THE RELATIONSHIP OF SOURCES OF PREPARATION TO PERCEIVED PERFORMANCE IN TEACHING ROLE ACTIVITIES OF RECENTLY GRADUATED REGISTERED NURSES

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CHAPTER I

INTRODUCTION

The role of the nurse as teacher is clearly defined in the nurse practice acts of all states which give nurses the responsibility to teach. The role has evolved in the health care profession since the turn of the century. Early leaders in nursing understood the importance of the teaching role. The National League of Nursing Education (1918) was concerned with preparing nurses for the role of teacher:

> Another limitation of the ordinary training is that it deals only or mainly with disease, neglecting almost entirely the preventive and educational factors which are such an essential element in the many new branches of public work, such as school and visiting nursing, infant welfare, industrial welfare, and hospital social service (p. 6).

Nursing is the largest single service in the health field and the one most intimately involved with the patient-consumer (National League for Nursing, Annual Report, 1970, NLN Archive). Nurses teach health care practices to people and in so doing prevent disease, maintain health, facilitate coping, and enable the individual to reestablish healthful living patterns. All nurses function as teachers and teaching is inherent in the nurses' role whether or not the nurse consciously cultivates and exhibits teacher behavior (Douglas and Bevis, 1983).

Through the years nursing has adapted its role and educational programs to meet the changing need of society. Attention has been focused on nursing in the health care system and on the roles of nurses. Reports such as 'An Abstract for Action' (1970) and 'Extending the Scope of Nursing Practice' (1971) addressed the changing role of the nurse as one step in improving the delivery of health care in this country. The nurse functions in a variety of roles and teaching is one of them.

Because delivery of health care has moved from illness-oriented to health-oriented, sicker patients are released from the hospital to spend part of their recovery time at home. The role of teacher has gained greater emphasis in order to meet this changing trend. Due to this increased emphasis and the rapidly changing health care environment, there is a need for an analysis of nurses' performance in the teaching role, and of the sources of preparation and role acquisition that prepared the nurse to implement the role of teacher. Nurses may not be adequately prepared for their role as teacher of patients and families.

Statement of the Problem

The problem with which this study dealt was the perception that neither academic programs for nursing students or hospital educational programs adequately prepared nurses for their roles as teachers of patients and

families.

Need for the Study

Identification of factors which contribute to the most effective performance of practicing nurses is a major concern to those who educate nurses, those who hire nurses, and nurses themselves (Schwirian, 1981). As the acuity of hospitalized clients increases in a health-oriented system, the role of the nurse as teacher holds greater importance. Clients are leaving health care institutions with increased requirements for self-care. Financial constraints have contributed to this trend as prospective payment based on diagnostic related groups is mandated by government. Most insurance carriers, as well, have based payment upon specified criteria which usually require the client to have greater self care abilities.

Patient teaching is the responsibility of every member of the health care team. The nurse, however, is viewed as a primary teacher (Joint Commission on the Accreditation of Hospitals, 1983; American Hospital Association, 1974). Physicians treat illness while nurses treat the human response to actual or potential problems. This difference in professional focus emphasizes the broader responsibility of the nurse to teach the patient. The delivery of health care has moved from "illness-oriented" to "wellness oriented".

Because the nurse is responsible for the care of

patients on a 24 hour basis and spends more time than anyone else with them, she is in the best position to evaluate patient needs regarding basic information, readiness to learn, and achievement. As self-care abilities of the patient are also well known to the nurse, she is making a critical link in planning patient discharge as the one who teaches the patient those abilities. In addition to health management teaching, preventive health teaching is also emphasized by the nurse as teacher.

"Most nurses do not think of themselves as teachers," was a statement delivered by a nationally recognized consultant in nursing at a professional workshop (Neiderbaumer, Sept. 25, 1986, Tulsa, OK). Many practicing nurses have not complied with goal directed care as describe in Standard IV of the Joint Commission on the Accreditation of Hospitals' standard for nursing services, which emphasizes integrating patient and family teaching into their professional clinical practice (Sovie, 1982). Standard IV states, "Individualized, goal-directed nursing care shall be provided to patients through the use of the nursing process. Patient education and patient/family knowledge of self-care shall be given special consideration in the nursing plan" (Accreditation Manual for Hospitals, p. 119).

Nurses are currently at varying levels in their acceptance and performance of selected tasks (Singleton and Nail, 1984). Often staff nurses place a high value on

patient teaching, yet feel unprepared to teach. Most commonly they feel they have a lack of content knowledge, of teaching expeience, of skill in teaching techniques, or a lack of time (Sullivan and Decker, 1985). Those who educate and hire nurses, as well as the nurses themselves, must analyze the factors related to role implementation which affect nursing performance and utlimately patient wellness.

Purpose of the Study

The purpose of the study was to compare the performance self ratings of recently graduated nurses as teachers to their ratings of their academic programs and hospital educational programs in teaching preparation.

Research Questions

The study attempted to answer the following questions:

Which teaching role activities have novice nurses performed?

How well have novice nurses perceived that they performed teaching role activities?

Which sources of preparation for the teaching role have novice nurses experienced?

How well have novice nurses perceived that sources prepared them for their teaching role?

Was there a relationship between how well novice nurses perceived that they performed teaching role activities and

how well they perceived that sources prepared them for their teaching role?

Limitations of the Study

The following limitations were identified in this study.

1. Only registered nurses in their first two years of employment were studied.

2. Only registered nurses employed in acute care areas were studied.

3. Registered nurses in psychiatry, surgery, and critical care areas were excluded from the study.

4. Registered nurses in the study were employed in one metropolitan area, Tulsa, Oklahoma.

5. Responses on the survey were self-reported.

Assumptions

The following assumptions were identified for this study.

1. The study subjects responded truthfully to the survey.

2. The study subjects responded according to their instructions.

Definitions

The following terms have been defined for use in this study.

Academic Preparation--the basic educational preparation for registered nurse licensure.

Acute Care--general medical and surgical nursing units, excluding critical care, surgery, and psychiatry.

Basic Educational Preparation--the generic educational program that permits nurses to become licensed.

Mentor--an individual who teaches the learner so that there is a development of ability in relation to work, guides the learner into the world of work, advises at critical stages, provides a model which the learner can admire and seek to emulate, and fosters the relationship from which both participants grow (Levinson, 1978).

Novice Nurses--registered nurses practicing within the first two years of employment following graduation.

Performance--the conduct of activities which reflect the purpose and responsibilities of the role.

Preceptor--a staff nurse paired with a new graduate in the clinical setting establishing a relationship which allows the new graduate to work and identify with a competent role model who is involved on a daily basis in decisions, processes, and protocols of patient and unit management (Friesen and Conahan, 1980).

Registered Nurse (R.N.)--a professional nurse licensed in the State of Oklahoma. (Present law permits licensing nurses as registered nurses from associate degree, diploma, and bacclaureate educational programs.)

Role--a set of behaviors which are a result of synthesis of culture, social structure, and the self (Meleis, 1975).

Role of the Teacher--a position with responsibilities for teaching patients and families as well as collaborating with others who contribute to the patient's well being.

Service Administrators--individuals working in administrative positions in institutions that provide nursing services.

Self-directed Learning--a process in which individuals take initiative in diagnosing their learning needs, formulating learning goals, identifying human and material resources for learning strategies, and evaluating learning outcomes (Knowles, 1975).

Socialization--a process by which values and norms of a professional group are internalized into one's own behavior and self-conception (Jacox, 1973).

Summary

The role of nurse as teacher is unquestioned in the literature. Due to professional, economic, and social factors, that role has escalated. Whether academia as well as employers have tailored their programs to meet this increasing demand is a concern to all.

The following chapter will highlight the role of the nurse as teacher, the factors which have made that role more important, the implications for health care delivery

systems, and sources of preparation for the role of teacher. Chapter Three will explain the methodology used to identify the population and to collect data. Chapters Four and Five will report the findings of the study and provide an analysis of the data.

CHAPTER II

REVIEW OF LITERATURE

This chapter provides a review of the related literature about the role of the nurse as teacher as well as about nursing performance in that role. The role of the professional nurse is defined legally in nurse practice acts and includes the role of teacher. Since the turn of the century the role of the nurse has changed and evolved according to the needs of the profession and society. This review includes literature which addresses factors that support the teaching role of the registered professional nurse and role acquisition, and sources of preparation that influence performance.

Teaching Role of the Registered Professional Nurse

The role of the nurse as teacher of hospitalized patients is clearly documented in the literature. Nursing recognized the importance of patient education decades before the topic came to the forefront in health care. Nursing practice acts passed by legislative bodies gave nurses the responsibility to teach. Early in the century the National League of Nursing Education (1918) identified

the teaching role. The American Nurses Association Statement of Function, Standards, and Qualifications (1956) accepted by general duty nurses lists "instruction of patients" as a nursing function The teaching function has remained an integral part of the profession's standards of practice with an increased emphasis over recent years.

According to the Oklahoma State Nursing Practice Act, (1981):

> The practice of nursing means the performance for compensation of any acts in the observation, care and counsel of the ill, injured or infirm, or in the maintenance of health or prevention of illness of others, or in the supervision and teaching of other personnel, or the administration of medications and treatments, as prescribed by a licensed physician or dentist, requiring substantial specialized judgment and skill based on knowledge and application of the principles of biological, physical and social science. The foregoing shall not be deemed to include acts of medical diagnosis or prescription of therapeutic or corrective measures (p.1).

Schwirian (1978) developed and validated a tool to accurately operationalize the variable, "nursing performance". Nursing performance reflected those observable nurse behaviors which represented the purpose and responsibilities of the role. Performance measures included those which were consistent with the nursing process model, applicable to a variety of settings, for nurses practicing within two years following graduation, usable as a performance appraisal, and interpreted consistently without further explanation.

Data were collected from a literature review related to

the prediction of successful nursing performance of practicing nurses with fewer than two years of clinical experience following graduation. A Delphi technique was used to determine behaviors of good nursing practice from nursing educators, nurse graduates, and their employers. Seven nursing performance areas were identified, including teaching. The other six performance areas were planning nursing care, implementing nursing care, evaluating nursing care, interpersonal relations, leadership, and professional development.

Dunn (1970) developed an instrument to measure nursing performance by doing a task analysis of nursing procedures. This analysis narrowed the list of "ideal" nurse behaviors to five procedures, teaching being one of the five.

Based on the legal and professional responsibility and accountability, the member of the health care team who primarily teaches the patient is the nurse. Unlike physicians whose primary focus is treating illness, the nurse treats the human response to actual or potential problems. Preparing the patient for discharge and teaching the patient self care abilities are primary nursing responsibilities (Joint Commission on the Accreditation of Hospitals, 1983).

Conversely, various patient bills of rights have emerged with the premise that the patient has the right to receive health education. The Patient's Bill of Rights was adopted in 1972 by the American Hospital Association

"...with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, his physician, and the hospital organization" (McCormick and Gibson-Parkevich, 1979, p. 6).

Given, Given, and Simoni (1979) identified the patient's knowledge and understanding of the disease and therapeutic regimen as important outcome dimensions of the process components of nursing care. The focus of process components included diagnostic, therapeutic, and compliance variables. The focus also included the activities which the nurse implemented in responding to various patient needs. Teaching was identified as a component in the therapeutic approach.

From their study of the interaction of processes of patient care outcomes, a comprehensive therapeutic approach was related to an improvement in clinical health status, and in the patient's perception of health status and care. In addition, patient compliance with therapeutic regimens was positively related to patients' health state as well as to their knowledge and perceptions of the disease and its therapy. Therapeutic nursing care processes, including the teaching component, certainly provided for positive attitudes toward the therapeutic regimen, fewer complications, and a longer and more productive life for patients.

Conversely, Hinshaw and Atwood (1982) constructed a patient satisfaction scale using prior research enumerating the nursing activities considered and valued by clients. Client education was one of the subscales. Counter to theoretical predictions, none of the types of patient satisfaction was directly influenced by the teaching activities (p. 175).

Yet, in a review of research on patient and family instruction, other significant benefits to patients and their families were identified. For example, patients and families who were given instruction preoperatively about what to expect from surgery and recovery and how to deal with it, were better able to cope with unusual postoperative experiences, had lower levels of anxiety, had decreased number of complications, decreased need for narcotics, and thereby a reduction in their recovery time (Moss, 1986, p.1107).

Patients regarded the nurse as an important source of information. Most preferred individualized instruction for themselves as well as for their families. One study found that patients were more cooperative, experienced less anxiety, asked fewer questions, and made fewer postoperative demands when their family was involved (Dziurbejko and Larkin, 1978).

In 1976 President Ford signed into law the National Consumer Health Information and Health Promotion Act (P.L. 94-317). "Through health education programs, hospitals and

other health care institutions can contribute to important health care goals, such as improved quality of patient care, better utilization of outpatient services, fewer admissions and readmissions to inpatient facilities, shorter lengths of stay, and reduced health care costs" (American Hospital Association, 1974, p. 2). Thus, consumerism emerged as a force in the increased emphasis on patient education.

Chalmers and Farrell (1983) identified selected nursing interventions for health promotion, further delineating the nurse's role in this area. Specific interventions included record keeping, role playing, audio and video feedback, imagery, visual mapping and experimentation, with the aim of increasing the patient's health promotion behaviors.

Even the Joint Commission on Accreditation of Hospitals (1983) has provided guidelines which specify that criteria for education should be established. Without approval from the Joint Commission on Accreditation of Hospitals, health care institutions are not reimbursed for services that are provided to patients by most insurance carriers paying for hospital care. The economics of health care became another force which emphasized the increased importance and expectation for patient teaching.

According to the American Hospital Association, patient education responsibilities are part of the professional practice acts for several health care professions, including medicine, nursing, dietetics, and pharmacy. Because this

role sharing of the teaching responsibility exists among health care professionals, identifiable health education practices must be determined. (Shine, Sitva, and Weed, 1983).

A study completed by these researchers identified specific health education competencies which were appropriate for baccalaureate level nursing. Content areas were identified to assist in the mastery of the health education competencies, including theories of teaching-learning, principles of adult education, purposes and outcomes of health education, health education as practiced by different health providers, and a definition of nursing practice roles and functions (p. 23).

White (1972) collected data on the perceptions of patients and professional nurses concerning the importance of common nursing activities and found statistically significant differences between the views of the two groups. One category in the four part framework was "preparing for discharge", which was concerned with teaching and planning continuity. Neither patients nor professional nurses considered activities preparing for discharge an important responsibility of the hospital staff nurse (p. 12). This study confirms the need to prepare nurse graduates who will be competent to teach patients and families effectively and to plan with them for continuing health care.

Another of several forces that converged to bring health teaching to prominence was the increased number of

malpractice suits as well as the need to control health care's spiraling costs (American Hospital Association, 1982). Failure to insure that the patient is adequately informed about his care may place both professionals and hospitals in danger of liability. The burden of liability was heaviest upon the nurse as the one with the responsibility and accountability for the care of the patient on a 24 hour basis, including teaching the patient and family self care.

Winslow (1976) indicated that the responsibility for patient education lies with every member of the professional health care team, with the nurse as one of the most appropriate persons to teach the patient (p. 213). Pohl (1973) identified a fundamental premise that nurse practitioners have a social and professional responsibility to promote good health practices by meeting the health learning needs of patients. She recognized that teaching is one aspect of the nurse's total obligation (p. viii). Trail (The Oklahoma Nurse, 1977) delineated one of the predicted roles for nurses as teaching the basic health promotion concepts. Patient education is an integral part of professional nursing care (Durback and Nendick, 1986).

Role Acquisition and Performance

The review of literature related to the prediction of successful nursing performance and factors associated with

the successful role of the nurse as teacher has revealed varied information concerning the exact role of the nurse, role acquisition, and educational preparation. McCloskey (1983) states that "any attempt to define or describe nursing is frustrated by the sheer size of the profession, its diversity in education and its work demands" (p. 63). Role delineation, socialization, and academic preparation, are important areas which influence performance in the teaching role. Several methods involved in the socialization process had contributed to nurses more clearly defining their role as teacher. Role clarification enhanced performance and ultimately retention in the nursing profession. Many nurse professionals have attempted to delineate nurse roles and performance.

Roles are discovered, created, modified or simply defined by role taking and role clarification. Mastery of the knowledge or the specific information and cues needed to perform a role is known as role clarification (Meleis, 1975). A role, including the role of teacher is learned and internalized in a variety of ways. For example, a role can be learned through the process of socialization and includes role models such as preceptors and mentors. Intentional role instruction through theoretical and clinical information is another means by which socialization takes place. Processes utilized for role learning and role clarification are communication and social interaction (p. 268). When poor role definition, poor dynamics of role relationships, or

simply the lack of knowledge of role behaviors exist, role insufficiency may result.

Role insufficiency denotes behavior affiliated with any felt disparity in fulfilling role obligations or expectations by self or others. Meleis (1975) indicated that when self- perceived role performance was inadequate, movement out of the role or termination of the role resulted.

Because of significant changes taking place in the health care delivery system and the various levels of nursing practice, there is a diffusion of nursing's professional responsibilities. Nurses are at varying levels of acceptance and performance of selected tasks. There is also a lack of distinction in the allocation of responsibilities to nurses with various types of academic preparation (Singleton and Nail, 1984). These elements have a negative impact on role clarification.

Corwin (1961) developed the instrument, Nursing Role Conception Scale, to measure nurses commitment to the hospital bureaucracy, the nursing profession, and the patient. He found the differences between role conceptions of 296 graduate and student nurses from several institutions in a midwestern city. Results identified a difference in role conception among those nurses with different educational preparation. Baccalaureate degree nurses maintained high professional role conceptions more

frequently than did diploma nurses. This study indicated that role diffusion exists among those of different educational preparation.

Kramer (1970) found a significant increase in role deprivation in baccalaureate graduates. She defined role deprivation as the difference between the actual situation and ideal situation. As a result of adjustments made by baccalaureate graduates in role conception within the hospital bureaucracy, it was determined that more successful nurses have a higher role conception than do less successful nurses who had a higher role deprivation (Kramer, 1974). As a result, a clear bureaucratic role conception can be equated with successful performance.

Coler and Sutherland (1983) attempted to demonstrate professional role image in a psychiatric unit's staff. These researchers linked the numbers of nouns defining role to nursing professionals, other professionals, and non professionals. Other professionals consisted of physicians and therapists. Non professionals were psychiatric assistants and technicians, practical nurses, and recreational workers.

In the nursing professional group, "nurse" and "friend" were the most frequently selected nouns to define role, with "teacher" among the next highest selected group of nouns. Other descriptive nouns included "counselor", "leader", "learning", "mother", and "role model". The other professionals listed "teacher" at a greater frequency than

the professional nurses did. Even though the study represented a small population of fewer than 20 subjects, the nurses in this study displayed confusion between role and performance (p. 228). In addition, a sharing of the role of teacher among the various health professionals was identified.

The Interim Report on the Study of Nursing Practice (1986), conducted by the National Council of State Boards of Nursing, attempted to examine differences in practice patterns for various categories of nursing personnel and job setting. The goal of the study was to obtain the information needed for a detailed job analysis and role delineation. From the analysis of data a correlation of 0.91 was identified for newly registered medical-surgical nurses and the activities of teaching home-care givers about patients' therapy. These results provided strong positive support for the teaching activity as an important role.

Unclear role delineation even existed among the leaders in the nursing profession, due mainly to the various forms of educational preparation. Nurses became registered following a diploma, associate, or baccalaureate program in nursing. Differences between the types of educational preparation and undifferentiated job expectations were a concern to those who educated and hired nurses. Statements made by individuals representing nursing service and nursing education revealed a lack of consensus on practice for

associate degree nurse and baccalaureate degree nurse graduates (Primm, 1987). Those in nursing education believed that service had not utilized graduates in the roles for which they were prepared, but collectively grouped all registered nurses under one job description. This mentality perpetuated the myth that "a nurse is a nurse is a nurse".

Conversely, it was commonly believed within nursing service that nursing educators had not defined or differentiated the roles for which they prepared graduates. They believed that educators had not prepared graduates for realistic practice (Primm, 1987).

With a Kellogg Foundation Grant, Primm (1987) analyzed nursing behaviors and functions that represented differentiated practice among baccaleaureate and associate degree nurses. For example, baccalaureate graduates used complex communication skills with the patient in designing and implementing a comprehensive teaching plan for health promotion. By contrast, the associate graduate used basic communication skills with the patient by modifying and implementing a standard teaching plan in order to restore, maintain, and promote health (p. 223). Consensus of differentiated practice contributed to a clearer role delineation among various types of nurses. However, total consensus has not yet been achieved.

Performance in certain roles may be influenced by role strain. Role strain is defined by Goode (1960) as the felt

difficulty in fulfilling role obligations. Ward (1986) identified role strain as an undesirable state perceived by the individual within a role arising from stress associated with the role. Strain is derived in this definition as a condition resulting in application of some external force which is closely tied to role insufficiency.

When new or novice nurses experienced a discrepancy between their educational preparation and expectations and the realities of working on an acute care unit, they experienced what is termed "reality shock" (Kramer, 1974). External forces such as economics and societal influences which had impact upon nursing performance have been previously identified. The manifestation of this phenomenon, whatever exact terminology is used, is job dissatisfaction and burnout.

When job dissatisfaction occurs, whether due to poorly defined roles, frustration, or unclear expectations, a stressful situation arises. Stressful situations reduce performance in any nursing role. Not only is patient care eroded, but the cost of stress to the nurse and the employing institution is immense.

The cost of stress in terms of loss of production, treatment, and prevention was 1-3% of the gross national product (Wadsworth, Clark, & Hollefreund, 1986). "Role conflict and role ambiguity are major sources of work-related stress" (p. 26). Brief, Aldag, Van Sell, and Melone

(1979) found that role stress increased with the degree of professional training. Baccalaureate nurses reported the greatest amount of stress.

Socialization

Parallel to this process of role acquisition is the professional socialization of nurses. Socialization is a process by which values and norms of a professional group are internalized into one's own behavior and self-conception (Jacox, 1973). Nurses acquire identity characteristics of a profession by service orientation, autonomy, and specialized education. Service orientation can be accomplished through educational programs provided by employing institutions, or by self-directed learning. Autonomy is granted when society is confident that members of the profession possess a specialized body of knowledge and offer a unique service. Specialized education is determined by those practicing in the profession, leaders from education as well as the service setting (p. 10).

The nursing profession recognized role confusion among health professionals, especially the role of teacher. Coupled with the various types of educational preparation and methods of socialization into the profession, novice nurses have experienced role strain and burnout. These conditions affect nursing performance and retention in the profession.

High attrition rates and slow transition of graduate

nurses into effective practice roles have prompted many institutions to shift their emphasis from nurse recruiting to nurse retention. Frohman (1977) described the first six months of any newly hired nurse's experience as the most critical period, affecting productivity, learning time, attitudes, and turnover.

Preceptor

Institutions have developed preceptor programs to enhance service orientation and staff development. Included in the preceptor model of orientation is the socialization process. A preceptor is an individual who assists a novice nurse or new nurse in orientation and socialization (Sullivan and Decker, 1985). The primary goal for the preceptor is to assist the novice nurse to acquire the necessary skills in order to function effectively on the specific unit. Preceptors offer clinical competence, organizational skills, and knowledge to the novice nurse which provides the opportunity for an on-the-job training program tailored specifically for that nurse's needs.

The preceptor relationship allows the nurse to work and identify with a competent role model who is involved in decisions, processes, and protocols of the specific unit. The novice nurse is able to derive satisfaction from the work setting without extensive role deprivation or frustration. Role clarification has beeen determined to be

enhanced by role models.

The benefit of this type of service orientation is that it reduces burnout and job turnover. According to a National League for Nursing study on graduate nurses practicing within six to eight months after graduation, approximately 25 per cent had worked for two or more institutions (Friesen and Conahan, 1980). It was estimated that the replacement cost was between $1500 and $3000, plus the reduction in quality patient care while a replacement was located. Without socialization into the role, nurses leave the institution and even the profession.

Mentor

Mentoring has been recognized with increased importance as helping professional nurses adapt to and function effectively in the vastly changing health care world (Darling, 1985). Mentors are individuals who give support to and teach the mentee how to do a job. A mentee could be a student nurse, novice nurse, or experienced nurse. This is another method of socializing an individual to function in a specific role. Mentors are knowledgeable individuals who are willing to share their expertise without being threatened by the mentee's potential for equaling or surpassing them (Hunts and Michaels, 1983). Without professional mentors and role models, without opportunities for growth in nursing through collegiality, the need for professional belongingness and socialization is thwarted.

(Billings, 1987).

Orientation

Early staff development and service orientation was identified as an essential aspect in retaining new nurses and enhancing their performance. Belanger (1978) designed a plan for staff development progressing from orientation to safe practice to skilled practice, which ultimately enhanced the quality of patient care. It included skill development, problem solving, and comprehensive care at level increments based on established criteria. Opportunities for advanced knowledge and skill development were given to those nurses which enhanced the orientation program. Institutions that succeeded in creating exciting career opportunities for professional nurses were found not to have a nursing shortage (Sovie, 1982).

Self-directed Learning

Self-directed learning is another way nurses have been able to enhance their performance in the role of teacher (Knowles, 1975). Because the natural tendency of the human organism is toward growth, learning, and problem solving, acquiring the knowledge and skill to fulfill any maturational need is evident. Self-directed learning is a process in which individuals take initiative in diagnosing their learning needs, formulating learning goals,

In addition, self-mentoring has been identified as a process which actively involves the individual in providing for his own guidance and direction when a learning need exists. By talking to people, reading a book, watching how others do things, taking a class, an individual can figure things out (Darling, 1985).

Academic Preparation and Performance

The analysis of competencies of new graduates which define effective clinical performance has been attempted by many nurse researchers (White, 1972; McCaffery, 1978; Schwirian, 1978; Scott, 1979; Smania, McClelland & McCloskey, 1978; Benner, 1982). Nursing is learned in the context of direct delivery of patient care, commonly accomplished through a relationship with a practitioner role-model in the clinical area. Academia is interested in research of this nature in order to prepare the clinically competent nurse.

Education programs have failed to provide students with the knowledge and skill required to become competent practitioners in the complex reality of our current health care system (Jones, 1985). The following studies examine performance related to academic preparation.

Schwirian (1981) developed a six dimensional scale of nursing performance by obtaining information from basic professional nursing schools about criteria used by them to

predict successful nursing performance and evaluating the relative merits of these criteria for subsequent on-the-job performance of the schools' graduates. The six dimensional scale consisted of subscales including leadership, teaching and collaboration, critical care, interpersonal relationships and communication, planning and evaluation, and professional development (p. 347).

Analysis of the data from Schwirian's study showed that diploma, associate, and baccalaureate nurses collectively rated their performance highest in the interpersonal relationships and communication subscale, and lowest in the teaching and collaboration subscale. As a group, diploma nurses also rated their performance highest in the interpersonal relationships and communication subscale, and lowest in the teaching and collaboration subscale. Associate degree nurses rated themselves lowest on all six subscales. Baccalaureate graduates rated themselves higher in the teaching and collaboration and planning and evaluation subscales than the other two types of graduates had rated themselves.

However, when supervisors' evaluations of the same nurse graduates were analyzed, the results indicated substantial differences by educational preparation on two of the six subscales. The baccalaureate graduates were rated higher in the teaching and collaboration, and in the planning and evaluation subscales, than were associate degree and diploma graduates.

The supervisors' evaluations corresponded more closely to the self-perceptions of the baccalaureate graduates and at least as closely to those of the diploma graduates (Schwirian, 1981, p. 249). Again, a difference existed between what nurse educators predicted to be successful nursing performance, what service administrators expected in performance, and what novice nurses perceived their roles to be.

The Nursing Research Consortium of Long Island was concerned that nurses with various educational backgrounds were used interchangeably in the practice setting of acute care hospitals (1987). The consortium developed an 18-item checklist of selected competencies for the new baccalaureate nurse and a 12-item checklist for the new associate nurse, using the American Nurses Association Standards of Nursing Practice as a framework. See Appendix A for both checklists.

During their two week study, the competency for baccalaureate nurses which called for individual teaching plans was found to be recorded on only 11 per cent of charts (p. 52). Associate degree nurses documented information given to patients according to teaching protocol on 40 percent of the charts (p. 54). Fifty per cent of the baccaleaureate nurses perceived their overall performance to be competent without assistance and 75 per cent of the associate degree nurses expressed confidence in their

ability to function competently.

Nelson (1978) examined baccalaureate, diploma, and associate degree nursing program graduates regarding self perceptions of their competency in technical, communicative, and administrative skills. She also examined their supervisors' perceptions of their competency. Differences were found. Diploma nursing graduates rated themselves higher in technical skills and administrative skills than did baccalaureate and associate degree nursing graduates.

In relation to communicative skills, Nelson found that baccalaureate nursing graduates rated themselves significantly higher than did associate degree and diploma graduates. Diploma graduates rated themselves higher in all three skills combined.

The area of administrative skills included the competency of evaluating health care learning needs of people and independently delegating teaching responsibilities to appropriate people. Baccalaureate nursing graduates and their respective supervisors differed in their perception of the graduates' overall competence. In addition, supervisors of baccalaureate nursing graduates rated the graduates' overall competence significantly higher than did supervisors of associate degree and diploma graduates (p. 125). Most nursing graduates and supervisors believed graduates were least competent in the area of administrative skills.

Benner (1982) used the Dreyfus Model of Skill

Acquisition as a guide to study five levels of nursing performance based upon experience as well as education. The five levels of the model included novice, advanced beginner, competent, proficient, and expert. The competent level was comparable to the nurse who had been on the job two to three years. Experience used in the acquisition of expertise was not defined as the mere passage of time or longevity, but as the refinement of preconceived notions and theory through practice situations. It was determined that nursing performance on the first two levels did not demonstrate acceptable performance in the function of teaching the patient because those nurses were deficient in aspect recognition. Aspects are "overall, global characteristics that require prior experience in actual situations for recognition" (p. 403).

Aspect recognition is an appropriate learning goal for new graduates and for the preceptors who assist in their skill development. The major implication for both preservice and inservice education is the opportunity for guidance and practice in aspect recognition in order to prepare a more competent practitioner. Benner recognized that advanced beginners needed help in setting priorities since they operated on general guidelines and were only beginning to perceive recurrent meaningful patterns in their clinical practice. The advanced beginner had fewer than two years of clinical experience. In addition, their patient

care needed to be backed up by competent level nurses to ensure that important patient needs did not go unattended since the advanced beginner could not yet sort out what was most important. The Dreyfus Model applied to nursing, combined with an interpretive approach to describing nursing practices, offers guidelines for career and for knowledge development in clinical nursing practice.

A comparison was made by generic baccalaureate nursing students of satisfaction about professional and personal development prior to graduation and one year after graduation. Respondent perceptions of teaching skills or levels of preparedness at the time of assuming their first clinical position revealed that 80 per cent felt prepared and 20 per cent felt minimally prepared or less (Cassells, Redman, & Jackson, 1986).

The frequency of application of nursing concepts in their practice was also reported. Respondents indicated that teaching/learning theory was used frequently 58 per cent of the time. Twelve per cent of the respondents used teaching/learning theory infrequently or not at all.

From the follow-up at one year after graduation, these same respondents indicated their general level of preparedness. Seventy-two per cent of the respondents felt prepared while 23 per cent felt minimally or unprepared. Preparedness specific to the teaching function or academic preparation was not reported on the follow-up (p. 117).

DeBack and Mentkowski (1986) related nurses'

performance to basic educational preparation. The question which was analyzed asked whether the level of education mattered in performance or whether assumed advantages of higher basic academic preparation could be substituted by experience. Compentency categories included "conceptualizing", "emotional stamina", "ego strength", "positive expectations", "independence", "reflective thinking", "helping", "influencing", and "coaching", defined as a teaching behavior (p. 283).

This study found that the more highly educated nurses frequently demonstrated competence in "coaching". The competencies of "ego strength", "coaching", and "independence" appeared attributable to education alone and experience accounted only for the positive aspects of "conceptualizing". Taking both experience and education, performance reflected an active, thinking, influential style in which the nurse assisted the patient to take on more responsibility for self care (p. 284). As a result, more education was determined to have long-term benefits.

Summary

This research has implications for nursing educators who strive to improve instructional strategies and assessment techniques, and also for nurse administrators in the service areas who evaluate the effective performance of practitioners. An understanding of the social,

technologic, and economic factors that affect health care delivery is imperative for professionals to meet the changing needs of the consumer. The movement from an illness-oriented health care delivery system to a health-oriented one has proven to be more beneficial to patients, yet a challenge to educators and service providers.

The goal of developing the clinically competent practitioner can only be met by a dual effort from both educators and supervisors of nursing. Clear role delineation in various educational as well as clinical settings must be made. At a time when nurses are leaving the profession at a record rate, and potential nurses are choosing other fields, the outlook for recruitment and retention in the profession whose responsibilities are determined to be ambiguous is a concern to all.

The research also has implications for educators and for nurse administrators in the service setting to identify the effective performance of practitioners and their potentials for advancement, and to support those nurses who perform the abilities needed for contempory practice.

CHAPTER III

METHODOLOGY

This chapter explains the procedures for collecting data relevant to nurses' perceived performance in the role of teacher, and identifies sources of role acquisition and education and training. Included are (1) the selection of the subjects, (2) data gathering instruments, (3) collection of the data, and (4) the procedures selected for analyzing the data.

This study was conducted in three 500+ bed hospitals in Tulsa, Oklahoma. The location was chosen because the population of nurses would potentially come from area colleges of nursing, including one state supported and two private baccalaureate degree nursing programs and two associate degree programs within a thirty mile radius. No diploma degree programs were available within thirty miles.

Population and Sample

Criteria were established for the selection of the subjects for this study. Novice nurses were identified in the study by Benner (1982) as those with two years or less of clinical experience. Schwirian, who developed the tool used in the study, identified nurse performance behaviors

for nurses practicing within two years following graduation. Socialization into the various roles of the nurse had been determined to occur within the first two years of practice, so the study population included only registered nurses who had not worked more than two years in an acute care nursing unit.

The population of novice nurses was anticipated to provide approximately 150 participants. This number was based on the projection that most of the recently graduated nurses in the metropolitan Tulsa area were or would be attracted to employment by the three participating hospitals. Additional data was obtained from the three hospitals about the number of job openings that existed. From this data, the number of potential novice nurses was determined. Head nurses were depended upon to identify those novice nurses that met the population requirements.

Acute care was defined as work done by those nursing units that cared for adults and children with medical and surgical problems. Excluded from the study were psychiatric care areas, as the teaching role would be altered in caring for this classification of patient, and intensive care areas, where patients were fighting for life without readiness for teaching activities. Teaching patients was not a high priority for the nurse in intensive care areas. Intensive care areas included any area that was labeled "intensive", as well as the operating room, recovery room, and emergency room. Rehabilitation units were also excluded

since patients did not have an acute illness.

Research Questions

The study attempted to answer the following questions:

Which teaching role activities have novice nurses performed?

How well have novice nurses perceived that they performed teaching role activities?

Which sources of preparation for the teaching role have novice nurses experienced?

How well have novice nurses perceived that sources prepared them for their teaching role?

Was there a relationship between how well novice nurses perceived that they performed teaching role activities and how well they perceived that sources prepared them for their teaching role?

Data Gathering Instruments

A three part questionnaire was adopted for use in this study. Part I addressed 42 factors related to job performance. The subjects were requested to rate their level of performance on each item that they performed. Part II dealt with rating sources of preparation or role clarification and acquisition for the teaching function of nursing. Part III of the questionnaire provided demographic data about the subjects, including educational background,

length of tenure in nursing and length of tenure on the present job.

The Six-Dimension Scale of Nursing Performance developed by Schwirian (1978) was the tool used in this study. The tool was chosen because it reflected data from both nursing service and nursing education and was found to be suitable for research. Also, the tool was used because it evaluated performance of nurses within their first two years of clinical practice. The scale consisted of 53 nursing behaviors in the six performance subscales of leadership, critical care, teaching and collabortion, planning and evaluation, interpersonal relations and communication, and professional development. The subscale of teaching and collaboration was extracted as the primary section to provide information vital to this study. This subscale described behaviors in which nurses teach patients and families.

Schwirian (1978) obtained a random sample of 151 schools and requested the deans or directors to provide names of nurses who were considered most promising, approximately the top 25 percent of the students. Questionnaires were mailed to this sample with 914 usable instruments or 30.4 percent, returned. Names of the supervisors of these 914 nurses had also been requested, and subsequently were asked to provide data about the nurses' performance on the same behaviors that had been included in the nurses' self appraisal forms. A response rate of 89

percent was obtained.

Construct and content validity were determined by a ten year literature review relative to academic and clinical nursing performance, materials shared by other investigators and educators, operational definitions of "effective nursing performance" and a "successful nurse" provided by responding deans or directors of the 151 basic schools of nursing, review of the developing scale and subsequent recommendations and consensus by immediate colleagues, project consultants, and the individuals who served as pilot respondents (Schwirian, 1978).

Cronbach's alpha was used to compute the reliability of each subscale of the Six Dimension Scale of Nursing Performance. The alpha coefficients ranged in value from a low of .84 for the leadership subscale to .98 for the professional development subscale, for both the graduates' self-appraisals and their supervisors' appraisals (Schwirian, 1978). The uniformly high reliability values of the Six-Dimension subscales attested to their potential utility for assessing nursing performance (p.350). See Appendix B for Schwirian's Six-Dimension Scale of Nursing Performance and Appendix C for a letter granting permission to utilize the tool in this study.

The Schwirian tool was modified for use in this study. The professional development section of the tool was omitted because it added unnecessary length. The remaining

five subscales were left intact and were used in evaluating performance.

Items specific to each of the five subscales were used and arranged randomly to reduce the likelihood of a social response set. Those items related to the teaching function of the nurse were extracted for analysis. See Appendix D for the adapted Six-Dimension scale, entitled "Survey of Nursing Performance".

A pilot test of the instrument was administered to 12 expert registered nurses who were not part of the study group. It was determined during this field test that a minimum of 15 minutes was needed to respond to all questions. The instrument was adapted to improve clarity and visual appearance and to refine the demographic section as suggested by the test group. The portion of the tool that was developed by Schwirian was unchanged.

A second pilot test was accomplished in a 500+ bed institution in another state using nurses practicing within the first two years of clinical practice. Minimal suggestions were made by the subjects and it was determined that the tool was ready for implementation.

Collection of Data

An overview of this study was presented to the directors of nursing education at the three hospitals targeted for the study. They provided the authority through their respective institutional review boards for

distribution of the instrument to registered nurses with no more than two years of clinical experience working in acute care units. See Appendix E for institutional permission.

Participation in the study was voluntary and completion of the instrument constituted consent to participate in the study. See Appendix F for a copy of the cover letter given to each participant in the study. A packet including the cover letter, the Survey of Nursing Performance, a stamped and pre-addressed envelope in which to return the completed survey, and a pre-addressed and stamped postcard to separately request a summary of the study results was given to each participant by her head nurse. See Appendix G for the communication memorandum to head nurses outlining their responsibilities.

Anonymity was provided in this manner to encourage high rates of return for data collection. The importance of anonymity was detemined to be a major factor that could have influenced the return rate. Novice nurses were asked to provide truthful evaluations of their performance in teaching role activities. If they had believed they could be identified in any way, a lower response rate would have resulted. Because of the importance of an anonymous response, follow-up was not considered. Follow-up was also not considered because threats such as test-retest reliability, maturity, and history would have interfered with the results.

Analysis of Data

To analyze the data, the questionnaires were first checked for completeness. Any incomplete questionnaire was dropped from the study. The responses were compiled in the following manner. In Part I the number of self-rated responses for each of the 11 factors relating to the teaching and collaboration subscale was calculated to determine which teaching role activities novice nurses frequently performed. Then, a value based on a four point Likert Scale was assigned to each of the 11 factors to determine how well those nurses perceived their performance in the teaching role activities. The number one on the four point Likert scale indicated low performance. Each subsequent number indicated an increasingly higher performance to a maximum of four.

In Part II the frequency of each source of preparation or role acquisition for the teaching role was identified. A value was given to each source based on the same Likert Scale to determine how well each source was perceived to prepare the novice nurse for the teaching role. A table format was used to report the findings and to answer each question.

To answer the question of whether a relationship existed between how well novice nurses perceived that they performed the teaching role activities and how well they perceived that sources prepared them for their teaching

role, the Spearman rho was used to determine the strength of the relationship. This measure was used because the sets of data to be correlated were on an ordinal scale. The component scores were compared for the three groups of nurses, the diploma, associate degree, and baccalaureate degree graduates.

CHAPTER IV

PRESENTATION OF FINDINGS

In this chapter the results of the survey of nursing performance given to the nurses at three large metropolitan hospitals in Tulsa, Oklahoma are presented. The chapter is divided into three sections, presented in the following order: (1) response rate, (2) demographic characteristics, and (3) answers to study questions.

Response Rate

A total of 66 nurses met the criteria established for the subjects participating in this study. Questionnaires were distributed to these nurses by their immediate supervisors. The 35 percent response rate of participants in this study was considered sufficient for analysis. Follow-up contact was not made because participants were anonymous. One questionnaire was discarded due to incompleteness.

The relatively low number of participants and the lower than expected response rate may have been influenced by any of several factors. First, there was a critical shortage of nurses available to fill the many hospital vacancies at the time the survey was conducted. Enrollments in colleges of

nursing were low contributing to fewer numbers of novice nurses available for employment. As a result, existing novice nurses were hired into the area of highest priority related to critical care. The novice nurse population was then reduced because critical care areas were not considered in this study.

In addition, the economic climate in the metropolitan area, as well as the state, was severely depressed. As a result, many people moved out of the state. Both phenomena contributed to a surprisingly low number of participants for this study.

Response rate was also affected. Many of the nurses who remained in the study were working in understaffed environments, which have been determined to be a factor in job "burn out". This condition may have contributed to a lowered response rate.

Also, the Joint Commission on the Accreditation of Hospitals made a visit to the largest hospital participating in the study during the time of data collection. This visit typically contributes to increased anxiety in all hospital staff. During the visit many nurses were required to provide added services to the hospital, again creating an atmosphere that was ripe for overload and 'burnout'.

Demographic Characteristics

The nurses who participated in the study were graduates from three levels of nursing education: baccalaureate,

diploma, and associate degree programs. Participants were requested to indicate the length of time in months and years they had been employeed in nursing, in their current position, and what shift they worked. In addition, the state in which they received their basic academic preparation in nursing was requested. The year of their birth and any previous academic degrees they had earned were additional items.

Table I shows the demographic characteristics of the population. Of the 22 subjects, seven (32 per cent) were graduates of a baccalaureate program, 14 (63 per cent) were graduates of an associate degree program, and one was a graduate of a diploma program. One participant had an associate degree in medical technology, one was enrolled in a baccaleaureate nursing program, and one was previously a dietition.

The average age of the participants was 29.7 years. The age ranged from a low of 20 to a high of 51 years with the greatest number in the 20-25 year range. Ninety-one percent of the participants received their basic academic preparation for nursing in Oklahoma. Texas and Kansas were also represented.

All participants had been working in general acute care areas less than two years. Six of the nurses worked the day shift, eight worked the evening shift, three worked the night shift, and five rotated shifts.

TABLE I

DEMOGRAPHIC CHARACTERISTICS OF NURSES BY ACADEMIC PREPARATION

	B.S.N. N	A.D. N	Diploma N	Total N
TYPE OF EDUCATION	7	14	1	22
PLACE OF EDUCATION				
OK	7	13	0	20
TX	0	0	1	1
KS	0	1	0	1
AGE-RANGE				
20-25	3	6	1	10
26-30	2	2	0	4
31-40	1	4	0	5
41 and over	1	2	0	3
SHIFT WORKED				
DAY	1	5	0	6
EVENING	4	3	1	8
NIGHT	1	2	0	3
ROTATE	1	4	0	5

Answers to Study Questions

The following are responses to the study questions based on a four point Likert scale with the number one indicating low performance and four representing high performance.

Question 1. Which teaching role activities have novice nurses performed? Table II illustrates the number of nurses who performed teaching role activities. All 11 of the teaching role activities were performed. However, three activities were not performed by all of the novice nurses. Those activities included "teach preventive health", "identify community resources", and the least performed, "communicate facts in writing". Three baccalaureate and two associate degree graduates did not perform all teaching role activities. The diploma graduate performed all activities.

TABLE II

TEACHING ROLE ACTIVITIES PERFORMED
BY ACADEMIC PREPARATION

Activities	Number of subjects			
	BSN	AD	Dip	Group Total
1. Teach about patient needs.	7	14	1	22
2. Teach preventive health.	6	13	1	20
3. Identify community resources.	6	14	1	21
4. Adapt teaching methods.	7	14	1	22
5. Develop innovative methods.	7	14	1	22
6. Promote use of others.	7	14	1	22
7. Use teaching aids.	7	14	1	22
8. Encourage family participation.	7	14	1	22
9. Identify agency resources.	7	14	1	22
10. Communicate facts in writing.	5	12	1	18
11. Plan patient needs with family.	7	14	1	22

Question 2. How well have novice nurses perceived that they performed teaching role activities? Table III illustrates the rank order of performance in teaching role activities. The number four represents a high perceived performance score based on the Likert scale.

Each type of graduate ranked "encourage family participation" and "identify agency resources" equally and within the highest three ranked activities. Baccalaureate graduates ranked all teaching activities higher than did the associate degree graduates, except in the areas of "communicate facts in writing" and "identify community resources". The diploma graduate ranked teaching role activities more closely to the rankings of the baccalaureate graduates than the associate graduates. Collectively the graduates ranked the activity "encourage family participation" highest, but the associate degree graduates ranked "promote use of others" highest.

TABLE III

RANK ORDER OF PERFORMANCE IN TEACHING ROLE ACTIVITIES

Activity	Median values BSN	AD	Dip	Total
8. Encourage family participation.	3.14	2.79	4.00	3.00
9. Identify agency resources.	3.14	2.79	4.00	2.86
6. Promote use of others.	3.00	2.86	3.00	2.82
4. Adapt teaching methods.	2.86	2.71.	3.00	2.77
1. Teach about patient needs.	2.57	2.64	3.00	2.63
7. Use teaching aids.	2.71	2.36	2.00	2.45
11. Plan patient needs with family.	2.43	2.29	2.00	2.32
2. Teach preventive health.	2.43	2.29	2.00	2.23
5. Develop innovative methods.	2.14	1.64	2.00	1.82
10. Communicate facts in writing.	1.14	1.86	2.00	1.64
3. Identify community resources.	1.29	1.71	1.00	1.55

Question 3. Which sources of preparation for the teaching role have novice nurses experienced? Table IV identifies those sources of preparation which were experienced by novice nurses.

All sources of preparation were experienced, yet only "orientation", "in-service education", and "self-directed learning" were found to be used by all nurses. Two associate degree graduates did not experience the use of any of the three "academic objectives" as sources of teaching role preparation. Six nurses in this group also identified "other continuing education" as a source that did not contribute to preparation for the role as teacher. "Mentor" was the least used source identified by all three types of nurse graduates.

TABLE IV

SOURCES OF TEACHING ROLE PREPARATION EXPERIENCED BY ACADEMIC PREPARATION

	Number of subjects			
	BSN	AD	Dip	Group Total
1. Academic Course Objective	7	12	1	20
2. Academic Theory Objective	7	12	1	20
3. Academic Clinical Objective	7	12	1	20
4. Orientation	7	14	1	22
5. In-service Education	7	14	1	22
6. Other Continuing Education	7	8	1	16
7. Preceptor	6	9	0	15
8. Mentor	4	9	0	13
9. Self-directed Learning	7	14	1	22

Question 4. How well have novice nurses perceived that sources prepared them for their teaching role? Table V identifies in rank order how well all sources of preparation prepared novice nurses for their teaching role.

Weighted on the total number of participants in the three categories of educational preparation, the "academic clinical objective" and "self-directed learning" ranked highest. "Preceptor" was ranked in third place. "Orientation" was ranked the lowest by the three groups collectively as well as individually.

The baccalaureate degree and diploma graduates identified "self-directed learning" as the highest ranked source of preparation. Associate degree graduates ranked "mentor" highest.

TABLE V

RANK ORDER OF SOURCES OF PREPARATION
BY ACADEMIC PREPARATION

Source of Preparation	Median Values			
	BSN	AD	Dip	Total
3. Academic Clinical Objective	2.71	3.08	3.00	2.95
9. Self-directed Learning	3.00	2.86	4.00	2.95
7. Preceptor	2.43	3.00	1.00	2.86
2. Academic Theory Objective	2.57	2.75	3.00	2.80
1. Academic Course Objective	2.57	2.83	3.00	2.75
8. Mentor	2.50	3.11	0	2.69
5. In-service Education	2.71	2.71	2.00	2.68
6. Other Continuing Education	2.57	2.88	3.00	2.63
4. Orientation	2.14	2.64	1.00	2.41

Question 5. Was there a relationship between how high novice nurses perceived their performance in teaching role activities to be and how well they perceived that sources prepared them for their teaching role? Table VI illustrates the Spearman rho analysis used in this study.

Novice nurses as a group did not perceive a relationship between their performance and sources of preparation. A correlation coefficient of .33 was obtained.

However, when broken into groups by educational preparation, the baccalaureate nurses' correlation coefficient of .78 showed a stronger positive correlation between sources of preparation and perceived performance in the role of teacher than did the associate degree graduates with a .27 correlation. The correlation coefficient was not calculated for the diploma category since there was only one subject.

TABLE VI

RELATIONSHIP BETWEEN SOURCES OF PREPARATION AND PERFORMANCE IN TEACHING ACTIVITIES BY ACADEMIC PREPARATION

Groups	Spearman rho
Combined	.33
B.S.N.	.78
A.D.	.27
Diploma	---

Table VII illustrates the Spearman rho in relation to each source of preparation and the combined group's performance in teaching activities.

The strongest positive correlation of .41 was indicated for "self-directed learning" followed by "preceptor" with a .29 correlation. Both "mentor" and "academic course objective" had strong negative correlations with -.91, and -.82, respectively.

TABLE VII

RELATIONSHIP BETWEEN EACH SOURCE OF PREPARATION AND PERFORMANCE IN TEACHING ACTIVITIES

Sources of Preparation	Spearman rho
1. Academic Course Objective	-.82
2. Academic Theory Objective	.23
3. Academic Clinical Objective	.17
4. Orientation	.06
5. In-service Education	.27
6. Other Continuing Education	-.41
7. Preceptor	.29
8. Mentor	-.91
9. Self-directed Learning	.41

Summary

Data compiled from the survey of novice nurses revealed that baccalaureate graduates and the diploma graduate had similar perceptions about their performance in teaching role activities, as well as in their ranking of teaching role activities and sources of preparation. Differences between the associate degree and baccalaureate degree graduates were more frequently identified.

CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

The content of this chapter is divided into four sections. A summary of the study is presented in the first section followed by the conclusions and implications of the study. The final sections contain the recommendations for further research and for practice.

Summary

The purpose of this study was to identify novice nurses' perceptions about their own activities performed in the role of teacher. Additionally, this study attempted to identify their perceptions about their own educational preparation for the role of teacher. An attempt was made to determine whether a relationship existed between self perceptions about sources of preparation for and about performance in teaching activities.

This study sought to answer the following questions:

1. Which teaching role activities have novice nurses performed?

2. How well have novice nurses perceived that they have performed teaching role activities?

3.Which sources of preparation for the teaching role

have novice nurses experienced?

4. How well have novice nurses perceived that those sources prepared them for their teaching role?

5. Was there a relationship between how well novice nurses perceived their performance in teaching role activities to be and how well they perceived that sources prepared them for their teaching role?

A comprehensive review of the literature was conducted. The review indicated strong support for teaching activities as part of the role of the professional nurse. Several factors, such as legal and professional responsibilities, consumerism, and economics, have increased the importance of the role. Individuals in the nursing profession have responded to this increased importance by conducting research about various nursing activities and the benefits to patients. The review indicated that the teaching activities of nurses have provided numerous benefits to patients and their families.

The review also identified barriers to role acquisition. Several health related professions, such as pharmacy, medicine, and dietitics, also share teaching role activities. This condition leads to role diffusion which can lead to job dissatisfaction. Also, role insufficiency was determined to be present. Role insufficiency resulted from unclear expectations, poor preparation, and lack of role models. It also contributed to job dissatisfaction and, eventually, "burn-out".

Socialization into the teaching role of the nurse was highlighted in the literature. Methods of enhancing socialization, such as orientation, in-service and continuing education programs, and mentoring and preceptorships were discussed. Self-directed learning was also identified as enhancing role acquisition.

In addition, academic preparation for the role of teacher as well as the clinical teaching role expectations were identified by both academia and service administrators. Differences were identified among individuals in each setting. Attempts at improving communication between the two groups and consensus building were presented in the review. Efforts to bridge the gap regarding expectations for teaching role behavior between those who prepared nurses, those who hired nurses, and nurses themselves were described.

The 22 participants cooperating in this study were novice nurses employed at three large hospitals in Tulsa, Oklahoma. The participants were practicing within two years following graduation from their nursing programs. The three types of nursing programs were represented: diploma, associate, and baccalaureate. Data were collected between August and December, 1987.

The instrument, a three part questionnaire, was designed to address demographic characteristics, perceived performance in the role of the nurse as teacher, and sources of preparation for that role. The performance of nursing

activities was measured by an instrument developed by Schwirian (1979). The tool was determined to have sufficient validity and reliability for measuring performance among novice nurses and was adopted for use in this study.

The data were compiled and analyzed utilizing descriptive statistics. Medians and ranks were used to present the data. In addition, the Spearman rho correlation was used to determine whether a relationship existed between perceptions about sources of preparation and about performance in teaching role activities.

Conclusions of the Study

The conclusions that resulted from the findings are as follows:

1. Forty-five per cent of the novice nurses were in the 20-25 year age range. Most were graduates of an associate degree program in Oklahoma. The work shifts were evenly distributed among day, evening, night, and rotating.

2. Teaching activities were performed by nurses in all 11 categories provided on the instrument. However, not all nurses performed all activities. Because teaching activities were determined to benefit patients and families, all 11 activities were considered to be a part of the role of novice nurses practicing in the acute care areas.

Three out of seven baccalaureate and two of the 14

associate degree nurse graduates were identified as those novice nurses who did not perform all teaching activities. "Teaching preventive health", "identifying community resources", and "communicating facts in writing" were those activities that were not performed by all. The high proportion of baccalaureate graduates who did not perform these activities was not expected. All three of the activities identified are considered stronger components of baccalaureate education than of associate or diploma education. Academia must take this outcome into consideration when planning course objectives in order to include or emphasize this content.

Baccalaureate education focuses on a broader philosophy of health care delivery than do the other programs. The "health-oriented" health care delivery system emphasized in baccalaureate education usually includes "teaching preventive health" and "identifying community resources". In addition, the communication process, another emphasis in baccalaureate education, usually includes an abundance of written expectations. As these activities were lacking in three of the seven baccalaureate graduates and two of the 14 associate graduates, a weaker knowledge base is identified.

3. Self-rated performance in the 11 teaching activities revealed several activities that were perceived as well performed. Based on the four point Likert scale, three activities were highly rated in performance by novice nurses. The three activities were "encouraging family

participation", "identifying agency resources", and "promoting the use of others". These activities, which are components of all three types of educational programs, were expected to be ranked highly because they represent a more "health-oriented" health care delivery system. These activities also emphasize the trend toward encouraging self care abilities among patients and their families.

Collectively, those items ranking low in performance included "developing innovative teaching methods", "communicating facts in writing", and "identifying community resources". Of the three groups, baccalaureate graduates ranked "develop innovative teaching methods" highest. This finding would support the fact that baccalaureate education puts more emphasis on teaching/learning theory and practice than do the other types of educational preparation. Yet, the fact that this item was ranked among the lowest suggests a void in content in teaching methodology.

Baccalaureate nurses ranked "communicating facts in writing" the lowest of all teaching activities. This phenomenon could be a result of the baccalaureate graduates' increased sensitivity to legal liabilities if information is in writing. Or, more likely, this phenomenon could reflect a lack of knowledge about the specific subject or the inability to use teaching/learning theory in practice.

Associate degree nurses ranked "developing innovative teaching methods" the lowest of all teaching activities.

This finding is not unexpected because teaching as a process, including methodology, is not emphasized as much as teaching/learning theory. As practice is differentiated for two levels of nursing, the associate and baccalaureate graduates, teaching as a function for associate graduates consists of modifying and implementing a standard teaching plan designed by the baccalaureate graduate.

The diploma graduate ranked "identifying community resources" the lowest activity. Since this graduate was educated in another state, unfamiliarity with existing community resources was not unexpected.

4. Novice nurses identified the use of all sources of preparation for the teaching role. "Orientation", "in-service education", and "self-directed learning" were used by all nurses participating in this study. Even though most nurses identified all sources, not all nurses experienced all sources. "Mentoring" was identified by only 13 graduates, "preceptor" was identified by 15, and "other continuing education" was identified by only 16 graduates. Opportunities for exposure to or experience with either of these two sources of preparation was lacking.

Most hospitals require some form of "orientation" which could be the reason that "source of preparation" was identified by all graduates. Also, "in-service education" is required in some institutions. Service administrators use attendance at "in-service education" as a method of quality control and employee evaluation. These factors

provide rationale for the high use of both sources of preparation.

"Self-directed learning" was also implemented by all of the nurse graduates. "Self-directed learning" for teaching content is questionable. If the respondents were truthful in stating that they all used this source of preparation, more teaching of patients at increasingly higher levels of expertise would exist. However, the literature does not support this conclusion. What is positive about the reportedly high use is the fact that nurse graduates recognize "self-directed learning" as an important source of preparation for additional or advanced knowledge.

Baccalaureate nurses relied upon "mentors" and "preceptors" less than other sources of preparation. This finding was not expected as many baccalaureate education programs utilize a preceptorship or a form of mentoring in the leadership/management component of their curriculum. Most hospitals also take advantage of this source of preparation as a component in their orientation process. The low reported use of these sources of preparation could be contributed to confusion with terminology.

Associate degree nurses identified that "other continuing education" was carried out least often as a source of preparation. These results are incongruous with the frequent utilization of "self-directed learning". It

would seem that if one were self-directed, that participation in " other continuing education" would be used as a source of preparation more frequently than reported. A possible rationale for this finding is that the hospital does not offer "other continuing education", or does not offer the quality of content or area of interest to the nurse graduates. In addition, the hospital may not encourage nurse graduates in seeking "other continuing education" due to financial considerations, such as providing time off or expense reimbursement.

What was most unexpected was that the associate degree graduates appeared to implement all three types of academic objectives less frequently than did the other graduates.

5. When questioned about how well sources prepared them for teaching role activities, novice nurses collectively ranked "academic clinical objective" and "self-directed learning" the highest. Close in rank was "preceptor". The literature supports this finding. Practical application of theory, and an opportunity to practice skills in the clinical area, was determined to enhance role acquisition and performance.

"Orientation" ranked lowest as a source of preparation among the groups collectively as well as individually. Because "orientation" is usually required by the institution and focuses on policies and procedures, this finding was not unexpected.

6. The relationship between sources of preparation and

perceived performance in the role of teacher was weak. The nursing profession is in a state of disequilibrium regarding practice roles in the health care environment. The role of teacher is shared by several disciplines, adding to role confusion. In addition, differentiated practice for professional nurses is only in the developmental stage. Presently, service administrators have the same expectations, and the same job description, for nurses educated in three totally different environments. Until differentiated practice is a reality and, therefore, an expectation of both service administrators and educators, role confusion will remain.

When divided into groups based on educational preparation, a stronger relationship between sources of preparation and perceived performance in the role of teacher was apparent for the baccalaureate graduates. This may be attributable to the longer length of programs where students are exposed to more learning opportunities. Conversely, the associate degree group spend half as much time as the baccalaureate group in educational preparation, limiting this group's learning opportunities.

Weak positive relationships were identified in each source of preparation and total performance. "Self-directed learning" was ranked highest in performance by the groups collectively. The literature emphasizes the fact that as adults, we are more self directed. What was

unexpected was the low correlation coefficient on "academic clinical objective". The literature supports the practice of theoretical content in the clinical area as facilitating role acquisition and performance.

Two strong negative correlations were identified. "Mentor" and "academic course objective" were sources of preparation that indicated a negative influence on performance in teaching role activities. This result was not expected as the literature supports these sources having a positive influence on performance.

Recommendations for Further Research

The following recommendations for further research are offered.

1. A similar study on performance in teaching role activities should be given to all professional nurses at the participating hospitals. This would be beneficial to service administrators since the role of nurse as teacher has increased in recent years. The information would provide data to determine role acquisition and perceived performance among all nurse employees. Performance based on educational preparation could be extracted from the data and compared to differentiated practice expectations. This information would assist both service administrators and educators in planning educational and clinical opportunities that enhance role acquisition and performance at two levels.

2. A similar study on performance in teaching role

activities and sources of preparation could be conducted comparing two different areas of the United States. This would be beneficial for academia to determine the relationship between common characteristics and regional differences.

3. A replication of this study using a population that provided a larger number of participants would result in additional data.

Recommendations for Practice

Based on the findings of this study, the following recommendations for practice are presented.

1. Consensus building among educators and service administrators must continue to differentiate teaching role activities based on two levels of academic preparation, baccalaureate and associate degree.

2. Opportunities must be provided by both education and service administrators to improve socialization into the role of the nurse as teacher.

3. The nursing profession as a whole must define and delineate aspects of its role, such as teaching patients and their families self care abilities, which are autonomous from other health professions which share the teaching role. Those other professions include medicine, pharmacy, and dietetics.

4. Educators must build teaching and learning theory

and methodology into ther educational programs based on a differentiated practice model, one part for associate and the other for baccalaureate nurse graduates. See Appendix A for checklists of expected compentencies.

5. Service administrators must differentiate job descriptions between baccalaureate and associate degree nurses in teaching role activities based on role distinctions. This clearer explanation of expectations for each job reduces role confusion among the various levels of nursing practice.

6. Both educators and service administrators must provide opportunities for advanced practice in teaching role activities, not only for novice nurses but for all nurses.

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APPENDIXES

APPENDIX A

CHECKLISTS OF SELECTED COMPETENCIES

BACCALAUREATE

1. Records data obtained from performing a nursing health assessment.
2. Records nursing diagnosis(es) dealing with a present problem.
3. Records nursing diagnosis(es) dealing with a potential problem.
4. Records initial short-term goals on nursing care plan.
5. Records at least one long-term goal on nursing care plan.
6. Records planned interventions for each established goal on nursing care plan.
7. Records individualized teaching plan on patient's chart.
8. Records implementation of planned interventions on patient's progress record.
9. Records nursing actions based on individualized teaching protocol.
10. Records data pertinent to medical/dental orders.
11. Records intra-and/or interdisciplinary referral of the patient's progress record.
12. Records presence of infection, accident or injury on patient's progress record.
13. Records nursing orders pertaining to infection, accident or injury on nursing care plan.
15. Records achievement of established short-term goals of the nursing care plan.
16. Revises short-term goals based on data.

17. Records additional nursing diagnoses on nursing care plan.

18. Discharge summary completed.

Nursing Research Consortium of Long Island. (1987). BSNs and ADNs: What competencies can we expect of new graduates? Nursing Management 6, 51-58.

ASSOCIATE DEGREE

1. Records additional data obtained from observation and inspection on patient's progress record.
2. Records actual patient problem on patient's progress record.
3. Records additional short term goals for an established nursing diagnosis on the nursing care plan.
4. Records nursing protocols related to addition short term goals on nursing care plan.
5. Records implementation of planned interventions of patient problem record.
6. Records information on patient problem record given to patients according to teaching protocol.
7. Records data pertinent to medical/dental regimen.
8. Records presence of accident, infection or injury.
9. Records the implementation of established nursing orders related to accident, infection or injury.
10. Records implementation of nursing protocols in crisis/emergency situations.
11. Records acheivement of established short term goals on the nursing care plan.
12. Revises short term goals based on data.

Nursing Research Consortium of Long Island. (1987). BSNs and ADNs: What competencies can we expect of new graduates? Nursing Management 6, 51-58.

APPENDIX B

SIX-DIMENSION SCALE OF NURSING PERFORMANCE

SIX-DIMENSION SCALE OF NURSING PERFORMANCE (6-D SCALE)

Performance of Nursing Behaviors

Instructions: This section contains a list of activities in which nurses engage with varying degrees of frequency and skill. For those activities that you do perform in your current job, please indicate how well you perform them by using numbers from the following key:

1 - Not very well
2 - Satisfactorily
3 - Well
4 - Very well
X - Not expected in my current job

TC ___ Teach a patient's family members about the patient's needs.
PE ___ Coordinate the plan of nursing care with the medical plan of care.
L ___ Give praise and recognition for achievement to those under your direction.
TC ___ Teach preventive health measures to patients and their families.
TC ___ Identify and use community resources in developing a plan of care for a patient and his family.
PE ___ Identify and include in nursing care plans anticipated changes in patient's condition.
PE ___ Evaluate results of nursing care.
IPR ___ Promote the inclusion of the patient's decisions and desires concerning his care.
PE ___ Develop a plan of nursing care for a patient.
PE ___ Initiate planning and evaluation of nursing care with others.
CC ___ Perform technical procedures: e.g., oral suctioning, tracheostomy care, intravenous therapy, catheter care, dressing changes, etc.
TC ___ Adapt teaching methods and materials to the understanding of the particular audience: e.g., age of patient, educational background, and sensory deprivations.
PE ___ Identify and include immediate patient needs in the plan of nursing care.
TC ___ Develop innovative methods and materials for teaching patients.
IPR ___ Communicate a feeling of acceptance of each patient and a concern for the patient's welfare.
IPR ___ Seek assistance when necessary.
IPR ___ Help a patient communicate with others.
CC ___ Use mechanical devices: e.g., suction machines, Gomco, cardiac monitor, respirator, etc.
CC ___ Give emotional support to family of dying patient.
IPR ___ Verbally communicate facts, ideas, and feelings to other health team members.
IPR ___ Promote the patient's right to privacy.
IPR ___ Contribute to an atmosphere of mutual trust, acceptance, and respect among other health team members.
L ___ Delegate responsibility for care based on assessment of priorities of nursing care needs and the abilities and limitations of available health care personnel.

IPR ___ Explain nursing procedures to a patient prior to performing them.
L ___ Guide other health team members in planning for nursing care.
L ___ Accept responsibility for the level of care provided by those under your direction.
CC ___ Perform appropriate measures in emergency situations.
TC ___ Use teaching aids and resource materials in teaching patients and their families.
CC ___ Perform nursing care required by critically ill patients.
TC ___ Encourage the family to participate in the care of the patient.
TC ___ Identify and use resources within your health care agency in developing a plan of care for a patient and his family.
IPR ___ Use nursing procedures as opportunities for interaction with patients.
IPR ___ Contribute to productive working relationships with other health team members.
IPR ___ Help a patient meet his emotional needs.
PE ___ Contribute to the plan of nursing care for the patient.
CC ___ Recognize and meet the emotional needs of a dying patient.
TC ___ Communicate facts, ideas, and professional opinions in writing to patients and their families.
TC ___ Plan for the integration of patient needs with family needs.
CC ___ Function calmly and competently in emergency situations.
L ___ Remain open to the suggestions of those under your direction and use them when appropriate.
IPR ___ Use opportunities for patient teaching when they arise.

Performance of Professional Development Behaviors

Instructions: Using the following key, please indicate on the line at the left of each item the number that best describes the frequency with which you engage in the following behaviors. Key:

1 - Seldom or never
2 - Occasionally
3 - Frequently
4 - Consistently

PD ___ Use learning opportunities for on-going personal and professional growth.
PD ___ Display self-direction.
PD ___ Accept responsibility for own actions.
PD ___ Assume new responsibilities within the limits of capabilities.
PD ___ Maintain high standards of self-performance.
PD ___ Demonstrate self-confidence.
PD ___ Display a generally positive attitude.
PD ___ Demonstrate knowledge of the legal boundaries of nursing.
PD ___ Demonstrate knowledge of the ethics of nursing.
PD ___ Accept and use constructive criticism.

In addition to your self-appraisal of your performance of these behaviors, we would like to have your immediate superior rate you on these same behaviors using the Employer Appraisal of Nursing Performance Form. Would you please provide us with the following information:

APPENDIX C

LETTER OF PERMISSION FOR USE OF TOOL

AJN AMERICAN JOURNAL OF NURSING COMPANY
555 WEST 57TH STREET • NEW YORK, NEW YORK 10019
(212) 582-8820

September 22, 1987

Donna Manzelmann, RN, MS
Assistant Professor
Grand Canyon College
3300 West Camelback Road
Phoenix, Arizona 85017-1097

Dear Professor Manzelmann:

Thank you for your letter of September 14, 1987.

You have permission to use the Six-Dimensional Scale of Nursing Performance reported in Dr. Patricia Schwirian's article titled, "Evaluating the Performance of Nurses: A Multidimensional Approach" in your research.

Please have our standard credit line appear as follows on any reprints:

> Copyright YEAR the American Journal of Nursing Company. Reproduced with permission from JOURNAL, MONTH, VOL., NO. All rights reserved.

Should you plan to microfilmor publish your research in the future, please inform us so formal permission applications can be filed.

We appreciate your interest and cooperation.

Sincerely,

Gloria Gay
Permissions Editor

/gmg

APPENDIX D

SURVEY OF NURSING PERFORMANCE

SURVEY OF NURSING PERFORMANCE

I. Instructions: This section contains a list of activities in which nurses engage with varying degrees of frequency and skill. For those activities that you perform in your current job, please indicate how well you perform them by using numbers from the following key:

1 - Not very well
2 - Satisfactorily
3 - Well
4 - Very well
X - Not expected in my current job

___Teach a patient's family members about the patient's needs.

___Coordinate the plan of nursing care with the medical plan of care.

___Give praise and recognition for achievement to those under your direction.

___Teach preventive health measures to patients and their families.

___Identify and use community resources in developing a plan of care for a patient and his family.

___Identify and include in nursing care plans anticipated changes in patient's condition.

___Evaluate results of nursing care.

___Promote the inclusion of the patient's decisions and desires concerning his care.

___Develop a plan of nursing care for a patient.

___Initiate planning and evaluation of nursing care with others.

___Perform technical procedures: e.g., oral suctioning, trach care, I.V. therapy, catheter care, dressing changes, etc.

___Adapt teaching methods and materials to the understanding of the particular audience: e.g., age of the patient, educational background, and sensory deprivations.

___Identify and include immediate patient needs in the plan of nursing care.

___Develop innovative methods and materials for teaching patients.

___Communicate a feeling of acceptance of each patient and a concern for the patient's welfare.

___Seek assistance when necessary.

___Help a patient communicate with others.

___Use mechanical devices: e.g., suction machines, Gomco, cardiac monitor, respirator, etc.

___Give emotional support to family of dying patient.

___Verbally communicate facts, ideas, and feelings to other health team members.

___Promote the patient's right to privacy.

___Contribute to an atmosphere of mutual trust, acceptance, and respect among other health team members.

___Delegate responsibility for care based on assessment of priorities of nursing care needs and the abilities and limitations of available health care personnel.

___Explain nursing procedures to a patient prior to performing them.

___Guide other health team members in planning for nursing care.

___Accept responsibility for the level of care provided by those under your direction.

___Perform appropriate measures in emergency situations.

___Promote the use of interdisciplinary resource persons.

___Use teaching aids and resource materials in teaching patients and their families.

___Perform nursing care required by critically ill patients.

___Encourage the family to participate in the care of the patient.

___Identify and use resources within your health care agency in developing a plan of care for a patient and his family.

___Use nursing procedures as opportunities for interaction with patients.

___Contribute to productive working relationships with other health team members.

___Help a patient meet his emotional needs.

___Recognize and meet the emotional needs of a dying patient.

___Communicate facts, ideas, and professional opinions in writing to patients and their families.

___Plan for the integration of patient needs with family needs.

___Function calmly and competently in emergency situations.

___Remain open to the suggestions of those under your direction and use them when appropriate.

___Use opportunities for patient teaching when they arise.

II. This section contains a list of sources of preparation for the role of nurse as teacher. For those sources that you have experienced, please indicate how well they prepared you by using numbers from the same key:

1 - Not very well
2 - Satisfactorily
3 - Well
4 - Very well
X - Not applicable

___Academic course objective

___Academic theory objective

___Academic clinical objective

___Orientation

___In-service education

___Other continuing education

___Preceptor

___Mentor

___Self-directed learning

___Specify source not listed:

_____

_____

III. Background information.

1. Please indicate the year in which you completed your basic academic preparation in nursing:

	year
Diploma in nursing	____
Associate degree in nursing	____
Bachelor's degree in nursing	____

2. Name the State in which you received your basic academic preparation in nursing. _____

3. Please specify additional degrees earned by type (for example, A.A., B.S., M.A., Ed.D., Ph.D.), area (for example, nursing, education, management), and year of completion.

	type	area	year
Associate degree	____	____	____
Bachelor's degree	____	____	____
Master's degree	____	____	____
Doctorate	____	____	____

4. Length of time you have been employed in your current position:

   years_____ months_____

5. Length of time you have worked in nursing:

   years_____ months_____

6. Your work shift:

   day_____ evening_____ night_____ rotate_____

7. Year of your birth: _____

APPENDIX E

INSTITUTIONAL PERMISSION

ST. JOHN MEDICAL CENTER
Medical Excellence · Compassionate Care

August 19, 1987

Donna Manzelmann, R.N., M.S.N.
10287 East San Salvador Drive
Scottsdale, Arizona 85258

Dear Donna:

The Nursing Research Committee has reviewed and approved your proposal. Two of the members are Sr. Agnes Basgall and Becky Hale, and they both had very nice things to say about you and your project.

I have asked Benda Hamilton to coordinate distribution of the questionnaires, and I will be your primary contact for the project.

I look forward to receiving the questionnaires, and good luck on your project.

Sincerely,

Marlene

Marlene McAllister, R.N., M.S.N.
Director, Research & Development

MM/mjw

Enclosure

1923 South Utica Avenue · Tulsa, Oklahoma 74104 · (918) 744-2345

APPENDIX F

COVER LETTER

August 5, 1987

Dear Colleague,

I am a registered nurse conducting a research study about nurses' perceptions of how well they perform in certain roles. The trend in health care of discharging clients with more complex self-care needs has emphasized the importance in identifying those factors which affect nursing performance in certain roles.

As a nurse practicing within the first two years following graduation from nursing school, you are among those who can best contribute information to this project. Please take 15 minutes and complete the following survey in the order in which it was prepared. To eliminate any bias, it is best that you not discuss any aspect of this research study with other nurses.

Your name is not required on the survey. Your response is strictly anonymous.

You will receive a summary of the project results. Just fill out the enclosed postcard and return it to me and I will send you a copy.

Return the completed survey in the pre-addressed, stamped envelope at your earliest convenience, preferably by Sept. 15, 1987.

Thank you for participating.

Sincerely,

Donna Manzelmann

Donna Manzelmann
R.N., M.S.

Enclosure

APPENDIX G

COMMUNICATION MEMORANDUM

MEMO TO: HEAD NURSES

FROM: DONNA MANZELMANN RN, MS

TOPIC: DISTRIBUTION OF PACKETS

Thank you very much for your assistance in my research project. The packets are to be distributed to R.N.'s in general medical/surgical units who are practicing with less than 2 years of clinical experience. Omit critical care units, rehab, and psych. Each brown envelope is a packet. It includes the survey, a pre-addressed stamped envelope, and a postcard for requesting a summary of the project results. Hillcrest will automatically receive the results. Nurses who participate in the study are not identified and anonymity is maintained. Just distribute the packets to those nurses who fit the sample population. They can decide if they wish to participate. However, a little encouragement from you would be appreciated. Please keep a record of how many packets you distribute and give that information to Carol as I need that information in the study.

I sincerely appreciate your efforts on my behalf. Thank you.

VITA

Donna Smith Manzelmann

Candidate for the Degree of

Doctor of Education

Thesis: THE RELATIONSHIP OF SOURCES OF PREPARATION TO PERCEIVED PERFORMANCE IN TEACHING ROLE ACTIVITIES OF RECENTLY GRADUATED REGISTERED NURSES

Major Field: Occupational and Adult Education

Biographical:

Personal Data: Born in Tulsa, Oklahoma, July 18, 1949, the daughter of Betty Jane Just Smith and Grover Hayward Smith.

Education: Graduated from Owasso High School, Owasso, Okahoma, 1967; received a Bachelor of Science in Nursing degree from The University of Oklahoma, Norman, Oklahoma, in 1971 received a Master of Arts degree from The University of Tulsa, Tulsa, Oklahoma, in 1976; received a Master of Science degree from The University of Oklahoma Health Sciences Center, Oklahoma City, Oklahoma, in 1985; completed requirements for the Doctor of Education degree in Occupational and Adult Education, with an emphasis in Adult and Continuing Education, at Oklahoma State University, Stillwater, Oklahoma, in May, 1988.

Professional Experience: Staff Nurse, Hillcrest Medical Center, Tulsa, Oklahoma, 1971-1972. Staff and Head Nurse, Paramount General Hospital, Paramount, California, 1972-1973: Head Nurse, Presbyterian Intercommunity Hospital Whittier, California, 1973-1974; Instructor, Hillcrest Medical Center School of Nursing, 1974; Instructor in Nursing, The University of Tulsa, 1974-1975, Instructor in Nursing, Tulsa Junior

College, 1975-1976; Director of Nursing Education, and Project Director, Creative Specialist's Inc., Tulsa, Oklahoma, 1976-1985; Instructor in Nursing, Tulsa Junior College, 1985; Manager of Patient Intervention Services and Stroke Team Coordinator at Saint Francis Hospital, Tulsa, Oklahoma, 1985-1987; Assistant Professor of Nursing at Grand Canyon College, Phoenix, Arizona, 1987 to 1988.

Professional Organizations: American Nurses Association; Arizona Nurses Association; National Safety Council, Health Care Section, ANPAC

Honors: President's Leadership Class, The University of Oklahoma; Sigma Theta Tau, International Honor Society of Nursing; W.K. Kellogg Fellow