of administrators of nursing service and administrators of nursing education programs. A rating scale of 30 items was utilized. In the grouped comparisons, the general findings were that significant differences were demonstrated on 8 items of the rating scale. The items nursing service administrators and nursing education administrators rated higher are shown in Table 2.

Cantor, Schroeder, and Kurth (1981, p. 17) postulated that it was possible that neither nursing service administrators nor nursing education administrators were focusing on the content most relevant to patient well-being and comprehensive nursing care programs. Could both groups be

neglecting to foster the knowledge and environment most conducive to a high standard of nursing care?

Table 1
Areas the Head Nurses and Nurse Educators Valued

Head nurses	Nurse educators
Ability in leadership, especially over lesser prepared personnel	Directiveness in evaluating work of others questioning doctor's orders
Obedience to authority	Sensitivity to emotional needs of the patients
Conformity to organization rules and regulations	Emotional supportiveness toward patients
Cooperation	Physical supportiveness in patient care
Friendliness	Cognitive skills applied to an intellectual analytical approach to nursing care
Good personal appearance	
Composure while functioning in the work setting	
A good-humored approach to daily activities	

Note. From "Discrepancies on the Role-Specific Values of Head Nurses and Nurse Educators" by K. Smith, 1965, Nursing Research, 14, pp. 199-200.

If Cantor et al. (1981) is correct, could it be that nursing as a profession has not identified distinctive characteristics? Koewing (1972) stated that to identify distinctive characteristics of a particular profession compared with other professions, a useful discussion starter is the question, How is nursing unique?

Table 2

Items Rated High by Nursing Service Administrators
and Nursing Education Administrators

Nursing service administrators	Nursing education administrators
Importance of interpersonal relationships (Item 22)	Providing a safe environ- ment for the patients (Item 5)
Cognizance of group dynam- ics necessary for effective practice (Item 23).	Evaluating patient care (Item 6)
	Incorporating community agencies in providing con- tinuity of care (Item 11)
	Establishing priorities in planning patient care (Item 13)
	Altering the plan of patient care (Item 13)
	Applying problem-solving techniques to nursing ac- tivities (Item 30)

Note. From "An examination of competency ratings for be-
ginning nurse practitioners" by T. M. Dickerson, 1975/
1976, Dissertation Abstracts International, 36, p. 1937.

Once the uniqueness of nursing is determined, the readiness to begin practice in a profession can be evaluated. To determine readiness to practice, a selection system is necessary. Menges (1975, p. 173) stated that there are four types of evidence in any selection system: (a) personality characteristics, (b) knowledge of the subject matter, (c) application of subject matter, and

(d) performance on the job. The first three of Menges's criteria are evaluated in the educational process in nursing. All four of the criteria are evaluated in the practice setting. The problem of role transformation from student nurse to practitioner is difficult for the new graduate. The first job is crucial in the occupational socialization of the nurse because of the involvement and drive to develop his or her identity as a practitioner. This is a pivotal time for an effective role transformation whereby the conflicts between school values and work values are mediated (Kramer & Schmalenberg, 1977a, p. 1).

The problem of role transformation is unique to the past 30 years in nursing. Prior to that time, the majority of nurses were prepared in hospital-based and controlled programs. Learning was almost completely apprenticeship in nature. There was little discrepancy between the beliefs and practices in school and at work, hence little or no reality shock.

In the last 30 years, education of the nurse has moved from the hospital setting to the college or university. The change in the locus of education has been supported by the professional organization, the American Nurses' Association. They stated in their first position paper on education in 1965 that nursing education should take place in institutions of higher learning and that the minimum preparation for professional practice should be

the baccalaureate degree. During the past 30 years, the percentage of nurses being prepared in hospital-based programs (diploma) has diminished with the higher percentage of nurses being educated in a college setting.

The goal of baccalaureate nursing education is to prepare a liberally educated person to function as a professional nurse in a variety of nurse roles and health care settings. Roles are made up of a constellation of functions. Most baccalaureate programs prepare their graduates for the functions inherent in five specific roles or positions: the caregiver function, which is the mainstay of the staff nurse position in both hospitals and community health agencies; the beginning managerial-leadership function, which is inherent in such roles as team leader, assistant head nurse, or head nurse in centralized settings; the health promotion and health supervision function, which predominates in positions in community health nursing, school nursing, and mental health clinics, and is needed in the hospital staff nurse position; the teaching or counseling function, which is or should be an integral part of almost every nursing position; and the health and illness screening function, which predominates in primary care, but is also increasingly demanded in hospital staff nurse positions. (Kramer, 1981, p. 224)

Today's nursing students must, in a brief, four-year span, master the increasingly sophisticated techniques that will equip them to respond to the needs of the individuals that they will serve. Coleman (1986) stated that she knows of no other profession that asks so much of its undergraduates.

Several programs have been instituted to assist the new graduate with the transition from student to practitioner. One approach was the bicultural training

advocated by Kramer and Schmalenberg (1977c).

Biculturalism is the ability to get along in two cultures or subcultures without fusing with or being absorbed by either of them completely. Biculturalism is the ability to understand the new subculture sufficiently to react in appropriate ways, establishing an individual identity within it, and effectively initiate new ideas or values within it. A bicultural nurse makes integrative choices and comes up with creative solutions to the conflicts caused by the two disparate value systems. The key to achieving biculturalism is interpersonal competence. The person possessing interpersonal competence (a) can define the cultural differences between self and another clearly, (2) possesses a repertoire of strategies that are potentially useful in situations where the norms and behavior representative of different subcultures might conflict and (3) can select from among these strategies and implement those that are useful and appropriate to a given situation. (Kramer & Schmalenberg, 1977c, pp. 3-4).

A second approach was the nurse intern program. The most common nurse intern program used a preceptor for the clinical component (Dell & Griffith, 1977; Friesen & Conahan, 1980; Hammerstad, Johnson, & Land, 1977; May, 1980; McGrath & Loewing, 1978; Minor & Thompson, 1981). The preceptor became the role model and the confidant as well as the person who guided the learning process. The preceptor modeled leadership behaviors, i.e., decision making, delegation, and priority setting, which the new graduate could emulate in situations in the future (Murphy & Hammerstad, 1981; Plasse & Lederer, 1981).

A third approach was to design a comprehensive orientation program which went beyond the "need to know" of

hospital policies and procedures (Joint Commission on Accreditation of Hospitals [JCAH], 1983) and added some "nice to know" experiences in the health care setting.

A fourth approach was the extern program. Student nurses were given the opportunity to practice their skills (Bushong & Simms, 1979). Student nurses, hired the summer before their senior year, practiced most aspects of the graduate nurse role under the guidance of skilled nurses (Hartin, 1983). These programs provided a job to earn money for school and the reality of the nurses' work world.

Topp (1984) studied new graduates who had participated in one of four programs: orientation, intern, extern/intern, and extern/orientation, as part of the transition from student to practitioner. Results of this small study of job satisfaction demonstrated no significant conclusions. All graduates had comparable scores on the Index of Work Satisfaction regardless of the entry into practice route. It should be remembered that all four programs provided some transition from school to work experiences.

Several approaches to assist the graduate in the transition from student nurse to practitioner have not been as successful as was hoped (Orleck, 1982, p. 23). Closer collaboration between nurse educators and practicing nurses who provide patient services seems essential to

give students an appropriate balance of academic and clinical practice perspectives and skills during the educational process.

Whitney (1986, p. 42) identified four strategies or actions which would result in closer collaboration: (a) improvement and documentation of the nursing product, (b) development of care systems in which nurses would play major roles, (c) the education and use of nurse managers, and (d) research programs that contribute theoretic and practical knowledge.

Significance of the Study

An economic view of collaboration between nursing service and education illustrates the importance of defining common products, goals, and markets. By recognizing the professional advantages of sharing resources and expertise, nursing education and nursing service may gain greater influence in the changing health care system. (Whitney, 1986, p. 42)

The health care system has experienced major changes since the advent of a federal prospective payment system, which renders fixed payments to hospitals in advance on the basis of the patient's diagnosis. Diagnostic related groups (DRGs) have placed medical institutions at financial risk for the first time (Maraldo, 1984, p. 12).

The constrained economic environment in health care inhibits funding for expansion and improvement. It exerts pressure on all providers to economize, to cut

back, and to do more with fewer resources. The term "cost-containment" must be operationalized in health care (Ginsberg, 1981, p. 29).

Nurse educators and nursing service administrators must communicate and collaborate if nursing is to survive the change in health care delivery. The concept of productivity in health care and education is relatively new. Measures of output in complex environments, such as nursing service and education, cannot fully reflect all service units delivered. Education is being analyzed in terms of definable product outputs. Yet the "product" in education remains elusive with perceptions varying among institutions, educators, parents, and students (Whitney, 1986, p. 39).

This study provides direction to nurse educators and nursing service administrators to insure that the graduates have the necessary knowledge and skills for a smooth transition to the practice world.

Statement of the Problem

What does the product, the baccalaureate graduate nurse, think about his or her preparation for the practice world? The purpose of this study was to identify ideal and real expectations of entry level performance as perceived by nurses who graduated in 1985 from 17 baccalaureate programs represented in the Consensus on Entry

Skills project.

The research questions were:

1. Do new baccalaureate graduates perceive that ideal performance expectations match real performance expectations at graduation?

2. Is there consensus among new baccalaureate graduates, nurse educators, and nurse administrators regarding ideal and real performance expectations of the baccalaureate graduate nurse?

In summary, there is a need for further research on the entry level performance of the baccalaureate graduate nurse. Several authors have stated that there is a gap between the expectations of nurse educators and the expectations of nursing service administrators regarding the ability of the baccalaureate graduate to function in the clinical setting at graduation. The graduates have expressed their frustrations as well (Caghan, 1970; Finkelstein, 1979). There is a paucity of empirical research that documents the perceptions of the three groups.

For the purposes of this study the views of graduates from 17 baccalaureate nursing programs from large universities and small colleges throughout the Midwest were surveyed within the graduates' first year of practice.

This study provides graduates of baccalaureate degree programs, nurse educators, and nurse administrators with an understanding of the entry level performance

expectations for the baccalaureate graduate nurse. Entry level performance was assessed through the following dimensions of nursing practice: technical skills, critical care skills, leadership skills, teaching/ collaboration, and planning and evaluation. A glossary is located in Appendix A.

Outline of the Study

In Chapter II, nursing is defined, an historical view of nursing education and nursing practice are provided, and theoretical literature and research findings related to the dimensions of nursing practice mentioned in the study are reviewed. The methodology used to carry out the study is outlined in Chapter III. Chapter IV contains a presentation of the data and the data analysis narrative. Chapter V includes the discussion of the results, limitations of the study, implications of the study for practice, and recommendations for future research.

CHAPTER II

REVIEW OF THE LITERATURE

"Nursing stands at the brink of disaster--or just a step away from professional fulfillment. That contradictory assessment reflects the uncertainties that face not only nursing but the entire health care industry" (Lee, 1984, p. 26).

A 1978 publication of the American Nurses' Association (ANA), Nursing, A Social Policy Statement, defines nursing as the "diagnosis and treatment of human responses to actual or potential health problems" (p. 9). This definition provides a newly stated identity of nursing. Therefore, it is relatively fragile, although a review of journal articles and books published by nurses over the past several decades substantiates that this definition of nursing practice has been emerging for several decades (Peplau, 1981, p. 6).

History of Nursing

Nursing today was formed by its historical antecedents. Its development since ancient times, within the social contexts of those times, explains many things: its power or lack of power, its educational confusion, and the

makeup of its practitioners. The changing relationship between nursing and other health care professions, nursing and other disciplines, and nursing and the public can be traced and better understood with the knowledge of past history (Kelly, 1985, p. 4).

In earlier centuries, beginning in A.D. 1 with the dawn of Christianity, the function of nursing was to heal, according to Dock and Stewart (1920). This function began to be lost as the field of medicine gained ascendancy during the Industrial Revolution (Ehrenreich & English, 1979). The rapid development of medical science and related technology following World War II put the healing function squarely in the domain of medicine and physicians. Since nursing was not an autonomous profession at that time, the profession did not know what its function should be. It left nurses in a major identity crisis (Peplau, 1981, p. 6). Nurses became medical assistants, by focusing their attention on monitoring the technology and machines spawned by the demands of an expanding medical science (Peplau, 1977). Gradually, with the development of clinical specialization in nursing (beginning in 1943 but expanding in the 1960s to the present time) nurses through their practices and their publications began to recognize, investigate, and define nursing as the diagnosis and treatment of human responses to actual and potential health problems. This definition is not

entirely new as it was an ingredient in nursing's age old healing function, but claiming it, seeking public recognition and social support of it, is barely a decade old (Peplau, 1981).

History of Nursing Education

In addition to the changing focus of nursing practice from ancient times to the present, there has been a change in the education of the nurse. Nursing care was provided for ill individuals primarily by family members or members of religious orders in colonial America. Care was given in the home. The first hospitals were not established until the early eighteenth century. The early hospitals were staffed by hospital sisters and laywomen who received on-the-job training (Deloughery, 1977).

In 1798, Dr. Valentine Seaman, a surgeon from New York, began to provide instruction to nurses. His was an early attempt to educate nurses by other than on-the-job training. Several subsequent attempts to reorganize nursing education occurred in the early 1800s. However, the field of medicine was just beginning to develop in the United States, and since nursing was under the auspice of medicine, nursing had to wait for development. Following the model established by Florence Nightingale when she organized the school of nursing at St. Thomas Hospital in London in 1860, American nursing education began in

hospital schools of nursing (Kalisch & Kalisch, 1978). Two cardinal principles established by Miss Nightingale were that nurses should be trained in hospitals designed to do the training and that the nursing education units should be separately administered and should not be an integral part of hospital administration. Since the Nightingale School was privately funded by the Nightingale Endowment, it was feasible to organize as an autonomous unit. The nurses educated at the Nightingale School received one year of training in hospital nursing which incorporated the concept of home care (Deloughery, 1977).

In 1873, three important schools of nursing which greatly influenced the development of American nursing were established. The three pioneering schools were Bellevue Hospital of Nursing in New York, New England Hospital School of Nursing in Boston, and Connecticut Training School for Nurses in New Haven. Although Florence Nightingale had advocated separation of nursing education and nursing service, for financial reasons the U.S. schools chose to merge the two entities under the control of hospital administration. With education being controlled by administration, the autonomy of diploma school education was lost at the beginning (Deloughery, 1977; Kalisch & Kalisch, 1978).

Although the diploma school model typified American nursing education for many years, periodically there were

efforts to suggest that nursing education be placed in the mainstream of higher education. The first formal challenge to the diploma model came in 1909 with the establishment of a baccalaureate program at the University of Minnesota (Deloughery, 1977). This three year curriculum awarded graduates a diploma rather than a degree, but the fact that the program was located in a university setting challenged nurse educators to examine the benefits of university education for nurses.

In 1917, the Standard Curriculum for Schools of Nursing (National League for Nursing, 1917) was published in an attempt to unify and upgrade content in nursing schools. The advent of World War I delayed the cause of moving nursing education into universities. Although wars may slow progress, the need for nurses in wartime highlights nursing and ultimately validates the need for nursing education. In 1918 the Vassar Training Camp Program was established to train college women for careers in nursing. While meeting the short-range needs for nurses, the Vassar Training Camp Program also heightened the interest for nursing education to move to colleges and universities (Kalisch & Kalisch, 1978).

As a consequence of World War I and progress in medical care, nursing leaders recognized that pre-World War I nursing education needed upgrading in order to meet post-World War I needs. In 1920, a committee was

established to investigate and report on the need for standardization and improvement in nursing education. In 1923, a landmark report entitled Nursing and Nursing Education in the United States (Committee on the Study of Nursing Education, 1923) was published by the committee. Three major points were offered by the report:

1. Public health nursing was being neglected.
2. Many nursing schools lacked qualified faculty, had inadequate facilities, and failed to relate theory to practice.
3. The chief nurse of the hospital should not be head of the school of nursing.

In 1924, the Yale School of Nursing was established as the first autonomous collegiate school of nursing. Yale offered the Bachelor of Nursing degree following a 28 month course of study.

World War II brought new challenges to American nursing and nursing education. Of primary importance in the early 1940s was the recruitment and preparation of sufficient numbers of nurses to meet the needs of both armed forces and civilian agencies. Medicine and nursing progressed rapidly during and immediately after World War II. Public health nursing and psychiatric-mental health nursing expanded as nursing specialties. In 1946, high school graduation became a universal requirement of professional licensure (Kalisch & Kalisch, 1978).

A landmark report, entitled Nursing for the Future, by E. Brown was published in 1948. E. Brown of the Russell Sage Foundation directed this study which recommended that schools of nursing should have separate budgets. The E. Brown report recommendations contributed to the development of nursing as a collegiate discipline and to the placement of nurses as integral members of the health team. E. Brown was the first to use the terms professional and technical to differentiate types of nurses (Deloughery, 1977).

In 1951, Montag proposed a new type of nursing personnel, the nurse technician, who would be trained in a two year program. The associate degree nursing program was initiated to prepare technical nurses through a two year program located in a junior or community college. It was Montag's intent that the nurse technician would assist the professional nurse, not replace that position.

During the 1950s, baccalaureate nursing education continued to expand. Baccalaureate programs began to move from a five year plan (they had expanded from Yale's 28 month program to five years in the subsequent 25 years), to four years of requirements for the degree.

Currently, nursing has three levels of entry into practice: the two year associate degree, the three year diploma, and the four year baccalaureate degree. Graduates of all three types of programs can be licensed as

registered nurses if they pass the examination. Since 1965 the American Nurses' Association has stated that the associate degree and diploma graduates should be licensed as technical nurses, and the baccalaureate nurse as the professional nurse. The 1965 position paper (American Nurses' Association, 1965) generated an outcry among nurses, particularly diploma graduates. Rather than serving as impetus for change, the position paper became a divisive force which pitted nurses against one another.

Nursing is the only profession that has three levels of entry into practice. This has caused a great deal of confusion in the institutions in which nurses are employed, and with the other health care workers that do not understand the difference. Empirical research supports the differentiation of technical and professional nursing based on education (Primm, 1986, p. 3). Once there is a change in licensure, and job descriptions are written to reflect the different expectations of the technical and professional nurse, nursing can progress as a unified body.

Theoretical Framework

The frame of reference for this study is socialization theory. Socialization into a profession, or role taking, has been defined by a number of theorists (Huntington, 1957, p. 187; Jacox, 1978, p. 19; McKinney, 1957,

p. 187; W. Moore, 1970, p. 71). Among these definitions, several common factors associated with professional socialization can be derived. The first factor deals with the process of acquisition of not only the knowledge and skills associated with a particular profession, but also with the internalization of the attitudes, beliefs, and values of the profession into the individual's self-concept which then governs his or her behavior. The second factor is described by Abrahamson (1967), who stated that there are formal and informal components associated with professional socialization. The formal consists of teaching of theories and methods; the informal involves teaching the personal values and ways of behaving. The final factor involved in the definition of role socialization is that professional socialization is a process (Abrahamson, 1967; Huntington, 1957).

From this perspective this research views the situation of the newly hired, new graduate nurse as one phase in a developmental process which had its beginnings in the educational setting and which will culminate sometime in the future with the establishment of a stable pattern of professional values and behavior. The phase addressed here is of importance since it bridges two very different subcultures--nursing education and nursing practice, and it may be that nurses' adaptation during this period will prove significant for later role development. Corwin

(1960) was the first researcher to look at the impact of professional versus bureaucratic value orientations on nurses' initial adjustment to their role.

Studies on the Role of the Nurse

In studying the composition of the nurse role, Corwin (1960) established that a difference exists between role conceptions of nurses from diploma programs and those from college based programs. He determined that there are three types of role conceptions:

1. Bureaucratic role conception requires that the primary loyalty of the nurse be to the hospital and hospital administration, to the work routines, and the personnel supervision. The administrative rules, policies, and regulations which describe the nurse's job within a specific hospital are accepted. Emphasis is placed on values such as strict adherence to rules, routines, record-keeping, and punctuality.

2. Professional role conception requires that the primary loyalty of the nurse be to the profession. Emphasis is placed on nursing education programs being offered by institutions within the system of higher education rather than hospital schools of nursing. Values such as active participation and membership in the professional association and commitment to formal knowledge and to continued learning as the basis of the profession are stressed.

3. Service role conception requires that the primary loyalty of the nurse be to the patient as the recipient of humanitarian services. Nursing is conceived as a calling which suggests devotion to the patient as a person. Nurses engage in administering direct nursing care to patients from which they receive personal satisfaction. The values emphasized

include service to humanity, compassion, dedication, and understanding. (Corwin, 1960, p. 72)

Corwin (1960) defined role deprivation as the extent to which the perception of the ideal role conception of nursing differs from the perception of the real practice role of nursing. In his study of 296 nurses and nursing students, Corwin found that those holding high bureaucratic orientation and high professional orientation expressed greater role deprivation than those who held low bureaucratic and low professional role conceptions. Degree nurses were more likely to maintain a higher professional role conception than diploma nurses. Degree nurses also attempted to combine their high professional role orientation with a high bureaucratic orientation more frequently than diploma nurses, thus experiencing more conflicts. Diploma graduates were more likely to escape conflicts by maintaining both low bureaucratic and low professional role conceptions.

Corwin and Taves (1962) concluded from a study of 124 staff nurses and 74 nursing students that the type of role conception held, the certainty with which it was held, and the amount of role deprivation experienced differed for nurses from different educational programs. Corwin and Taves (1962) demonstrated, as did Corwin (1960), that baccalaureate nurses were more susceptible to role deprivation because they held higher professional role

conceptions than did diploma nurses. Corwin (1960) referred to the role transformation process (from student to practitioner) that did not meet expectations as a depriving experience which provided a reality shock.

In 1971, Kramer, building on Corwin's (1960) work, investigated the effects of a bureaucracy on the role conception and role deprivation of graduate nurses. She administered the Corwin Role Conception Scale at graduation from a baccalaureate program, 3 months after graduation, and 6 months after beginning employment.

Kramer (1971) found the following:

1. There was significant increase in loyalty to bureaucratic values following employment and a significant decrease in professional values. Those nurses in the sample who did not make this alteration left hospital work or nursing in significantly greater numbers than those who did.

2. There was a significant increase in the magnitude of role deprivation of the group as a whole three months after graduation. The magnitude of role deprivation receded to graduation level six months after employment, but the composition of the group had changed by this time to exclude those who were most role deprived in previous testing.

3. Subjects who left nursing practice, changed jobs because of dissatisfaction, or returned to school had significantly higher role deprivation scores than subjects who remained in the same job for the six-month period of the study. (p. 429)

A follow-up of these same nurses 2 years later showed an even further decrease in professional role conception from the 6-month postgraduation testing, with an increase

in bureaucratic role conception. The nurses who chose to remain in the setting were assimilating the work values (Kramer, 1974).

Kramer (1974) continued her studies of the dilemmas confronting the new graduate by investigating the effects of an anticipatory socialization program on the value orientation, chosen work locales, and career patterns of two classes of baccalaureate nurses. The anticipatory socialization program was designed to help graduates deal with conflicts between school and work values and thereby reduce role deprivation. Graduates were exposed to the realities of the bureaucratic work scene and were assisted to develop integrative role behaviors that would permit them to survive and be successful in the bureaucratic setting while retaining professional values (Kramer, 1974).

Integrative role behavior, as defined by Kramer (1974), is an effective compromise between behavioral choices that support professional values and those that support bureaucratic values. It is measured by the Kramer Role Behavior Scale which asks the respondent to state the extent to which he or she would enact certain behaviors. Kramer concluded that the anticipatory socialization program was effective in decreasing role deprivation upon employment, in increasing the length of time that nurses remained in their initial jobs and in nursing practice,

and in helping nurses develop integrative role strategies useful in managing conflicts (Kramer, 1974).

During this study on the effects of anticipatory socialization program, Kramer (1974) developed the reality shock theory and first used the term "reality shock" synonymously with role deprivation. According to Kramer, the underlying cause of reality shock is the degree of professional-bureaucratic conflict that one experiences. Shock occurs because the professional and bureaucratic modes of work organization are inherently antithetical. The bureaucratic work system is based on the partial-task approach in which tasks are subdivided into such patient care tasks as taking blood pressures, temperatures, and giving medications. This leads to a need for external supervision, a hierarchical control structure, and written rules for maintenance of desired standards. The professional system promotes the use of judgment, autonomy, cognitive skills, and internalized standards (Kramer, 1972). Conflicts between these modes produce a disparity between what the nurse thinks should happen and what in reality is happening, i.e., role deprivation (Kramer, 1974).

To help make a smoother and more effective transition from school to the work world, Kramer and Schmalenberg (1977c) developed a Bicultural Training Program. The program lasted from 6 weeks after beginning employment until

5-1/2 months after beginning employment. The program consisted of three components: (a) Referent Group Development, designed to help graduates deal with conflicts on the emotional level; (b) Path to Biculturalism, designed to provide the knowledge needed to resolve conflicts between value systems; and (c) Conflict Resolution Workshops, designed to provide the opportunity to utilize and practice the knowledge and skills gained from the instructional programs in the resolution of typical work conflicts (Kramer & Schmalenberg, 1977c).

Kramer and Schmalenberg (1977c) did a follow-up study on Bicultural Training, with graduates of diploma programs, associate degree graduates, and baccalaureate graduates. It was found that nurses who had the Bicultural Training Program retained a higher professional role conception and reported more bicultural behavior choices when faced with nursing conflict situations. These nurses were also more involved and more effective in change-agent activity and more empathetic with co-workers. It was concluded that the Bicultural Training did not significantly lower role deprivation. However, the educational program from which the nurses graduated did affect the professional role conception and role deprivation. Baccalaureate nurses had the highest professional and service role conceptions and total role deprivation on both the pretest and posttest. Diploma graduates showed the

highest bureaucratic role conceptions and lowest total role deprivation at pretest time; however, on posttesting, the associate degree graduates had increased their bureaucratic role conception to the point that they were even with the diploma graduates. Thus, as in other studies, the baccalaureate nurse was found to experience the greatest difficulty in making the change from school to work; the change was most congruent for the diploma nurse; and the associate degree nurse experienced initial difficulty but quickly adopted the bureaucratic role conceptions of the work subculture (Kramer & Schmalenberg, 1977c).

Wesorick (1986) developed a clinical model which differentiates professional nursing from institutional nursing. Like Corwin (1960) and Kramer (1971), she studied the professional-bureaucratic conflict. Wesorick stated that nurses need to practice professional nursing not institutional nursing in a bureaucratic setting. She defined institutional nursing as a dependent role. Nurses who practice institutional nursing are treating the human responses of patients only as directed by the physician and the institution's policies and procedures. For years, bureaucratic policies have dictated nursing practice. Wesorick contends that there must be an interface between professional nursing practice and the bureaucracy. To practice professional nursing, the independent and the interdependent roles of nursing must be utilized, not just

the dependent role (Wesorick, 1986).

Primm (1986) developed a practice model that identifies the role components of the nurse. Primm's model includes three major and three minor components of nursing practice. The three major components of the practice role of the nurse are provider of care (technical skills), communicator (interpersonal skills), and manager of care (leadership skills).

Primm's visual model (Figure 1) shows the three minor components of the practice role of the nurse: teaching, coordination of care, and delegation of care.

Primm (1986) has defined the practice role of the nurse using the three major components provider of care, communicator, and manager of care for the associate degree graduate and the baccalaureate degree graduate. Job descriptions were written for both levels of graduates. The job descriptions, with associate degree in nursing (ADN) and bachelor of science in nursing (BSN) graduates functioning under the appropriate one, have been implemented in five medical centers. Evaluation is forthcoming (Primm, 1986, pp. 3-4).

In addition to Primm's (1986) research, the American Association of Colleges of Nursing (AACN, 1986) has written a report entitled, Essentials of College and University Education for Professional Nursing. The report identified three major roles of the nurse: provider of care,

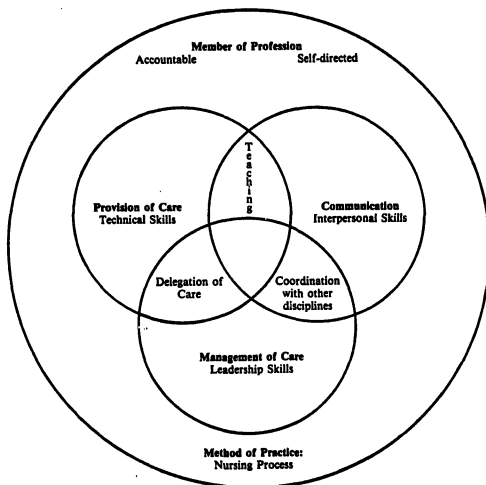


Figure 1. Practice Role of Nurse: Interface of Role Components. From "Defining and Differentiating ADN and BSN competencies" by P. Primm, 1986, Issue, 7(1), p. 1.

coordinator of care, and member of a profession.

Several studies on the role of the nurse have described the professional-bureaucratic conflict. The later studies focused on the practice role of the nurse, and the components or dimensions of that role.

The terms components or dimensions have been used to describe the parts, constituents, or elements of the role of the nurse. The dimensions/components of the role of the nurse discussed were technical skills, critical care skills, interpersonal skills/communication, planning and evaluation, and teaching and collaboration. Multidimensions/components of the role were included. Studies have shown that a profession cannot be defined by one dimension, but by a compilation of dimensions, that become the scope of the role of the nurse.

Studies of the Technical Skills of the Nurse

Primm's (1986) model clearly identifies the importance of technical skills in nursing practice. Kramer (1974) also suggested that nursing education prepare students to be knowledgeable and competent in their performance of basic manual-technical skills. She stated that skill-learning, which is one of the initial and primary goals of the new graduate, consumes enormous amounts of energy.

Historically, when nursing education was hospital-sponsored and controlled, it stressed the practice element more than theoretical content. Technical skills were the mainstay of nursing performance. Instructors supervised students in doing the same procedure repeatedly in both laboratory and clinical settings until expertise

developed. Educational practice in nursing programs gradually changed in response to societal and health care trends, particularly in baccalaureate settings where the focus of student achievement shifted from a clear-cut emphasis on technical skills to a broader application of intellectual skills (Sweeney, Regan, O'Malley, & Hedstrom, 1980, p. 37).

Many factors may have influenced the educational planning for baccalaureate programs; the need to incorporate the liberal arts into nursing education, the use of multiple clinical practice sites; the strong association of technical skills with nonbaccalaureate education; the evolution of in-service education departments in hospitals to assist new graduates; the popularity of educational philosophies that perceived the learning of specific technical skills as an activity most appropriate for the practice setting following graduation; and the placement of baccalaureate students in nonconventional clinical areas such as schools, homes, and industrial clinics where technical skills are not required (Sweeney et al., 1980, p. 37).

The technical skills that were once the most important part of nursing care seem to have been devalued somehow in the evolution of the educational process. Baccalaureate nursing education now places primary emphasis on psychosocial behaviors and the acquisition of teaching,

communication, research, and leadership skills. The decreasing concern for teaching the technical aspects of nursing care led one educator to write that some nursing programs have de-emphasized technical skills to the point that "students may graduate without ever having learned or done many of the procedures that they would be required to know as a staff nurse in a general hospital" (Wooley, 1977, p. 309).

Ream (1982) stated the belief that except in America's three year hospital diploma schools, "students are now drenched in academic courses and gypped on skill training" (p. 17). This is especially true in the costly baccalaureate programs whose priorities now seem to be "power and prestige." The move to produce a "professional" nurse has demeaned skill training as unworthy and unnecessary (Ream, 1982, p. 17).

In 1974, Benner and Benner (1979) conducted a study to evaluate the competencies and work entry experiences of newly graduated baccalaureate nurses. To test the competencies, new graduates, nurse educators, and nursing service administrators were given a Competency Appraisal Scale composed of 112 nursing skills and asked to indicate for each skill (a) the degree of competency they would ideally expect from a new graduate, and (b) what competency they actually expected a new graduate to have in the work situation. The authors found basic disagreement

about ideal and real expectations, particularly between the new graduate and the nursing service group. Most new graduates thought that, ideally, they should be highly competent with few educational needs upon graduation. However, nurse educators and nursing service administrators had lower ideal expectations of the new graduate.

According to their expectation of the real work situation, each group was dissatisfied with the way things were. Benner and Benner (1979) contended that the difference between people's perception of the ideal level of competency of the new graduates and the level of competency actually expected of him or her can be viewed as a measure of discontent among the three sectors of nursing.

Based on the work of Corwin (1960), Kramer (1971), and Benner and Benner (1979), Ellington (1980) predicted that nurse graduates who had low discrepancy scores on the Benner Proficiency Scale (formerly called the Benner Competency Appraisal Scale), i.e., those nurses whose ideal performance expectations more closely approximated their real appraisals, would experience less reality shock on their new job. In her study, Ellington predicted that high proficiency scores and low discrepancy scores on the Benner Proficiency Scale would be positively correlated with low role deprivation scores on the Corwin Professional-Bureaucratic Role Deprivation Scale (Corwin & Taves, 1962). This prediction was confirmed; the higher

the perception of skill mastery, the lower the degree of reality shock.

Larson (1984) studied patients' perceptions of nurses' caring behaviors. She pointed out that "caring permeates the cure and coordination dimensions of nursing practice, but for some patients perceptions of caring are most closely associated with the cure dimension" (p. 50). Patients' responses gave highest priority to having skillful care, being organized, and being on schedule. Her findings suggest that patients appreciate demonstrated competency in providing physical care more than the psychosocial skills that nurses place a high value on (Larson, 1984, pp. 46-50).

One of the problems with nursing is the lack of agreement on the importance of the psychomotor domain (technical skills) among educators and practitioners. The literature reflects controversy about skill training in baccalaureate nursing programs. Nursing service personnel expect graduates to be technically competent. This controversy may contribute to the cultural shock of the graduates (Field et al., 1984, p. 288).

Nurses continue to be faced with a skill-demanding public: physicians, patients, and hospital administrators. Both patients and physicians tend to describe nurses primarily in terms of technical activities. They will probably continue to do so until they've experienced

the kind of care that focuses on the patient as a person and consists of assessments, plans, and actions that will make a difference in the patient's progress and well-being (Elliott, Jillings, & Thorne, 1982, p. 25).

The term "provider of care" has been operationalized as the technical skills of the nurse by several authors (AACN, 1986; Primm, 1986). Since there is such a great emphasis on technical skills in the practice world, for purposes of this study the following hypotheses were tested to assess the perceptions of graduates, nurse educators, and nurse administrators, on the ideal and real expectations of performance of technical skills at graduation:

Graduates would like to be more proficient in the performance of technical skills than they are at graduation.

Graduates have higher expectations than nurse educators on the ideal level of performance of technical skills expected at graduation.

Graduates have higher expectations than nurse administrators on the ideal level of performance of technical skills expected at graduation.

Graduates and nurse educators agree on the real level of proficiency of technical skills performed at graduation.

Graduates and nurse administrators agree on the real level of proficiency of technical skills performed at graduation.

Study of Critical Care Skills of the Nurse

Critical care skills represent more complex technical and decision-making skills. Preparation for specialty practice has not been commonly defined as appropriate for the baccalaureate level. Students have little experience in settings such as the intensive care unit (ICU/CCU), the neonatal intensive care unit (NICU), the operating room, and the emergency room. Minimal skills in these areas might be expected of the new graduates (Cassells, Redman, & Jackson, 1986, p. 117).

Since critical care skills are not emphasized in baccalaureate programs, and more critically ill patients are now treated in health care institutions because of the diagnostic related groups (DRGs) (prospective payment), for purposes of this study the following hypotheses were tested to assess the perceptions of graduates, nurse educators, and nurse administrators, regarding ideal and real expectations of performance of critical care skills at graduation:

Graduates have higher expectations on the ideal level of performance of critical care skills than on the real level of performance.

Graduates have higher expectations than nurse educators on the ideal level of performance of critical care skills expected at graduation.

Graduates have higher expectations than nurse administrators on the ideal level of performance of critical care skills expected at graduation.

Graduates and nurse educators agree on the real level of critical care skills performed at graduation.

Graduates and nurse administrators agree on the real level of critical care skills performed at graduation.

Multidimensions/Components of the Role

Boss (1981) stated that the results of her study clearly supported the position taken by Astin (1964), Dunnette (1963a), Ghiselli (1956), Ryans (1957), Thorndike (1949), and Toops (1944) that successful job performance is multidimensional. No single component, including technical skill proficiency, can adequately measure the performance dimensions of competent nursing practice.

Several researchers attempted to describe the product or outcome of their educational process, by defining the dimensions of their practice. The factor analytic approach was used.

Price, Taylor, Richards, and Jacobsen (1964) believed that "basic to better selection and more satisfactory training of medical students is a clearer knowledge than

we now possess of what we are trying to produce--a more definite concept of what is implied by the term 'a good physician'" (p. 230). To explore this concept a well-diversified representative sample of physicians (over 500) was selected and over 200 measures of physician information was collected on each. By factor analysis, dimensions of physician performance were derived and then factor score profiles were derived.

Johnson and Hurley (1976) used a factor analytic approach to identify the dimensions of entry level practice for dietitians. Cratio (1976) also used factor analysis to identify the major dimensions used by supervisors to evaluate the therapeutic effectiveness of students in their speech pathology clinical practicum.

To utilize a factor analytic approach, an essential ingredient is the identification of components/dimensions. A team of nursing service researchers in an extensive study reported by Gorham (1962) identified a pool of important nursing practice behaviors. Several instruments identified behaviors and traits judged to be important for competent nursing practice have been described in the literature. These include the Clinical Nursing Rating Scale (Reekie, 1970/1971), the Nurses' Professional Orientation Scale (Crocker & Brodie, 1974), the Slater Nursing Competencies Rating Scale (Wandelt & Stewart, 1975), the Nurse Competency Inventory (Nelson, 1978), and the Six-

Dimension Scale of Nurse Performance (Schwirian, 1978).

Boss (1981) used the Clinical Nursing Rating Scale for her study. The study was developed by Reekie (1970) as a measure of ability to assume the professional nursing role, i.e., to practice nursing competently. The study's results support the position that the components (dimensions) of a competent practice can be identified by empirically grouping behaviors and traits that are highly correlated (similarly rated) (Boss, 1981, p. 26).

Unquestionably three of the four factors, i.e., Factor 1, Factor 3, and Factor 4, were perceived components of competent nursing practice. Factor 1 represented a perceived interpersonal dimension of competent nursing practice. It primarily involved interpersonal relationships with patient and family members. Items dealing with interpersonal relationships among nursing colleagues and other peers were rated lower than the nurse-patient-family relationship. It was concluded that the faculty (the sample used in the Boss, 1981, study) overall viewed interpersonal relationships among those components identified as the most critical to competent nursing practice (Boss, 1981, p. 27). In Cassall's et al. (1986) study, graduates were asked to reflect back a year to beginning employment, as a professional nurse. They stated that they felt well-prepared in interpersonal/communication skills (p. 118).

Factor 3 reflected the leadership dimension/component of practice competency. Faculty in general rated this factor as slightly less important than Factor 1 but clearly still viewed this as an important perceived dimension of competent practice (Boss, 1981, p. 27).

Factor 1 and Factor 3 focused on independent nursing functions. Factor 4 emphasized dependent nursing functions, i.e., those functions that involve physicians and the performance of physician ordered therapies as well as those activities that involve routine hospital procedures and policies. The items composing Factor 4 encompassed a more traditional view of nursing practice. Clearly, faculty as a whole viewed these behaviors and traits relevant to competent nursing practice since they rated these items as slightly important to important. But the faculty placed less importance on Factor 4 in comparison to Factor 1 and Factor 3 (Boss, 1981, p. 27).

The Boss (1981) study concluded that the interpersonal dimension was the most critical to competent nursing practice, followed by the leadership dimension, and finally, the dimension which included the dependent functions of the nurse.

Water, Urreu, Chatee, Vivier, and Wilson (1972) conducted an exploratory study regarding the scope of professional nursing. They found that professional nursing involved relationships with members of other disciplines,

sharing responsibility for the health and welfare of all persons in the community at large, coordinating medical and other services as they contribute to patient care, assuming complete responsibility for total patient welfare and progress, guiding the work of technical and vocational practitioners, assuming leadership of the nursing team, planning for utilization of technical nurses and nursing assistants, and for continuing education of other nursing personnel (p. 125).

Nelson (1978) conducted a survey to examine baccalaureate, diploma, and associate degree nursing program graduates regarding their perception of their competency in technical, communicative, and administrative skills and their supervisors' perceptions of graduates' competency in these skills. Baccalaureate graduates were rated lower on technical skills, but higher on communication and administrative skills by their supervisors than the diploma and associate degree graduates. The baccalaureate graduates' self-rating was consistent with their supervisors (Nelson, 1978, pp. 121-125).

Studies of the Interpersonal Skills of the Nurse

The literature review suggested that nurses consider interpersonal skills/communication as an important dimension/component of nursing. Interpersonal skills are

valuable for a variety of reasons. Kimball (1970), Balint (1971), and Klein (1974) have stressed the importance of interpersonal skills for data-gathering and formulating a correct diagnosis. Although these studies refer to physicians, the same skills identified in these studies are necessary for nurses. Dye (1963) conducted a study which demonstrated the importance of having the nurse find out how the patient feels, what the patient thinks he or she needs, and whether the patient feels he or she has been helped: "Without such explorations, only five out of 14 patients studied in a medical-surgical unit could tell the nurse why they were in distress adequately enough for her to determine the nursing care they needed" (p. 56).

Interpersonal skills are viewed as important for promoting patient confidence in the health professional's skills (Ben-Sira, 1976); for establishing patient trust (Goldin & Russell, 1969); for reducing patient resistance to therapy and management (Smiley & Smiley, 1974); for increasing patient satisfaction (Aluise, 1977); for aiding patient catharsis and tension release (Worby & Babineau, 1974); for avoiding negative nonverbal communication with patients (Eldred, 1960); for promoting patient problem solving through acceptance of the patient's feelings (Klein, 1974); for aiding patient coping in situations of stress that cause illness (Mettlin & Woelfel, 1975); and for promoting the physical recovery of patients (Jourard,

1960).

The critical test of interpersonal skills for nurses is whether there is an effect on patient outcome indices. Patient outcome indices are of three types: psychological (e.g., patient satisfaction), physiological (e.g., changes in pulse rate), and behavioral (e.g., compliance). The importance of favorable patient outcomes makes it imperative that nurses develop good interpersonal skills.

Communication was operationalized as interpersonal skills in Primm's (1986) research. It was considered one of three major components of the role of the nurse. To test the importance of interpersonal skills this researcher developed the following hypotheses to assess the perceptions of graduates, nurse educators, and nurse administrators on the real and ideal expectations of performance of interpersonal skills at graduation:

Graduates have higher expectations on the ideal level of performance of interpersonal skills than on the real level of performance.

Graduates and nurse educators agree on the ideal level of performance of interpersonal skills expected at graduation.

Graduates and nurse administrators agree on the level of performance of interpersonal skills expected at graduation.

Graduates and nurse educators agree on the level of proficiency of interpersonal skills performed at graduation.

Graduates and nurse administrators agree on the level of proficiency of interpersonal skills performed at graduation.

Studies of the Leadership Skills of Nurses

Sugar and spice, and everything nice.
That's what little girls are made of.
(E. Johnson, Scott, & Sickels, 1948,
p. 12)

And little girls become nurses. Nurses have been described in traditional female terms such as dependent, sensitive, empathic, passive, subjective, emotional, non-aggressive, noncompetitive, submissive (Neal, 1982, p. 3). These traditional traits are not those usually ascribed to a leader. In nursing the leadership role is not viewed positively. As Ashley (1973, p. 133) indicated, few women enter nursing seeking the power, prestige, and status often associated with leadership. The low status accorded the nursing profession may be the detractor for males, who enter nursing in small numbers. A key factor that inhibits nursing leadership is the "prevailing negative sociocultural attitude toward authority, management, and leadership" (Leininger, 1974, p. 30).

Leininger (1979) contended that the problem with the health care system and the profession of nursing was a leadership crisis and was largely due to: (a) lack of adequate role socialization of nurse administrators for management; (b) lack of knowledge about the concept of power, politics, and territoriality; (c) lack of the professional nursing organizations to correct the knowledge base inadequacies; (d) pressures and politics encountered by nurse leaders; and (e) lack of support system for nurse leaders. She stated:

Such factors and others make one realize the critical need to document and systematically study power, politics, and leadership theories as they relate to problems in nursing and to develop innovative strategies to handle politically oriented situations. Developing a knowledge base and theories about nursing politics is essential for tomorrow. (Leininger, 1979, p. 33)

Mintzberg (1973) categorized behavioral patterns of leaders in eight categories:

1. Peer skills: the ability to establish and maintain a network of contacts with equals. . . .
2. Leadership skills: the ability to deal with subordinates and the kinds of complications that are created by power, authority, and dependence. . . .
3. Conflict-resolution skills: the ability to mediate conflict, to handle disturbances under psychological stress. . . .
4. Information processing skills: the ability to build a network, extract and validate information, and disseminate information effectively. . . .

5. Skills in unstructured decision making: the ability to find problems and solutions when alternatives, information, and objectives are ambiguous. . . .

6. Resource allocation skills: the ability to decide among the alternative uses of time and other scarce organizational resources. . . .

7. Entrepreneurial skills: the ability to take sensible risks and implement innovations. . . .

8. Skills of introspection: the ability to understand the position of the leader and its impact on the organization. (pp. 190-193)

S. Brown (1984) identified 84 leadership and management competencies that new graduate nurses need for nursing jobs. Additional objectives of her study were to determine (a) whether nurse educators, nursing service administrators, and new graduates agreed on the leadership competencies; (b) whether new graduate nurses' perceptions regarding the adequacy of their schooling in developing leadership management skills; and (c) whether new graduate nurses perceived that their employing institutions adequately assisted them in acquiring and/or developing the leadership/management competencies required. The S. Brown (1984) study focused on 84 competencies in the areas of planning, organizing, staffing, directing, and controlling. Approximately 65% of the new graduates rated basic educational preparation in those areas as adequate, while 62% rated employer assistance adequate. Responses indicated that more emphasis needs to be placed on planning

during the educational process.

Although the literature indicates a gap between nursing education and nursing service expectations, findings from S. Brown's (1984) study indicate a relatively high agreement among nurse educators, nursing service administrators, and new graduates as to the importance of leadership and management competencies.

Manager of care was the third major component of the role of the nurse identified in Primm's (1986) study. Leadership skills are essential for the manager of care. For purposes of this study, the following hypotheses were tested to assess the perceptions of graduates, nurse educators, and nurse administrators on the ideal and real expectations of leadership skills at graduation:

Graduates have higher expectations on the ideal level of performance of leadership skills than on the real level of performance.

Graduates and nurse educators agree on the ideal level of performance of leadership skills expected at graduation.

Graduates and nurse administrators agree on the ideal level of performance of leadership skills expected at graduation.

Graduates and nurse educators agree on the real level of proficiency of leadership skills performed at graduation.

Graduates and nurse administrators agree on the real level of proficiency of leadership skills performed at graduation.

Studies of Planning and Evaluation Skills of the Nurse

Nurses have been using the nursing process for two decades. The nursing process is an organized, systematic method of giving individualized nursing care that focuses on the unique human response of a person or group of people to an actual or potential alteration in health. It consists of five steps:

Assessment: Gathering information (data).

Diagnosis: Analyzing data to identify problems/nursing diagnoses.

Planning: Making a plan of action.

Implementation: Putting the plan into action.

Evaluation: Determining if the plan has worked. (Alfaro, 1986, pp. 6-8)

Planning is an integral part of the nursing process. Yet little is known about how nurses plan nursing care (Corcoran, 1986, p. 155). Mallick (1977) stated that nursing education has not produced nurses who can utilize the nursing process to plan, initiate, and carry out organized nursing activities in specific patient situations. Educators focus on content rather than a framework as the primary issue in defining good nursing education.

They have failed to go beyond a description of the nursing process to the point that it can be used by students and practitioners to organize their knowledge of health and disease, of procedures, and of nursing concepts. Moreover, they have not established the relationship between specific nursing knowledge such as the signs, symptoms, pathophysiology, and related nursing care measures in particular diseases, and specific segments of the nursing process (p. 245). Cantor et al. (1981) concurred with Mallick (1977); application of the nursing process for predicting and evaluating nursing care is poorly understood by new graduates (Cantor et al., 1981, p. 16).

Morgan, Hogan, and Burbank (1984) believed that nurses should not only be comfortable using the nursing process, but also with health planning. Health planning, like the nursing process, is a process. The health planning process and the nursing process are activated by a problem requiring resolution, and a goal, objective, or outcome criteria for which a plan of action is needed. Health planning includes establishing future levels of community health status and health care systems' performance, deciding what actions are necessary to attain the desired levels and evaluating the health planning decisions, goals, and actions (McLemore, 1980, p. 21).

Identifying the nurse's responsibility to participate in the health planning process is not adding another

function to the nursing role. It is clarifying a responsibility already inherent in nursing practice. The nurse's role as a health planner raises another aspect of nursing's responsibility for quality nursing care (DeBella-Baldigo, 1984, p. 124).

Quality nursing care can be defined only in relation to the goals that are set for the patient according to the patient's problems and needs. Quality would be assessed by measuring how well the goals have been met.

Abdellah (1964) stated, "a major deterrent to the measurement of quality in nursing is the lack of instrumentation to gauge it directly" (p. 4). According to Greenough (1968), standards of nursing practice "must be clear, concise, specific sentences worded in terms of action-and-behavior which describe intended outcomes that can be seen, measured, and judged" (p. 2157).

Cantor et al. (1981) developed a Goal-Directed Model, which was result- rather than process-oriented. This model determined patient needs and outcomes first, identified the nursing practices most likely to achieve these outcomes, and then specified the knowledge and skills required to perform these functions. Using the Goal-Directed Model for studying the learning needs of the new graduate entering hospital nursing, Cantor et al. (1981, pp. 10-17) found that new graduates lacked the ability to identify significant nursing care problems, determine

appropriate activities, and modify care in terms of evaluation of patient care.

In nursing, there has been an attempt to evaluate the care rendered to patients. In the past the evaluation was accomplished through rather informal, unstructured means. Today, the call for accountability is being demanded of all health care workers. There is careful scrutiny by a variety of groups representing consumers, third party payers, and an assortment of governmental and voluntary agencies. More systematic and formal programs are developing in an attempt to offer patients some measure of quality assurance. Quality assurance has as its goal the improvement of practice.

Felton, Frevert, and Galligan (1976) stated that a quality assurance program should contain the following steps:

1. Define needs, purposes and goals.
2. Define problem.
3. Specify constraints, capabilities, and resources.
4. Specify approach to problem solution.
5. State behavioral objectives and performance criteria.
6. List alternative solutions.
7. Analyze options.
8. Choose the best option.
9. Control and implement decisions.

10. Evaluate the effectiveness of practice. (p. 20)

Educators can contribute to quality assurance programs by preparing their students appropriately for the practice world (McClure, 1976, p. 367). A recent study indicated three major expectations for the baccalaureate graduate. Baccalaureate graduates were expected to (a) use literature sources in planning nursing interventions, (b) understand the rationale for nursing interventions as opposed to only carrying out physicians' orders, and (c) evaluate outcomes of nursing intervention in terms of time, supplies, and money (Rothweiler, 1986, p. 62).

S. Brown's (1984) results noted that more emphasis needs to be placed on planning during the educational process. Mallick (1977) and Cantor et al. (1981) stated that new graduates are unable to apply the nursing process in patient care situations, and they agree that there is a problem in the educational process.

Since planning and evaluation are major steps in the nursing process and are components of the nurses' role, for purposes of this study the following hypotheses were tested to assess the perceptions of graduates, nurse educators, and nurse administrators on the ideal and real expectations of planning and evaluation skills at graduation:

Graduates have higher expectations on the ideal level of performance of planning and evaluation than on the real level of performance.

Graduates and nurse educators agree on the ideal level of performance of planning and evaluation skills expected at graduation.

Graduates and nurse administrators agree on the ideal level of performance of planning and evaluation skills expected at graduation.

Graduates have lower expectations than nurse educators on the level of proficiency of planning and evaluation skills performed at graduation.

Graduates have higher expectations than nurse administrators on the level of proficiency of planning and evaluation skills performed at graduation.

Studies of Teaching and Collaboration Skills of the Nurse

In the late 1950s, Lambersten (1958), a respected leader in nursing education, defined nursing as a "dynamic, therapeutic, and educative process in meeting the health needs of society" (p. 80). At the present time, education about preventive health practices and health promotion is considered an essential component of comprehensive health care.

Nurses have engaged in a variety of health-teaching activities in their practice. Nurses have a wide range of experience in community and hospital settings with populations of diverse ages and health states. Health teaching is an essential part of the nurse's role today. In certain practice settings, it is the main focus of that role (Whitman, Graham, Gleit, & Boyd, 1986, p. vii).

Health teaching is not a new role for nurses. In the 1800s Florence Nightingale wrote about sanitation, housing, care of the sick in hospitals, and health teaching. Nightingale recognized that it was not enough for people to be interested in health information, but that the test was whether they practiced it later in their homes (Bennett, 1975). Another nurse, Wald (1915), was interested in health teaching. Wald developed a settlement house in New York City in the early 1900s that was the forerunner of the community center. Wald stressed her teaching role. She noted that for "the families who came to visit patients in the wards, I outlined a course of instruction in home nursing adapted to their needs" (p. 3). Wald also initiated instructional programs for new mothers, children, and invalids, who were not only taught about the health benefits of visits to the country but taken on such outings.

Recently, a broader concept of health and major achievements in health technology have enhanced the

teaching role of nurses. Health is no longer viewed as merely the absence of disease, but the presence of positive capacity to lead an energetic and productive life (Spradley, 1985, p. 8). It involves individuals seeking physical, mental, emotional, and spiritual well-being. As a result of this broadened concept, health promotion, disease prevention, and rehabilitation have become major objectives of health care, including nursing care. Comprehensive health care has led to an increased emphasis on the teaching role of the nurse (Whitman et al., 1986, p. 6).

Professionals other than nurses also participate in health teaching. A 1981 survey conducted within a major medical center assessing the views of individuals from seven disciplines (physicians, nurses, health science librarians, therapists, social workers, dietitians, and pharmacists) revealed that all 631 participants felt they should have a role in health teaching (University of Virginia Hospital, 1981). Clearly, many professionals from health-related disciplines see themselves involved with the educational process. In addition to those professionals more commonly identified with health care, health educators have emerged. Specialized education about program development and evaluation prepares health educators to conduct and evaluate health programs related to preventable health problems. Although a number of

professionals may participate in health teaching, nurses are increasingly responsible for this role (Whitman et al., 1986, p. 7).

Unfortunately, insurance reimbursement for health education programs is not routinely available, despite proven cost savings and lessened morbidity and mortality. It has been suggested in the literature that as physical numbers increase and the incomes decrease, the area of health education may be reclaimed by the physicians. Physicians would find a way to extract payment for their services (Ellwood & Ellwein, 1981, p. 81). However, at this time, teaching is an important dimension of professional nursing practice.

With the variety of health care workers that have identified health teaching as a component of their role, it seems essential that professionals collaborate. Collaboration has been defined as working with another person. Interest in collaboration has been encouraged by the shrinking resources in the health care industry, but the scarce resources have also promoted territoriality. Nurses must be wary, as parts of their work have been assumed by new health care workers in the last 20 years (e.g., respiratory therapists). Nurses also have assumed many of the physician's tasks. Given this trend, there is likely to be a considerable realignment of health care roles in the future, and conflict is inevitable. An

oversupply of physicians will change the roles of other health professionals and will ultimately increase costs (Andreoli & Musser, 1986, p. 48).

Given the nature of their role, nurses must collaborate with patients/clients, with their nurse colleagues, with other health care workers, and with physicians. Nurses seem most comfortable in working with the patient. As noted by Boss (1981), collaboration with colleagues was not seen as important as the nurse-patient relationship. There is a paucity of literature regarding nurse to nurse collaboration and how it affects patient care. The lack of collegial communication between physicians and nurses has been a problem for nurses since the early 1900s. Dubbed the "doctor-nurse game" almost 20 years ago by a psychiatrist (who called it stifling and anti-intellectual), it remains a stereotype of nurse-physician interaction (Stein, 1967, p. 699).

In the early 1900s nurses had decision-making power in the health care delivery system. Nurses worked as partners with physicians. This relationship was not destined to last long. Ashley (1973) described the situation:

As nursing power became manifest, physicians came to believe that nurses had to be intellectually and socially controlled. They began to talk about the fact that trained nurses were becoming too powerful and too self important, by organizing their professional association and

pretending they could become a "real profession like medicine itself."

Early manifestations of power in nursing gave rise to present and traditional arguments about whether or not nursing meets the criteria for a profession. The basic issue is really one of power for those recognized as more expert and more "professional" have more power and more authority. Precisely at the time when nursing organizations were being formed--a significant mark of professional development--medical men began to argue that nursing was not and could not become a profession. This argument has persisted through the years, and the issue has perhaps consumed more of nursing's energy and time than any other one issue, including ways and means of improving the quality of nursing care and service. (p. 639)

Through an historical perspective, it is relatively easy to see how the medical profession has achieved control of the health care delivery system and nursing. The past indicates that nursing has dissipated its strength by functioning compliantly in a bureaucracy dominated by physicians, having the educational function inexorably linked to service, expending energy in struggling toward the state of "professionalism," and supporting a philosophy which promotes institutional goals while delegating practice to paraprofessionals (Leininger, cited in Partidge, 1978, pp. 356-357).

In addition to nurses abdicating their strength and professional practice to the dictates of the bureaucracy and physicians, there are a number of other factors which cause communication problems between physicians and nurses. One perennial source of difficulty is that

physicians do not understand the functions and goals of the nurse and the nurse lacks insight into the scope of the physician's responsibilities. Physicians and nurses place different values on specific parts of the health care process, and these divergent values lead to differences between professionals in assessing the relative weight of patient problems. Traditionally, medical and nursing students have not studied together, nor have their curricula provided them with information about the contribution of the other. Consequently, they work their entire careers side by side without really understanding what the other is about. This fact has prompted the statement that physician-nurse communication is most characteristic of the parallel play of toddlers (Kalisch & Kalisch, 1977, p. 54).

A specific area of misunderstanding has been the greater emphasis the nurse has placed on the psychological aspects of patient care. Physicians believe that nurses have moved too far in this direction, that they are guilty of ignoring physical needs; and nurses believe that physicians have forgotten about the patient as a person (Kalisch & Kalisch, 1977, p. 54).

Kelly (1986, p. 4), in an editorial, reported about a study that provides evidence that the quality of nurse-physician communication and collaboration might literally be a matter of life or death for a patient. This study

focused on factors that affect patient outcomes in intensive care units (Knaus, 1986, pp. 410-418). Thirteen hospitals were ranked according to their ratio of actual to predicted death for 5,030 patients in intensive care units. The author found that there were important differences between predicted and observed death rates, and that the key difference appeared to relate to the interaction and communication between physicians and nurses. In the "best" hospital (Hospital 1), "excellent communication between physicians and nursing staff was ongoing to ensure that all patient care needs were met" (p. 417). In the hospital with the worst ratio, there was an atmosphere of distrust between doctors and nurses, with frequent disagreements. There was no policy for routine discussion of patient treatment and generally poor communication between physician and nursing staff. Kelly (1986) commented, "that collegial communication with all of the health care team is a matter of good practice, professional ethics, common sense and, perhaps, life or death" (p. 4).

Teaching is an important component of the nurse's role. In addition, the nurse must coordinate the care of the patient. Teaching and coordination skills are important dimensions of the role of the nurse.

The following hypotheses were tested to assess the perceptions of graduates, nurse educators, and nurse administrators on the ideal and real level expectations of

performance of teaching and collaborating skills at graduation:

Graduates have higher expectations on the ideal level of performance of teaching and collaborating skills than on the real level of performance.

Graduates have higher expectations than nurse educators on the ideal level of performance of teaching and collaborating skills expected at graduation.

Graduates have higher expectations than nurse administrators on the ideal level of teaching and collaborating skills expected at graduation.

Graduates have lower expectations than nurse educators on the real level of proficiency of teaching and collaborating skills performed at graduation.

Graduates have lower expectations than nurse administrators on the real level of proficiency of teaching and collaborating skills performed at graduation.

Results of Consensus on Entry Skills Project

Results of the Consensus on Entry Skills project (Stull, 1985) did not support the belief that nursing service and nursing education do not agree on skill expectations for new baccalaureate graduates. Two questionnaires which measure perceptions of ideal and real expectations of entry level performance of new graduates were completed by a convenience sample of 123 nurse educators

and nursing service administrators. Rather than differing with regard to ideal expectations, results of paired t tests indicated the major problem was the vast difference between ideal expectations and the real functioning of the graduates as perceived by nurse educators and nursing service administrators.

This researcher's study was conducted to identify ideal and real expectations of entry level performance, as perceived by nurses graduated in 1985 from a baccalaureate program. The perceptions of the graduates were compared to those of the nurse educators and nursing service administrators who participated in the Consensus on Entry Skills project (Stull, 1985). The dimensions of nursing practice assessed were: technical skills, critical care skills, interpersonal relations, leadership skills, planning and evaluation, and teaching and collaboration.

In summary, in this chapter nursing was defined and an historical view of nursing education and nursing practice was provided. The research studies of the role of the nurse and the dimensions of that role were discussed. The research hypotheses were presented in each section following the discussion of the dimension of the nursing role to be studied. The chapter concluded with the results of the Consensus on Entry Skills project and how they relate to this investigation.

CHAPTER III

METHODOLOGY

The purpose of this study was to identify the ideal and real expectations regarding entry level performance as perceived by nurses graduated in 1985 from 17 baccalaureate programs represented in the Consensus on Entry Skills project (Stull, 1985).

Sample

A letter requesting the names of the 1985 graduates from the 31 baccalaureate schools was requested from the Consensus on Entry Skills (Stull, 1985) nurse educator participants (Appendix B). Seventeen of the 31 schools participating in the Consensus on Entry Skills project agreed to participate in this study. Two of the schools had baccalaureate in nursing (B.S.N.) completion programs and did not meet the sample requirements. One baccalaureate school refused to participate, and the other schools had policies which stated that names and addresses of graduates could not be released. Three of the 17 schools that participated in this study requested that the packets be sent from their colleges. The graduates' names were given to the researcher. From the lists returned by the

educators, a sample of 310 graduates was randomly selected.

The following demographic data from each of the graduates was requested:

1. Sex.
2. Age.
3. Are you presently employed?
4. For how long?
5. Place of employment?
6. If employed in an acute hospital, which area?
7. Have diagnostic related groups (DRGs) been implemented in your agency?
8. Was there a special orientation for new graduates?
9. Describe the effectiveness of the orientation to you.
10. Generally how has the transition from school to work been?
11. What are your suggestions for making the transition easier? (See Appendix C.)

Graduates' anonymity was maintained by use of a code number which consisted of the number assigned to the school and the number assigned to the participant.

The graduates received a cover letter (Appendix C) which contained the elements of protection. The following information was included:

1. The researcher's name and educational status.

2. The purpose of the research study.
3. The researcher's affiliation with the agency from which the subjects were selected with a statement that the affiliation did not influence the subject's decision to participate.
4. The referral source who provided access to the subjects.
5. A description of the nature of subject's participation was included (e.g., fill out the forms).
6. Expected duration and time required to participate.
7. How long the data were kept on file.
8. Other sources of data to be utilized (e.g., Consensus participants).

The participants in the Consensus on Entry Skills project (Stull, 1985) were also considered part of the sample of this study. The graduates' results were compared to the results of the Consensus project.

The Consensus on Entry project (Stull, 1985) staff sent recruitment materials to 110 National League of Nursing accredited baccalaureate nursing programs and nurse administrators in 13 Midwestern states, requesting participants. One hundred and twenty-three nurse educators and nursing service administrators responded to the consensus staff's request for participants. The participants were selected as a team. Each team included at least one

administrative representative from each of the following settings: baccalaureate education, hospital, community-based nursing agency, and skilled nursing facility. The 29 teams represented the above agencies in 13 states.

Instrumentation

Major Variables

There were two major variables in this study.

Independent variable: The discrepancy between the baccalaureate graduates', the nurse educators', and nursing service administrators' perceptions of ideal expectations of proficiency in technical skills, critical care skills, interpersonal relations, planning and evaluation, teaching and collaboration, and leadership skills and the perceptions of the real performance of the graduate.

Dependent variable: The transition from school to work difficulties experienced by the graduate.

Two questionnaires were selected to measure expectations: the Benner Proficiency Scale and the Six Dimension Scale of Nurse Performance. These scales measure a representative sample of a variety of nursing skills. Both measures have been used extensively in similar types of projects and have strong instrumentation qualities.

Benner Proficiency Scale

The Benner Proficiency Scale consists of 60 items which primarily relate to technical nursing skills (Appendix D). Each item is rated according to the respondents' perceptions of the real or present functioning of the new graduate nurse and also according to the respondents' ideal expectations of how the new graduate nurse should be functioning.

The 60 items of the Benner Proficiency Scale rate both ideal and real expectations on a 5-point scale: 1 = high proficiency, 2 = moderate proficiency, 3 = safe but practice needed, 4 = supervision needed, and 5 = supervision and instruction needed.

Validity and Reliability of the Benner Scale

The Benner Proficiency Scale (formerly called the Benner Competency Appraisal Scale) was originally developed for use in a study of new graduate nurses in San Diego and Imperial Counties, California (Benner & Benner, 1975).

The content validity of the Benner Proficiency Scale was examined by a group of nurses in the San Diego area (Benner & Benner, 1975). After taking a pilot form of the scale, the nurses were interviewed on the clarity of the items, their centrality to nursing, and their level of

complexity. These nurses were also given the option of indicating any items which they did not consider representative of appropriate skilled performance in nursing. They were instructed to add items they thought were important but missing on the scale. The instrument was refined based upon this interviewing and pretesting, and was then subjected to further pilot testing with a group of staff nurses.

In 1978 the Benner Proficiency Scale was updated and shortened based upon a cluster analysis done on the data from the study in San Diego and Imperial Counties. Additional physical assessment and helping role skills were added to update the scale. The original 113 item scale was reduced to 80 items. The revised 80 item instrument was submitted to a panel of expert nurse clinicians for a critical review of the representativeness and comprehensiveness of the revised instrument.

The scale was then administered to 131 graduates and 119 nurse educators, and a factor analysis was conducted on the ideal scores of these two samples. Based on the factor analysis, the scale was further reduced from 80 to 60 items for the current form of the scale.

Construct Validity

The Benner Proficiency Scale was designed to be a self and other report of expected (ideal) level of

proficiency and of actual appraisal of level of proficiency. As a self and other reported appraisal, the scale provides opinions and reflects values related to skilled nursing practice. The Benner Proficiency Scale has consistently yielded statistically significant differences between performance expectations and appraisals of nursing service persons and those of educators and new graduates.

Predictive and Concurrent Validity

Ellington (1980) predicted that nurse graduates who had low discrepancy scores on the Benner Scale, i.e., those nurses whose ideal performance expectations more closely approximated their real appraisal, would experience less reality shock on the job. This prediction was demonstrated: the higher the perception of skill mastery, the lower the degree of reality shock.

Weiss (1977) used the Benner Proficiency Scale as a pretest and posttest measure for a control and an experimental group taking a specialized new graduate orientation program entitled, "Neophyte Nurse Transition Program." There were no significant differences between the experimental and control pretest scores on the Benner Proficiency Scale. However, there was a significant decrease in the discrepancy scores on the Benner Proficiency Scale for the experimental group 6 month post participation in the Neophyte Nurse Transition Program. There were no

significant differences in the discrepancy scores of the control group.

Reliability

A split-half test of internal consistency was performed taking the score of every other item on the Benner Proficiency Scale. This yielded a correlation coefficient for the two halves of the scale ranging from .934 to .942.

The measure of reliability which was computed for this study for the Benner Proficiency Scale was Cronbach's alpha. The results were:

Ideal Benner	Real Benner
Alpha = .976	Alpha = .946
Standardized item alpha = .976	Standardized item alpha = .946

The Six-Dimension Scale of Nurse Performance

The Six-Dimension Scale of Nurse Performance (Six-D Scale; Ideal, Appendix E; Real, Appendix F) consists of a series of 52 nurse behaviors grouped into six subscales: The critical care subscale (7 items) relates to nursing activities associated with the care of critically ill individuals--including the potential outcome of death. The content of the interpersonal relations/communication subscale (11 items) relates to the nurse's behaviors in the areas of interpersonal relations and communications

with clients and colleagues in the health care setting. The leadership subscale (5 items) measures leadership activities in which an individual engages regardless of job title. The planning/evaluation subscale (7 items) measures behaviors of planning and evaluating nursing care of clients. The teaching/collaboration subscale (11 items) describes teaching behaviors, as well as collaborative efforts with patients, families, and other health professionals (Appendix G).

Respondents were asked to rate on a 4 point scale (1 = no practice needed, 2 = some practice needed, 3 = guidance needed, and 4 = instruction and supervision needed) their perception of the ideal level of proficiency for new graduate nurses. On an alternate form, respondents were asked to rate on the same 4 point scale the real level of performance.

The first five subscales of the Six-D Scale (42 items) were used in the Consensus project (Stull, 1985) with the nurse educators and nurse administrators. The sixth subscale, professional development (10 items) were deemed inappropriate for the goals of that project. This study also used the first five subscales, as the Consensus project.

Validity and Reliability of the Six-D Scale

The Six-Dimension Scale of Nursing Performance was a product of a contract research project, Prediction of Successful Nursing Performance, awarded by the Division of Nursing to the Ohio State University Research Foundation. The general goals of the project were to: review critically the literature of the past 10 years relative to academic and clinical nursing performance, obtain current information from basic professional schools of nursing about prediction criteria in use by them, and evaluate the relative merits of these predictors for subsequent on the job performance of the school's graduates (Schwirian, 1978, p. 347).

One of the most crucial elements in a national study of this type was the identification and use of a valid, reliable tool that accurately operationalized the variable "nursing performance."

During the 9 months that the project staff worked to develop, review, and revise the tool, they depended on expert counsel and review throughout the process. The outcome of this activity, consultation, and collaboration was a set of 76 nurse behaviors and seven subscales. It was later reduced to a 52 item scale and six subscales, based on statistical analyses of the data.

The claim for the validity of the instrument as an appropriate appraisal of the performance of nurses in their job settings was based on the congruence of the factor structures of items between the responses of nurse graduates and their employers and on the fact that the performance subscales did differentiate between the performance of graduates who had been predicted to be "high performers" and those who had not been so identified.

Reliability. The measure of reliability which was computed for each of the Six-D subscales was Cronbach's alpha. Alpha, considered a fairly conservative index, has proved to be bound to true reliability (Armor, 1974). As a general measure, it has been shown to subsume the Kuder-Richardson coefficients as well as most of the split-half reliability coefficients.

Reliability estimates (Cronbach's) of the Six-D Nursing Performance subscales from graduate self-appraisals and employer appraisals are shown in Table 3.

A measure of reliability was computed for each of the Six-D subscales in this study using Cronbach's alpha. The results are shown in Table 4.

Data Collection Plan

The random sample of 310 graduates was sent an envelope containing a cover letter, a demographics sheet, a

Table 3

Reliability Estimates (Cronbach's) of the Six-D
Nursing Performance Subscales From Graduate
Self-Appraisals and Employer Appraisals

Subscale	Self- appraisals	Employer appraisals
Critical care	.919	.859
IPR/communication	.959	.907
Leadership	.901	.844
Planning/evaluation	.936	.900
Teaching/collaboration	.926	.899
Professional development	.978	.890

Note. From "Evaluating the Performance of Nurses: A Multidimensional Approach" by P. Schwirian, 1978, Nursing Research, 27, p. 350.

Benner Proficiency Scale, and two copies of the Six-Dimension Scale. One of the copies of the Six-D Scale was grey, that stated what the nurse should know at graduation. The other copy of the Six-D Scale was buff colored, that connoted how the graduate does perform at graduation. A stamped return envelope was also included. The subjects were asked to return the envelope containing the above items in a 2 week period. If they failed to do so, a postcard (Appendix H) was sent after the third week as a reminder.

Table 4
Measures of Reliability of the Six-D Subscales
Using Cronbach's Alpha

Subscale	Graduates self-appraisal			
	Ideal		Real	
	Alpha	Standard- ized item analysis	Alpha	Standard- ized item analysis
Critical care skills	.778	.775	.749	.747
Interpersonal relations	.876	.881	.863	.865
Leadership	.765	.761	.755	.759
Planning/evaluation	.845	.847	.814	.814
Teaching/collaboration	.905	.906	.866	.867

The returned envelopes were checked on the code sheet. The number and percentage of returns were determined from this sheet.

Fifty-three percent of the sample responded after the first mailing. An additional 3% responded to the postcard reminder. The telephone numbers were secured for the nonresponding sample. Of the 150 nonrespondents, 60 could not be located. Four weeks later, the third and final mailing with replacement questionnaires was sent to graduates who had not returned the questionnaires (Appendix I). The final mailing resulted in an additional 12% of the

graduates returning questionnaires. The total return rate was then 211 questionnaires for a response rate of 68% (see Table 5). Twenty-five, or 12%, of the returned questionnaires were from B.S.N. completion students and they did not fit the sample requirements. Thirty-two of the envelopes were returned because the addresses were not current.

Table 5
Number and Percentage of Sample Size, Return
Rate, Usable Returns, and Losses
(Sample Size $N = 310$)

Description	Number	Percent (rounded)
Return rate	211	68
Nonrespondents	99	32
Usable returns	154	50
Phone interviews (demographics and views secured)	3	1
<u>Losses</u>		
Returned, lack of current address	32	10
L.P.N./B.S.N. and R.N./B.S.N. completion students	25	8

Hypotheses

Thirty hypotheses were formulated. The following questions generated the hypotheses:

1. Do new baccalaureate graduates perceive that ideal expectations match real performance expectations?
2. Is there consensus among new baccalaureate graduates, nurse educators, and nurse administrators regarding ideal and real performance expectations of the baccalaureate graduate nurse?

The hypotheses were presented in the following format to assist the reader. The 30 hypotheses were divided into the six dimensions of the nurse's role: technical skills, critical care skills, interpersonal skills, leadership, planning and evaluation, and teaching and collaboration. Under each of the six dimensions, five hypotheses were presented that represent the graduate's nurse educator's, and nurse administrator's ideal and real expectations of the new baccalaureate graduate nurse's performance. The research and statistical hypotheses were restated for the reader.

The statistical analyses were completed in testing the directional hypotheses using a probability of .05 for committing a Type I error (alpha). The statistical analyses were completed in testing the no difference hypotheses using a probability of .20 for committing a Type I error (alpha).

Ideal and Real Performance Expectations of Graduates,
Nurse Educators, and Nursing Service Administrators Re-
garding Technical Skills on the Benner Proficiency Scale

Graduates: Ideal vs. Real

Research Hypothesis 1: Graduates would like to be more proficient in the performance of technical skills than they are at graduation.

Statistical Hypothesis 1: The graduates' mean on ideal expectations is greater than the graduates' mean on real expectations on the Benner Scale.

Graduates and Educators: Ideal vs. Ideal

Research Hypothesis 2: Graduates have higher expectations than nurse educators on the ideal level of performance of technical skills expected at graduation.

Statistical Hypothesis 2: The graduates' mean on ideal expectations is greater than the nurse educators' mean on the Benner Scale.

Graduates and Administrators: Ideal vs. Ideal

Research Hypothesis 3: Graduates have higher expectations than nurse administrators on the ideal level of proficiency of technical skills expected at graduation.

Statistical Hypothesis 3: The graduates' mean on ideal expectations is greater than the nurse administrators' mean on the Benner Scale.

Graduates and Educators: Real vs. Real

Research Hypothesis 4: Graduates and nurse educators agree on the real level of proficiency of technical skills performed at graduation.

Statistical Hypothesis 4: The graduates' mean on real expectations is equal to the nurse educators' mean on the Benner Scale.

Graduates and Administrators: Real vs. Real

Research Hypothesis 5: Graduates and nurse administrators agree on the real level of proficiency of technical skills performed at graduation.

Statistical Hypothesis 5: The graduates' mean on real expectations is equal to the nurse administrators' mean on the Benner Scale.

Ideal and Real Performance Expectations of Graduates, Nurse Educators, and Nursing Service Administrators Regarding Critical Care Skills Measured by the Six-Dimension Scale of Nurse Performance

Graduates: Ideal vs. Real

Research Hypothesis 6: Graduates have higher expectations on the ideal level of performance of critical care skills than on the real level of performance.

Statistical Hypothesis 6: The graduates' mean on the ideal expectations of the Critical Care subscale is

greater than the graduates' mean on the real expectations.

Graduates and Educators: Ideal vs. Ideal

Research Hypothesis 7: Graduates have higher expectations than nurse educators on the ideal level of performance of critical care skills expected at graduation.

Statistical Hypothesis 7: The graduates' mean on ideal expectations of the Critical Care subscale is greater than the nurse educators' mean.

Graduates and Administrators: Ideal vs. Ideal

Research Hypothesis 8: Graduates have higher expectations than nurse administrators on the ideal level of critical care skills expected at graduation.

Statistical Hypothesis 8: The graduates' mean on ideal expectations of the Critical Care subscale is greater than the nurse administrators' mean.

Graduates and Educators: Real vs. Real

Research Hypothesis 9: Graduates and nurse educators agree on the real level of critical care skills performed at graduation.

Statistical Hypothesis 9: The graduates' mean on real expectations of the Critical Care subscale is equal to the nurse educators' mean.

Graduates and Administrators: Real vs. Real

Research Hypothesis 10: Graduates and nurse administrators agree on the real level of critical care skill performed at graduation.

Statistical Hypothesis 10: The graduates' mean on real expectations of the Critical Care subscale is equal to the nurse administrators' mean.

Ideal and Real Performance Expectations of Graduates, Nurse Educators, and Nursing Service Administrators Regarding Interpersonal Skills Measured by the Six-Dimension Scale of Nurse Performance

Graduates: Ideal vs. Real

Research Hypothesis 11: Graduates have higher expectations on the ideal level of performance of interpersonal skills than on the real level of performance.

Statistical Hypothesis 11: The graduates' mean on the ideal expectations of Interpersonal Relation subscale is greater than the graduates' mean on the real level of performance.

Graduates and Educators: Ideal vs. Ideal

Research Hypothesis 12: Graduates and nurse educators agree on the ideal level of performance of interpersonal skills expected at graduation.

Statistical Hypothesis 12: The graduates' mean on ideal expectations of the Interpersonal Relations subscale is equal to the nurse educators' mean.

Graduates and Administrators: Ideal vs. Ideal

Research Hypothesis 13: Graduates and nurse administrators agree on the ideal level of performance of interpersonal skills expected at graduation.

Statistical Hypothesis 13: The graduates' mean on ideal expectations of the Interpersonal Relations subscale is equal to the nurse administrators' mean.

Graduates and Educators: Real vs. Real

Research Hypothesis 14: Graduates and nurse educators agree on the level of proficiency of interpersonal skills performed at graduation.

Statistical Hypothesis 14: The graduates' mean on real expectations of the Interpersonal Relations subscale is equal to the nurse educators' mean.

Graduates and Administrators: Real vs. Real

Research Hypothesis 15: Graduates and nurse administrators agree on the level of proficiency of interpersonal skills performed at graduation.

Statistical Hypothesis 15: The graduates' mean on real expectations of the Interpersonal Relations subscale

is equal to the nurse educators' mean.

Ideal and Real Performance Expectations of Graduates, Nurse Educators, and Nursing Service Administrators Regarding Leadership Skills Measured by the Six-Dimension Scale of Nurse Performance

Graduates: Ideal vs. Real

Research Hypothesis 16: Graduates have higher expectations on the ideal level of performance of leadership skills than on real expectations.

Statistical Hypothesis 16: The graduates' mean on the ideal expectations of the Leadership Skills subscale is greater than the mean on real expectations.

Graduates and Educators: Ideal vs. Ideal

Research Hypothesis 17: Graduates and nurse educators agree on the ideal level of performance of leadership skills expected at graduation.

Statistical Hypothesis 17: The graduates' mean on ideal expectations of the Leadership Skills subscale is equal to the nurse educators' mean.

Graduates and Administrators: Ideal vs. Ideal

Research Hypothesis 18: Graduates and nurse administrators agree on the ideal level of performance of leadership skills expected at graduation.

Statistical Hypothesis 18: The graduates' mean on ideal expectations of the Leadership Skills subscale is equal to the nurse administrators' mean.

Graduates and Educators: Real vs. Real

Research Hypothesis 19: Graduates and nurse educators agree on the real level of proficiency of leadership skills performed at graduation.

Statistical Hypothesis 19: The graduates' mean on real expectations of the Leadership Skills subscale is equal to the nurse educators' mean.

Graduates and Administrators: Real vs. Real

Research Hypothesis 20: Graduates and nurse administrators agree on the level of proficiency of leadership skill performed at graduation.

Statistical Hypothesis 20: The graduates' mean on real expectations of the Leadership Skills subscale is equal to the nurse administrators' mean.

Ideal and Real Performance Expectations of Graduates, Nurse Educators, and Nursing Service Administrators Regarding Planning and Evaluation Skills Measured by the Six-Dimension Scale of Nurse Performance

Graduates: Ideal vs. Ideal

Research Hypothesis 21: Graduates have higher expectations on the ideal level of performance of planning and

evaluation than on real expectations.

Statistical Hypothesis 21: The graduates' mean on the ideal expectations of the Planning and Evaluation subscale is greater than the graduates' mean on the real.

Graduates and Educators: Ideal vs. Ideal

Research Hypothesis 22: Graduates and nurse educators agree on the ideal level of performance of planning and evaluation skills expected at graduation.

Statistical Hypothesis 22: The graduates' mean on ideal expectations of the Planning and Evaluation subscale is equal to the nurse educators' mean.

Graduates and Administrators: Ideal vs. Ideal

Research Hypothesis 23: Graduates and nurse administrators agree on the ideal level of performance of planning and evaluation skills expected at graduation.

Statistical Hypothesis 23: The graduates' mean on ideal expectations of the Planning and Evaluation subscale is equal to the nurse administrators' mean.

Graduates and Educators: Real vs. Real

Research Hypothesis 24: Graduates have lower expectations than nurse educators on the level of proficiency of planning and evaluation skills performed at graduation.

Statistical Hypothesis 24: The graduates' mean on real expectations of the Planning and Evaluation subscale is less than the nurse educators' mean.

Graduates and Administrators: Real vs. Real

Research Hypothesis 25: Graduates have higher expectations than nurse administrators on the level of performance of planning and evaluation skills performed at graduation.

Statistical Hypothesis 25: The graduates' mean on real expectations of the Planning and Evaluation subscale is greater than the nurse administrators' mean.

Ideal and Real Performance Expectations of Graduates, Nurse Educators, and Nursing Service Administrators Regarding Teaching and Collaboration Skills Measured by the Six-Dimension Scale of Nurse Performance

Graduates: Ideal vs. Real

Research Hypothesis 26: Graduates have higher expectations on the ideal level of performance of teaching and collaborating skills than on real expectations.

Statistical Hypothesis 26: The graduates' mean on the ideal expectations of the Teaching and Collaboration subscale is greater than the graduates' mean on the real.

Graduates and Educators: Ideal vs. Ideal

Research Hypothesis 27: Graduates have higher expectations than nurse educators on the ideal level of teaching and collaborating skills expected at graduation.

Statistical Hypothesis 27: The graduates' mean on the ideal expectations of the Teaching and Collaboration subscale is greater than the nurse educators' mean.

Graduates and Administrators: Ideal vs. Ideal

Research Hypothesis 28: Graduates have higher expectations than nurse administrators on the ideal level of teaching and collaborating skills expected at graduation.

Statistical Hypothesis 28: The graduates' mean on the Teaching and Collaboration subscale is greater than the nurse administrators' mean.

Graduates and Educators: Real vs. Real

Research Hypothesis 29: Graduates have lower expectations than nurse educators on the real level of performance of teaching and collaborating skills performed at graduation.

Statistical Hypothesis 29: The graduates' mean on the Teaching and Collaboration subscale is less than the nurse educators' mean.

Graduates and Administrators: Real vs. Real

Research Hypothesis 30: Graduates have higher expectations than nurse administrators on the real level of performance of teaching and collaborating skills performed at graduation.

Statistical Hypothesis 30: The graduates' mean on the Teaching and Collaboration subscale is greater than the nurse administrators' mean.

Data Analysis Plan

The information from the demographics sheet, the Benner Proficiency Scale, and two copies (ideal and real) of the Six-Dimension Scale of Nurse Performance was transferred to marked sense sheets and inputted into the VAX computer at Western Michigan University. The Statistical Package for the Social Sciences ([SPSS-X], 1983) was used to analyze the data.

The Benner Proficiency Scale was scored through the computation of overall mean scores. The overall mean (average) of ideal and real expectations was calculated by totaling the ratings of ideal and real expectations, respectively, and dividing each by the number of items scored. Paired t tests (SPSS-X, 1983, pp. 430-436) were used to determine significant differences between graduates (ideal) and graduates (real), graduates and nurse

educators, and graduates and nursing service administrators on ideal and real expectations of technical skills.

The five subscale scores were calculated through the computation of overall mean scores. The overall mean (average) of ideal and real expectations was calculated by totaling the ratings of ideal and real expectations respectively and dividing each by the number of items scored on each subscale.

Paired t tests were used to determine significant differences between graduates (ideal) and graduates (real), graduates and nurse educators, and graduates and nursing service administrators on ideal and real expectations of the following subscales: the critical care skills subscale (Hypotheses 6 through 10), the interpersonal skills/communication subscale (Hypotheses 11 through 15), the leadership skills subscale (Hypotheses 16 through 20), the planning and evaluation subscale (Hypotheses 21 through 25), and the teaching and collaboration skills subscale (Hypotheses 26 through 30).

The mean scores of the graduates on the Benner Proficiency Scale and the five subscales of the Six-Dimension Scale of Nurse Performance (Ideal and Real Expectations) were compared to the scores of the nurse educators and nurse administrators.

In addition, a ranking was presented of the ideal performance expectations of the baccalaureate graduates,

by graduates, nurse educators, and nursing service administrators regarding critical care skills, interpersonal relations skills, leadership skills, planning and evaluation skills, and teaching and collaboration skills.

A ranking was presented on the real performance expectations of baccalaureate graduates by graduates, nurse educators, and nursing service administrators on the five subscales mentioned above.

Summary

In summary, this chapter has provided a description of the methodology employed in the present investigation, including the design of the study and the criteria for sample selection. The instruments used to measure perceptions of entry level performance of baccalaureate nurses were discussed in terms of composition, validity, and reliability. The theoretical and statistical hypotheses were identified. In addition, the procedures for collecting and analyzing the data were explained.

CHAPTER IV

RESULTS

The data analysis chapter consists of four sections: (a) characteristics of the sample, (b) analysis of the 30 hypotheses, (c) a summary of data analysis, and (d) responses of three open-ended questions posed to the graduates.

Characteristics of the Sample

The sample was composed of 154 nurses who graduated from a baccalaureate program in 1985 from 17 schools. The 17 schools were located in 11 of 13 Midwestern states represented in the Consensus on Entry Skills project (Stull, 1985) (see Table 6).

The 154 graduates that comprised the sample were a mobile group. Although the nurses attended Midwestern colleges and universities they practiced in a variety of locations. In addition to receiving responses from the states listed in Table 6, graduates responded from several other places (see Table 7).

Not only did the graduates change locations, several married and several of the previously married graduates had children during their first year of practice. In

addition to the many changes in their personal lives, they were adjusting to the transition from student nurse to practitioner.

Table 6
Participating Schools and Location

Name of school	State
Southern Illinois University	Illinois
Loyola University	Illinois
Ball State University	Indiana
Valparaiso University	Indiana
Indiana University-Indianapolis	Indiana
University of Iowa	Iowa
Wichita State University	Kansas
Saginaw Valley State College	Michigan
Mercy College	Michigan
Nazareth College	Michigan
Winona State College	Minnesota
University of Minnesota	Minnesota
St. Louis University	Missouri
University of North Dakota	North Dakota
Mary College	North Dakota
University of Akron	Ohio
Central State University	Oklahoma

Table 7
Responses Received From Additional Locations

Location	Location	Location
Alaska	Hawaii	Tennessee
Arizona	Maryland	Texas
California	Nebraska	Virginia
Colorado	New York	Washington
Florida	APO New York (European assignment)	Washington, D.C.
Georgia		Wisconsin

The following demographic data were compiled on the 154 baccalaureate graduates:

The sample was comprised predominantly of females (95%) between the ages of 21 and 30 years of age (86%). The ages of the additional 14% varied from 31 to 57 years of age.

In regard to employment status, 87% were working full time, 9% part time, and 4% were not working. Seventy-three percent of the respondents were working in their first job since graduation, 20% had changed jobs, and 8% did not answer. Several of their first jobs were in a hospital setting (86.7%), and 60% of those worked on medical-surgical units. These findings compare with previous literature. The surprising fact was that 19% of the graduates worked in intensive care or critical care units.

New graduates have not been traditionally hired in these units, until they have had a year's experience on a medical-surgical floor. In 66% of the health care institutions, diagnosis related groups were implemented. Eighty percent of the new graduates had a special orientation, and 6 weeks was the most common length of time for that orientation.

Analysis of Major Hypotheses

The 30 hypotheses were grouped in six sections. The first section (Hypotheses 1-5) relates to technical skills; the second, critical care skills (Hypotheses 6-10); the third, interpersonal relations skills/communication (Hypotheses 11-15); the fourth, leadership skills (Hypotheses 16-20); the fifth, planning and evaluation skills (Hypotheses 21-25); and the sixth section relates to teaching and collaborating skills (Hypotheses 26-30). A graphical depiction follows each of the six sections which contain five hypotheses.

The Benner Proficiency Scale and the Six-Dimension Scale of Nurse Performance were the instruments used to measure ideal and real expectations of entry level performance of graduates, as perceived by the graduates, nurse educators, and nursing service administrators. For ease in interpretation, the scales on the Benner scale and the Six-Dimension Scale of Nurse Performance were reversed

before statistical analysis, (e.g., 1 in the scale became 4). Paired t tests were used to compare mean scores of graduates (ideal) to the graduates (real), graduates and nurse educators, and the graduates and nursing service administrators. When the graduates' ideal and real expectations were compared, 153 degrees of freedom (df) were used. When the graduates and educators and/or the administrators were compared 16 df were used to represent the five individuals as a team.

The team consisted of a baccalaureate graduate, a nurse educator, and nursing service administrators from the hospital setting, community health agency, and a nursing home. A composite score was used for the three nursing service administrators.

Ideal and Real Performance Expectations of Graduates, Nurse Educators, and Nursing Service Administrators Regarding Technical Skills on the Benner Proficiency Scale

Graduates: Ideal vs. Real

Research Hypothesis 1: Graduates would like to be more proficient in the performance of technical skills than they are at graduation.

Statistical Hypothesis 1: The graduates' mean on ideal expectations is greater than the graduates' mean on real expectations on the Benner scale.

From Table 8 one can conclude that the graduates' mean on ideal expectations was greater than the graduates' mean on real expectations of performance of technical skills at graduation. For an alpha level of .05, the p of .000 is evidence to reject the null hypothesis of no difference between the means and accept the statistical as well as the research hypothesis as tenable.

Table 8
Comparison of Ideal Expectations of Graduates
to Real Expectations of Graduates
Regarding Technical Skills

Technical skills	Mean	<u>SD</u>	<u>t</u>	<u>df</u>	<u>p</u>
Ideal expectations	3.99	.588	21.81	153	.000*
Real expectations	3.05	.465			

* $p < .05$ probability for one-tailed test.

Graduates and Educators: Ideal vs. Ideal

Research Hypothesis 2: Graduates have higher expectations than nurse educators on the ideal level of technical performance expected at graduation.

Statistical Hypothesis 2: The graduates' mean on ideal expectations is greater than the nurse educators' mean on the Benner scale.

From Table 9 one can conclude that the graduates' mean was greater than the nurse educators' mean on ideal

expectations of performance of technical skills. For an alpha level of .05, the p of .009 is evidence to reject the null hypothesis of no difference between the means and accept the statistical as well as the research hypothesis as tenable.

Table 9

Comparison of Ideal Expectations of Graduate Nurses
and Ideal Expectations of Nurse Educators
Regarding Technical Skills Performance

Technical skills	Mean	<u>SD</u>	<u>t</u>	<u>df</u>	<u>p</u>
Ideal (graduates)	3.99	.236	-2.64	16	.009*
Ideal (educators)	3.69	.473			

* $p < .05$ probability for one-tailed test.

Graduates and Administrators: Ideal vs. Ideal

Research Hypothesis 3: Graduates have higher expectations than nurse administrators on the ideal level of proficiency of technical performance expected at graduation.

Statistical Hypothesis 3: The graduates' mean on ideal expectations is greater than the nurse administrators' mean on the Benner scale.

From Table 10 one can conclude that the graduates' mean was greater than the nurse administrators' mean on ideal expectations of performance of technical skills.

For an alpha level of .05, the p of .001 is evidence to reject the null hypothesis of no difference between the means and accept the statistical as well as the research hypothesis as tenable.

Table 10

Comparison of Ideal Expectations of Graduates and
Ideal Expectations of Nurse Administrators
Regarding Technical Skill Performance

Technical skills	Mean	<u>SD</u>	<u>t</u>	<u>df</u>	<u>p</u>
Ideal (graduates)	3.99	.236	-4.34	17	.001*
Ideal (administrators)	3.70	.279			

* $p < .05$ probability for one-tailed test.

Graduates and Educators: Real vs. Real

Research Hypothesis 4: Graduates and nurse educators agree on the real level of proficiency of technical skills performed at graduation.

Statistical Hypothesis 4: The graduates' mean on real expectations is equal to the nurse educators' mean on the Benner scale.

From Table 11 one can conclude that there was no difference between the graduates' mean on real expectations of performance of technical skills from the nurse educators' real expectations. For an alpha level of .20,

the p of .764 is evidence to accept the null hypothesis and accept the research hypothesis as tenable.

Table 11

Comparison of Real Expectations of Graduate Nurses
and Real Expectations of Nurse Educators
Regarding Technical Skills Performance

Technical skills	Mean	<u>SD</u>	<u>t</u>	<u>df</u>	<u>p</u>
Real (graduates)	3.05	.232	0.30	16	.764*
Real (educators)	2.99	.506			

* $p > .20$ probability for two-tailed test.

Graduates and Administrators: Real vs. Real

Research Hypothesis 5: Graduates and nurse administrators agree on real level of proficiency of technical skills performed at graduation.

Statistical Hypothesis 5: The graduates' mean on real expectations is equal to the nurse administrators' mean on the Benner scale.

From Table 12 one can conclude that there is no evidence to support this statistical hypothesis. For an alpha level of .20, the p of .001 is evidence to fail to accept the null hypothesis; and therefore, there is no evidence to support the research hypothesis that graduates and nurse administrators agree on real level of proficiency of technical skills performed at graduation.

Table 12

Comparison of Real Expectations of Graduate Nurses
and Real Expectations of Nurse Administrators
Regarding Technical Skills Performance

Technical skills	Mean	<u>SD</u>	<u>t</u>	<u>df</u>	<u>p</u>
Real (graduates)	3.05	.232	-4.08	16	.001
Real (administrators)	2.61	.288			

*p > .20 probability for two-tailed test.

Graduates ideally would like to be more proficient in the performance of technical skills than they are at graduation. Graduates had higher ideal expectations of technical skill performance than the nurse educators or nurse administrators.

Graduates and nurse educators agreed on the real expectations of performance of technical skills; however, graduates had higher real expectations than the nurse administrators (see Figure 2).

Ideal and Real Performance Expectations of Graduates, Nurse Educators, and Nursing Service Administrators Regarding Critical Care Skills Measured by the Six-Dimension Scale of Nurse Performance

Hypotheses 6-10 refer to the Critical Care Skills subscale of the Six-Dimension Scale of Nurse Performance.

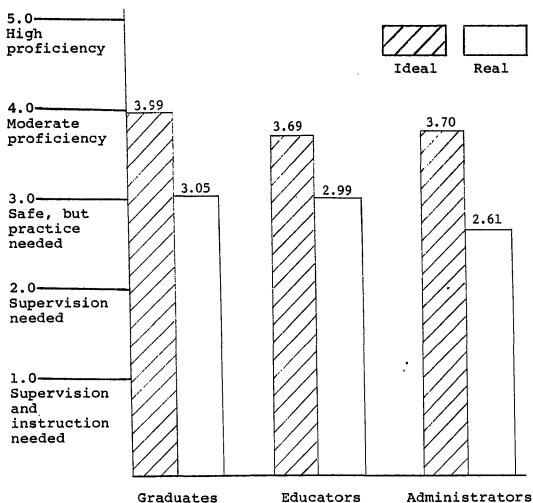


Figure 2. Comparison of Group Mean Scores of Graduates, Nurse Educators, and Nurse Administrators on Ideal and Real Performance Expectation of Technical Skills.

Graduates: Ideal vs. Ideal

Research Hypothesis 6: Graduates have higher expectations on the ideal level of performance of critical care skills than on the real level of performance.

Statistical Hypothesis 6: The graduates' mean on the ideal expectations of the critical care subscale is greater than the graduates' mean on the real expectations.

From Table 13 one can conclude that the graduates' mean on ideal expectations was greater than the graduates' mean on real expectations of critical care skills. For an alpha level of .05, the p of .000 is evidence to reject the null hypothesis of no difference between the means and accept the statistical as well as the research hypothesis as tenable.

Table 13

Comparison of Ideal Expectations of Graduates to
Real Expectations of Graduates on
Critical Care Skills

Critical care skills	Mean	<u>SD</u>	<u>t</u>	<u>df</u>	<u>p</u>
Ideal (graduates)	2.95	.445	15.38	153	.000*
Real (graduates)	2.31	.442			

* $p < .05$ probability for one-tailed test.

Graduates and Educators: Ideal vs. Ideal

Research Hypothesis 7: Graduates have higher expectations than nurse educators on the ideal level of critical care skills expected at graduation.

Statistical Hypothesis 7: The graduates' mean on ideal expectations of the critical care subscale is greater than the nurse educators' mean.

From Table 14 one can conclude that the graduates' mean on ideal expectations was greater than the nurse educators' mean on critical care skills. For an alpha level of .05 the p of .002 is evidence to reject the null hypothesis of no difference between the means and accept the statistical as well as the research hypothesis as tenable.

Table 14

Comparison of Ideal Expectations of Graduates and Nurse Educators Regarding Critical Care Skills

Critical care skills	Mean	<u>SD</u>	<u>t</u>	<u>df</u>	<u>p</u>
Ideal (graduates)	2.95	.128	-3.35	16	.002*
Ideal (educators)	2.59	.387			

* $p < .05$ probability for one-tailed test.

Graduates and Administrators: Ideal vs. Ideal

Research Hypothesis 8: Graduates have higher expectations than nurse administrators on the ideal level of critical care skills expected at graduation.

Statistical Hypothesis 8: The graduates' mean on ideal expectations of the critical care subscale is

greater than the nurse administrators' mean.

From Table 15 one can conclude that the graduates' mean on ideal expectations of critical care skills was greater than the nurse administrators' ideal expectations. For an alpha level of .05, the p of .000 is evidence to reject the null hypothesis of no difference between the means and accept the statistical as well as the research hypothesis as tenable.

Table 15
Comparison of Ideal Expectations of Graduates
and Nurse Administrators Regarding
Critical Care Skills

Critical care skills	Mean	<u>SD</u>	<u>t</u>	<u>df</u>	<u>p</u>
Ideal (graduates)	2.95	.128	-8.46	16	.000*
Ideal (administrators)	2.53	.271			

* $p < .05$ probability for one-tailed test.

Graduates and Educators: Real vs. Real

Research Hypothesis 9: Graduates and nurse educators agree on the real level of critical care skills performed at graduation.

Statistical Hypothesis 9: The graduates' mean on real expectations of the critical care subscale is equal to the nurse educators' mean.

From Table 16 one can conclude that there is no evidence to support this statistical hypothesis. For an alpha level of .20, the p of .097 is evidence to fail to accept the null hypothesis, and therefore, there is no evidence to support the research hypothesis that graduates and nurse educators agree on the real level of critical care skills performed at graduation.

Table 16
Comparison of Real Expectations of Graduates and
Nurse Educators Regarding Critical Care Skills

Critical care skills	Mean	<u>SD</u>	<u>t</u>	<u>df</u>	<u>p</u>
Real (graduates)	2.31	.136	1.76	16	.097
Real (educators)	2.56	.581			

* $p > .20$ probability for two tailed test.

Graduates and Administrators: Real vs. Real

Research Hypothesis 10: Graduates and nurse administrators agree on the real level of critical care skills performed at graduation.

Statistical Hypothesis 10: The graduates' mean on real expectations of the critical care subscale is equal to the nurse administrators' mean.

From Table 17 one can conclude that there was no difference between the graduates' mean on real

expectations of performance of critical care skills from the nurse administrators real expectations. For an alpha level of .20 the p of .294 is evidence to accept the null hypothesis and accept the research hypothesis as tenable.

Table 17
Comparison of Real Expectations of Graduates
and Nurse Administrators Regarding
Critical Care Skills

Critical care skills	Mean	<u>SD</u>	<u>t</u>	<u>df</u>	<u>p</u>
Real (graduates)	2.31	.136	-1.09	16	.294*
Real (administrators)	2.17	.527			

* $p > .20$ probability for two-tailed test.

Graduates had higher ideal expectations of the performance on critical care skills than on the real expectations of performance. The graduates also had higher ideal expectations than the nurse educators and nurse administrators.

There was a difference between the graduates and nurse educators. Graduates felt less proficient in the real performance of critical care skills than the nurse educators' assessment. The graduates and the nurse administrators agreed on the real expectations of level of performance (see Figure 3).

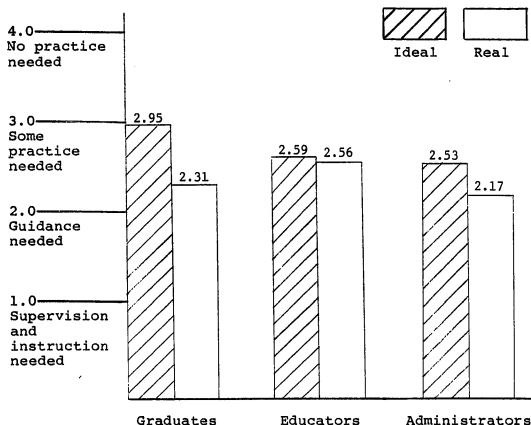


Figure 3. Comparison of Group Mean Scores of Graduates, Nurse Educators, and Nurse Administrators on Critical Care Subscale of the Six-Dimension Scale of Nurse Performance.

Ideal and Real Performance Expectations of Graduates, Nurse Educators, and Nursing Service Administrators Regarding Interpersonal Skills Measured by the Six-Dimension Scale of Nurse Performance

Hypotheses 11-15 refer to the Interpersonal Relations Skills/Communication subscale of the Six-Dimension Scale of Nurse Performance.

Graduates: Ideal vs. Real

Research Hypothesis 11: Graduates have higher expectations on the ideal level of performance of interpersonal skills than on the real level of performance.

Statistical Hypothesis 11: The graduates' mean on the ideal expectations of interpersonal relations subscale is greater than the graduates' mean on the real expectations of performance.

From Table 18 one can conclude that the graduates' mean on ideal expectations was greater than the graduates' mean on real expectations on the interpersonal relations/communication skills subscale. For an alpha level of .05, the p of .000 is evidence to reject the null hypothesis of no difference between the means and accept the statistical as well as the research hypothesis as tenable.

Table 18

Comparison of Graduates' Ideal Expectations and Real Expectations on the Interpersonal Relations Skills/Communication Subscale of the Six-Dimension Scale of Nurse Performance

Interpersonal relations/communication	Mean	<u>SD</u>	<u>t</u>	<u>df</u>	<u>p</u>
Ideal (graduates)	3.70	.318	13.29	153	.000*
Real (graduates)	3.34	.382			

* $p < .05$ probability for one-tailed test.

Graduates and Educators: Ideal vs. Ideal

Research Hypothesis 12: Graduates and nurse educators agree on the ideal level of performance of interpersonal skills expected at graduation.

Statistical Hypothesis 12: The graduates' mean on ideal expectations of the interpersonal relations subscale is equal to the nurse educators' mean.

From Table 19 one can conclude that there was no difference between the graduates' mean on ideal expectations and the nurse educators' ideal expectations regarding interpersonal relations skills. For an alpha level of .20, the p of .295 is evidence to accept the null hypothesis and accept the research hypothesis as tenable.

Table 19

Comparison of Ideal Expectations of Graduates and
Nurse Educators Regarding Interpersonal
Relations Skills

Interpersonal relations/communication	Mean	<u>SD</u>	<u>t</u>	<u>df</u>	<u>p</u>
Ideal (graduates)	3.70	.125	-1.08	16	.295*
Ideal (educators)	3.58	.324			

* $p > .20$ probability of two-tailed test.

Graduates and Administrators: Ideal vs. Ideal

Research Hypothesis 13: Graduates and nurse administrators agree on the ideal level of performance of interpersonal skills expected at graduation.

Statistical Hypothesis 13: The graduates' mean on ideal expectations of the interpersonal relations subscale is equal to the nurse administrators' mean.

From Table 20 one can conclude that there is no evidence to support this statistical hypothesis. For an alpha level of .20, the p of .007 is evidence to fail to accept the null hypothesis; and therefore, there is no evidence to support the research hypothesis that graduates and nurse administrators agree on the ideal level of performance of interpersonal skills expected at graduation.

Table 20

Comparison of Ideal Expectations of Graduates
and Nurse Administrators Regarding
Interpersonal Relations Skills

Interpersonal relations/communication	Mean	<u>SD</u>	<u>t</u>	<u>df</u>	<u>p</u>
Ideal (graduates)	3.70	.125	-3.12	16	.007
Ideal (administrators)	3.48	.244			

* $p > .20$ probability for two-tailed test.

Graduates and Educators: Real vs. Real

Research Hypothesis 14: Graduates and nurse educators agree on the level of proficiency of interpersonal skills performed at graduation.

Statistical Hypothesis 14: The graduates' mean on real expectations of the interpersonal relations subscale is equal to the nurse educators' mean.

From Table 21 one can conclude that there was no difference between the graduates' mean on real expectations of performance of interpersonal skills and the nurse educators' mean on real expectations. For an alpha level of .20, the p of .380 is evidence to accept the null hypothesis and accept the research hypothesis as tenable.

Table 21

Comparison of Real Expectations of Graduates and
Nurse Educators Regarding Interpersonal
Relations/Communication Skills

Interpersonal relations/communication	Mean	SD	t	df	p
Real (graduates)	3.34	.120	0.90	16	.380*
Real (educators)	3.24	.382			

* $p > .20$ probability for two-tailed test.

Graduates and Administrators: Real vs. Real

Research Hypothesis 15: Graduates and nurse administrators agree on the level of proficiency of interpersonal skills performed at graduation.

Statistical Hypothesis 15: The graduates' mean on real expectations of the interpersonal relations subscale is equal to the nurse administrators' mean.

From Table 22 one can conclude that there is no evidence to support this statistical hypothesis. For an alpha level of .20, the p of .001 is evidence to fail to accept the null hypothesis; and therefore, there is no evidence to support the research hypothesis that graduates and nurse administrators agree on the level of proficiency of interpersonal skills performed at graduation.

Table 22

Comparison of Real Expectations of Graduates
and Nurse Administrators Regarding
Interpersonal Relations Skills

Interpersonal relations/communication	Mean	<u>SD</u>	<u>t</u>	<u>df</u>	<u>p</u>
Real (graduates)	3.34	.120	-4.19	16	.001
Real (administrators)	2.98	.337			

* $p > .20$ probability for a two-tailed test.

Graduates had higher expectations on the ideal level of performance than the real level of performance on interpersonal relations/communication skills. The graduates and the nurse educators agreed on the ideal level of interpersonal relations skills. Graduates had higher expectations than the nurse administrators on the ideal level of interpersonal relations skills.

The graduates and the nurse educators agreed on the real level of performance of interpersonal relations skills. Graduates had higher expectations than the nurse administrators on the real level of interpersonal relations skills (see Figure 4.)

Ideal and Real Performance Expectations of Graduates, Nurse Educators, and Nursing Service Administrators Regarding Leadership Skills Measured by the Six-Dimension Scale of Nurse Performance

Hypotheses 16-20 refer to the Leadership Skills subscale on the Six-Dimension Scale of Nurse Performance.

Graduates: Ideal vs. Real

Research Hypothesis 16: Graduates have higher expectations on the ideal level of performance of leadership skills than on real expectations of performance.

Statistical Hypothesis 16: The graduates' mean on the ideal expectations of the leadership skill subscale is greater than the mean on real expectations.

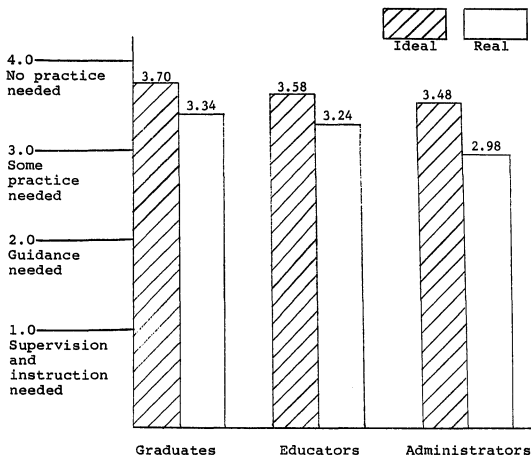


Figure 4. Comparison of Group Mean Scores of Graduates, Nurse Educators, and Nurse Administrators on Interpersonal Relations Subscale of the Six-Dimension Scale of Nurse Performance.

From Table 23 one can conclude that the graduates' mean on ideal expectations of leadership skills was greater than the graduates' mean on real expectations. For an alpha level of .05, the p of .000 is evidence to reject the null hypothesis of no difference between the

means and accept the statistical as well as the research hypothesis as tenable.

Table 23
Comparison of Ideal and Real Expectations of
Graduates Regarding Leadership Skills

Leadership skills	Mean	<u>SD</u>	<u>t</u>	<u>df</u>	<u>p</u>
Ideal (graduates)	3.38	.411	11.95	153	.000*
Real (graduates)	2.94	.498			

* $p < .05$ probability for a one-tailed test.

Graduates and Educators: Ideal vs. Ideal

Research Hypothesis 17: Graduates and nurse educators agree on the ideal level of performance of leadership skills expected at graduation.

Statistical Hypothesis 17: The graduates' mean on the ideal expectations of the leadership skills subscale is equal to the nurse educators' mean.

From Table 24 one can conclude that there is no evidence to support this statistical hypothesis. For an alpha level of .20, the p of .002 is evidence to fail to accept the null hypothesis; and therefore, there is no evidence to support the research hypothesis that graduates and nurse educators agree on the ideal level of performance of leadership skills expected at graduation.

Table 24

Comparison of Ideal Expectations of Graduates and
Nurse Educators Regarding Leadership Skills

Leadership skills	Mean	<u>SD</u>	<u>t</u>	<u>df</u>	<u>p</u>
Ideal (graduates)	3.38	.154	-3.81	16	.002
Ideal (educators)	3.01	.384			

*p > .20 probability for a two-tailed test.

Graduates and Administrators: Ideal vs. Ideal

Research Hypothesis 18: Graduates and nurse administrators agree on the ideal level of performance of leadership skills expected at graduation.

Statistical Hypothesis 18: The graduates' mean on ideal expectations of the leadership skills subscale is equal to the nurse administrators' mean.

From Table 25 one can conclude that there is no evidence to support this statistical hypothesis. For an alpha level of .20, the p of .000 is evidence to fail to accept the null hypothesis; and therefore, there is no evidence to support the research hypothesis that graduates and nurse administrators agree on the ideal level of performance of leadership skills expected at graduation.

Table 25

Comparison of Ideal Expectations of Graduates
and Nurse Administrators Regarding
Leadership Skills

Leadership skills	Mean	SD	t	df	p
Ideal (graduates)	3.38	.154	-6.12	16	.000
Ideal (administrators)	3.01	.384			

*p > .20 probability on a two-tailed test.

Graduates and Educators: Real vs. Real

Research Hypothesis 19: New graduates and nurse educators agree on the level of proficiency of leadership skills performed at graduation.

Statistical Hypothesis 19: The graduates' mean on real expectations on the leadership subscale is equal to the nurse educators' mean.

From Table 26 one can conclude that there is no evidence to support this statistical hypothesis. For an alpha level of .20, the p of .007 is evidence to fail to accept the null hypothesis; and therefore, there is no evidence to support the research hypothesis that graduates and nurse educators agree on the level of proficiency of leadership skills performed at graduation.

Table 26

Comparison of Real Expectations of Graduates
and Nurse Educators Regarding
Leadership Skills

Leadership skills	Mean	<u>SD</u>	<u>t</u>	<u>df</u>	<u>p</u>
Real (graduates)	2.94	.170	-3.09	16	.007
Real (educators)	2.65	.319			

*p > .20 probability on a two-tailed test.

Graduates and Administrators: Real vs. Real

Research Hypothesis 20: Graduates and nurse administrators agree on the level of proficiency of leadership skills performed at graduation.

Statistical Hypothesis 20: The graduates' mean on real expectations of the leadership subscale is equal to the nurse administrators' mean.

From Table 27 one can conclude that there is no evidence to support this statistical hypothesis. For an alpha level of .20, the p of .000 is evidence to fail to accept the null hypothesis; and therefore, there is no evidence to support the research hypothesis that graduates and administrators agree on the level of proficiency of leadership skills performed at graduation.

Table 27
Comparison of Real Expectations of Graduates
and Nurse Administrators Regarding
Leadership Skills

Leadership skills	Mean	SD	t	df	p
Real (graduates)	2.94	.170	-6.62	16	.000
Real (administrators)	2.18	.424			

*p > .20 probability for a two-tailed test.

Graduates had higher expectations on the ideal level of performance of leadership skills than on the real level of performance. Graduates had higher expectations than and the nurse educators and the nurse administrators on the ideal level of performance for leadership skills.

Graduates had higher real expectations of performance of leadership skills than the nurse educators and the nurse administrators (see Figure 5).

Ideal and Real Performance Expectations of Graduates, Nurse Educators, and Nursing Service Administrators Regarding Planning and Evaluation Skills Measured by the Six-Dimension Scale of Nurse Performance

Hypotheses 21-25 refer to the Planning and Evaluation subscale of the Six-Dimension Scale of Nurse Performance.

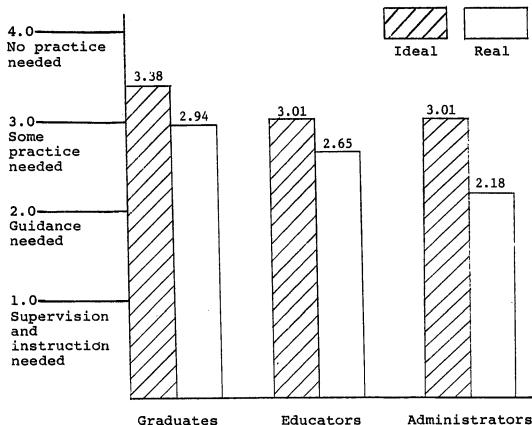


Figure 5. Comparison of Group Mean Scores of Graduates, Nurse Educators, and Nurse Administrators on Leadership Subscale of the Six-Dimension Scale of Nurse Performance.

Graduates: Ideal vs. Ideal

Research Hypothesis 21: Graduates have higher expectations on the ideal level of performance of planning and evaluation than real expectations.

Statistical Hypothesis 21: The graduates' mean on ideal expectations of the planning and evaluation subscale is greater than graduates' mean on the real.

From Table 28 one can conclude that the graduates' mean on ideal expectations of planning and evaluation skills was greater than the graduates' mean on real expectations. For an alpha level of .05, the p of .000 is evidence to reject the null hypothesis of no difference between the means and accept the statistical as well as the research hypothesis as tenable.

Table 28
Comparison of Ideal and Real Expectations
of Graduates on Planning and
Evaluation Skills

Planning and evaluation skills	Mean	<u>SD</u>	<u>t</u>	<u>df</u>	<u>p</u>
Ideal (graduates)	3.53	.397	13.88	153	.000*
Real (graduates)	3.11	.430			

* $p < .05$ probability on a one-tailed test.

Graduates and Educators: Ideal vs. Ideal

Research Hypothesis 22: Graduates and nurse educators agree on the level of performance of planning and evaluation skills expected at graduation.

Statistical Hypothesis 22: The graduates' mean on ideal expectations of the planning and evaluation subscale is equal to the nurse educators' mean.

From Table 29 one can conclude that there was a difference between the graduates' mean on ideal expectations of planning and evaluation skills and the nurse educators' mean on ideal expectations. For an alpha level of .20, the p of .415 is evidence to accept the null hypothesis and accept the research hypothesis.

Table 29
Comparison of Ideal Expectations of Graduates
and Nurse Educators of Planning and
Evaluation Skills

Planning and evaluation skills	Mean	<u>SD</u>	<u>t</u>	<u>df</u>	<u>p</u>
Ideal (graduates)	3.53	.174	-0.84	16	.415*
Ideal (educators)	3.41	.355			

* $p > .20$ probability on a two-tailed test.

Graduates and Administrators: Ideal vs. Ideal

Research Hypothesis 23: Graduates and nurse administrators agree on the ideal level of performance of planning and evaluation skills expected at graduation.

Statistical Hypothesis 23: The graduates' mean on ideal expectations of the planning and evaluation subscale is equal to the nurse administrators' mean.

From Table 30 one can conclude that there is no evidence to support the statistical hypothesis. For an

alpha level of .20, the p of .001 is evidence to fail to accept the null hypothesis; and therefore, there is no evidence to support the research hypothesis that graduates and nurse administrators agree on the ideal level of performance of planning and evaluation skills expected at graduation.

Table 30

Comparison of Ideal Expectations of New Graduates
and Nurse Administrators of Planning and
Evaluation Skills

Planning and evaluation skills	Mean	<u>SD</u>	<u>t</u>	<u>df</u>	<u>p</u>
Ideal (graduates)	3.53	.174	-3.91	16	.001
Ideal (administrators)	3.25	.235			

* $p > .20$ probability for a two-tailed test.

Graduates and Educators: Real vs. Real

Research Hypothesis 24: Graduates have lower expectations than nurse educators on the level of proficiency of planning and evaluation skills performed at graduation.

Statistical Hypothesis 24: The graduates' mean on real expectations of the planning and evaluation subscale is less than the nurse educators' mean.

From Table 31 one can conclude that there was no difference between the graduates' mean on real

expectations of performance of planning and evaluation from the nurse educators' real expectations. For an alpha level of .05, the p of .225 is evidence to accept the null hypothesis and accept the research hypothesis as tenable.

Table 31
Comparison of Real Expectations of Graduates
and Nurse Educators of Planning and
Evaluation Skills

Planning and evaluation skills	Mean	<u>SD</u>	<u>t</u>	<u>df</u>	<u>p</u>
Real (graduates)	3.11	.290	0.13	16	.225
Real (educators)	3.04	.367			

* $p < .05$ probability for a one-tailed test.

Graduates and Administrators: Real vs. Real

Research Hypothesis 25: Graduates have higher expectations than nurse administrators on the level of proficiency of planning and evaluation skills performed at graduation.

Statistical Hypothesis 25: The graduates' mean on real expectations of the planning and evaluation subscale is greater than the nurse administrators' mean.

From Table 32 one can conclude that the graduates' mean on real expectations of planning and evaluation skills was greater than the nurse administrators' mean on

real expectations. For an alpha level of .05, the p of difference between the means and accept the statistical as well as the research hypothesis as tenable.

Table 32

Comparison of Real Expectations of Graduates and
Real Expectations of Nurse Administrators
on Planning and Evaluation Skills

Planning and evaluation skills	Mean	<u>SD</u>	<u>t</u>	<u>df</u>	<u>p</u>
Real (graduates)	3.11	.290	-3.42	16	.004*
Real (administrators)	2.73	.315			

* $p < .05$ probability for a one-tailed test.

Graduates have higher expectations on the ideal performance of planning and evaluation skills than on the real level of performance. The graduates and the nurse educators agreed on the ideal expectations of planning and evaluation, but the graduates and the nurse administrators did not agree. The graduates had higher ideal expectations than the nurse administrators.

The graduates and the nurse educators agreed on the real level of performance of planning and evaluation skills. The nurse administrators had lower expectations than the graduates (see Figure 6).

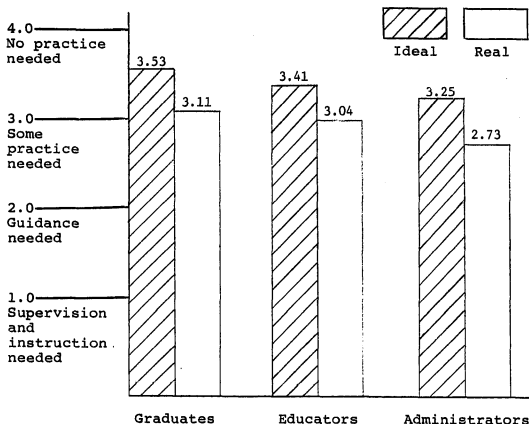


Figure 6. Comparison of Group Mean Scores of Graduates, Nurse Educators, and Nurse Administrators on Planning and Evaluation Subscale of the Six-Dimension Scale of Nurse Performance.

Ideal and Real Performance Expectations of Graduates, Nurse Educators, and Nursing Service Administrators Regarding Teaching and Collaboration Skills Measured by the Six-Dimension Scale of Nurse Performance

Hypotheses 26-30 refer to the Teaching and Collaboration subscale of the Six-Dimension Scale of Nurse Performance.

Graduates: Ideal vs. Real

Research Hypothesis 26: Graduates have higher expectations on the ideal level of performance of teaching and collaboration skills than on real expectations.

Statistical Hypothesis 26: The graduates' mean on the ideal expectations of the teaching and collaboration subscale is greater than the graduates' mean on real expectations.

From Table 33 one can infer that there was a difference between the graduates' mean on ideal expectations of teaching and collaboration skills and the graduates' mean on real expectations. For an alpha level of .05, the p of .000 is evidence to reject the null hypothesis of no difference between the means and accept the statistical as well as the research hypothesis as tenable.

Table 33

Comparison of Ideal Expectations to Real Expectations
of Graduates Regarding Teaching and
Collaboration Skills

Teaching and collaborating skills	Mean	<u>SD</u>	<u>t</u>	<u>df</u>	<u>p</u>
Ideal (graduates)	3.30	.450	15.36	153	.000*
Real (graduates)	2.84	.452			

* $p < .05$ probability for a one-tailed test.

Graduates and Educators: Ideal vs. Ideal

Research Hypothesis 27: Graduates have higher expectations than nurse educators on the ideal level of teaching and collaboration skills expected at graduation.

Statistical Hypothesis 27: The graduates' mean on the ideal expectations of the teaching and collaboration subscale is greater than the nurse educators' mean.

From Table 34 one can infer that there was no difference between the graduates' ideal expectations and the nurse educators' ideal expectations regarding teaching and collaboration skills. For an alpha level of .05, the p of .108 is evidence to fail to reject the null hypothesis and no evidence to support or not support the research hypothesis.

Table 34

Comparison of Ideal Expectations of Graduates and
Nurse Educators Regarding Teaching and
Collaboration Skills

Teaching and collaborating skills	Mean	<u>SD</u>	<u>t</u>	<u>df</u>	<u>p</u>
Ideal (graduates)	3.30	.225	-1.70	16	.108
Ideal (educators)	3.08	.372			

* $p < .05$ probability for a one-tailed test.

Graduates and Administrators: Ideal vs. Ideal

Research Hypothesis 28: Graduates have higher expectations than nurse administrators on the ideal level of teaching and collaboration skills expected at graduation.

Statistical Hypothesis 28: The graduates' mean on the teaching and collaboration subscale is greater than the nurse administrators' mean.

From Table 35 one can conclude that the graduates mean on ideal expectations of teaching and collaboration skills is greater than the nurses administrators mean on ideal expectations. For an alpha level of .05, the p of .000 is evidence to reject the null hypothesis of no difference between the means and accept the statistical as well as the research hypothesis as tenable.

Table 35

Comparison of Ideal Expectations of Graduates and
Nurse Administrators Regarding Teaching and
Collaboration Skills

Teaching and collaborating skills	Mean	<u>SD</u>	<u>t</u>	<u>df</u>	<u>p</u>
Ideal (graduates)	3.30	.225	-5.06	16	.000*
Ideal (administrators)	2.80	.282			

* $p < .05$ probability for a one-tailed test.

Graduates and Educators: Real vs. Real

Research Hypothesis 29: Graduates have lower expectations than nurse educators on the real level of performance of teaching and collaboration skills.

Statistical Hypothesis 29: The graduates' mean on the teaching and collaboration subscale is less than the nurse educators' mean.

From Table 36 one can conclude that the graduates mean on real expectations of teaching and collaboration skills was lower than the nurse educators' mean on real expectations. For an alpha level of .05, the p of .772 is evidence to fail to reject the null hypothesis and no evidence to support or not support the research hypothesis.

Table 36

Comparison of Real Expectations of Graduates and
Nurse Educators Regarding Teaching and
Collaboration Skills

Teaching and collaborating skills	Mean	<u>SD</u>	<u>t</u>	<u>df</u>	<u>p</u>
Real (graduates)	2.84	.306	0.30	16	.772
Real (educators)	2.86	.515			

* $p < .05$ probability for a one-tailed test.

Graduates and Administrators: Real vs. Real

Research Hypothesis 30: Graduates have higher expectations than nurse administrators on the real level of performance of teaching and collaboration skills.

Statistical Hypothesis 30: The graduates' mean on the teaching and collaboration subscale is greater than the nurse administrators' mean.

From Table 37 one can conclude that the graduates' mean on real expectations of teaching and collaboration skills was less than the nurse administrators' mean on real expectations. For an alpha level of .05, the p of .003 level is evidence to reject the null hypothesis of no difference between the means and accept the statistical as well as the research hypothesis as tenable.

Table 37

Comparison of Real Expectations of Graduates and Nurse Administrators Regarding Teaching and Collaboration Skills

Teaching and collaborating skills	Mean	<u>SD</u>	<u>t</u>	<u>df</u>	<u>p</u>
Real (graduates)	2.84	.306	-3.48	16	.003*
Real (administrators)	2.45	.286			

* $p < .05$ probability for a one-tailed test.

The graduates had higher expectations on the ideal level of performance of teaching and collaboration than the real level of performance. The graduates also have higher expectations than the nurse educators and nurse administrators.

The graduates and the nurse educators agreed on the real level of performance on teaching and collaboration. The nurse administrators had lower expectations than the graduates (see Figure 7).

Significant Findings of Graduates'
Ideal vs. Real Expectations

The following hypotheses were supported at the .05 alpha level.

1. Graduates would like to be more proficient in the performance of technical skills than they are at graduation.

6. Graduates have higher expectations on the ideal level of performance of critical care skills than on the real level of performance.

11. Graduates have higher expectations on the ideal level of performance of interpersonal skills than on the real level of performance.

16. Graduates have higher expectations on the ideal level of performance of leadership skills than on real expectations of performance.

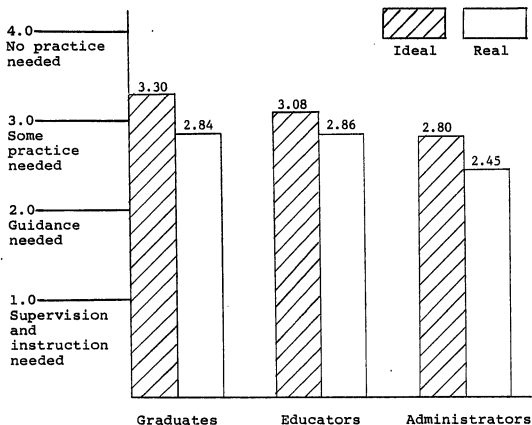


Figure 7. Comparison of Group Mean Scores of Graduates, Nurse Educators, and Nurse Administrators on Teaching and Collaboration Subscale of the Six-Dimension Scale of Nurse Performance.

21. Graduates have higher expectations on the ideal level of performance of planning and evaluation than on the real expectations of performance.

26. Graduates have higher expectations on the ideal level of performance of teaching and collaboration skills than on real expectations of performance.

Significant Findings of Ideal vs. Ideal Expectations
as Perceived by Graduates, Nurse Educators,
and Nurse Administrators

The following hypotheses were supported, the directional hypotheses at .05 alpha level and the no difference hypotheses at .20 alpha level.

Technical Skills

2. Graduates have higher expectations than nurse educators on the ideal level of technical performance expected at graduation.

3. Graduates have higher expectations than nurse administrators on the ideal level of proficiency of technical performance expected at graduation.

Critical Care Skills

7. Graduates have higher expectations than nurse educators on the ideal level of critical care skills expected at graduation.

8. Graduates have higher expectations than nurse administrators on the ideal level of critical care skills expected at graduation.

Interpersonal Relations Skills/Communication

12. Graduates and nurse educators agree on the ideal level of performance of interpersonal skills expected at

graduation.

Planning and Evaluation Skills

22. Graduates and nurse educators agree on the ideal level of performance of planning and evaluation skills expected at graduation.

Teaching and Collaboration Skills

27. Graduates have higher expectations than the nurse educators on the ideal level of teaching and collaboration skills expected at graduation.

28. Graduates have higher expectations than nurse administrators on the ideal level of teaching and collaboration skills expected at graduation.

Significant Findings of Real vs. Real Expectations as Perceived by Graduates, Nurse Educators, and Nurse Administrators

The following hypotheses were supported, the directional hypotheses at .05 alpha level and the no difference hypotheses at the .20 alpha level.

Technical Skills

4. Graduates and nurse educators agree on the real level of proficiency of technical skills performed at graduation.

Critical Care Skills

10. Graduates and nurse administrators agree on the real level of critical care skills performed at graduation.

Interpersonal Relations Skills/Communication

14. Graduates and nurse educators agree on the level of proficiency of interpersonal skills performed at graduation.

Planning and Evaluation Skills

25. Graduates have higher expectations than nurse administrators on the level of proficiency of planning and evaluations skills performed at graduation.

Teaching and Collaboration Skills

30. Graduates have higher expectations than nurse administrators on the real level of performance of teaching and collaboration skills.

Nonsupported Findings of Ideal vs. Ideal Expectations
as Perceived by Graduates, Nurse Educators,
and Nurse Administrators

The alpha level for the directional hypotheses was .05 and .20 alpha level for the no difference hypotheses.

Interpersonal Relations Skills/Communication

13. Graduates and nurse administrators agree on the ideal level of performance of interpersonal skills expected at graduation.

Leadership Skills

17. Graduates and nurse educators agree on the ideal level of performance of leadership skills expected at graduation.

18. Graduates and nurse administrators agree on the ideal level of performance of leadership skills expected at graduation.

Planning and Evaluation Skills

23. Graduates and nurse administrators agree on the ideal level of performance of planning and evaluation skills expected at graduation.

Nonsupported Findings of Real vs. Real Expectations
as Perceived by Graduates, Nurse Educators,
and Nurse Administrators

The alpha level for directional hypotheses was .05 and .20 alpha level for no difference hypotheses.

Technical Skills

5. Graduates and nurse administrators agree on the real level of proficiency of technical skills performed at graduation.

Critical Care Skills

9. Graduates and nurse educators agree on the real level of critical care skills performed at graduation.

Interpersonal Relations Skills/Communication

15. Graduates and nurse administrators agree on the real level of proficiency of interpersonal skills performed at graduation.

Leadership Skills

19. Graduates and nurse educators agree on the level of proficiency of leadership skills performed at graduation.

20. Graduates and nurse administrators agree on the level of proficiency of leadership skills performed at graduation.

Planning and Evaluation Skills

24. Graduates have lower expectations than nurse educators on the level of proficiency of planning and

evaluation skills performed at graduation.

Teaching and Collaboration Skills

29. Graduates have lower expectations than nurse educators on the real level of performance of teaching and collaboration skills.

Summary of Data Analysis

The summary of the data analysis was divided into three parts:

1. The ideal and real expectations of the 1985 graduates were presented regarding technical skills, critical care skills, interpersonal skills, leadership skills, planning and evaluation skills, and teaching and collaboration skills.

2. The ideal expectations of the graduates as compared to the ideal expectations of the nurse educators and the nurse administrators on the same dimensions of nursing practices listed above.

3. The real expectations of the graduates as compared to the real expectations of the nurse educators and nurse administrators.

4. A ranking was presented of the ideal performance expectations of baccalaureate graduates by graduates, nurse educators, and nursing service administrators regarding critical care skills, interpersonal relations/

communication skills, leadership skills, planning and evaluation skills, and teaching and collaboration skills.

5. A ranking was presented on the real performance expectations of baccalaureate graduates by graduates, nurse educators, and nursing service administrators on the five subscales mentioned in Number 4.

Ideal vs. Real Expectations of the 1985 Graduates

Graduates would like to be more proficient in the performance of technical skills than they are at graduation. Graduates had higher ideal expectations of the performance of critical care skills, interpersonal skills, leadership skills, planning and evaluation skills, and teaching and collaboration skills than the real expectations of performance at graduation.

Ideal vs. Ideal Expectations of Graduates, Nurse Educators, and Nurse Administrators

Graduates had higher ideal expectations of performance of technical skills than nurse educators and nurse administrators. Graduates also had higher ideal expectations of performance of critical care skills than nurse educators and nurse administrators.

Graduates and nurse educators agree on the ideal level of performance of interpersonal skills and planning and evaluation skills expected at graduation.

Graduates have higher expectations than nurse educators and nurse administrators on the ideal level of teaching and collaboration skills expected at graduation.

Real vs. Real Expectations of Graduates, Nurse Educators, and Nurse Administrators

Graduates and nurse educators agreed on the real expectations of performance of technical skills; however, graduates had higher expectations than the nurse administrators.

Graduates thought of themselves as less proficient in the real performance of critical care skills than the nurse educators' assessment. The graduates and the nurse administrators agreed on the real expectations of level of performance.

The graduates and the nurse educators agreed on the real level of performance of interpersonal relations skills. There was a tendency for the graduates to have higher expectations than the nurse administrators regarding interpersonal relations skills.

There was a tendency for the graduates to have higher expectations on the real expectations of performance of leadership skills than the nurse educators and the nurse administrators.

The graduates and nurse educators agreed on the real level of performance of planning and evaluation skills.

The nurse administrators had lower expectations than the graduates.

The graduates and nurse educators agreed on the real level of performance of teaching and collaboration skills, but the nurse administrators had lower expectations of the graduates.

Ranking of Five Dimensions of Nursing Practice
(Ideal and Real Expectations)

Thirty hypotheses represented six dimensions of nursing practice. The dimensions were technical skills, critical care skills, interpersonal skills, leadership skills, planning and evaluation skills, and teaching and collaboration skills. Technical skills were measured using the Benner Proficiency Scale. The perceptions of graduates, nurse educators, and nursing service administrators regarding technical skills were calculated on a 5-point scale.

Critical care skills, interpersonal skills, leadership skills, planning and evaluation skills, and teaching and collaboration skills were measured using five subscales of the Six-Dimension Scale of Nurse Performance. A 4-point scale was used in this instrument. The perceptions of graduates, nurse educators, and nursing service administrators were compared on five of the six dimensions of nursing practice included in this study. The

difference in the scales (4-point Benner and 5-point) prevented a comparison of the three groups' perceptions on the sixth dimension of technical skills.

The mean scores of the graduates, nurse educators, and nursing service administrators were compared regarding ideal expectations of how the graduate nurse should be functioning on the five subscales of the Six-Dimension Scale of Nurse Performance. The five subscales were ranked according to the mean scores of the three groups. The three groups concurred on the ranking of Subscales 1, 2, and 5; but they did not concur on Subscales 3 and 4 (see Table 38 and Figure 8).

The mean scores of the graduates, nurse educators, and nursing service administrators were compared regarding real expectations of how the graduate nurse is presently functioning on the five subscales of the Six-Dimension Scale of Nurse Performance. The five subscales were ranked according to the mean scores of the three groups. The three groups concurred on the ranking of Subscales 1, 2, and 5; but they did not concur on Subscales 3 and 4 (see Table 39 and Figure 9).

In summary, the mean scores of graduates which represent ideal expectations were higher than the mean scores of the nurse educators and the nursing service administrators. The dimensions of nursing practice compared were critical care skills, interpersonal relations/

Table 38

Ranking of Mean Scores of Five Subscales of Six-Dimension of Nurse Performance of Graduates, Nurse Educators, and Nursing Service Administrators (Ideal Expectations)

Graduates	Nurse educators	Nursing service administrators
1. Interpersonal skills (3.70)	1. Interpersonal skills (3.58)	1. Interpersonal skills (3.48)
2. Planning and evaluation (3.53)	2. Planning and evaluation (3.41)	2. Planning and evaluation (3.25)
3. Leadership (3.38)	3. Teaching and collaboration (3.08)	3. Leadership (3.01)
4. Teaching and collaboration (3.30)	4. Leadership (3.01)	4. Teaching and collaboration (2.80)
5. Critical care skills (2.95)	5. Critical care skills (2.59)	5. Critical care skills (2.53)

communication, leadership skills, planning and evaluation, and teaching and collaboration. The mean scores of the nurse educators ranked higher than the nursing service administrators on four of the five subscales. The two groups concurred on the leadership dimension.

The mean scores of graduates which represent real expectations were higher than the mean scores of nurse educators on interpersonal skills, leadership skills, and planning and evaluation. The mean scores of the nurse

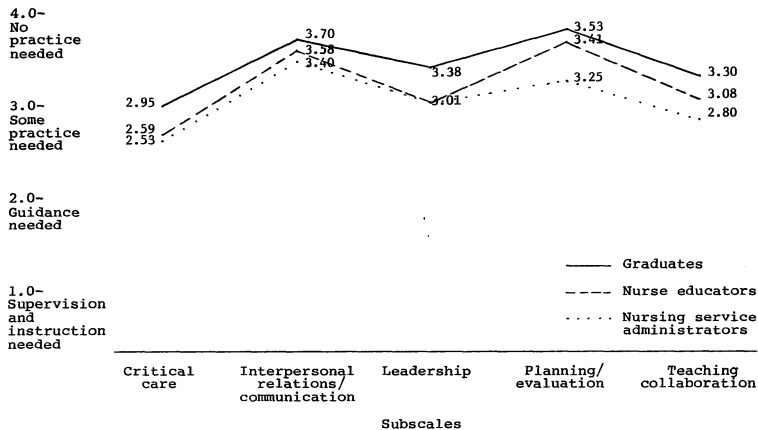


Figure 8. Ideal Expectations of Graduates, Nurse Educators, and Nursing Service Administrators on Six-Dimension of Nurse Performance Subscales.

Table 39

Ranking of Mean Scores of Five Subscales of Six-Dimension of Nurse Performance of Graduates, Nurse Educators, and Nursing Service Administrators (Real Expectations)

Graduates	Nurse educators	Nursing service administrators
1. Interpersonal skills (3.34)	1. Interpersonal skills (3.24)	1. Interpersonal skills (2.98)
2. Planning and evaluation (3.11)	2. Planning and evaluation (3.04)	2. Planning and evaluation (2.73)
3. Leadership (2.94)	3. Teaching and collaboration (2.86)	3. Teaching and collaboration (2.45)
4. Teaching and collaboration (2.84)	4. Leadership (2.65)	4. Leadership (2.18)
5. Critical care skills (2.31)	5. Critical care skills (2.56)	5. Critical care skills (2.17)

educators were higher than the graduates on critical care skills and teaching and collaboration. The mean scores of the nursing service administrators were lower than the graduates and the nurse educators.

Graduate Responses to Open-Ended Questions

Three open-ended questions were asked of the graduates. The responses were categorized into school preparation and work environment. They were further delineated

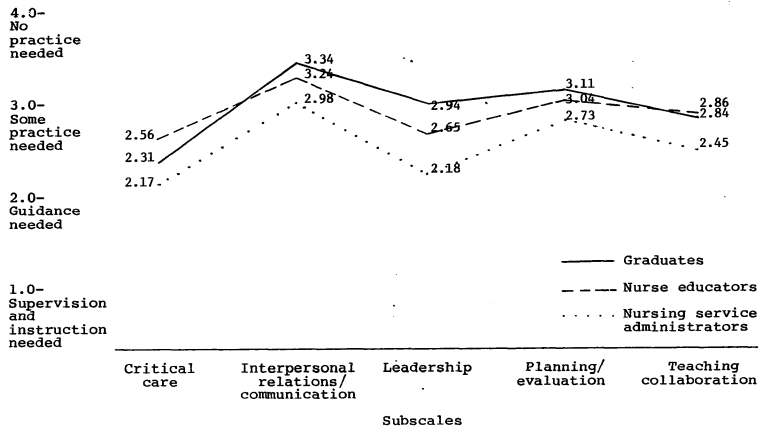


Figure 9. Real Expectations of Graduates, Nurse Educators, and Nursing Service Administrators on Six-Dimension of Nurse Performance Subscales.

into positive, negative, and neutral responses under the two major categories of school preparation and work environment.

Graduates' responses to the question, Generally how has the transition from school to work been? focused on the following areas: the lack of technical skills, the importance of the support of co-workers, the collaboration with other disciplines, the stress of caring for critically ill and dying patients, the difficulty of giving emotional support to patients and families, the need for time management skills, the lack of commitment to the nursing profession observed in co-workers, the shift changes and the physical demands of the work, the personal disillusionment of nursing, and importance of self-confidence in assuming the role of a practitioner (see Appendix I).

Many of the items that the graduates noted could be placed under one of the six sections tested by the 30 hypotheses. The graduates responded during the time that they were making the critical adjustment from student nurse to practitioner. This was congruent with the theoretical framework of this study, that of socialization theory.

Graduates' responses to the question, What are your suggestions for making the transition easier? suggested the following: that educators provide more clinical

experience and emphasize technical skill building; that educators relate theory to practice more effectively; teach assertiveness and role-play likely situations; include more emphasis on leadership skills; provide experience where students relate to doctors, nurses, and other health care personnel; and offer optional courses in specialized nursing which provide specific information and skills related to the student's choice.

In the work environment graduates stated the orientation period should include organizational skills, prioritizing, that newcomers need to be supported and their workload gradually increased, that more feedback should be given, and that methods need to be taught to unite nurses (see Appendix J).

Graduates' responses to the question, Describe the effectiveness of orientation to you, mentioned that the preceptor was most important to the learning process, that skills were taught that had not been emphasized in school, and that many resources both inside and outside of the hospital were identified.

Some graduates found the wealth of information presented in a short amount of time overwhelming, that the orientation was repetitious and boring, and that more emphasis needed to be on the clinical portion rather than the classroom component of the orientation (see Appendix K).

In summary, in this chapter data were provided pertaining to the demographic characteristics of the sample. Data were presented regarding the ideal and real expectations of entry level performance of graduates, as perceived by graduates, nurse educators, and nurse administrators. The findings of the data state graduates have higher ideal expectations than real expectations of performance of technical skills, critical care skills, interpersonal skills, leadership skills, planning and evaluation skills, and teaching and collaboration skills.

Graduates agreed with nurse educators more than with nurse administrators on ideal and real expectations of performance.

In six instances the graduates had higher ideal and real expectations of their performance than the nurse educators and nursing service administrators.

In many instances the graduates did not agree with either the nurse educators or the nurse administrators.

Three open-ended questions posed to the graduates regarding transition from student nurse to practitioner were discussed.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

This study identified the perceptions of ideal and real expectations of graduates, nurse educators, and nursing service administrators regarding entry level performance of 154 graduates of baccalaureate programs in 1985. Throughout this paper, the term graduates refers to baccalaureate graduate nurses who have completed a four-year program in nursing education. The Benner Proficiency Scale, two copies (ideal and real) of the Six-Dimension Scale of Nurse Performance, and three open-ended questions on the demographics sheet were the research instruments utilized.

This chapter provides a discussion of the results, identification of the limitations of the study, identification of the implications of the study for practice, and recommendations for future research.

Discussion of the Results

Each of the following six dimensions of nursing practice includes the comparison of the graduates' perceptions of ideal expectations and the graduates' perceptions of real expectations of performance, the graduates'

perceptions of ideal expectations compared to the nurse educators and nursing service administrators, and the graduates' perceptions of real expectations as compared to nurse educators and nursing service administrators. The six dimensions of nursing practice examined in this study were technical skills, critical care skills, interpersonal skills/communication skills, leadership skills, planning and evaluation, and teaching and collaboration.

Technical Skills

It was found that graduates had higher ideal expectations than real expectations. The graduates would like to be more proficient in the performance of technical skills than they are at graduation. Graduates had higher ideal expectations of performance of technical skills than nurse educators and nursing service administrators. Graduates and the nurse educators agreed on the real expectations of performance; however, the nursing service administrators had lower real expectations of performance.

The findings of this study concur with Benner and Benner's 1979 findings on ideal expectations of baccalaureate graduates. Ideally, the graduates believed that they should be highly competent in the performance of technical skills, with few educational needs upon graduation. However, nurse educators and nursing service administrators had lower ideal expectations of the new

graduate.

In regard to the entry level performance of baccalaureate graduates, the graduates, nurse educators, and nursing service administrators had lower real expectations than ideal expectations. The graduates and the nurse educators did agree on the real expectations. The administrators' had lower real expectations of the graduates' performance than the graduates and the nurse educators.

The three groups were not satisfied with the functioning of the baccalaureate graduate nurse. Benner and Benner (1979) contended that the difference between people's perception of the ideal level of competency and the graduates' real level of competency can be viewed as a measure of great concern among the three groups.

The frequency distribution of the real expectations of the graduates' responses on the Benner Proficiency Scale was subjected to an item-by-item analysis. The results show that 25% or more of the graduates indicated that supervision and instruction were needed or supervision was needed on 31 items out of 60 items (51.6%). The 31 items have an asterisk in front of each item on the Benner Proficiency Scale in Appendix D. This indicates that 25% or more of the baccalaureate graduates do not feel confident in performing the skills indicated by these items. The items relate to medium and higher level technical skills, leadership skills, and communication skills

related to emotionally supporting the patient and family in crisis.

Critical Care Skills

It was found that graduates had higher ideal expectations of critical care skills than real expectations of performance at graduation. Graduates had higher ideal expectations of performance of critical care skills than the nurse educators and the nursing service administrators. Graduates believed that they were less proficient in the real performance of critical care skills than the nurse educators. The graduates and the nursing service administrators agreed on the real expectations of performance on critical care skills. These findings concur with Cassell's et al. 1986 statement that minimal skills in this area are expected of the new graduate.

It was reported in this study that 19% of the 1985 graduates surveyed began nursing practice in a critical care area. Acute care facilities (hospitals) are providing care for serious health problems. The increased acuity level of hospitalized patients was predicted when DRGs were instituted. Patients are returning home to be cared for by the family or a home health care worker. The patients that remain hospitalized often require specialized care provided by critical care nurses. In American Nurse, the official newspaper of the American Nurses'

Association, Selby (1986, p. 7) reported that there is a shortage of specialty nurses (critical care nurses).

In the past, hospitals were able to attract experienced nurses for critical care. Suddenly there are not enough experienced nurses to fill the need. Hospitals have hired new graduates to meet its nursing needs. Keele, director of nursing services at Jefferson Davis Hospital, Houston, stated: "I've been a nurse for 25 years, and during that time there have always been problems with the supply of nurses, but I have never seen change as dramatic as in the past few years" (p. 7).

The changes in the health care environment will affect the education of the baccalaureate nurse. The need for emphasis on higher level technical skills and home health care seems apparent.

Interpersonal Relations/Communication

It was found that graduates had higher ideal expectations of interpersonal skills than the real expectations of performance at graduation. Graduates and the nurse educators agreed on the ideal and the real expectations of level of performance. The nursing service administrators had slightly lower expectations. There was agreement by the three groups that interpersonal relations skills were used most skillfully by baccalaureate graduates. These

findings concur with the findings of Nelson (1978) and Boss (1981).

Leadership Skills

It was found that graduates had higher ideal expectations of leadership skills than real expectations of performance at graduation. Graduates had higher ideal and real expectations of leadership skills than the nurse educators and the nursing service administrators. These findings do not concur with S. Brown's (1984) findings that graduates, nurse educators, and nursing service administrators agree on the relative importance of leadership skills. It should be noted that S. Brown used a different instrument that contained 84 leadership/management competencies. The leadership subscale on the Six-D Scale contained five items. Since there is such a difference in the instruments used for the two studies, it is difficult to compare the results.

Planning and Evaluation

It was found that graduates had higher ideal expectations of planning and evaluation skills than real expectations of performance at graduation. Graduates and nurse educators agreed on the ideal expectations of planning and evaluation; however, the nursing service administrators had lower ideal expectations. The graduates and the nurse

educators agreed on the real level of performance of planning and evaluation skills. The nursing service administrators had lower expectations than the graduates.

The three groups agreed that planning and evaluation skills were well-developed in the baccalaureate graduates. The mean scores of the graduates, nurse educators, and nursing service administrators attest to this statement. The findings concur with Waters et al. (1972) that baccalaureate graduate nurses plan and evaluate care. S. Brown's (1984) study stated that graduates felt deficient in planning skills. Mallick (1977), Cantor et al. (1981), and Corcoran (1986) stated that application of the nursing process for predicting and evaluating nursing care was poorly understood by new graduates. The findings of this study do not concur with S. Brown, Cantor et al., Corcoran, or Mallick.

Teaching and Collaboration

It was found that graduates had higher ideal expectations of teaching and collaboration skills than the real expectations of performance at graduation. The graduates had higher ideal and real expectations than the nursing service administrators. The graduates and nurse educators agreed on ideal and real expectations of teaching and collaboration. It is interesting to note that teaching and collaboration skills incorporate interpersonal skills.

The graduates, nurse educators, and the nursing service administrators stated that interpersonal skills were the most important skills for the new graduate. Boss noted in her 1981 study that the nurse-patient relationship is the most comfortable one for most nurses. The interactions between the nurse and family members and/or other health care workers appear more difficult. Perhaps Kelly's (1986) comments regarding the importance of Knaus's (1986) findings of the importance of collaboration between physicians and nurses warrants further investigations because of their effect on patient outcomes. Collaboration is also necessary as evidenced by the variety of health care workers who stated that teaching was a part of their role (University of Virginia Hospital, 1981). Health teaching with patients and families and collaboration with other health care workers should be emphasized in educational preparation and the work setting.

In addition to the previous data analysis, the frequency distribution of the real expectations of the graduates on the five subscales of the Six-D Scale was subjected to an item-by-item analysis. The results showed that 25% or more of the graduates indicated that supervision and instructions were needed or that guidance was needed on 18 of the 42 items (42.8%). The items were indicated with an asterisk in front of each item in Table 40.

Table 40
Five Subscale Items of Six-Dimension
Scale of Nurse Performance

Subscale	Item No.	Item content
Critical care	*11	Perform technical procedures; e.g., oral suctioning, tracheostomy care, intravenous therapy, catheter care, dressing changes
	18	Use mechanical devices; e.g., suction machine, Gomco, cardiac monitor, respirator
	*19	Give emotional support to family of dying patient
	*27	Perform appropriate measures in emergency situations
	*30	Perform nursing care required by critically ill patients
	*37	Recognize and meet the emotional needs of a dying patient
	*40	Function calmly and competently in emergency situations
Interpersonal relationships/communications	8	Promote the inclusion of patient's decisions and desires concerning his care
	15	Communicate a feeling of acceptance of each patient and a concern for the patient's welfare
	16	Seek assistance when necessary
	17	Help a patient communicate with others
	20	Verbally communicate facts, ideas, and feelings to other health team members

Table 40--Continued

Subscale	Item No.	Item content
	21	Promote the patients' rights to privacy
	22	Contribute to an atmosphere of mutual trust, acceptance, and respect among other health team members
	24	Explain nursing procedures to a patient prior to performing them
	33	Use nursing procedures as opportunities for interaction with patients
	34	Contribute to productive working relationships with other health team members
	35	Help a patient meet his emotional needs
	42	Use opportunities for patient teaching when they arise
Leadership	3	Give praise and recognition for achievement to those under your direction
	*23	Delegate responsibility for care based on assessment of priorities of nursing care needs and the abilities and limitations of available health care personnel
	*25	Guide other health team members in planning for nursing care
	*26	Accept responsibility for the level of care provided by those under your direction

Table 40--Continued

Subscale	Item No.	Item content
Planning/ evaluation	41	Remain open to the suggestions of those under your direction and use them when appropriate
	*2	Coordinate the plan of nursing care with the medical plan of care
	*6	Identify and include in nursing care plans anticipated changes in a patient's conditions
	7	Evaluate results of nursing care
	9	Develop a plan of nursing care for a patient
	10	Initiate planning and evaluation of nursing care with others
	13	Identify and include immediate patient needs in the plan of nursing care
	36	Contribute to the plan of nursing care for the patient
Teaching/ collaboration	1	Teach a patient's family members about the patient's needs
	4	Teach preventive health measures to patients and their families
	*5	Identify and use community resources in developing a plan of care for a patient and his family
	*12	Adapt teaching methods and materials to the understanding of the particular audience; e.g., age of patient, educational background, and sensory deprivations

Table 40--Continued

Subscale	Item No.	Item content
	*14	Develop innovative methods and materials for teaching patients
	*28	Promote the use of interdisciplinary resource persons
	29	Use teaching aids and resource materials in teaching patients and their families
	31	Encourage the family to participate in the care of the patient
	*32	Identify and use resources within your health care agency in developing a plan of care for a patient and his family
	*38	Communicate facts, ideas, and professional opinions in writing to patients and their families
	*39	Plan for the integration of patient needs with family needs

Note. Items with asterisk (*)refer to 25% or more of the graduates stating instruction and supervision were needed or that guidance was needed on the item. Items refer to real expectations of the graduates.

In addition to the item-by-item analysis of the 42 items contained in the five subscales, the five subscales of the Six-D Scale were ranked. The mean scores of the graduates, nurse educators, and nursing service administrators regarding ideal expectations of how the graduate should function were compared. The three groups concurred

on the ranking of Subscale 1, interpersonal relations/communication; Subscale 2, planning and evaluation; and Subscale 5, critical care skills. However, they did not concur on Subscale 3, leadership, and Subscale 4, teaching and collaboration. The graduates and nursing service administrators placed leadership skills on ideal expectations ahead of teaching and collaboration skills. The nurse educators ranked teaching and collaboration skills as more important than leadership skills for the beginning nurse.

The mean scores of the graduates, nurse educators, and the nursing service administrators were compared regarding real expectations of how the graduate nurse is presently functioning. The five subscales were ranked according to the mean scores of the three groups. The three groups concurred on the ranking of Subscale 1, interpersonal skills, Subscale 2, planning and evaluation; and Subscale 5, critical care skills; but they did not concur on Subscale 3, leadership, and Subscale 4, teaching and collaboration. Nurse educators' mean scores were higher than those of the graduates on teaching and collaboration and critical care skills. The mean scores of the nursing service administrators were lower than the graduates and the nurse educators. There is a difference in the real expectations of baccalaureate graduates as perceived by graduates, nurse educators, and nursing

service administrators.

In addition to the Benner Proficiency Scale and the Six-Dimension Scale of Nurse Performance, three open-ended questions were included on the demographics sheet to elicit information from the graduates on the transition from student to practitioner.

Graduate Responses to Open Ended Questions

1. Generally how has the transition from school to work been?

Graduates' responses to the question focused on the following areas: the lack of technical skills, the importance of the support of co-workers, the collaboration with other disciplines, the stress of caring for critically ill and dying patients, the difficulty of giving support to patients and families, the need for time management skills, the lack of commitment to the nursing profession observed in co-workers, the shift changes and the physical demands of the work, the personal disillusionment of nursing, and the importance of self-confidence in assuming the role of a practitioner.

2. What are your suggestions for making the transition easier?

Graduates' responses to the question suggested the following: That educators provide more clinical experience while emphasizing technical skill building; relate

theory to practice more effectively; teach assertiveness and role-play likely situations; include more emphasis on leadership skills; provide experience where students relate to doctors, nurses, and other health care personnel; and offer optional courses in specialized nursing which provide specific information and skills related to the student's choice.

Referring to the work environment, graduates stated that the orientation period should include organizational skills and prioritizing, that newcomers need to be supported and that their workload should be gradually increased, that more feedback should be given, and that methods need to be taught to unite nurses.

3. Describe the effectiveness of orientation to you.

Graduates' responses to the question mentioned that the preceptor was most important to the learning process, that skills were taught that had not been emphasized in school, and that many resources both inside and outside of the hospital were identified.

Some graduates found the wealth of information presented in a short amount of time overwhelming, that the orientation was repetitious and boring, and that more emphasis needed to be on the clinical portion rather than the classroom component of the orientation.

Research Past and Present

There has been a great deal of research on the role of the nurse involved in the professional-bureaucratic struggle (Corwin, 1960; Kramer, 1974; Wesorick, 1986), as well as the dimensions/components of the nurse's role (AACN, 1986; Boss, 1981; Nelson, 1978; Primm, 1986). There have been many studies on the transition of the student nurse to graduate nurse (Bushong & Simms, 1979; Dell & Griffith, 1977; Kramer, 1971; Kramer & Schmalenberg, 1977c; Topp, 1984). Yet another approach is being proposed by Manderino (1986). Manderino's assumption is that if the potential work related stressors are identified for the student nurse during the educational preparation and if appropriate stress management techniques are taught, the graduate will be able to cope when the stressors are encountered in the work setting. Some of the graduates' responses from this researcher's study are presented under the stressor categories developed by Manderino for her forthcoming research project. The stressors were discussed with the appropriate skills in this study when possible.

Interpersonal Stressors: Communication and Collaboration Skills

These stressors involve conflictual or problematic relationships nurses might encounter in the work

environment. Communication problems and/or lack of respect from other team members may contribute to interpersonal stressors.

Graduates' responses:

1. "We need to learn to collaborate with other disciplines."
2. "We need to learn assertiveness skills."
3. "New graduates need support from co-workers."
4. "Teach methods to unite nurses."
5. "I feel a lot of the transition is how well you get along with the patients, co-workers, [and] doctors."

Direct Patient Care Stressors: Technical and Critical Care Skills

These stressors include situations such as working with critical, unstable patients, dying patients, emergency situations; working with relatives of critically ill patients; and ethical issues such as the unnecessary prolongation of life.

Graduates' responses:

1. "It is very stressful to care for critically ill and dying clients."
2. "It is difficult to recognize signs and symptoms of patients going into a more critical condition."
3. "It is difficult to give emotional support to patients and families."

4. "It would be helpful to role play likely emergency situations; e.g., code, gastrointestinal bleed, [and] myocardial infarction."

Physical and Mental Fatigue

Physical and mental fatigue may be the consequence of working under highly stressful conditions and may be a stressor in and of itself.

Graduates' responses:

1. "I was not aware of the physical demands of the work."
2. "It's hard to get used to shift change."

Time Stressors: Leadership Skills, Planning, and Evaluation, and Teaching

Multiple work demands to be accomplished within a limited amount of time may lead to stress.

Graduates' responses:

1. "We need to learn time management skills."
2. "We need more emphasis on leadership skills."
3. "Included organizational skills, prioritizing, and team leading in undergraduate programs."
4. "Real world time pressures and patient--staff ratios don't allow a lot of things that I should be doing like patient teaching."

Internal Stressors

These kinds of stressors have to do with stress-producing thinking patterns or attitudes. For example, perfectionistic standards and extreme self-criticism.

Graduates' responses:

1. "I am disillusioned with the nursing profession."
2. "I am still enthused about nursing, but I'm concerned with the disillusionment with my colleagues."
3. "Newcomers need support. Support groups should be formed."
4. "New graduates need accurate timely feedback."
5. "New graduates need assistance in building self-confidence."

Graduates mentioned the importance of building self-confidence during their educational preparation and transition to practice. Nursing instructors and co-workers should encourage and help the new learner rather than criticize or find fault.

Branden (1986) stated that there are two interrelated aspects of self-esteem:

self-confidence and self respect (the sense of worthiness). In focusing on confidence, one must distinguish a person's basic type of confidence, from the other more superficial and localized types of self-confidence. The localized type of self-confidence reflect a person's sense of efficacy at particular tasks or in particular areas. The basic self-confidence is not a judgment passed on one's knowledge or special skills; it is a judgment passed on that

which acquires knowledge and skills. It is a judgment (an implicit judgment, not necessarily conscious) passed on one's characteristic manner of facing and dealing with the facts of reality. (p. 113)

Graduates appear to be asking nurse educators and nursing service administrators to assist them in dealing with the reality of the practice world.

In addition to the graduates in this study adjusting to the transition from student nurse to practitioner, the graduates changed locations, several married, and several of the previously married had children during their first year of practice. The new baccalaureate graduate faces a number of stressors that nurse educators and nursing service administrators should be aware of, as the graduate is making the transition to the practice setting.

Summary

In summary, this study suggests that graduates ideally would like to be more proficient in the performance of technical skills, with few educational needs at graduation. However, nurse educators and nursing service administrators had lower ideal expectations of the new graduate. Graduates and nurse educators agreed on the real expectations of performance of technical skills; however, the nursing service administrators had lower real expectations of the graduates. In regards to the performance of baccalaureate graduates, nurse educators and

nursing service administrators had lower real expectations than ideal expectations. The three groups were not satisfied with the technical skills of the new baccalaureate graduate.

Ideal and real expectations of graduates, nurse educators, and nursing service administrators were discussed regarding critical care skills, interpersonal skills/communication, leadership skills, planning and evaluation, and teaching and collaboration skills.

Five subscales of the Six-Dimension Scale of Nurse Performance were ranked. The mean scores of graduates, nurse educators, and nursing service administrators regarding ideal expectations of how the graduates should be functioning were compared. The three groups concurred on the ranking of Subscales 1, interpersonal relations skills, 2, planning and evaluation, and 5, critical care skills; but they did not on Subscales 3, leadership, and 4, teaching and collaboration.

The mean scores of the graduates, nurse educators, and nursing service administrators were compared regarding real expectations of how the graduate is presently functioning. The five subscales were ranked according to the mean scores of the three groups. The three groups concurred on the ranking of Subscales 1, interpersonal skills, 2, planning and evaluation, and 5, critical care skills; but they did not concur on Subscales 3,

leadership, and 4, teaching and collaboration.

Graduates' responses to three open-ended questions were discussed. Manderino's (1986) stress categories were identified. The stressors are interpersonal stressors, direct patient care stressors, physical and mental fatigue, time stressors, and internal stressors. Some of the graduates' responses from this researcher's study were presented under Manderino's stressor categories.

Limitations of the Study

The results of this study are limited by the nature of the sample. The 123 nurse educators and nursing service administrators volunteered to participate in the Consensus on Entry Skills project (Stull, 1985). The schools were determined by the nurse educators' interest in the Consensus project. A random sample of baccalaureate graduates was selected from 17 of 29 baccalaureate nursing programs that met the selection criteria. Two of the baccalaureate programs were completion programs for nurses educated in a diploma or an associate degree program. The Consensus schools may already have been biased. Results of a similar study with different schools could result in different conclusions.

Another limitation was the 32% of the random sample who chose not to participate. There may be differences among the subjects that chose not to respond.

The subjects included in this study were educated in the Midwestern section of the United States. There maybe the limitation of extending the results beyond the geographic boundaries of the Midwest.

Implications for Practice

The results of this study have several implications for nursing practice. The most important implication is that graduates, nurse educators, and nursing service administrators have different perceptions of ideal and real expectations of baccalaureate graduate nurses. Nurse educators and nursing service administrators should collaborate on the educational preparation of students to insure that the product of baccalaureate education meets the needs of the practice world.

Estimating the future needs of nursing education is complicated by the differing perceptions of nurse educators and nursing service administrators about the appropriate base of knowledge and skills new graduates need. These differences, as stated in Chapter I, began to be apparent when nursing education moved away from its historical base in hospitals in response to abuses and inadequacies that were believed to characterize the apprentice type of training they provided. These differences continue to plague the nursing profession. Many nursing service administrators believe that academic nurse

educators, removed from the realities of the employment setting, are preparing students to function in ideal environments that rarely exist in the real and extremely diverse worlds of work (Institute of Medicine, 1983, p. 126). The report of a task force of the American Association of Colleges of Nursing (1981) observes that "conflicting philosophies, values, and priorities between nurse educators and nursing service administrators have generally served to deter a mutual understanding and acceptance of responsibility for quality patient care" (p. 1).

If nursing is to survive this critical period in its history, as described by Lee (1984), Maraldo (1986), and other authors, nurse educators and nursing service administrators must collaborate. It has been suggested for years by a number of authorities that the two groups collaborate; but perhaps now that scarce financial resources are available to both groups, they will begin to work together.

Collaboration has not been found to be easy for groups who have attempted to collaborate. Difficulties were experienced by educators and practitioners in collaborative efforts discussed by Hoff (1984). Six categorical problems emerged during their collaborative efforts:

1. The problem of identification of what and where collaboration can occur.

2. The problem of reality shock, i.e., verbalization of willingness to collaborate in principle but experiencing reluctance in reality.

3. The problem of mistrust due to lack of communication and internal time constraints.

4. The problem of differences in perception of each other's roles.

5. The problem of obtaining funding for mutual collaborative efforts.

6. The problem of dealing with reality of changing times.

Before confronting the subject matter of collaborative efforts between nurse educators and nursing service administrators, Hoff's (1984) six problems of collaborative efforts need to be discussed by the collaborative groups. Perhaps some role switching activities could assist the nurse educators and nurse administrators to understand the frustrations and time constraints of the other professional's role. One of the initial steps might be in requesting funds to support the collaborative efforts. The scarce financial resources allocated to nursing education and nursing administration preclude that neither organization can support the collaborative efforts. The uncertainty in health care makes it

difficult for nurse educators and nursing service administrators to develop long-range plans. Therefore, ongoing collaborative relationships should be established.

Transition of Student Nurse to Practitioner

Nursing service administrators should serve on curriculum planning committees of colleges and universities. Although this is a reality at some institutions, it should become more common. Nurse educators from colleges and universities should serve on the planning committees that develop nurse orientations programs for hospitals. In this way, both groups can voice their ideas and concerns in assisting in the transition of the student nurse to practitioner.

Historically, nurses educated in diploma programs received many hours of clinical experience and very little nursing theory. As the baccalaureate programs began to flourish, there was a shift to the other extreme. There is now another shift under way in nursing education. An attempt is being made to balance the two types of learning. A new type of internship, which includes well-planned intensive clinical experiences, has been designed to let the student know what to expect in the "real world." Scheffel (1986), a member of the University of Iowa faculty, stated "that this type of program is really the wave of the future" (p. 1). Iowa graduates spoke

highly of this program in their responses to this researcher. They believed that the program assisted them in the transition from student nurse to practitioner.

Some nursing service administrators believe that nursing students who work as aides in patient care settings often make the most successful transition to nursing after they graduate. Several of the graduates surveyed in this study commented that their experience in hospitals had helped them with the transition. They stated that they could then concentrate on the change in their role. Cantor's et al. (1981, p. 21) data support that students employed as aides learn more about the organization in which they work. While focusing on the organization, they do not identify nursing interventions that impact on positive patient outcomes. If the focus of hospital orientations or post graduation internships is on the organization and on methods for delivering patient care rather than on patient outcome objectives, then the student may have mastered much of the content required for fitting into the organization. After reviewing Cantor's et al. work, it is easy to wonder how far nursing has come since Corwin's (1960) original work on the professional-bureaucratic struggle.

Another problem related to hospital orientation programs was mentioned by several of the graduates surveyed in this study. They believe that too much information is

given to the new graduates at one time. Perhaps an orientation plan like the one sponsored by Miles Laboratories (MacMillan, 1986) could be considered. In the Miles orientation program, survival skills are given the first few days. A month later, other materials are presented. Six months later, more orientation information was given to the employee. Perhaps the Miles Laboratories orientation timelines could be adopted by nursing. Initial survival skills and an overview of the organization could be given the first few days. After 1 month, more information about the hospital organization and the graduate's role could be included. At 6 months, either a leadership/management orientation or a critical care orientation could be given.

In addition to changing the hospital orientation timelines, several of the graduates mentioned the importance of the right preceptor. The preceptor guides the learning process of the new graduate. The preceptor becomes the role model and confidant to the learner. The transition from student nurse to practitioner is greatly enhanced by well-trained preceptors with excellent communication skills, who are interested in teaching. Special programs should be designed to train preceptors for their special role.

Findings Regarding the Dimensions/Components of the Nurse's Role

Primm (1986) has identified technical skills, interpersonal skills/communication, and leadership/management skills as the major components of the nurse's role.

Technical Skills

This study supports the graduates' request for increasing training in technical skills. This study's findings support Kramer (1971), Benner and Benner (1979), and Primm (1986) that technical skills continue to be an important dimension of the professional nurse's role. The American Association of Colleges of Nursing (1986) report has identified skills that should be learned by baccalaureate nursing students. Hopefully, nurse educators will adopt the recommendations and include skill training as an important part of their curriculum. Nurse educators, then, could no longer think of skill training as demeaning or just a part of the technical nurse's role. Nursing service administrators would know what skills the baccalaureate graduate had been exposed to in the educational process, and would then be able to proceed from that point.

Interpersonal Skills

Interpersonal skills/communication were perceived as the most highly developed skills of the baccalaureate graduate nurses, by graduates, nurse educators, and nursing service administrators in this study. This finding supports the Boss (1981) study.

Although interpersonal skills are considered to be well developed in nursing programs, it seems that more emphasis should be placed on higher level communication skills. Many respondents commented on the difficulty they had in emotionally supporting the critically ill or dying patient and family members.

Kramer and Schmalenberg (1977c) contended that interpersonal competence is necessary to achieve biculturism. Biculturism is the ability to get along in two cultures or subcultures without fusing with or being absorbed by either of them completely. The two subcultures refer to the different values ascribed to nursing education and nursing service. Graduates contend that transition to the work setting is difficult. Many of the difficulties relate to interacting with co-workers and other health care professionals. Students need assistance in the educational program to learn to deal with the potential interpersonal problems.

Leadership Skills

As indicated in this study nurse educators and nursing service administrators' ideal and real expectations of graduates' performance on leadership skills were lower than the graduates' real expectations.

Leadership skills need to be addressed. If the nurse is to be the coordinator of care, he or she must have the skills needed to perform that role. Replication of the S. Brown (1984) study in other locations and settings seems appropriate. The S. Brown leadership/management competencies instrument could be used to design a leadership/management course in a baccalaureate curriculum or to update one in progress.

Recommendations for Future Research

There are several areas in which more research is needed in order to further understand the transition of student nurse to practitioner. Continued research is needed on programs that assist the transition from student nurse to practitioner, such as externships, college sponsored internships, and hospital orientation programs and internships.

Kramer (1974) described reality shock theory in 1974 and defined its stages. Graduates are told about it in school but when they experience it in the work setting,

the cognitive aspects are handled very nonchalantly by co-workers. "You're in Stage 2," but the feeling component of the graduate is not. Support groups composed of new graduates, perhaps led by a practitioner a few years older may be helpful. Research could be conducted on such a project.

Leadership in nursing should be studied. Not only the role of the nursing leader but also the academic courses, skills, attitudes, and personalities needed to fit the present and future roles.

Planning and evaluation should be studied. Recent research states that little is known about how nurses plan, make decisions, and evaluate care.

Collaboration among nurses, nurse educators, and nursing service administrators, nurses and physicians, and nurses and other health care workers, and how their collaborative efforts affect patient outcomes should be studied. For nurses to collaborate effectively, they should be skilled in group process, negotiation, and conflict management.

Research has focused for years on the role of the nurse and the organizations in which he or she functions. It seems imperative that nursing research focus on patient outcomes. This researcher agrees with Cantor et al. (1981) that identification of the positive patient outcomes and the nursing interventions most likely to achieve

the outcomes, should be researched. Nurse educators and nursing service administrators should be able to embrace this body of knowledge, as it would not be tied to a work setting. Perhaps the answer could be found to Koewing's (1972) question, What is unique about nursing? The answer should come from nurses and the patients they care for, and not the nurses' employer.

Nurses, be they educators or administrators, need to "pull together" and support one another if the nursing profession is to advance. This researcher does not wish to compare nurses to donkeys; however, the parable seems appropriate at this time.

Once upon a time there were six donkeys hitched to a wagon pulling a heavy load up a steep hill. Two of the donkeys were not achievement oriented and decided to coast along and let others do most of the pulling. Two others were relatively young and inexperienced, and had a difficult time pulling their share. One of the remaining two suffered from a slight hangover from consuming fermented barley the night before. The sixth donkey did most of the work.

The wagon arrived at the top of the hill. The driver got down from his seat, patted each of the donkeys on the head, and gave six carrots to each. Prior to the next hill climb, the sixth donkey ran away. (McConkey, 1974, p. 81)

APPENDICES

Appendix A

Glossary

Baccalaureate graduate nurse: a nurse prepared in the liberal arts and the practice of nursing, in a four year university program.

Collaboration: the act or process of working with another (Random House Dictionary, 1966, p. 289).

Communication--interpersonal skills: refers to the process of human beings responding to the face-to-face symbolic behavior of other persons (Adler, 1985, p. 4). Interpersonal skills are necessary to express feelings, to establish social realities--to confirm, to change and influence, and to work and create (Bennis, Berlew, Schein, & Steele, 1973, p. 7).

Critical care skills: the complex technical skills required of nurses functioning in intensive care settings.

Evaluation: the comparison of performance to some standards to determine whether discrepancies exist (Provus, 1971). Evaluation is the fifth step of the nursing process. Evaluation involves establishing the criteria for evaluation, evaluating goal achievement, assessing variables affecting goal achievement, and modifying the plan of care/terminating nursing care (Alfaro, 1986, p. 152).

Ideal expectations: "reflects how you think most new graduates should be prepared" (Benner Proficiency Scale).

Leadership: the art of influencing individual or group activities toward the achievement of goals (Bedeian,

1986, p. 482).

Nurse administrators: representatives from hospitals, community health agencies, and skilled facilities that are team members with the 17 nurse educators from the Consensus project. The three groups were collectively considered the administrators.

Nurse educators: faculty members of the 17 baccalaureate programs from the Consensus on Entry Project, who have consented to participate in this study.

Planning: the third step of the nursing process. It follows identifying specific nursing diagnoses and collaborative problems for an individual patient or client. Planning involves: setting priorities, establishing client goals/expected outcomes; determining nursing actions/intervention; and documenting the plan of nursing care (Alfaro, 1986, p. 91).

Real expectations: "reflects how you think graduates actually are prepared" (Benner Proficiency Scale).

Teaching: to impart knowledge or skill, to give instruction (Random House Dictionary, 1966, p. 1457).

Technical (psychomotor) skill: psychomotor is defined as pertaining to muscular movements resulting from or caused by mental processes. Skill is defined as proficiency or technical ability in any art, science, handicraft demonstrated by ease or expertness in performance or application (Field et al., 1984, p. 288).

Appendix B

Letter to Educators

**Nazareth
College**
In Kalamazoo

NAZARETH, MICHIGAN 49074
616-349-7783

February 19, 1986

Dear Consensus on Entry Colleagues:

I need your help! In addition to my involvement in the consensus project, I am completing a doctorate in Educational Leadership at Western Michigan University. I have a B.S.N. from Loyola University and a M.A. in Nursing from the University of Iowa.

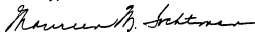
The subject of my dissertation is the Ideal and Real Performance Expectations of Baccalaureate Graduates as perceived by the 1985 graduates of the 30 baccalaureate schools in the consensus on entry project. You can assist me by sending a list of the names and addresses of the 1985 traditional graduates. The graduates names and responses will be kept confidential.

From the 30 lists you send me a random sample of 300 graduates will be selected. I plan to send the graduates copy of the Benner scale and two copies of the 6 Dimension Scale of Nursing Performance. The graduates' results will then be compared to the nurse educators' and nurse administrators' results from the Consensus study. This comparison will add a broader dimension to our project. I will be sure to let you know the results of my study.

As time is always of essence in conducting research and practicing nursing, I am requesting that the list of the traditional 1985 graduates from your school be sent by March 6, 1986. If I need to contact another person, please advise me.

Thank you for your assistance.

Sincerely,



Maureen M. Fochtman, R.N., M.A.N.
Associate Professor
5006 Lake Forest Drive
Portage, Michigan 49002

MF:ER

Appendix C

First Mailing to Graduates

Nazareth College

In Kalamazoo

HAZARETH, MICHIGAN 49074
616-349-7783

April 22, 1986

Dear 1985 Baccalaureate Nurse Graduate:

I need your help! My research project is of great value to nursing and your participation is vital to the success of the study.

My dissertation is a spin off of a 13 state regional study. A nurse from your school, and nurse administrators from your clinical agencies are participants in the Consensus on Entry Project.

You are one of 300 graduates randomly selected from a population of 1500. A code number located in the upper right corner of the inventories, will be used for follow up purposes. The number will be discarded after data analysis. Your name and responses will be kept confidential.

If you are interested in receiving results of the study, please indicate that by completing the 3 x 5 card enclosed.

Your responses are essential to the study, and the future of baccalaureate nursing education. If you have questions, call 616-342-4140 collect. Thank you for your assistance.

Sincerely,

Maureen M. Fochtman, M.N., R.N.
Associate Professor
Nazareth College in Kalamazoo
3333 Gull Road
Kalamazoo, MI 49001-1282

P.S. As an added incentive, a \$50.00 gift will be sent to one of the 300 participants. One code number will be drawn from the pool. You may be the fortunate participant!

My dissertation is entitled: A Research Study of the Ideal and Real Performance Expectations of Baccalaureate Nursing Graduates as Perceived by Graduates, Nurse Educators, and Nurse Administrators.

You can help me by completing the following items. It will take about 30 minutes of your time.

_____ The demographics sheet.

_____ The green Benner Scale (you do not need a #2 pencil).

_____ The gray Six-Dimension Scale of Nurse Performance
(Real Dimension) - Do have

_____ The beige Six-Dimension Scale of Nurse Performance
(Ideal Dimension) - Should have

_____ A 3 x 5 card (if you are requesting results of the study).

Please check each item after completion.

Fold the materials and insert in envelope

Thank you

Demographics:

Sex: F M (Please circle one)

Age: _____

You are a:

traditional student _____
 L.P.N. Completion _____
 R.N. Completion _____

You are presently employed:

Yes _____ No _____

Full time _____

Part time _____

Is this your first job since graduation?

Yes _____ No _____

Where are you employed?

Hospital _____ doctor's office _____
 community agency _____ other - please list _____

If you are employed in an acute care setting, what type of unit do you work on?

ICU _____ Pediatrics _____
 Medical-Surgical _____ ER _____
 Obstetrics _____ Other - Please list _____

Have Diagnosis Related Groups been implemented in your place of employment?

Yes _____
 No _____
 Don't know _____

Did you have a special orientation as a new graduate?

Yes, How long? _____
 No _____

Please turn over

Describe the effectiveness of the orientation to you.

Generally how has your transition from school to work been?

What are your suggestions for making the transition easier?

Appendix D

Benner Proficiency Scale

BENNER PROFICIENCY SCALE

PART I: PERFORMANCE EXPECTATIONS

- 1=High Proficiency
 2=Moderate Proficiency
 3=Safe but Practice Needed
 4=Supervision Needed
 5=Supervision & Instruction Needed

FOR OFFICE USE ONLY									
	1	2	3	4	5	6	7	8	9
	1	2	3	4	5	6	7	8	9
	1	2	3	4	5	6	7	8	9
	1	2	3	4	5	6	7	8	9
	1	2	3	4	5	6	7	8	9
	1	2	3	4	5	6	7	8	9
	1	2	3	4	5	6	7	8	9
	1	2	3	4	5	6	7	8	9
	1	2	3	4	5	6	7	8	9
	1	2	3	4	5	6	7	8	9

PLEASE SEE THE ENCLOSED YELLOW SHEET
 FOR DEFINITIONS OF THE ABOVE TERMS AND INSTRUCTIONS
 FOR MARKING THE FOLLOWING SCALE.

- ERASE COMPLETELY TO CHANGE
- EXAMPLE:

IDEAL	1	2	3	4	5
REAL	1	2	3	4	5

1. Turn and position a patient in bed	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
* 2. Ensure patient's rights to continuity of nursing care when patient is transferred	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
3. Ask for assistance in completing assignment when needed	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
4. Ambulate post-operative patients for the first time after surgery	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
* 5. Do colostomy irrigation	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
6. Respect the patient's rights to privacy when discussing patient's condition with colleagues	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
7. Contribute to productive working relationships with other health team members	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
8. Prepare and give oral meds to groups of patients	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
9. Write patient care standards for patients with similar problems	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
* 10. Do closed chest massage for patient requiring resuscitation	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
* 11. Do urinary catheterization	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
12. Use therapeutic communication skills to identify and reduce anxiety in the patient and/or family	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
13. Complete daily assignment within regular working hours (excluding emergencies or staff shortages)	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
* 14. Assess the stages of labor during the childbirth process	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
* 15. Measure central venous pressure	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5

FEED THIS DIRECTION

SCRM-TRIM® Form No. 2343-SFC

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1=High Proficiency
2=Moderate Proficiency

3=Safe but Practice Needed
4=Supervision Needed

5=Supervision & Instruction Needed

2

* 16	Communicate therapeutically with emotionally disturbed patients.	IDEAL REAL	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
* 17	Carry out role and responsibilities of team leader	IDEAL REAL	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
* 18	Convert medication dosages and units appropriately for children	IDEAL REAL	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
19	Assess the resources, constraints and demands of the patient's social support system	IDEAL REAL	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
20	Give an inter-shift report with all pertinent information	IDEAL REAL	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
* 21	Observe for reactions and complications with blood infusions	IDEAL REAL	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
* 22	Give tracheostomy care, including dressing change	IDEAL REAL	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
* 23	Insert naso-gastric tube	IDEAL REAL	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
* 24	Help patient break down the management problems of chronic illness into workable units	IDEAL REAL	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
25	Notify appropriate physician about significant changes in patient's condition	IDEAL REAL	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
* 26	Recognize early trends in vital signs associated with impending shock	IDEAL REAL	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
* 27	Assume responsibility for the level of care provided by team members	IDEAL REAL	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
* 28	Instruct patient on how to detect pacemaker failure	IDEAL REAL	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
* 29	Give gastric tube feedings	IDEAL REAL	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
* 30	Help families choose a mutually satisfying level of participation in caring for the dying patient	IDEAL REAL	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
31	Teach the patient routine measures to prevent post-operative complications	IDEAL REAL	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
* 32	Detect major dangerous cardiac arrhythmias on cardiac monitors	IDEAL REAL	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
* 33	Help patients sort and understand health information so they can make informed choices about therapy	IDEAL REAL	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
34	Participate effectively in a multidisciplinary team conference	IDEAL REAL	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
* 35	Place electrodes on patients for cardiac monitoring	IDEAL REAL	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5

FEED THIS DIRECTION

1=High Proficiency
2=Moderate Proficiency

3=Safe but Practice Needed
4=Supervision Needed

5=Supervision & Instruction Needs.

3

SCM-TIRM® Form No. 2343-SFC

36. Ensure that the dying patient is not abandoned	IDEAL REAL	1: 2: 3: 4: 5:	1: 2: 3: 4: 5:
37. Identify need for community and home health referrals and initiate discharge planning	IDEAL REAL	1: 2: 3: 4: 5:	1: 2: 3: 4: 5:
* 38. Detect signs and symptoms of acute pulmonary edema	IDEAL REAL	1: 2: 3: 4: 5:	1: 2: 3: 4: 5:
39. Coach the patient in pain management techniques	IDEAL REAL	1: 2: 3: 4: 5:	1: 2: 3: 4: 5:
40. Provide for the safety needs of patients having seizures	IDEAL REAL	1: 2: 3: 4: 5:	1: 2: 3: 4: 5:
41. Use isolation techniques correctly e.g., hand washing, gowning, and gloving	IDEAL REAL	1: 2: 3: 4: 5:	1: 2: 3: 4: 5:
42. Help patients take responsibility for their own health	IDEAL REAL	1: 2: 3: 4: 5:	1: 2: 3: 4: 5:
* 43. Teach stoma care to ileostomy patients	IDEAL REAL	1: 2: 3: 4: 5:	1: 2: 3: 4: 5:
44. Take nursing histories that guide the provision of individualized patient care	IDEAL REAL	1: 2: 3: 4: 5:	1: 2: 3: 4: 5:
45. Participate in identification of unsafe patient care practices and assume responsibility for intervention	IDEAL REAL	1: 2: 3: 4: 5:	1: 2: 3: 4: 5:
46. Write nursing care plans for individual patients	IDEAL REAL	1: 2: 3: 4: 5:	1: 2: 3: 4: 5:
* 47. Check arteriovenous shunts for patency and flow	IDEAL REAL	1: 2: 3: 4: 5:	1: 2: 3: 4: 5:
48. Interact purposefully with other team members to keep them informed of changes in the patient's condition	IDEAL REAL	1: 2: 3: 4: 5:	1: 2: 3: 4: 5:
49. Prepare and administer sliding scale insulin	IDEAL REAL	1: 2: 3: 4: 5:	1: 2: 3: 4: 5:
* 50. Detect signs and symptoms of digitalis toxicity	IDEAL REAL	1: 2: 3: 4: 5:	1: 2: 3: 4: 5:
51. Administer and monitor oral-nasal oxygen therapy	IDEAL REAL	1: 2: 3: 4: 5:	1: 2: 3: 4: 5:
52. Evaluate P.R.N. medications so patients are not undermedicated or overmedicated	IDEAL REAL	1: 2: 3: 4: 5:	1: 2: 3: 4: 5:
* 53. Assist with a spinal tap	IDEAL REAL	1: 2: 3: 4: 5:	1: 2: 3: 4: 5:
* 54. Predict the influence of physiological responses, such as shivering on Central Venous Pressure readings	IDEAL REAL	1: 2: 3: 4: 5:	1: 2: 3: 4: 5:
* 55. Start intravenous fluids	IDEAL REAL	1: 2: 3: 4: 5:	1: 2: 3: 4: 5:

FEED THIS DIRECTION

1=High Proficiency
2=Moderate Proficiency

3=Safe but Practice Needed
4=Supervision Needed

5=Supervision & Instruction Needed

56. Conduct physical exam of the chest	IDEAL REAL	1 2 3 4 5 1 2 3 4 5
* 57. Evaluate signs of increased intracranial pressure	IDEAL REAL	1 2 3 4 5 1 2 3 4 5
* 58. Monitor the fluid and electrolyte balance of patients receiving hyperalimentation therapy	IDEAL REAL	1 2 3 4 5 1 2 3 4 5
59. Observe for and prevent circulatory problems for patients with orthopedic casts	IDEAL REAL	1 2 3 4 5 1 2 3 4 5
* 60. Judge changes and trends in infant's hydration by palpation of fontanels	IDEAL REAL	1 2 3 4 5 1 2 3 4 5

PART II: PLEASE SEE THE ENCLOSED WHITE INSTRUCTION SHEET FOR COMPLETE QUESTIONS AND RESPONSES FOR THE FOLLOWING SECTION.

1. Age	1 2 3 4
2. Nursing-related experience prior to your most recent nursing program (new graduates only)	1 2 3 4 5
3. Employment status	1 2 3 4 5 6
4. Area of employment	1 2 3 4 5 6 7 8 9
5. Career choice	1 2 3 4 5 6 7 8 9 10
6. Nursing program you completed initially	1 2 3 4
7. Highest degree obtained	1 2 3 4 5 6 7 8
8. Teaching role (educators only)	1 2 3
9. Involvement in direct patient care.	1 2 3 4

THE LAST TWO QUESTIONS PERTAIN TO NURSING SERVICE PERSONS ONLY.

10. Number of new graduates you work with	1 2 3 4 5
11. Current position	1 2 3 4 5 6

Note. Copy here is 74% reduction of original.

Appendix E

Six-Dimension Scale of Nurse Performance--Ideal

CODE # _____

SIX-DIMENSION SCALE OF NURSE PERFORMANCE

Please use the following rating scale to respond to each item on this questionnaire with regard to how a new baccalaureate graduate should function. In other words, respond to each item with regard to the level of skill you believe the new baccalaureate nurse *should* have upon graduation rather than the level of skill the new baccalaureate graduates *do* have upon graduation. Place the appropriate number on the line to the left of each item.

1. NO PRACTICE NEEDED:

Expected to be able to perform efficiently and effectively

2. SOME PRACTICE NEEDED:

Expected to be able to perform effectively without supervision but more practice needed to perform efficiently.

3. GUIDANCE NEEDED:

Expected to need guidance because of limited practice and experience.
Exposure to theory and principles assumed.

4. INSTRUCTION AND SUPERVISION NEEDED:

Expected to need instruction and supervision because of lack of practice and experience. Exposure to theory and principles not assumed.

- _____ 1. Teach a patient's family members about the patient's needs.
- _____ 2. Coordinate the plan of nursing care with the medical plan of care.
- _____ 3. Give praise and recognition for achievement to those under his/her direction.
- _____ 4. Teach preventive health measures to patients and their families.
- _____ 5. Identify and use community resources in developing a plan of care for a patient and his/her family.
- _____ 6. Identify and include in nursing care plans anticipated changes in a patient's condition.

- | | |
|-------------------------|---------------------------------------|
| 1. NO PRACTICE NEEDED | 3. GUIDANCE NEEDED |
| 2. SOME PRACTICE NEEDED | 4. INSTRUCTION AND SUPERVISION NEEDED |

- _____ 7. Evaluate results of nursing care.
- _____ 8. Promote the inclusion of patient's decisions and desires concerning his/her care.
- _____ 9. Develop a plan of nursing care for patient.
- _____ 10. Initiate planning and evaluation of nursing care with others.
- _____ 11. Perform technical procedures, e.g., oral suctioning, tracheostomy care, intravenous therapy, catheter care, dressing changes.
- _____ 12. Adapt teaching methods and materials to the understanding of the particular audience, e.g., to age of patient, educational background, sensory deprivations.
- _____ 13. Identify and include immediate patient needs in the plan of nursing care.
- _____ 14. Develop innovative methods and materials for teaching patients.
- _____ 15. Communicate a feeling of acceptance of each patient and a concern for the patient's welfare.
- _____ 16. Seek assistance when necessary.
- _____ 17. Help a patient communicate with others.
- _____ 18. Use mechanical devices, e.g., suction machine, Gomco, cardiac monitor, respirator.
- _____ 19. Give emotional support to the family of a dying patient.
- _____ 20. Verbally communicate facts, ideas and feelings to other health team members.
- _____ 21. Promote patient's right to privacy.
- _____ 22. Contribute to an atmosphere of mutual trust, acceptance, and respect among other health team members.
- _____ 23. Delegate responsibility for care based on assessment of priorities of nursing care needs and the abilities and limitations of available health-care personnel.

1. NO PRACTICE NEEDED	3. GUIDANCE NEEDED
2. SOME PRACTICE NEEDED	4. INSTRUCTION AND SUPERVISION NEEDED

- _____ 24. Explain nursing procedures to a patient prior to performing them.
- _____ 25. Guide other health team members in planning for nursing care.
- _____ 26. Accept responsibility for the level of care provided by those under his/her direction.
- _____ 27. Perform appropriate measures in emergency situations.
- _____ 28. Promote the use of interdisciplinary resource persons.
- _____ 29. Use teaching aids and resource materials in teaching patients and their families.
- _____ 30. Perform nursing care required by critically ill patients.
- _____ 31. Encourage the family to participate in the care of the patient.
- _____ 32. Identify and use resources within his/her health-care agency in developing a plan of care for a patient and his/her family.
- _____ 33. Use nursing procedures as opportunities for interaction.
- _____ 34. Contribute to productive working relationships with other health team members.
- _____ 35. Help a patient meet his/her emotional needs.
- _____ 36. Contribute to the plan of nursing care for the patient.
- _____ 37. Recognize and meet the emotional needs of a dying patient.
- _____ 38. Communicate facts, ideas, and professional opinions in writing to patients and their families.
- _____ 39. Plan for the integration of patient needs with family needs.
- _____ 40. Function calmly and competently in emergency situations.
- _____ 41. Remain open to the suggestions of those under his/her direction and use them when appropriate.
- _____ 42. Use opportunities for patient teaching when they arise.

Appendix F

Six-Dimension Scale of Nurse Performance--Real

CODE # _____

SIX-DIMENSION SCALE OF NURSE PERFORMANCE

Please use the following rating scale to respond to each item on this questionnaire with regard to how most new baccalaureate graduates actually function. In other words, respond to each item with regard to the level of skill you believe most new baccalaureate nurses *do* have upon graduation rather than the level of skill the new baccalaureate graduates *should* have upon graduation. Place the appropriate number on the line to the left of each item.

1. NO PRACTICE NEEDED:

Expected to be able to perform efficiently and effectively

2. SOME PRACTICE NEEDED:

Expected to be able to perform effectively without supervision but more practice needed to perform efficiently.

3. GUIDANCE NEEDED:

Expected to need guidance because of limited practice and experience. Exposure to theory and principles assumed.

4. INSTRUCTION AND SUPERVISION NEEDED:

Expected to need instruction and supervision because of lack of practice and experience. Exposure to theory and principles not assumed.

- _____ 1. Teach a patient's family members about the patient's needs.
- _____ 2. Coordinate the plan of nursing care with the medical plan of care.
- _____ 3. Give praise and recognition for achievement to those under his/her direction.
- _____ 4. Teach preventive health measures to patients and their families.
- _____ 5. Identify and use community resources in developing a plan of care for a patient and his/her family.
- _____ 6. Identify and include in nursing care plans anticipated changes in a patient's condition.

- | | |
|-------------------------|---------------------------------------|
| 1. NO PRACTICE NEEDED | 3. GUIDANCE NEEDED |
| 2. SOME PRACTICE NEEDED | 4. INSTRUCTION AND SUPERVISION NEEDED |

- _____ 7. Evaluate results of nursing care.
- _____ 8. Promote the inclusion of patient's decisions and desires concerning his/her care.
- _____ 9. Develop a plan of nursing care for patient.
- _____ 10. Initiate planning and evaluation of nursing care with others.
- _____ 11. Perform technical procedures, e.g., oral suctioning, tracheostomy care, intravenous therapy, catheter care, dressing changes.
- _____ 12. Adapt teaching methods and materials to the understanding of the particular audience, e.g., to age of patient, educational background, sensory deprivations.
- _____ 13. Identify and include immediate patient needs in the plan of nursing care.
- _____ 14. Develop innovative methods and materials for teaching patients.
- _____ 15. Communicate a feeling of acceptance of each patient and a concern for the patient's welfare.
- _____ 16. Seek assistance when necessary.
- _____ 17. Help a patient communicate with others.
- _____ 18. Use mechanical devices, e.g., suction machine, Gomco, cardiac monitor, respirator.
- _____ 19. Give emotional support to the family of a dying patient.
- _____ 20. Verbally communicate facts, ideas and feelings to other health team members.
- _____ 21. Promote patient's right to privacy.
- _____ 22. Contribute to an atmosphere of mutual trust, acceptance, and respect among other health team members.
- _____ 23. Delegate responsibility for care based on assessment of priorities of nursing care needs and the abilities and limitations of available health-care personnel.

1. NO PRACTICE NEEDED
2. SOME PRACTICE NEEDED

3. GUIDANCE NEEDED
4. INSTRUCTION AND SUPERVISION NEEDED

- _____ 24. Explain nursing procedures to a patient prior to performing them.
- _____ 25. Guide other health team members in planning for nursing care.
- _____ 26. Accept responsibility for the level of care provided by those under his/her direction.
- _____ 27. Perform appropriate measures in emergency situations.
- _____ 28. Promote the use of interdisciplinary resource persons.
- _____ 29. Use teaching aids and resource materials in teaching patients and their families.
- _____ 30. Perform nursing care required by critically ill patients.
- _____ 31. Encourage the family to participate in the care of the patient.
- _____ 32. Identify and use resources within his/her health-care agency in developing a plan of care for a patient and his/her family.
- _____ 33. Use nursing procedures as opportunities for interaction.
- _____ 34. Contribute to productive working relationships with other health team members.
- _____ 35. Help a patient meet his/her emotional needs.
- _____ 36. Contribute to the plan of nursing care for the patient.
- _____ 37. Recognize and meet the emotional needs of a dying patient.
- _____ 38. Communicate facts, ideas, and professional opinions in writing to patients and their families.
- _____ 39. Plan for the integration of patient needs with family needs.
- _____ 40. Function calmly and competently in emergency situations.
- _____ 41. Remain open to the suggestions of those under his/her direction and use them when appropriate.
- _____ 42. Use opportunities for patient teaching when they arise.

Appendix G

Second Mailing: Postcard Reminder to Graduates

June 1986

A few weeks ago a packet was mailed to you. I was seeking your perceptions of ideal and real expectations of the new baccalaureate graduate nurse.

If you have already completed and returned it to me, please accept my sincere thanks. If not, I would appreciate your completing and returning the questionnaires at your earliest convenience.

Please call me collect if you need a replacement packet.
Telephone 616-342-4140.

Thank you,
Maureen Fochtman

Appendix H

Third Mailing to Graduates

Nazareth College

In Kalamazoo

NAZARETH, MICHIGAN 49076
616-349-7783

June 8, 1986

Dear 1985 Baccalaureate Nurse Graduate:

A number of weeks ago, I requested your help in identifying the ideal and real performance expectations of baccalaureate nurse graduates at the time of your graduation. Fifty-three (53%) of the sample responded. However, for nurse educators and nurse administrators to listen to what graduates are saying, a response rate of 90% is necessary.

Would you please take 30 minutes and complete the enclosed items? Your responses are essential to the study, and the future of baccalaureate nursing education.

Thank you for your assistance.

Sincerely,

Maureen M. Fochtman, M.N., R.N.
Associate Professor
Nazareth College in Kalamazoo
3333 Gull Road
Kalamazoo, MI 49001-1282

MEF:la

Enc:

P.S. As an added incentive, a \$50.00 gift will be sent to one of the 300 participants. One code number will be drawn from the pool. You may be the fortunate participant!

Appendix I

First Question to Graduates--Table 41

Table 41
1985 Baccalaureate Graduates' Responses
Generally, How Has the Transition From School to Work Been?

Positive	Negative	Neutral
<u>School preparation:</u>		
Very easy--my education from Valparaiso was obviously excellent. The clinical skills I lacked were learned in the first week of orientation.	Difficult--school and work bear no similarities at all. In school, self-confidence was never enhanced.	Going from the cloistered world of nursing school to the actual working world was like culture shock.
School successfully prepared me for the transition between school and work.	Although I learned quite a bit in school, it was an awakening to find out how much I had not been exposed to in school. As far as preparation for the real world, I had next to nothing.	Because I adapt well to change, I was able to assimilate the transition without detriment. Being placed in a sink or swim situation was very challenging to me and I met the challenge.
	A little shocking, in school everything is so ideal.	We new grads are hard on ourselves and we expect so much! There is realistically no way we could know everything by graduation.

Table 41--Continued

Positive	Negative	Neutral
	<p>The transition has been difficult because of lack of clinical experience with technical skills versus care plans and patient teaching.</p>	<p>I guess I had a glorified picture of nursing, although toward the end of my school during an internship period in the hospital, I began to realize that nursing isn't the satisfying profession I thought that it was.</p>
	<p>Nothing in the work world is ideal. School should teach us to deal with the unexpected in terms of short cuts and time management.</p>	
	<p>I feel student nurses don't get a realistic picture in clinical. My work as an aide helped my transition.</p>	
	<p>I am realizing that the nursing degree I obtained lacks in technical/practical areas.</p>	

Table 41--Continued

Positive	Negative	Neutral
<u>Work environment:</u>		
Work is much easier than school. My co-workers help boast my self-confidence with encouragement.	I was not prepared for the stressful environment on the floor and critically ill patients.	Pretty smooth. At times I felt inadequate, and that I didn't have enough schooling or information.
My head nurse was easy to talk to; she was willing to help me and make me feel welcome.	It was hard to accept the fact that many nurses don't care about the future of the nursing profession; it's just a job to them.	At times it was very rough, but I look back at all I've done and learned and I'm proud of myself.
Fairly easy, I was employed on the same floor for 9 months prior to graduation, so I was familiar with the routine and type of patients.	It was very difficult to adapt to the physical demands of the job.	Pretty easy. The most difficult parts were the things we didn't get to practice in school, such as how to talk effectively with doctors and how to handle emergencies effectively.
Fairly comfortable because the orientation program at the hospital was super and the university where I studied nursing provided us with 2-6 week clinical rotations for practicum and leadership opportunities. I have a lot to learn, but my previous	Many co-workers were unsupportive of my efforts; it depressed me!	Getting used to shift work was difficult.
	Real world time pressures and patient-staff ratios don't allow a lot of things I feel I should be doing, such as, patient teaching.	My transition has progressed slower than expected. I do not feel that I'm really adding to the staff.

Table 41--Continued

Positive	Negative	Neutral
<p>instructors assured me of that and my present employer is providing me with the learning opportunities I need to do just that.</p> <p>Exceptionally smooth as I felt somewhat knowledgeable about underlying politicking of the everyday work world. I was not as frustrated nor stunned that situations do not always resolve as they should, or true to the ideal.</p>	<p>It was a reality shock! It's been very frustrating at times, to the point of wanting to quit nursing.</p> <p>It has taken a lot of time to build some self-confidence and adjust to the responsibility of being an RN.</p> <p>I entered my first job expecting stress and anxiety. It's been just that extremely stressful. I'm definitely experiencing reality shock.</p> <p>My biggest shock was the amount of death I found. I wasn't prepared to deal with all those people dying of their own self-destructive life styles.</p> <p>Rocky; I knew it would be as I had low expectations of nursing.</p>	<p>I feel a lot of the transition is how well you get along with patients, coworkers, and doctors.</p> <p>It's an adjustment to assume total responsibility.</p> <p>The staff nurses with whom I worked were very helpful to me as long as I wasn't too proud to ask questions.</p> <p>It's very emotionally draining for the nurse to give emotional support.</p> <p>The most important thing that I have learned is that in our profession we are constantly learning and it is perfectly fine to ask questions.</p> <p>Fairly smooth; I was warned about reality shock, etc., and I was</p>

Table 41--Continued

Positive	Negative	Neutral
	Recognizing early signs/ symptoms of when a patient is becoming critical which you only learn through experience was a big stressor at first.	prepared to expect a change. Traumatic but bearable. Emotionally draining be- cause of the role change from dependent student to independent practioner. I'm trying to get used to three cultures--nursing, the Navy, and a different part of the country.

Appendix J

Second Question to Graduates--Table 42

Table 42

What Are Your Suggestions for Making
the Transition Easier?

School preparation	Work environment
More clinical experience.	I feel any experience in a health care position while in school can help the transition.
Stressing the reality of the work world.	
A more coordinated faculty would be helpful in establishing better continuity between knowledge learned in the classroom are real live patients in the clinical settings.	Suggest new graduates talk with many other new graduates about what they are experiencing and let them know they are not the only ones who feel stupid.
More emphasis should be given to familiarizing nursing students with certain important nursing skills, e.g., tracheostomy, tube feeding, and emergency treatment.	Talk with someone who they can trust to be a type of mentor and confidant; someone they can ask questions and not feel ignorant.
In school continue to stress the correct way of doing things and teach idealistically but give us an adequate dose of realism, too.	For management and other staff nurses to be patient and willing to share their knowledge.
Teach assertiveness, do more role-playing of likely situations and teach how to cope with the potentially difficult transition. The preparation for the real world has to begin in school.	Do not let new graduates on their own for at least 3 months, or for some it may take longer.
We were told in nursing school to expect culture shock; that in itself has	I have talked, no preached, nurse internships ever since I was first in the nursing program. I consider it ideal.
	I feel that I have not been allowed to use my skills to the fullest; I have concentrated my efforts on fitting into the team. However, the team has

Table 42--Continued

School preparation	Work environment
<p>helped. The last semester should be directed towards a clinical experience of our own choice.</p>	<p>squelched temporarily my zealoussness for nursing. Yes, there is a gap between school and work.</p>
<p>Carefully select a preceptor, someone with lots of patience who really enjoys teaching.</p>	<p>Longer thorough orientation period concentrating on organizational skills, prioritizing, team leading, and assertiveness skills.</p>
<p>More emphasis needs to be placed on leadership; I didn't realize that I wouldn't have a choice of whether to be in charge or not. Require business management courses.</p>	<p>I believe it is important to support and assist the newcomers. In addition to support, a gradual increase in workload to avoid overwhelming the new nurse.</p>
<p>Allow students more clinical experience where they must directly relate to doctors, nurses, and other health care personnel rather than having the faculty member be the liaison person.</p>	<p>I was put in charge of a 40-bed unit after 4 weeks. I was not ready for the responsibility.</p>
<p>A reality-based education. Nurses need to know how much frustration is associated with a staff nurse position.</p>	<p>Have nurses from local hospital contribute to the curriculum of nursing schools.</p>
<p>As a long-term suggestion, nurses may do best to diversify as expectations of our knowledge are unrealistic.</p>	<p>Remember we are new nurses! Give more feedback!</p>
<p>Cover emergency situations and verbally discuss what things are important to do in those situations.</p>	<p>Teach methods for uniting nurses.</p>

Table 42--Continued

School preparation	Work environment
Have 1-year graduates explain the transition and what to expect.	
Offer optional courses in specialized nursing areas which provide specific information and skills related to the student's choice.	
Rotation through the emergency room and critical care areas.	

Appendix K

Third Question to Graduates--Table 43

Table 43

Describe the Effectiveness of Orientation to You

Positive	Negative
<p>Valuable--The educators had the new graduates fill out an assessment checklist. The list gave the preceptor an idea of how much nursing experience graduates had.</p>	<p>Ineffective--I was placed on large units for 1 week each. I felt I had been tossed out to sink or swim.</p>
<p>The preceptors make all the difference in the world; especially, if they have written expectations for each week and share well-prepared materials.</p>	<p>Somewhat overwhelming to get all that information in 6 weeks.</p>
<p>Effective--Taught many skills not taught in school, not only the complex ones but the simple ones we never practiced.</p>	<p>The general orientation is soon forgotten and a short reorientation with some work behind me may be helpful, if they had it.</p>
<p>A graduate hired by the Alaska Area Health Service to staff bush hospitals stated her 5-month orientation period was excellent. She worked in all areas of the hospital. She wished every graduate had the opportunity.</p>	<p>Orientation was not effective due to the fact that as a graduate nurse I was expected to function as if I had 5 years experience. The lack of support and assistance seemed to be the rule rather than the exception.</p>
<p>Introduction to many available resources both inside and outside of the hospital.</p>	<p>Orientation was what I would describe as a "dream world." You had a job, all day was policy, procedures, and protocol. You basked in being a graduate. The orientation was not harmonious with the real 8-12 hour work world.</p>
	<p>Very boring and repetitious about things we learned about in school. We need more orientation with actual patients.</p>
	<p>Orientation periods lasting all day lost their effectiveness. After about 11:00, there's more interest in clock watching.</p>

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